CHAPTER-1

Conceptual Framework

Much is being said and written on population, fertility behaviour, birth control, family planning or family welfare programmes or the more recent *avatār* reproductive health\(^1\), that any attempt to enter in this arena, the research worth and uniqueness immaterial, seems to be on beaten tracks and needs ‘overt justification’ even before the start. Almost, two and half decades earlier Bose himself felt strongly to justify the necessity of his voluminous *From Population to People* because, to borrow his own words, ‘an information explosion has overtaken the population explosion.’\(^2\) In fact, the decade’s 1960s-70s\(^3\) and even 1980s did witness a spate of books and edited volumes each *par excellence* and each recalled that the bulk of literature on subject was written even before the Indian Independence\(^4\). A great many bibliographies were prepared listing number and nature of population studies undertaken specially after 1951-52 i.e. official launch of family planning programme. The

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\(^1\) The ICPD (International Conference on Population and Development) definition of Reproductive Health (RH) is: A state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. See UN, "International Conference on Population and Development, Cairo, Egypt, Sep. 5-13, 1994," (United Nations (A/CONF. 171/13), 1994).


\(^4\) The term here is simply used to highlight the urgency of problem and to distinguish the studies that were undertaken before and after Indian Independence from British yolk in 1947.
question becomes further important as the closing eyes of the previous millennium witnessed International Conference on Population and Development (in 1994 at Cairo, Egypt) which marked the paradigm shift with passionate addition and deletion of ‘terms’, ‘concepts’ and ‘strategies’ to usher with a new ‘Plan of Action’. The new millennium witnessed influx of studies dwelling on ICPD plan of action and rhetoric for individual and reproductive rights; client-centred, demand driven and target free approach. Furthermore, World Conference on Women (in 1995 at Beijing, China) also stressed the ‘explicit recognition and reaffirmation of the rights of all women to control all aspects of their health, particularly fertility’. Thus, further flattening the size of question mark on the rational of study, that also one which dwells on family welfare programmes and the determinants of contraceptive adoption? There is yet another important and interesting question quite authoritatively being posed that there is nothing like a population problem, and this question accordingly questions the very relevance of a study on family planning. They boldly quote that ‘development is the best contraceptive’ (without knowing

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5 Today, there is so much concern and apathy to data, targets and number-settings (like reduction in birth rate, CPR and TFR achievements) that Bose titled his most recent work as Beyond Demography and argues that many of technical demographers, both in India and abroad, get so engulfed by data that they often fail to dwell on the more important non demographic issues, particularly, socio-cultural practices. See Ashish Bose, Beyond Demography- Dialogue with People (Delhi: B.R. Publishing Corp, 2006), Preface, p. ix. Elsewhere he has described family planning target chasing (for ‘ease’) as a disease which he calls targetitis. See Ashish Bose, “The Family Welfare Programme in India: Changing Paradigm,” in The Family Welfare Programme in India, ed. Hari Mohan Mathur (New Delhi: Vikas Pub. House in association with the HCM Rajasthan State Institute of Public Administration, 1995), p. 8.


7 This much quoted slogan was given by Dr. Karan Singh, then Minister of Health and Family Planning, Government of India at World Population Conference (Bucharest, 1974). Interestingly, same Minister back at home in 1976 formulated and executed a population
how much steadfast to it was the very person who gave this mantra. At this juncture, suffice it is to take recourse in Asok Mitra’s apt assertion, ‘wholly unnecessary and harmful rigid postures have been taken. Champions of economic growth have ignored the harmful effect of runaway population growth. Champions of population control have underestimated the utter necessity of economic growth. Few have stressed that economic growth and population control are the two sides of the same coin...........Overstatement in any direction can create undue optimism with its inevitable backlash of disappointment and despair and nothing is so hurtful to a nation’s progress as pessimism and loss of self confidence [italics mine].’

Talwar similarly noted that the role of population becomes very crucial in the economic growth of countries like India where resources are already over stretched to meet the current needs of the population.

Interesting are many more questions, most of which are adequately answered by a plethora of past studies, but few questions seem to be quite perennial and hence, pave way for the present research. The subsequent paragraphs will unearth, with parsimony to abundant literature, the necessity of this study.

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policy which contained ‘a permissive clause for the states to introduce compulsory sterilisation, if they want to do so.’ See Bose, From Population to People, p. xxii.


1.1 Understanding Global Population Debates— from pre-Malthusian prescriptions to Malthusian prognosis and neo-Malthusian ascendancy

The historical studies abound discussion on mortality.\textsuperscript{10} However, during the latter part of the 20\textsuperscript{th} century, one of the three main processes of population, fertility which has more than the other two processes, that is, mortality and migration, attracted attention for research and policy purposes.\textsuperscript{11} This increasing fervent of population studies (or more specifically studies on population growth) rests on Malthusian pessimism of historic past and prospective neo-Malthusian takeover. However, there was also the period when population growth was a welcome omen turned upside-down as Malthusian mantras became acceptable. This sub-chapter, although restricted only to fertility as one of population processes, attempts a panoramic view of population debates from pre Malthusian prescriptions to Malthusian prognosis and thereafter series of post Malthusian melodies making Malthus immortal. The forthcoming paragraphs in this sub-chapter rely heavily on a very recent work of Rao\textsuperscript{12}, from population control to reproductive health, which (as one of the reviewers noted) is a powerful history and critique of population control in India.

Pre-Malthusian Prescriptions

Unlike the present day population growth puzzle, there was also a time when population growth was symbolic of nation’s robustness. For example, French intellectuals of eighteen century pondered over the scarce population of their country and large population and imperial might of England. Montesquieu was one of the most influential writers on the population question at this time. His work *Lettres Persanes*, published in 1721, made a profound impact on Enlightenment thinkers. In his view, ‘the French nation was degenerate and the population, therefore declining’ and further comparing the contemporary France to a supposedly populous ancient Greece, he argued that ‘a government must be concerned with increasing the population through the provision of employment. This coupled with political liberty led, in his view, to the wealth of a nation.’ Further on population dynamics, Marquis de Mirabeau, the author of *The Friends of Mankind*, or Treatise on population (1756), argued, ‘population was one of the essential requirements for economic growth and that the function of state policy should be to induce population growth.’ Furthermore, the population growth was even taken as a yardstick for good governance. For example Jean-Jacques Rousseau in *Du Contrat Social* (1962) wrote, ‘the rest being equal, the government under which, without external aids, without naturalisation or colonies, the citizens increase and multiply most

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14 Cited in Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 76.

15 Cited in Ibid., p. 76.
is beyond question the best.'¹⁶ By the late eighteenth century, however, the
perception of the population question had altered fundamentally. The reasons
for this shift in the perception are enormously complex and are to be sought in
the socio-economic milieu of those turbulent times.¹⁷ Here onwards, Malthus
among other contemporaries/ predecessors emerged as historical actor to
reshape views on population growth.

Malthusian Prognosis

Malthus became immortal with the publication of his masterpiece *An Essay on
the Principle of Population as It Affects the Future Improvement of Society
with Remarks on the Speculations of Mr. Godwin, M. Condorcet and Other
Writers* in 1798. He forwarded two basic propositions: ‘First, that food is
necessary to the existence of man. Secondly, that the passion between the
sexes is necessary and will remain nearly in its present state.’¹⁸ According to
Rao, Malthus went to write ‘one of the most famous, or notorious, passages in
the social science’ and that:

> Assuming my postulates as granted, I say, that the power of
> population is indefinitely greater than the power in the earth to
> produce subsistence of man. *Population, when unchecked,
> increases in a geometric ratio. Subsistence increases only in an
> arithmetic ratio.* A slight acquaintance with numbers will show

¹⁶ Cited in Ibid., p. 76.
¹⁷ Ibid., p. 78.
Population Control to Reproductive Health: Malthusian Arithmetic*, p. 79.
the immensity of the first power in comparison of the second [italics mine].

With this prognosis, Malthus delineated the counter checks and noted when numbers grow beyond that point, the growth of population is halted by the two means; one he called the positive checks, that is, hunger, famines, and pestilence; and the other, preventive checks, that is, a foresight of the difficulties attending the rearing of a family acts as a preventive check. The former inevitably and 'naturally', fall on the lower classes of society. To attempt to raise the standard of living of the lower classes by increasing wages would, through the operation of the law of nature, be render ineffectual. Their population would then only increase further, till checked by a subsistence crisis. Rao noted thus emerges an iron law of wages: the subsistence wage is the just wage, because if wages are higher, population growth occurs till checked by poverty. Poverty, then, was 'seen as a natural condition of human existence and not as a product of human institutions. The role of the poor was to accept misery for 'the misery that checks population falls chiefly, as it always must do, upon that part whose conditions is lowest in the scale of society. The rich are in no way responsible for poverty; they are enjoined not to exert themselves to do something about it for no possible contributions or sacrifices of the rich, particularly in money, could for any time prevent the recurrence of distress among the lower members of society.' Malthus was also very forthright in his view: "the truth is that the pressure of distress on this

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21 Cited in Ibid., p. 80.
part of the community (viz. the lower classes) is an evil so deeply seated that no human ingenuity can reach it.\textsuperscript{22} In the second edition of his essay in 1803 he even argued that the poor have no moral right to relief.\textsuperscript{23} Amartya Sen\textsuperscript{24} drawing attention to the pessimism in Malthus as opposed to reason optimism in Condorcet, points out that:

The difference in approach between these thinkers on the population question becomes even more apparent when we think of solutions. Condorcet would thus call for the absence of Malthusian fatalism, and the willingness to look for solutions to difficult social problems, rather than accepting the inevitability of misery. This would also mean a rational search for the effectiveness of alternative social and economic policies. Above all, it would mean keeping faith in the voluntary, reasoned, decisions of people rather than any element of compulsion in decisions involving fertility.

Rao also lashes on Malthusian premises and argued, 'the major propositions, or assumptions, that population when unchecked grows in a geometric ratio while food can grow only in an arithmetic ratio, the foundation of the Malthusian edifice, are, in fact, entirely arbitrary. It is on the basis of these arbitrary propositions that the entirely complex issue of the relationship between resources and population is examined [italics mine].'\textsuperscript{25} He further noted 'the nineteenth century English experience of a surge in population

\textsuperscript{22} Cited in Ibid., p. 81.
\textsuperscript{23} Cited in Ibid., p. 82.
\textsuperscript{25} Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 85.
accompanied by rising per capita income, discredited the ideas of Malthus. As England completed her industrial and health revolutions, and as birth rates subsequently commenced a secular decline, Malthusianism lost its bite, its urgency, its pungency. It was not, however, put to deserved rest. _It continued to be resurrected as an explanation of poverty in other parts of the world_ [italics mine].

Rao’s assertion will get more weight as the next few paragraphs of this sub-chapter briefly dwells on the ‘new avatars’ of Malthus-eugenics, birth controllers and the true ‘heir’ neo-Malthusians.

**Eugenics Quest and Debacle**

Like Malthus _Essay_, there is another classic that is, *Descent of Man* by Charles Darwin (published in 1871). Darwin’s enunciation of the principle of _survival of the fittest_ has inspired (both positively and negatively) many movements, of which, eugenics movement was no exception. Like the two fold Malthusian propositions, the eugenics had as their prime concerns- ‘racial purity and improvement of the racial stock’ [italics mine]. The eugenics movement was named by one of its illustrious founders, a cousin of Darwin’s, Francis Galton. Galton inaugurated the Eugenics Educational Society and brought out a journal called _Eugenics Review_. He was also responsible for the founding of the biometric laboratory at the University College, London and its journal _Biometrika_. Rao noted, ‘Galton’s passion was the application of statistics to data on genealogies and the collection of data on the lineage of the pedigreed. _He was firmly committed to the idea that only the bright and best should be_”

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26 Ibid., p. 90.
27 Ibid., p. 93.
encouraged to breed [italics mine].^28 Jane Hume Clapperton published the principal text of the eugenics, *Scientific Meliorism* in 1885. She went to write:

The racial blood shall not be poisoned by moral disease. The guardians of social life in the present day dare not be careless of the happiness of coming generations; therefore the criminal is forcibly restrained from perpetuating vicious breed...........To promote the contentment of congenital criminals within their prison home, where they are detained for life, an alternative to celibacy might be offered, viz. a surgical operation rendering the male sex incapable of reproduction.^29

Given the overwhelming influence of Darwin (indeed the age is frequently referred to as the age of Darwin), it is not surprising that many commentators of this time introduced Darwinian metaphors to social arrangements. Social Darwinists, believing that biology was destiny, at least for the poor, thus began to identify an extraordinary series of social and of behavioural facts as inheritable. It was not far from this to asserting that only ‘fit’ should be encouraged to procreate and that the ‘unfit’ discouraged.^30 This wave of thoughts did also attract Adolf Hitler. His cabinet promulgated a Eugenic Sterilisation Law in 1933 to ‘prevent poisoning the entire bloodstream of the race.’^31 Soon eugenic policies merged with racial policies resulting into Hitler’s horrible final solution. However, precedent for eugenic laws in Germany had in fact, been set in the US. Dr. Harry C. Sharp, physician to the Indiana State Reformatory in 1899 pioneered the sterilisation of the unfit by

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^28 Ibid., p. 93.
^29 Cited in Ibid., p. 93.
^30 Cited in Ibid., p. 94.
^31 Cited in Ibid., p. 95.
vasectomy. The first state to pass sterilisation laws was Indiana in 1907. Eugenics were scientifically discredited by that famous biologist J.B.S. Haldane. But it was Herman Muller's discovery of mutation in the early 1940 that demanded it of the very last vestiges of scientific respectability. The eugenic lobby now turned to what they called crypto-eugenics or population control.\textsuperscript{32} It may be added that eugenics having also been maligned due to the 'final solution' went underground and disguised themselves to be reborn as the propagators of birth control movement.

Birth Control Movements

It is rightly noted that various streams of thought jostling uneasily with one another, congealed, into the birth control movement in the nineteen-century gathering strength in the early twentieth century.\textsuperscript{33} Rao tracked four such major streams.\textsuperscript{34} One stream was that of the radical feminists, tracing their descent in modern times to Marry Wollstonecraft's publication in 1792 of The Vindication of the Rights of Women. These persons believed, and believed strongly, that it was women's right to control their own destinies, their own bodies. Access to birth control, then banned, was one element in their larger struggle for democratic rights. The second stream was that of the socialists. Their ideas on birth control were coloured by the feeling that the burden of repeated pregnancies was harmful to the health of working women; and by the belief that it was in the interests of capitalists, who needed an unlimited supply of cheap labour, and not of the working class, to have large populations.

\textsuperscript{32} Cited in Ibid., p. 99.
\textsuperscript{33} Ibid., pp. 99-100.
\textsuperscript{34} Ibid.
Further, on the question of Marxism *per se* and birth control B. Z. Urlanis noted, ‘world literature widely expresses the view that Marxism does not recognise birth control and is opposed to its practice. In fact this is not so at all.’ He argues that Engle’s very clearly expressed himself on this question is his letter to Kautsky dated 18 February, 1881. In this letter he wrote that if communist were ever forced to regulate the production of people it could do so without difficulty. Later on, in that letter Engle’s reminded Kautsky that the process of birth regulation is already developed in France and lower Austria. He concluded that Soviet demographers believe that together with an economic solution there must also be a demographic solution, that is to say, a lowering of birth rates by means of an effective demographic policy. The aim of such policy must be to spread planned families, and this implies the use of birth control by the population. Moreover, Marx and Engles, besides reserving a number of choice epithets for Malthus argued that there is no fixed, universal, eternal law of population. Marx noted ‘social factors create a law of population peculiar to the capitalist mode of production’, adding that ‘in fact every particular historic mode of population has its own special laws of population, historically valid within that particular sphere.’ Interestingly, we are also being reminded of the dismal fact that the issue of birth control is the only one in which the Vatican and the Kremlin are in

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36 Ibid., pp. 287-288.

agreement. The third and important stream, which came to dominate the birth control movement, was that of the neo-Malthusian. Finally, the last and least significant was an offshoot of the Romantic movement, the free lovers who believed in the liberating powers of the sexual act which they believed should be untrammelled from its association with procreation. However, as Rao noted these contending tendencies produce certain inbuilt tension in the birth control movement. The movement was ultimately taken over by the neo-Malthusians by the 1920s. Thus, neo-Malthusian ascendancy merits further discussion.

**Neo Malthusians Ascendancy**

The late nineteenth century witnessed the birth of a new ‘avatar’ of Malthusianism, namely, neo-Malthusianism. Malthusianism and neo-Malthusianism are not conceptually or methodologically distinct. They differ in, so far as the victims of their ideas or methods are concerned. While Malthusians were concerned with the poor of their own countries, neo-Malthusians looked across the seas at the poor in developing countries. And while Malthusians spoke of moral restraint neo-Malthusians came equipped contraceptive technology. Margaret Sanger, an American nurse, possibly did more than anybody else to ultimately put birth control on the world agenda. Powerful and influential, she has been described as the ‘messiah of

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40 Ibid., p. 92.
medicalised birth control.' She brought out a pamphlet entitled *Family Limitation* in 1914. Her primary aim was to limit what she perceived as the excessive fertility of the poor. Large families, Sanger wrote, are associated with poverty, fighting, jails; the small ones with cleanliness, leisure, freedom, light, space, sunshine. Her most famous book was the 1920 publication *Women and the New Race*, an orthodox tract of eugenics: 'First, stop the multiplication of the unfit. This appeared the most important and greatest step towards race betterment.' She founded the American Birth Control League in 1921, a national organization for medicalised birth control. In 1925, she organised the International Neo-Malthusian and Birth Control Conference in New York bringing together leading eugenics and birth controllers and in 1927, the First World Population Conference in Geneva, which brought together American and European eugenics and Neo-Malthusians. In 1935 Sanger undertook a triumphant tour across India. In 1940 Henry Pratt Fairchild, President of the American Eugenics Society, told the annual meeting of the Birth Control Federation, the new incarnation of the American Birth Control League. This momentous marriage had the financial backing of American corporate capital that had earlier supported eugenics: Gordon notes that 'in no academic field was the coalition between corporate capital and scholars developed more fully than in eugenics.' It is this co-option of eugenics into birth control movement on one hand and eugenics debacle in Europe due to the Nazi’s penchant ‘support’ for it, on the other, all attention turned to third-world countries. Thus, post-world war era witnessed huge

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41 Ibid., p. 101.
42 Ibid., 108.
inflow of funds for population control in third world countries. However, before going into the details of population control dynamics in the third world, few words on a theory that was developed out of the decades of these movements and which, later provided justification and inspiration for the population lobbies, seem pertinent.

The edifice on which birth control movement, (more specifically neo-Malthusians) rested and took succour was the theory of demographic transition which was presented as general theory of population. Cowgill has presented a brilliant sketch of how the transition theory evolved from Pearl and Reed (1920) logistic Curve theory to Thompson (1929) and Notestein (1945) demographic transition model i.e. different stages of progression through the transition: "High potential growth", "Transitional" and "Incipient Decline". Cowgill (1963) made this implicit dynamics, explicit and noted, "transition theory deals with two conditions of stability and one of change. It asserts that the modern growth cycle is essentially a transition from: stage 1, under which both birth and death rates are under a minimum of human control, through stage 2, the period of growth, to stage 3, under which both birth and death rates are extensively controlled and are balanced at a low level." In 1970 Cowgill warned for correlating and drawing inspiration from European demographic transition, which deserve lengthy quotation as under:

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The conditions in the developing countries since World War II definitely and emphatically do not parallel the experiences of the European countries on which the transition theory (and Pearls application of logistic curve) was based. Whereas it took European countries 150 to 200 years to reduce their death rate below 15, this is being done in developing countries now in 15 or 20 years. The European countries had to invent their technology of death control as they developed economically; in the developing countries today, all of this technology of death control can be imported practically overnight and this is almost literally what is happening. It took 150 to 200 years for European countries to cut their birth rates below 20. So far, there is little indication of declining fertility in developing countries, even though some of them are consciously attempting to bring this about.

If it is appropriate to call the demographic change in Europe over the last two centuries "demographic transition", it is certainly not appropriate to use the same term for what is happening in the developing countries today. A one per cent rate of increase is definitely different from a three per cent rate of increase. A fifty per cent reduction in the death rate in a hundred year is quite different from a fifty per cent reduction in ten years. What is happening in the developing countries is not a "transition"; it is, Kingsley Davis has said an "explosion".

The developing nations are involved in a growth process which is entirely new in human history. They dare not rely on models developed in past centuries on the basis of European countries. They must blaze their own trails. the only reasonable and rational course, under these circumstances is to make the maximum use of the technology of birth control, indigenous or foreign, in the effort
to bring the birth rates within economically digestible range of death rates [italics mine].

Khan also supports the above logic and argued that while the analysis of the demographic transition in western countries do provide us some clues to the understanding of fertility behaviour, their reasoning may not be applicable for our study (or perhaps for any study in a developing society). There are some basic differences in the social structure of western countries and Indian society (representing the developing countries). India, Talwar noted, in its journey towards demographic transition has assumed a unique profile of its own because of its living pattern wherein 74 per cent of its people live in 600000 plus villages, several of them remotely located, with typical social and cultural practices. It is also argued, ‘the problem of population growth in India is essentially a regional problem. The future decline in the growth rate of Indian population would largely depend on the decline in the birth rates of the major states like Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan and Haryana.’

1.2 The Third World Population—dynamics of population growth, birth control and development

A. R. Desai, the renowned Indian sociologist in his brilliant critique of family planning published in 1980, made a very exhaustive survey of literature on


48 Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 32.

family planning, including the changing perspectives on family planning in the
developed countries, and their increasing concern for the population of third
world countries, and summed the scenario as:

From the inception, the Government of India, along with all the
Third World governments, as well as the prime “aid” giving,
developed imperialist countries of the First World, have
assumed that the chief reason for backwardness,
underdevelopment and the inability of the Third World
countries to cross the threshold of take-off and become
developed, prosperous societies, is the runaway population of
these countries, experiencing a demographic transition, due to
rapid decline in death rate not paralleled by similar decline in
“Unprecedented Trend in population increase as a dreadful
mirage to the future development of the Third World” and
various other catch phrases evolved to highlight the need for
population control, clearly point to the central assumption of
the family planning movement launched by the Government of
India, along with a number of countries in the Third World.
This assumption can be stated thus. Rapidly growing
population is the chief obstacle to the plans of development of
the Third World countries, by eating up the little available
fruits of development, as well as by minimizing the “Saving”
and “Investment” potential of the already “overpopulated,
Third World”. ..........In fact, eminent theoreticians and policy
makers have pointed out that first “decade of hope” viz; fifties,
due to inability to control the population explosion,
transformed sixties into a “decade of despair”. And the third
decade viz; seventies, because of still unabated population
explosion is becoming a decade of tensions and social
explosions, leading to near "Breakdown of modernisation."
The situation with regard to "Population" according to the theorist of and policy makers of the First and the Third World countries, wedded to specific path of development has reached such a critical stage that the UN designated year 1974 as the World Population Year.  

With this account of history, Desai lashed on the "population control" objective in India and also in large number of Third World countries and argued that it liberates the government from the task of providing necessary infrastructural matrix for a family even to survive not to talk of a better and balanced life, and to perform, along with its replacement function, other functions properly. He quoted J.C. Kavoori who described the 'population control' as the 'sickness syndrome' for the family planning programme. However, before dwelling on the limitations of the family planning programme, which will be discussed in the later sections, let's have a wider and in-depth understanding of how the chase for wild goose (i.e. population control and development) started in third world countries in general, and India in particular.

The Third World Population- international intellectual debates, donor agencies and lobbies

Davis noted that most observers are surprised by the swiftness with which concern over the population problem has turned from intellectual analysis and

51 Ibid., pp. 139.
debate to policy and action. Much of the credit (or blame) goes to 'over supply' of money from international donor agencies that prevailed over the post- World War scenario. Demerath and Hudson have thoroughly pondered over the manoeuvre of these donor agencies. For example, Demerath noted with the co-option of eugenics into the population control movement, funds began flowing, initially from the Ford Foundation and Rockefeller Foundation, into demography as an academic discipline and its policy counterpart, the population control lobby. Between 1952 and 1975, the Ford Foundation spent more than $150 million on population control. Of this, about $80 million went into research and training in reproductive biology. About $35 million was use to finance family planning programmes. Indians received more than $20 million. Hudson has also drawn attention to establishment of Population Council by John D. Rockefeller in 1952 and thereafter much impetus to population research. For example, Population Council stated publication of journals (still the leading journals), Studies in Family Planning, and Population and Development Review. Likewise, Ford Foundation provided seed capital for Demography, and USAID funded publication of the International Family Planning Perspectives. The forthcoming paragraphs of this section will dwell on the dynamics of population control movement in pre and post independent India.

Lobbying in Pre Independent India – responses and reactions

P.B. Desai has very brilliantly outlined the history of India’s population policy. He noted:

Faint beginnings of the birth control movement can be traced to the early twenties. Beginning with the attendance of Indian representatives in the first international birth control conference in London in 1922 and the New York birth control conference in 1925, the birth control movement in India became progressively more organised until its culmination in the formation of the Family Planning Association of India in 1949 (it was first christened as Family Planning Committee later in 1951 renamed to Family Planning Association of India). This Association convened the first All-India Conference on Family Planning in 1951 under the Presidentship of Professor S. Chandrasekhar and also organised in 1952 in Bombay an International Conference on Family Planning which was inaugurated by Vice-President Dr. S. Radhakrishnan. Important among the intervening events contributing to the growth of interest in family planning were: the founding of the Neo-Malthusian League in Madras in 1928; Mysore Government’s step to direct State hospitals to give birth control advice in 1930 (interestingly this move of Maharaja of Mysore, became historical as ‘the world’s first


57 Rao also noted that the FPAI (Family Planning Association of India) has been a major force shaping population policy in the country. Indeed it takes credit for playing an active note in inducing the first Planning Commission to incorporate family planning in health. Financial assistance to the FPAI is largely provided by international agencies, particularly the Rockefeller Foundation supported International Planned Parenthood Foundation (IPPF); in 1982 the FPAI received a project grant of US $ 2,782,000. See Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 109.

58 Additions in parenthesis are mine.
Government-sponsored birth control clinic); the founding of the Family Hygiene Society and of the Journal of Marriage Hygiene by Pillay in 1935; the discussion of the question of birth control by the Lucknow Population Conference in 1936; the nation-wide tour of Margaret Sanger in the same year; the convening of the First Family Hygiene Conference in conjunction with the Second-All India Population Conference in 1938 (it was organised by Lady Rama Rao and Sanger); and the strong recommendation of the Health Survey and Development Committee for taking up propagation of family planning as an official responsibility.

Desai went on presenting the vivid account of lobbying by Margaret Sanger (in which she was to certain extent successful61) and her fruitless persuasion of Gandhi to support family planning. However, Gandhi made his position very clear, as Desai quotes him, ‘there can be no two opinions about the necessity of birth control. But the only method handed down from ages past is self-control or Brahmacharya. It is an infallible sovereign remedy doing good to those who practice it.’62 As a result of surcharged atmosphere, the Indian National Congress also pondered over the issue of growing population. The President of 1938 Session of Indian National Congress, Subhash Chandra Bose, pointed out in his address that ‘where poverty, starvation and disease are stalking the land, we cannot afford to have our population mounting up by

59 Added from Rao, From Population Control to Reproductive Health: Malthusian Arithmetic., p. 108. However, as individual initiatives, Karve opened the first family planning clinic in India in 1925.

60 Self addition, it may also be noted that Lady Rama Rao was instrumental in the formation of FPAl and was its founding President. Cited from Ibid., p. 109.

61 Rao also acknowledged the over all success of Sanger minus Mahatma Gandhi, when he writes, ‘Sanger undertook a triumphant tour across India, winning friends and influencing people, although she left Mahatma Gandhi singularly unimpressed.’ See Ibid., p. 108.

thirty million during a single decade.....It will therefore be desirable to restrict
our population until we are able to feed, clothe and educate those who already
exists. As its President, he constituted the National Planning Committee
(NPC) under the chairmanship of Pandit Jawaharlal Nehru, which considered
the report of its sub-committee on population in May 1940 and adopted
several resolutions two of which were- ‘i) We agree with the view that the size
of the Indian population is a basic issue in national economic planning, in so
far as its unrestricted increase, out of proportion to means of subsistence,
affects adversely the standard of living; and tends to defeat many social and
ameliorative measures; and ii) In the interest of social economy, family
happiness and national planning, family planning and a limitation of children
are essential, and the State should adopt a policy to encourage these. It is
desirable to lay stress on self-control, as well as to spread knowledge of cheap
and safe methods of birth control. Birth control clinics should be established
and other necessary measures taken in this behalf and to prevent the use or
advertisement of harmful methods.” During this period impetus also came
from a strong lady, Lakshmibai Rajwade, who was very instrumental in
shaping the above recommendations. Rao aptly commented on the same:

At a time when no nation in the world sponsored a family
planning programme, Lakshmibai Rajwade forcefully argued
the case for the inclusion of birth control, provision of goods,
instructions, demonstrations and consultations in maternal and
child health services. She (Rajwade) argued birth control is

63 Cited in Ibid., pp. 401-402.
64 National Planning Committee., “Population: Report of the Sub- Committee,” (Bombay:
Population Policy.,” pp. 401-402.
obviously a very important function in view of the fact that the high mortality among mothers and children is in part due to too frequent pregnancies involving a terrific strain on the nerves and on vitality already abnormally low.\ldots\ldots. The reproductive system has to be kept fresh and vitalised to respond creatively and must not therefore be subjected to that strain. That can only be done by controlling pregnancy by contraceptive methods \[italics\text{ mine}\].\footnote{Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, pp. 19-20.}

Desai rightly argued that the recommendations of the National Planning Committee were taken up in 1951, when the Congress Government of the new Republic of India introduced Central Planning as an instrument for social and economic development.\footnote{Desai, "The Perspective of India's Population Policy.", p. 401.} In the same stream the famous Health Survey and Development Committee, eponymously and commonly known as the Bhore Committee, was established in 1943. According to Rao, the Committee recognised 'health as a right of all citizens, irrespective of their ability to pay' and that 'notwithstanding financial constraints, the state could, and ought to, invest 10 per cent of its resources on health'.\footnote{Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 24.} Further noting that declines in birth rates had not followed declines in death rates, the Committee concluded that India was indeed confronted with a population problem that could have grave consequences, as 'uncontrolled growth of population would outstrip the productive capacity of the country'.\footnote{Cited in Ibid., p. 24.} Thus, on the very eve of Indian independence the ground was ready for the long series of matches to be played to curb the population growth.
No less were the researches undertaken during this period. Ashish Bose attempted a sketch of the moorings of population studies and shown that there was no dearth of studies on population even in pre-independent India but most of these focused on the ‘relationship between population and food’ and few scholars even (in early 1930s) went to extent of developing the ‘theory of optimum population.’ As early as 1946, Chandrasekhar lamented ‘the air today is thick with shouts of planning. blue prints and plans galore are offered for present post-War agriculture planning, industrial planning, educational planning and so on. While planning in all these fields is relevant and necessary there has been no talk of specific population planning [italics mine].’


71 Chandrasekhar, India's Population- Fact and Policy., p.75.
Post-Independent India’s Proactive Family Planning Initiatives and Donor Agencies

With the dawn of independence, the government of teeming millions with millions of problems made tryst with increasing population and launched under the “rubric of Family Planning” a comprehensive multi-sided programme to control the growth rate of population, and accordingly achieved the dubious ‘distinction of being the first national government in the world to adopt family planning as an integral part of its socio-economic development plans in 1952.’ Thus, ‘from the early days a family planning programme was envisaged as an integral part of a comprehensive social development programme.’ In the General Report on the post-independence first Census, R. A. Gopalaswami, the Registrar General of India, sounded a note of warning that ‘unless population was checked the future was indeed bleak.’ Before dwelling further on the problem of population growth, which today sounds more of rhetoric, it is wiser to first look at the pattern of population growth. Talwar noted four distinct periods in the pattern of population growth, which deserve full quote:

_The first is between 1901-1921 when the population remained almost stationary with both birth and death rates at very high levels of 45 and over per 1000 population. The year of 1921 is_

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72 Desai, _Urban Family Planning in India_, p. 125.
76 Talwar, "Determinants and Consequences of Rapid Population Growth.", pp. 35-36.
a period of great divide in the demographic history of India when mortality started to decline leading to acceleration in the rate of population growth. The next three decades 1921-51 represent the second period of population growth in India when the rate of population growth continued at a level of over one per cent per annum. The acceleration in the rate of population growth was contributed by decline in mortality with the disappearance of plague and improved control of cholera and other infective diseases. The slight dip in growth rate in 1941-51 partly reflects the Bengal famine of 1942-43 and the dislocations due to partition of India in 1947. The period of 1951-81 becomes the third period in the history of population growth in India. The rate of population growth accelerated to little over two per cent per annum because of sharper declines in mortality due to the success of public heath measures in the post independence period. The period 1961-81 showed the peak rate of population growth, that is, 2.2 per cent per year. During the first decade 1961-71, only mortality declined and the rate of population growth attained a peak. The second decade of this period, namely, 1971-81, showed an equal decline both in the birth rate and death rate, both balancing in such a way that the rate of population growth continued at a peak rate of about 2.2 per cent. This decade makes the turning point in the history of fertility in India, when it started declining and continued declining year after year. The turning point in the rate of population growth is the decade 1981-91 when it declined from 2.2 per cent per annum to 2.1 per cent. Though a welcome sign of decline in population growth rate has been noted, its pace is slow and not enough.


78 Visaria and Visaria noted that the expected life span of an average Indian has risen markedly (although rather gradually) since independence from about 32 to an estimated 62-63 years during 1996-2001; it represents a real gain in the welfare of the people. See Ibid., p. 66.
Talwar further noted that another feature of the growth of population in India is its absolute size of increase. Therefore though it is a feeling of satisfaction to see that the turning point in the rate of population growth has been achieved in 1981-91 but in terms of numbers we are still stuck with heavy pressure on our limited resources which are to be shared by the total number of people.\textsuperscript{79} Visaria and Visaria rightly observed that 'the momentum for growth built into the young age distribution of India's population makes it inevitable that even if all Indian couples were to decide immediately to have no more than two children; the rate of population growth would remain positive (or above zero) for the next 50 to 60 years. However, the size of the ultimate total population, at the time when population stabilizes, would be smaller than otherwise if the replacement level of fertility is reached sooner rather than later. Therefore, efforts to accelerate the progress towards the replacement level of fertility certainly need to be pursued' \textit{[italics mine]}\textsuperscript{80}

The role and place of international donor agencies in India's family planning programmes rest at the upper echelons (off course, of doubtful value). It is even argued that 'it is not possible to understand the Indian Family Planning Programme without reference to the international actors who set the agenda, primarily in the United States (US).\textsuperscript{81} Few scholars like Mass, Demerath,

\textsuperscript{79} Talwar, "Determinants and Consequences of Rapid Population Growth.", p. 36.

\textsuperscript{80} Visaria and Visaria, "India's Population.", p. 80. Else where they noted according to an analysis of the factors contributing to long-term population growth, momentum for growth is likely to account for about 58 per cent of the growth during 1991-2101 [Leela Visaria, Pravin M. Visaria, and Gujarat Institute of Development Research, \textit{Prospective Population Growth and Policy Options for India, 1991-2101} (Ahmedabad: Gujarat Institute of Development Research, 1996).] Further according to them an ongoing exercise suggests this proportion to be higher, almost 75 per cent [L. Visaria and P. Visaria, \textit{An Analysis of the Long-Term Population Projections for Various States of India, 1991-2101} (2000).]

\textsuperscript{81} Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 27.
Minkler, Hudgson, Connelly and (among Indians) Banerji, Raina, Bose and Rao have keenly observed and penned the donor driven events. Notable and persistence among this genre is Ashish Bose, and very recently Mohan Rao has also joined the rank. The works of both the scholars are extensively cited and even used as tertiary sources to comprehend the impact of international agencies on family planning programme. In 1952 the Ford Foundation’s representative in India informed Prime Minister Jawaharlal Nehru that his organization considered ‘India’s rapid population growth a major problem and was willing to consider appropriate aid in this field.’ But India’s family planning programme was already receiving international attention. Private international agencies rushed in with funds, consultants and technical advice. The Ford foundation also granted 9 million. The Ford Foundation ‘helped create two of India’s major institutions involved in the family planning programme, namely, the Central Family Planning Institute, later rechristen the National Institute of Family Planning (NIFP) and the National Institute of Health Administration and Education (NIHA).’ Indeed, it has been argued that ‘a small group men and women, in the US, many of them bankrolled by the Rockefeller Foundation, gave shape to the global population movement.’

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The post-war population control movement comprised a closely-knit group of public and private organisations including the Rockefeller Foundation, the Population Council, the Ford Foundation and the USAID, along with its counterparts in other western countries. Multilateral institutions, which followed the agenda set by these institutions at a later stage, included the United Nations Fund for Population Activities (UNFPA) and the World Bank.\(^\text{86}\) The Second Plan treatment of population growth as an independent variable (unlike the First Plan), and economic development, the dependent one reflected a change of perspective which was ‘actively being worked upon and current in the field of demography in the US during this period.’\(^\text{87}\) Hodgson noted, on this changed perspective, that earlier efforts towards understanding so complex a phenomenon as the relationship between population dynamics and socio-economic change had undergone a transformation towards a policy prescription for Third World countries.\(^\text{88}\) Similarly, Banerji observed the operational strategy of the family planning programme during the First Plan period was influenced by the approach of the International Planned Parenthood movement.\(^\text{89}\) Rao noted that this was the beginning of a period in the West when a sense of doom and panic was being created with reference to the ‘population bomb’ ticking away in Third World countries, posing not only a threat to themselves but to the entire world.\(^\text{90}\) In April 1963, the Director of Family Planning advised by Ford Foundation consultant, initiated a

\(^{86}\) Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 27.

\(^{87}\) Ibid., p. 29.


\(^{90}\) Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 31.
reorganisation. Even the shift from the passive clinical approach to the more active extension approach emanated from the community development movement in the US. The Report of the First Mission commended the intra-uterine device for it 'offers at present the best possibilities for large scale, successful programmes for reducing the birth rate in the country. The plastic loop convinced the Mission that every effort would be made to distribute it in a wide scale.' This role of the UN Family Planning Mission in 'endorsing' the loop was knowledge in the Report of the Second Mission. According to Rao, what is curious is that although the proportion of finances from international donors has never been significant- never, ever, exceeding a tenth of the total health budget, they have exerted a disproportionate share of influence. The greatest foreign involvement came after the droughts and economic crises of 1966 when the World Bank pressurised the Indian Government to intensify population control measure and the USAID replaced the Ford Foundation as the leading agency providing assistance to population control in India. In April 1966, the Department of Family Planning was constituted as a separate department in the Ministry of Health, Government of India. It is argued that this was done primarily to impress the World Bank and other aid agencies with a view to obtaining greater financial support.

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91 Demerath, Birth Control and Foreign Policy.
94 Rao, From Population Control to Reproductive Health: Malthusian Arithmetic., p. 35
noted that even the de-linking of Maternal and Child Health (MCH) activities from family planning was done on the recommendation of First UN Advisory Mission of 1966 that the Department of Family Planning should be relieved from other responsibilities such a maternal and child health and nutrition.\(^97\) Similarly, the World Bank, the UNFPA, and Swedish International Development Agency (SIDA) supported the ‘dynamic’ initiatives (of Earnakulam Collector on historic vasectomy targets) with considerable funds.\(^98\) In addition to these initiatives, the GOI, in collaboration with the USAID launched the Intensive District Programme in the 46 populous districts in the country.\(^99\) Rao also dwelled on the market lobbies and observed that 'it was well known that authorities in the USA and the UK were under tremendous pressure both from the manufactures of these drugs and the international population control establishment to licence them for use. This would enable the use of these contraceptives in the Third World, circumventing the accusation that they were being promoted in other countries.'\(^100\) Further, Ashish Bose observations are more critical, sharp and prescriptive. When family planning ‘red triangle’ was at its zenith, Bose described its three sides as- massive Indian inertia, obsolete British bureaucratic procedures and fancy American ideas, which he argued even hold good today.\(^101\) In a note to Planning Commission in 1979 Ashish Bose stated that 'the family planning programme must become wholly an Indian programme. It is unfortunate that ever since the programme was launched by


\(^{98}\) Ibid., p. 40.

\(^{99}\) Ibid., p. 41.

\(^{100}\) Ibid., p. 57.

\(^{101}\) Bose, *From Population to People.*, p. xxxvi.
the Government of India in 1952, foreign influence, funds and expertise have
confused the situation instead of strengthening the programme.'102 He further
argued that ‘our family planning programme must respect human dignity and
Indian values, the sacred institution of marriage and the solidarity of the
family and not preach mindless consumerism and selfish individualism to our
masses.'103 He went on to argue that ‘we have perceived the population
problem largely through western eyes. Right from the beginning, India’s
family planning programme has been heavily influenced by foreign funding
agencies and foreign experts of doubtful calibre.'104 ‘The issues raised do not
concern money as much as they concern policies. The whole orientation was
foreign and showed colossal ignorance of the Indian social context. The vulgar
advertising approach did not take into account Indian values and the respect
which the institution of marriage and family life enjoyed in the eyes of
millions of people.'105 Bose even went to extent of saying that ‘the role of
intellectual prostitution, and out-right corruption in our family planning
movement under foreign inspiration has yet to be understood by the people at
large.'106 In the second volume of his From Population to People, Bose even
devoted a full chapter on “Foreign Aided Health and Family Planning
Projects”107 and questioned ‘how is that in spite of the small investment made
by the foreign agencies, our health and family planning programme get

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102 Cited in Ibid., p. xxxvi.
103 Ibid., p. xlix.
104 Ibid., p. 4.
105 Ibid., p. 5.
106 Ibid., p. 42.
107 In Chapter 9 of this book Bose examined (as a case study) the foreign aided health and
family planning projects in India. See Ashish Bose, From Population to People, 2 vols., vol. II
hooked to these agencies so significantly and overwhelmingly? Why is there a
total dependence on foreign agencies in terms of any new idea, any new
slogan or any new innovation? Very recently Ashish Bose laments, I am
tired of commenting on foreign ‘kubuddhi’ (bad advice) which has vitiated our
family planning programme. He further argues that one need not be a cynic
to say that a lot of market research is going on in the name of population and
health surveys. Innocent demographers have yet to comprehend this new
phenomenon. RCH and HIV/AIDS bring instant money but how about some
solid social science research. On the usage of term ‘unmet need’ and NFHS
making it ‘fashionable’ Bose commented that this term smacks of what I
would call ‘market demography’, the basic objective being calculating the
demand for contraceptives to be supplied to India’s teeming millions by the
western countries. Bose even said that ‘donors have pumped in big money
which has only pampered demographers and statisticians and made them
greedy instead of scholarly researchers fascinated by the data.’ Nicholas J.
Demerath, an American sociologist who has worked as a family planning
expert in India in the 1960s, and wrote a critique in 1976 in a book which, as
Bose observed, thanks to the powerful international birth control lobby, hardly
received any attention in India or the US. Demerath devotes a whole chapter
on why family planning fails in poor countries? He observed that ‘the first
reason why family planning fails in poor countries is the obsession of the

108 Ibid., xlii.
109 Bose, Beyond Demography- Dialogue with People., p. 149.
110 Ibid., pp. 200-201.
111 Ibid., p. 203.
experts with techniques of contraception. The belief that just about any problem can and will be fixed by some new tool or technique is as Anglo-American as apple-pie.\textsuperscript{113} However, the revised report of Ministry of Health and Family Welfare dated November, 2000 warmly acknowledges the donor agencies added projects (and this expected from a government report). The report noted:

Area Development Projects are being implemented with the financial assistance from World Bank and other donor agencies for strengthening health and family welfare infrastructure in the States and reducing morbidity and birth rate and to increase the couple protection rate. These projects also have components for upgrading the skills of concerned manpower through training and for better programme management with the aim of reducing maternal and child mortality. Currently, 7 Area Projects are being implemented in 15 States and NCT of Delhi at a total cost of Rs. 1127.36 crores. The assistance in the case of UNFPA (United Nations Fund for Population Activities), DANIDA (Danish International Development Assistance), and DFID (Department for International Development, UK), is in the form of grant amounting to 100 per cent, 85 per cent and 75 per cent respectively of the total project cost, while the assistance in respect of World Bank projects is in the form of interest-free loans.\textsuperscript{114}

It is also noted that there is a large project in Uttar Pradesh, which is assisted by USAID. It has an outlay of US $ 225 million, over a 10 year period 1992-

\textsuperscript{113} Demerath, \textit{Birth Control and Foreign Policy.}, p. 90. Cited in Bose, \textit{From Population to People.}, pp. 7-8.

2002. It aims at reducing total fertility rate from 5.4 to 4.0 and increasing Couple Protection Rate from 35 per cent to 50 per cent over the project period. Interestingly, up to March 31, 2000 the CPR in UP was only 38.0 per cent.

1.3 Locating India’s Family Welfare Programmes in Five Year Plans- shifting focus, accelerating funds and changing paradigms

India has the distinction of being the first country in the world to have an official family planning policy and programme. In India, as in many developing countries, the family planning programme is the most direct public policy measure initiated to reduce the population growth rate, and ever ‘since the formal beginning of the programme in the early 1950s, it has gone through many structural, administrative and implementation strategy changes. The family planning programme, now family welfare programme, kept on shifting its focus sometimes as a sub-set of health, sometimes as interesting-set with health and also a time came when family planning programme was not only parallel to health but superseded it with the huge inflow of funds for family planning. Similarly, the approaches kept on changing from typical clinical to extension education and then an era of ‘targets’ forcing the scholars to

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115 Ibid., p. 165.
116 Ibid., p. 177.
119 Mitra rightly observed that unlike major investment to sectors of economy............family planning was not plagued by lack of outlay [italics mine]. See his Mitra, *India's Population-Aspects of Quality and Control*, p. 639; more interesting are the accounts of Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, pp. 19-70.
conclude that ‘the target has become an end in itself and not the means to bring about a decline in the birth rate’. In wake of ICPD came the rhetoric for client centred target free approach and more comprehensive reproductive health. A close scrutiny of each Five Year Plan will crystallise the changing facets of the world’s first officially launched family planning programme.

First Five-Year Plan (1951-56)

The First Five Year Plan acknowledged the serious ‘economic consequences of high fertility’ and for family planning the allotment of a modest budget of Rs. 6.5 million was made. It viewed ‘the rapid growth of population as a source more of embarrassment than of help to development planning.’ The need for birth control was presented primarily in terms of concern for the health and welfare of families and their individual members. At that time planners in India had good reason to proceed cautiously in inaugurating a population policy aimed at reducing fertility, because virtually nothing was...

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121 First Plan noted in ‘...in short run, there is no doubt that given a situation in which shortage of capital equipment rather than labour is the main limiting factor in development, a rapidly growing population is apt to become a source of embarrassment than of help to a programme of raising standard of living. In other words, the higher the rate of increase of population, the larger is likely to be the effort needed to raise per capita living standard [italics mine].’ See Asok Mitra, "Population in India's Development," in Population in India's Development - 1947-2000, ed. Ashish Bose, et al. (Delhi: Vikas, 1974), p.5. Also of interest are other articles in the volume Ashish Bose et al., eds., Population in India's Development - 1947-2000 (Delhi: Vikas, 1974). Equally vivid is the Desai account of first four plans, see his Desai, "The Perspective of India's Population Policy.", pp. 405-416.

122 Cited in Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 25.

known about the attitudes of the masses or the views of religious and other leaders.\textsuperscript{124} The First Plan further added, 'the pressure of population in India is already so high that a reduction in the rate of growth must be regarded as a major desideratum. To some extent, improvement in living standards and more widespread education, especially among women, will themselves tend to lower the rate. But positive measures are also necessary for inculcation of the need and techniques of family planning.'\textsuperscript{125} Ashish Bose\textsuperscript{126} rightly observed that the First Five Year Plan ‘clearly recognized the need for population control.’ In fact, the Plan listed under the family planning programme the following- ‘study of inter-relationships between economic, social and population changes. The information obtained by such studies will form the necessary background for the formulation of a national population policy and the development of appropriate measures for population planning based on factual information.’\textsuperscript{127} It may be recalled that the plan forcefully put forward the MCH (Maternal and Child Health) approach and family planning was a subset of health.\textsuperscript{128} Similarly, it is being argued that during the first decade of its existence, family planning was considered more a mechanism to improve the health of mothers and children than a method of population control.\textsuperscript{129}

\textsuperscript{124} Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India.", p. 5.
\textsuperscript{126} Bose, "Studies in Demography.", p. 23.
\textsuperscript{128} Bose, "Demographic Data- Overflow and Non-Utilization.", p. 4176.
Thus in the First Plan, as Rao rightly noted, the perspective was evidently one that envisaged demographic changes as dependent variables, responding to wide-ranging shift in social structural factors.\textsuperscript{130}

Second Five-Year Plan (1956-60)

The Second Plan taking into cognisance, the diagnosis (of population problem) in the First Plan, came with prescriptive assumption viz. curb on population growth as vital for economic development.\textsuperscript{131} The Plan noted:

The logic of facts is unmistakable and there is no doubt that under the conditions prevailing in countries like India, a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and of capital equipment relatively to population as in India the conclusion is inescapable that the effective curb on population growth is an important condition for rapid improvement in incomes and in levels of living. This is particularly so, if one bears in mind that the effects of improvements in public health and in the control of diseases and epidemics is to bring about an almost immediate increase in survival rates. While there may be differences as to the likely rates of population growth over the next 20 to 25 years, indications clearly are that even the utmost efforts which can be made- and has to be made- at this stage to bring down birth

\textsuperscript{130} Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 28.

\textsuperscript{131} The same assumptions, Desai observed, further acquired more articulate and assertive tone from the Third Five Year Plan and acquires harsher shrillness in the Fourth and the Fifth Plans. (see Desai, \textit{Urban Family Planning in India.}, pp. 134-135).
rates, population pressure is likely to become more acute in the coming years. This highlights the need for a large and active programme aimed at restraining population growth, even as it reinforces the case for a massive developmental effort [italics mine].

In this Plan, family planning was allotted Rs. 50 million while health was allotted a budget of Rs. 2.25 billion, out of a total plan outlay of Rs. 46.72 billion. This represented 0.10 and 4.81 per cent respectively of the Plan outlay for family planning and health. By the Second Plan, according to Rao, `the institutional structure for a separate, and powerful, vertical programme was established. The landmark being establishment of Central Family Planning Board, setting of State Family Planning Committees, commencement of contraceptive research at Mumbai, Calcutta, and Lucknow; setting of a Demographic Training and Research Centre at Mumbai along with regional centres; mobilisation of doctors, nurses and even school teachers and marked increase in rural and urban clinics. On the Plan population perceptive, Rao noted, `the Second Plan appeared to indicate that population growth was an independent variable and economic development the dependent one,


133 Cited in Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 29.

134 Ibid., p. 29.

135 For more detail and elaborate discussion see Bose, "Studies in Demography.", pp. 23-25; Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., pp. 29-30.
overturning a perspective that emerged out of years of demographic research.\textsuperscript{136}

Third Five-Year Plan (1961-65)

The Third Five Year Plan document heralded with the following statement which Asok Mitra remarks as “historic statement”:

A large part of the increase in output is absorbed by the growth of population. Improvement in conditions of health and sanitation will further lower the death rate, especially the rate of infant mortality, and may for a time even tend to raise the birth rate. \textit{The objective of stabilizing the growth of population over a reasonable period must therefore be at the very centre of planned development}. In this context, the greatest stress has to be placed in the Third and subsequent Five Year Plans on the programme of family planning. This will involve intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community [italics mine].\textsuperscript{137}

The outlay for family planning in the Third Plan was 0.5 billion: health obtained an outlay of Rs. 3.42 billion.\textsuperscript{138} Rao argued the emphasis on the family planning programme as the centre of planned development received impetus from the results of the 1961 Census which showed a high rate of

\textsuperscript{136} Rao, \textit{From Population Control to Reproductive Health: Malthusian Arithmetic.}, pp. 28-29.


\textsuperscript{138} Rao, \textit{From Population Control to Reproductive Health: Malthusian Arithmetic.}, p. 32.
population growth than expected. No less provoking was the recommendation of the Health Survey and Planning Committee, popularly known as Mudaliar Committee (in 1961) that ‘if the family planning movement is to produce early and effective results, it has to be in the nature of a mass movement’ [italics mine].

Rao assessing the approaches in Plans noted, ‘the limitations of the clinical approach were now being highlighted. The reorganised programme was to emphasise extension education, greater availability of contraceptive supplies, and less dependence on the traditional clinic approach. The result was massive expansion of the programme organisation.’ However, ‘as steps were being initiated to implement the recognized programme, the United Nations Advisory Mission visited India in 1965 and suggested the launch of a “reinforced programme” parallel to the former. Three courses of action were recommended under the reinforced programme, namely, an energetic loop (IUCD) programme, an intensified sterilisation programme, and the promotion of the use of condoms through wider availability via commercial channels. These recommendations shifted the focus from the reorganised programme with an extension education approach, to a forceful loop programme [italics mine]. Thus ‘the Plan

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139 Ibid., p. 32.

140 GOI, “Report of the Health Survey and Planning Committee,” (New Delhi: Planning Commission, Government of India (GOI), 1961), p. 675. Cited in Rao, From Population Control to Reproductive Health: Malthusian Arithmetic, p. 30. Further a supplement to this report (Minority Report) recommended the consideration of ‘appropriate legislative and administrative measures’ in view of the urgency of the problem, to ensure a fall in the birth rate of the country during the next five years. Thus, the Minority Report, Rao observed, foreboded in a sense, the shape of things to come: the iron hand of coercion behind the velvet glove of rhetoric; pp. 30-31.

141 Rao, From Population Control to Reproductive Health: Malthusian Arithmetic, p. 32.

142 Raina, Population Policy, p. 65.
witnessed IUD programme on mass level in 1965 but very soon proved to be a failure. The closing years of the plan also witnessed ‘completion of the reorganization of administrative set-up’ as a result of which ‘the process of intensification of the family planning programme was pursued during the Fourth Plan with greater vigour.’ Visaria and Chari noted the Third Plan marked a subtle shift in programme emphasis, from the welfare of women and children to the macro objective of population stabilisation. Rao concluded, ‘the Third Plan period witnessed the burgeoning of the family planning programme even as it showed several shifts of policy, strategy, and emphasis. Family planning came to dominate concerns in the field of health and increasingly contoured the directions of health policy.'

143 Sarah Israel noted in the history of family planning work in India, 1965 will be remembered as the year in which the Intra-uterine Device programme was launched as a mass drive all over the country. This was the year in which monthly insertions reached their peak and the States vied with each other to earn the much coveted Inter-State Award. See Sarah Israel, "An Assessment of the Lippes Loop," in Studies in Demography: Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970), p. 332.

144 Rao noted in 1966-67, over 900000 women were fitted with IUCDs. In the following year, the number declined to 669000 in spite of the best of efforts, on the part of health care workers, and from then on the decline was quite drastic. In other words, the IUCD strategy proved to be a failure. See Rao, From Population Control to Reproductive Health: Malthusian Arithmetic, p. 37.

145 Desai, "The Perspective of India's Population Policy.", p. 415. Desai gave the examples of the reorganization of administrative set-up viz.-appointment of a Commissioner of Family Planning and number of Regional Directors, establishment of an autonomous Central Family Planning Institute, constitution of high Cabinet Committee to take quick decisions and speeding up the implementation of the programme. The factories for manufacturing contraceptives were opened at Trivandrum (for condoms) and at Kanpur (for IUD). Similarly, Raina noted the revitalisation of PHC system to meet the family planning goals; see Raina, Population Policy, p. 65.

146 Visaria and Chari, "India's Population Policy and Family Planning Programme: Yesterday, Today and Tomorrow."

147 Rao, From Population Control to Reproductive Health: Malthusian Arithmetic, p. 36.
Fourth Five-Year Plan (1968-74)

The Fourth Plan was preceded by three Annual Plans and formation of separate Department of Family Planning in the Ministry of Health, and most significantly, resumption of office in 1967 by Mrs. Indira Gandhi’s government and the appointment of Dr. S. Chandrasekhar, leading demographer, researcher and scholar of repute, as the Minister of Health and Family Planning, Government of India. The Fourth Plan discovered that the problem had in fact grown even more acute. Equally ardent was the tone of The Small Family Norm Committee which noted ‘the future seems gloomy unless the nation effectively controls fertility by family planning methods’.

Thus, the Plan outline contends ‘under Indian conditions, the quest for equality and dignity of man requires as its basis both a high rate of economic growth and a low rate of population increase. Even far-reaching changes in social and economic fields will not lead to a better life unless population growth is controlled. Limitation of family is an essential and

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148 The Annual Plans (1966-69) were adopted in view of serious economic crisis due to debacle with China, consecutive bad monsoon and fall in food production. This however, Rao noted, ‘was not allowed to affect the population policy. Indeed, financial allocations to the programme continued to increase.’ Rather many vigorous population efforts were made for example- in 1966 Maternal and Child Health (MCH) activities were de-linked from family planning in order to enable fieldworkers to concentrate on family planning; in 1967 the Indian Council of Medical Research (ICMR) recommended the introduction of Oral Pills on a pilot basis and the Nirodh (Condom) marketing programme was launched in September 1968. See Ibid., pp. 36-37, 38.

149 Bose, however, noted, in spite of bold attempts, made by Dr. Chandrasekhar as the Minister of Health and family Planning, the problem of making a dent on the birth rate continues to be serious (see Bose, "Studies in Demography.", p. 27). Desai observed that ‘the programme gained momentum’ with these two developments (see Desai, "The Perspective of India’s Population Policy.", p. 417).

inescapable ingredient of development.\textsuperscript{151} The Plan emphatically observed ‘population growth thus presents a very serious challenge. It calls for a nation wide appreciation of urgency and gravity of the situation. A strong purposeful Government policy, supported by effective programme and adequate resources of finance, men and materials is an essential condition of success [italics mine].\textsuperscript{152} Thus, the draft plan outlay of Rs. 3 billion was revised upwards to Rs. 3.15 billion so that the programme could be strengthened and speeded up; health obtained an outlay of Rs. 4.35 billion.\textsuperscript{153} Further for intensifying the family planning programme, new schemes like the post-partum programme, supply of surgical equipments to hospitals, intensive district and selected area programmes, supply of vehicles at primary health centres have been included for implementation during the Fourth Plan.\textsuperscript{154} Desai observed ‘the Fourth Plan’s contribution in the evolution of the policy of population control has been to make family planning entirely a centrally sponsored programme for a period of the next ten years, the entire expenditure being met by the Central government; and to integrate maternity and child welfare with family planning by providing for the implementation of the schemes of prophylaxis against nutritional anaemia for mothers and children and the nutritional programme for control of blindness caused by Vitamin ‘A’ deficiency among children,


\textsuperscript{153} Rao, From Population Control to Reproductive Health : Malthusian Arithmetic, p. 38.

\textsuperscript{154} GOI, "Fourth Five Year Plan.\textquotedblright, Cited in Rao, From Population Control to Reproductive Health : Malthusian Arithmetic, pp. 38-39.
through Family Welfare Planning Centres [italics mine]. The Plan also proposed ‘to step up the target of sterilisations and IUCD insertions and to widen the acceptance of oral and injectable contraceptives.’ It is argued that the family planning programme ‘picked up momentum only from 1966-67 when the programme became target oriented and time bound.’ During this period, Rao noted, vasectomy received great official impetus. Given the failure of the IUCD approach, vasectomy came to occupy centre stage in the family planning programme. That’s the reason why, Second United Nations Mission to evaluate the programme was also ‘deeply impressed by the Government’s serious commitment to the programme and by the determination of the Government’s departments involved to secure its effective implementation.’ Pai Panandikar has rightly noticed how the much talked (as also maligned) compulsory sterilisation of emergency period gathered momentum in the preceding years and argued that ‘by the time Fourth Plan was launched the programme administrators had learnt through experience that whereas other methods of family planning were of doubtful effectiveness in terms of their adoption by the people, sterilisation was specific, sure and once for all method and therefore could be depended upon for substantive achievement. Consequently, a high reliance was placed on sterilisation for achieving the target. A new strategy employed for sterilising a

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156 Rao, From Population Control to Reproductive Health: Malthusian Arithmetic., p. 38.
157 Bose, From Population to People., p. 142.
large number of people was the ‘camp approach’. The entire administrative machinery of a district or tāluka (sub-division) was mobilised to hold sterilisation camps at different places during a year, to which a large number of people were brought from surrounding areas and sterilised on the spot.

In 1972-73, 3.1 million sterilisations were performed in India, a figure exceeding the number of sterilisations achieved in previous years. Two thirds of these were performed at camps. In 1971, the passing of Medical Termination of Pregnancy (MTP) Act, legalising abortion, carried out by recognised practitioners on medical grounds and among grounds for eligibility is the failure of a contraceptive device. Kartar Singh Committee of the period (in 1973) felt that integration (of vertical programmes) would be economical and feasible and went on to recommend the integration of the programmes. The workers of these programmes were to be re-trained and to be designated as multi-purpose workers. The shift in strategy was witnessed at the World Population Conference in Bucharest in 1974, the Indian Minister of Health and Family Planning stated that ‘development is the best contraceptive’ and observed- ‘we are quite clear that fertility levels can be effectively lowered only if family planning becomes an integral part of a broader strategy.

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160 This camp approach and sterilisation as a major method for reducing the birth rate, according to A.R. Desai, acquired frenzied, compulsive features during the emergency period. See Desai, Urban Family Planning in India., p. 128. Moreover this camp approach is credited to Mr. S.S. Krishna Kumar, Collector of Ernakulam district in Kerala, who, I may say; unlike the beaten track bureaucracy manoeuvres, pioneered, proved and added the master strategy of camp approach in the arsenal of family planning programme. Rao observed the enthusiastic Collector created a ‘festive atmosphere’ at the camp and the result was the ‘remarkable achievement’ of over 15,000 vasectomies in one month and in his second camp in July 1971 over 63000 vasectomies were performed that received a striking place in the annals of India’s family planning history; see Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 39.


162 Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 40.

163 Cited in Ibid., p. 42.
to deal with the problems of poverty and under development... Population policy is thus one of the several vital instruments for securing comprehensive social development, and it cannot be effective unless certain concomitant economic policies and social programmes succeed in changing the basic determinants of fertility.\textsuperscript{164} However, it is noted that ‘in 1974 the family planning programme has reached a state of financial and even philosophical disarray. With the total number of acceptors in 1973-74 down 27 per cent on the previous year, things looked gloomy for the programme.’\textsuperscript{165} Rao also observed, ‘towards the end of the period, it was increasingly being realised that the approach hitherto adopted had not yielded commensurate returns, indeed that the programme had reached a cold dead end.....It seemed that almost every thing had been tried that could be tried [italics mine].’\textsuperscript{166}

Fifth Five-Year Plan (1975-80)

The primary objective during the Fifth Plan was ‘to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups- children, pregnant women and lactating mothers.’\textsuperscript{167} The Plan noted ‘the inability to obtain the reduction in birth rate targeted in the Fourth Plan and aimed at the reduction of the birth rate by a more realistic five point by the end of the Fifth Plan period, that is, to a level of 30 per 10,000 population. To


\textsuperscript{166} Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 42.

this end, the programme for family welfare planning was to continue to be accorded the same high priority in the Fifth Plan as it occupied in the Fourth. The strategy adopted was to increasingly integrate family planning services with those of health, MCH and nutrition.\textsuperscript{168} The outlay for family planning was increased to Rs. 5.16 billion, health obtained an outlay of Rs. 7.97 billion out of a total Plan allocation of Rs. 537.5 billion, representing 0.96 and 1.49 per cent of the total outlay respectively.\textsuperscript{169} On the changing notions during the emergency, Zodgekar commented that although it is generally believed that development activities and family planning programmes are "mutually reinforcing complements" rather than "mutually exclusive", the Health Minister's policy statement of April 1976 stated, among other things, that "to wait for education and economic development to bring about a drop in fertility is not a practical solution".\textsuperscript{170} The National Population Policy (April 1976) noted:

With 2.4 per cent of the world’s land area, India has about 15 per cent of the world’s people. Indisputably we are facing a population explosion of crisis dimension which has largely diluted the fruits of the remarkable economic progress that we have made over the last two decades. If the future of the nation is to be secured and the goal of removing poverty to be attained, the population problem will have to be treated as a top national priority and commitment. \textit{The time factor}  

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\item Cited from Rao, \textit{From Population Control to Reproductive Health: Malthusian Arithmetic.}, pp. 44-45.
\item Ibid., p. 45.
\item Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India.\textquotedblright, p. 5. Interestingly, the policy statement is of the same Health Minister who clarion at Bucharest World Population Conference that \textit{development is the best contraceptive}. Why this drastic change in approach in less than two years time?
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is so pressing and the population growth so formidable that we have to get out of the vicious circle through a direct assault upon this problem as a national commitment. The question of compulsory sterilisation has been the subject of lively public debate over the few months. It is clear that the public opinion is now ready to accept much more stringent measures for family planning than before. However, the administrative and medical infrastructure in many parts of the country is still not adequate to cope with the vast implications of nation-wide compulsory sterilisation. We are of the view that where a State legislature, in the exercise of its own powers, decides that the time is ripe and it is necessary to pass legislation for compulsory sterilisation, it may do so [italics mine].

Many scholars are of opinion that this policy statement gave implicit succour to compulsory sterilisation, we will emphatically add that the policy document very explicitly showed glowing green signal for the race of compulsory sterilisation targets. The argument further scores if one reviews the address, Mrs. Indira Gandhi, then Prime Minister, gave just few months preceding the policy statement of 1976. Addressing the Joint Conference of the Association of Physicians in India in January 1976, Mrs. Gandhi stated- ‘we must now act decisively and bring down the birth rate. We should not hesitate to take steps which might be described as drastic. Some personal rights have to be held in abeyance for the human rights of the nation: the right to live, the right to

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172 Bose called this sterilisation by hook or crook as a SHOCK therapy. See Bose, From Population to People., p. xlv.
progress [italics mine].

Even, 'family planning performance became one of the criteria for financial allocations; 8 per cent of central aid to states was linked to their performance in family planning.' The Shah Commission noted:

It is thus not surprising then that sterilisations were performed with new zeal in this atmosphere. Targets for sterilisation were set. The states vied with each other to achieve the targets set. Indeed, these targets were raised to high levels by a number of state governments when chief ministers sought to ingratiate themselves with the powers that be at the Centre. Some states doubled their targets (e.g. Bihar and Maharashtra), other tripled their targets (e.g. Madhya Pradesh and Himachal Pradesh), still others, more enthusiastic, quadrupled it (e.g. UP and West Bengal) and the state like Punjab increased its targets by five times.

Indeed, the Joint Secretary in the Ministry of Health wrote to the Chief Secretaries of States that 'it might not be much of exaggeration to say that 1976 was the years of family planning in India [italics mine]. Further, the December 1976 issue of Centre Calling, a Ministry of Health publication, noted- 'Never in the history of the family planning programme have the States achieved the national sterilisation targets manifold. It ranges from 400 per cent

173 Cited in Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 47. To me it seems that then humble Minister mistook this address of Mrs. Gandhi as a dictation for the population policy statement thus ushering the era of compulsory sterilisations.

174 Ibid., pp. 46-47.


to more than 100 per cent in an overwhelming majority of the States and that too in eight months. On the question of target chasing and compulsory sterilisation, Desai aptly argued that ‘while expanding its intervention into the family life, in the name of family planning, through compulsory sterilisation campaigns, it has never bothered to ensure minimum prerequisites for family to survive or perform even its basic functions, including family planning.’

Moreover, these compulsory sterilisation campaign during the emergency resulted into a combination of coercion, cruelty, corruption and cooked figures, which Bose termed as ‘Sanjay Effect’ and also noted, though we have estimated that about 70 lakh persons were victims of Sanjay Effect during the emergency, the spread effect (through communication and rumours) must have been substantial, which can be termed as ‘Sanjay Multiplier’. However, what merits conclusion is that the move backfired and the family planning programme received a serious setback, from which it recovered only after about five years and in the election of 1977, the Congress Party was swept out of power largely due to what came to be described as the ‘excesses’ committed in the name of family planning.

The new Government after the emergency came with new policy statement (April 28, 1977) which noted:

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177 Cassen, India: Population, Economy, Society., p. 120.
178 Desai, Urban Family Planning in India., p. 48.
179 Bose, From Population to People., p. 52, 55.
180 Visaria and Visaria, "India's Population.", p. 68.
The President in his address to Parliament on March 28, 1977, stated that “family planning will be pursued vigorously as a wholly voluntary programme and as an integral part of a comprehensive policy covering education, health, maternity and child care, family welfare, women’s rights and nutrition.”

Government is totally committed to the Family Welfare Programme and will spare no efforts to motivate the people to accept it voluntarily in their own interest and in the interest of their children as well as in the larger interest of the nation. The family planning has, however, to be lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare. It must be part of the total concept of positive health. The change in the name of the programme from family planning to family welfare is a reflection of the Government’s anxiety to promote, through it, the total welfare of the family and the community. It is our intention to take the programme forward in the real sense as an investment in man. Compulsion in the area of family welfare must be ruled out for all times to come. Our approach is educational and wholly voluntary.

Even the Janata Government, according to Desai, ‘intensified the campaign of family planning programme increasingly creating a climate, if not of an open compulsion, of a subtle indirect one for justifying the need of using pressure (of various types and intensities) as a method of realising the target. Special statement by Prime Minister Morarji Desai, series of meetings by Ministers of States, a new debate launched by intellectuals and scholars through seminars,

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conferences, T.V. and other media, and climaxing into even Jayprakash Narayan being especially interviewed to secure his blessings and approval to intensify the programme of family planning by Government as a great priority for accelerating the tempo of economic and social development clearly highlight, how the family planning movement is being boosted as one of the top priorities by the Janata Government.\textsuperscript{183} Bose\textsuperscript{184} further adds salt to it and observed that the Janata Government which came to the helm in 1977 changed the nomenclature of family planning to family welfare but did precious little by way of introducing the welfare content and expanding the family planning programme either in qualitative or quantitative terms [italics mine]. Further the Working Group on Population Policy (appointed by Planning Commission) in 1980 asserted ‘population policy and general development strategy are the two sides of the same coin’ and recommended that ‘since women are the best votaries of the programme, the programme for the immediate future be increasingly centred around woman.’\textsuperscript{185} The programme, Rao noted, ‘henceforth came to be centred on women, since it was now abundantly clear that a programme focused on sterilising men was politically costly. In India’s culture of course, women were expected to silently contribute to their family’s welfare. It was on this fact and not on the need to

\textsuperscript{183} Desai, \textit{Urban Family Planning in India.}, pp. 128-129.

\textsuperscript{184} Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 3. Elsewhere he noted, like renaming third class as second class in the Indian railways, we have also renamed family planning as family welfare planning. See Bose, \textit{From Population to People.}, p. 34.

the increase the rights of women- that the programme now hinged itself, exploiting the weak and the defenceless.'

Sixth Five-Year Plan (1980-85)

Mrs. Gandhi, on coming back to power in 1980, 'proclaimed in her new 20 Point Programme that family planning was to be promoted on a voluntary basis as a people's movement (Item 13). She also made a sincere effort to fill the family welfare basket with nutrition and maternal and child health programmes.' Thus, noting the 'reverses' suffered by the programme, the Sixth Five Year Plan document, set out 'to arrest the trend'. The Plan observed, 'it is almost axiomatic that economic development can in the long run bring about a fall in fertility rates. However, developing counties with large populations cannot afford to wait for development to bring about a change in the attitude of couples to limit the size of their families as the process of development, itself is stifled by population growth. Limiting the growth of population is therefore one of the main objectives of the Sixth Plan.' The Plan adopted 'long term demographic goal of reducing the net reproduction rate to one by 1996 for the country as a whole, and by 2001 in all the states' and the strategy adopted emphasized 'an integrated approach to the problems of public health and proper coordination of activities of different departments having a bearing on family planning such as maternal and child

187 Bose, "The Family Welfare Programme in India: Changing Paradigm.", p. 3. Also see Bose, From Population to People., p. xiv.
care' and that 'the family planning programme has to be made part of the national effort for providing a better life to the people.'\(^9\) The Plan also acknowledged that 'high morbidity and mortality rates were responsible for the desire for more children.'\(^0\) The outlay on family planning was again increased and amounted to Rs. 10.1 billion while health obtained Rs. 18.2 billion out of a total Plan outlay of Rs. 975.5 billion, representing 1.03 and 1.80 per cent of the total outlay respectively.\(^1\) During the Plan period first post-independence National Health Policy was launched (in 1983) which noting the advances in health since independence, observed that -

'demographic and health picture still constitutes a cause for serious and urgent concerns. The high rate of population growth continues to have an adverse effect on the health of our people and quality of their lives' and while committing itself to the goal of Health for All by 2000 through the Primary Health Care system, the policy went on to argue that 'irrespective of changes, no matter how fundamental, that may be brought about in the overall approach to health care and the restructuring of the health care services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm and moving towards the goal of population stabilisation.'\(^2\) Thus, Rao laments, 'the cart of population control was placed before the horse of health care for

\(^9\) Cited in Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 53.
\(^0\) Ibid., p. 53.
\(^1\) Ibid., p. 54.
the people. In terms of operational strategy, what resulted was a focus on female sterilisation, often in camps. At the same time the availability of the laparoscope made it possible to carry out sterilisations in record time, in operations described as something like a war and also that this same militarist fervour led, during this period, to the launch of trials with more lethal weapons: injectables (Net En and Depo), implants (Norplant), and indeed a vaccine. The Plan period also witnessed youth Prime Minister, Mr. Rajiv Gandhi, coming to power (on account of Mrs Gandhi’s sad demise) with a visionary model of development and accordingly, he revised the 20 point programme, the Item 9 of which proposes to ‘bring about voluntary acceptance of the two child norm; promote responsible parenthood; reduce infant mortality; and expand maternity and child care facilities.’

Seventh Five-Year Plan (1985-90)

In view of the actual performance in the Sixth Plan period, the goal of reaching a net reproducing rate of one was pushed forward from 2006 to 2011. The Seventh Plan set forth the following targets to be reached by 1990: ‘an effective couple protection rate (CPR) of 42 per cent; a crude birth rate (CBR) of 29.1; a crude death rate (CDR) of 10.4; an infant mortality rate of 90 per 1000 live births; universal immunization of children, and antenatal care of 75 per cent of all pregnant women……..The Plan emphasized the need to pay

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194 Ibid., pp. 56-57.
195 Bose, From Population to People., p. 238 (Appendix II).
greater attention to MCH activities to enhance child survival [italics mine].

Rao noted in this Plan the allocation to family planning was again increased, to be almost on par with that of health, a case of the tail wagging the dog. Family planning and health obtained an outlay of Rs. 32.56 billion and Rs. 33.92 billion respectively out of a total outlay of Rs. 1800 billion, representing 1.80 and 1.88 per cent of the budget respectively. The plan period also witnessed the enunciation of another population policy. The National Population Policy (1986) which asserted that family planning 'is one of the essential components of the national strategy for growth which places equal emphasis on accelerated development and recognises the fact that the process of development is apt to be lopsided unless social-economic imbalances among the people, including the imbalances in the health services, are speedily removed. It looks at birth control not as an end in itself but as vital means to the attainment of ‘Health for All’ in the shortest possible time.'

The policy statement reiterates the Indian Government commitment to promote a voluntary, two-child norm. To this end, the policy committed itself to bring down morbidity and mortality rates, in particular early childhood mortality, through strengthened health services, enforcement of the law relating to age at

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Eighth Five-Year Plan (1992-97)

The Eight Five Year Plan noted, ‘containing population growth has been accepted by the Government as one of the six most important objectives of the Eight Plan with the aim of reducing the birth rate from 29.9 per thousand in 1990 to 26 per thousand in 1997. The IMR will be brought down from 80 per thousand live births in 1990 to 70 by 1997. To give a major thrust in this priority area, which constitutes the pivotal point for the success of all developmental efforts, a National Population Policy needs to enunciated and adopted by the Parliament.’^200^ Rao noted in a welcome departure, for the first time, no centrally fixed targets were specified. This was not, of course, to mean that targets did not exist.\(^201\) In this Plan, the operational strategy was spelt as area-specific, micro planning, linking population control with the programmes of female literacy, women’s empowerment, social security, access to health services and mother and child care.\(^202\) Health obtained an outlay of Rs. 75.82 billion while the allocation for family planning was Rs. 65 billion, representing 1.75 and 1.5 per cent of the total outlay respectively. The health outlay and family planning outlay thus declined from the allocations of

\(^{199}\) Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 60.


\(^{201}\) Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic*, p. 65.

1.88 and 1.81 per cent respectively of the total outlay of the Seventh Plan. Most significant event in the history of health and family welfare, world over, was the International Conference on Population and Development (ICPD) at Cairo, Egypt in 1994 and the commitment made to RCH (Reproductive and Child Health) approach by all participating nations, including India. Rao noted ‘one positive outcome of the Cairo conference was the removal, formally, of method-specific targets in April 1995 on an experimental basis from Kerala and Tamil Nadu and from 17 districts in other states. In April 1996, targets were removed from all over the country.’ Hereafter (April 1996), the Family Welfare Programme is being implemented on the basis of Community Needs Assessment Approach (CNAA). Furthermore, ‘the Government of India launched the Reproductive and Child Health (RCH) programme on 15.10.1997 for implementing during 9th Plan period by integrating and strengthening all the existing interventions under the Child Survival and Safe Motherhood (CSSM) interventions of fertility regulation and adding the component of Reproductive Tract Infection (RTI) and Sexually Transmitted Infections (STI). The concept of RCH is to provide need based, client centred, demand driven, high quality and integrated RCH services to the beneficiaries.’

203 Rao, From Population Control to Reproductive Health: Malthusian Arithmetic., p. 66.
204 Ibid., p. 66.
206 Ibid., p. 144.
The Reproductive and Child Health Programme, which was launched in 1997 (to being implemented in Ninth Plan), focuses on the principles of client satisfaction and utilizing the exiting health infrastructure to deliver high quality health services. The Ninth Plan stated that ‘reduction in the population growth rate has been recognised as one of the priority objectives during the Ninth Plan period’ and that ‘the current high population growth rate is due to- the large size of the population in the reproductive age group (estimated contribution 60 per cent); higher fertility due to unmet need for contraception (estimated contribution 20 per cent); high wanted fertility due to prevailing high IMR (estimated contribution about 20 per cent).’ The priorities in the Plan were to meet the felt needs for contraception, and to reduce the infant and maternal morbidity and mortality so that there was a reduction in the desired level of fertility. In terms of budget, family planning received an allocation of Rs. 151.20 billion, a huge increase from Eighth Plan outlay of Rs. 65 billion, and the outlay for health at Rs. 51.18 billion, was a significant decline from the outlay of Rs. 75.82 billion in the Eighth Plan period, and representing 0.6 per cent of the total outlay. The Government of India further proved its Cairo commitment and launched two major policies towards the end of Ninth Plan- that is National Population Policy (NPP), 2000 and National Health Policy (NHP), 2002. With the adoption of the National Population Policy, population and development have begun to once again

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207 Jejeebhoy et al., "Setting the Stage.", p. 13.
209 Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 68.
occupy centre-stage in the nation's agenda for social development.\textsuperscript{210} The National Population Policy 'provides a policy framework for achieving the twin objectives of population stabilisation and promoting reproductive health within the wider context of sustainable development. The immediate objectives of the National Population Policy are to address the unmet needs for contraception and health system personnel, and to provide integrated service delivery for basic reproductive and child health care. \textit{The National Population Policy affirms the Government's commitment to the provision of quality services, information and counselling and expanding contraceptive method options in order to enable people to make voluntary and informed choices} [italics mine].\textsuperscript{211} Further, NPP listed its objectives in three frames—the immediate objective of the NPP was to meet the unmet need for contraception and health infrastructure. The \textit{medium-term objective} is to bring the total fertility rate to replacement levels by 2010 through inter-sectoral action, while the \textit{long-term objective} is to achieve a stable population, consistent with sustainable development, by 2045.\textsuperscript{212} NPP also stressed the need for decentralized planning, the empowerment of women for population stabilisation, child health and survival, collaboration with the voluntary and NGO sector, and encouragement of research in contraceptive technology.\textsuperscript{213} Bose made a lengthy statement on trajectory of the National Population Policy and noted:

\begin{thebibliography}{9}
\item GOI., "National Family Welfare Programme.", p. 141.
\item Cited in Jejeebhoy et al., "Setting the Stage.", pp. 13-14.
\item Cited in Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 213.
\item Ibid., p. 213.
\end{thebibliography}
As a member of the Swaminathan Committee on Population Policy which prepared a draft population policy in 1994 (before the much glamorised ICPD Cairo conference was held), I recall that we had suggested linking population to basic needs and 100 per cent fulfilment of the Minimum Needs Programme. The very first item in our list of national socio-economic goals for the year 2010 was implementation in totality of the Minimum Needs Programme. Unfortunately this was cut out in the National Population Policy (2000) which put the first national socio-demographic goals for 2010 as follows- “Address the unmet needs for basic reproductive and child health services, supplies, and infrastructure.” Glory to our population commission, India’s decimal point demography and agents of market demography.214

In pursuance of the objectives of the NPP, the National Commission on Population (NCP) was constituted in May 2000 under the chairmanship of hon’ble Prime Minister to promote inter-sector co-ordination across agencies of the Central and State Governments, to involve the civil society and the private sector in planning and implementation and to explore the possibilities of international co-operation in support of the goals set out in the National Population Policy, 2000.215 The National Health Policy aptly specified the common ground between NHP and NPP and noted- ‘efforts made over the

214 Bose, Beyond Demography- Dialogue with People., pp. 203-204.
years for improving health standard have been partially neutralized by the rapid growth of the population. It is well recognized that population stabilization measures and general health initiatives, when effectively synchronized, synergistically maximize the socio-economic well-being of the people. The synchronized implication of these two policies—National Population Policy, 2000 and National Health Policy, 2002—will be the very cornerstone of any national structural plan to improve the health standards in the country.  

Tenth Five-Year Plan (2002-2007)

Tenth Plan outlines efforts in three broad areas: a) meeting the unmet need for contraception; b) reducing infant and maternal mortality; and c) enabling families to achieve their reproductive goals. The targets included reduction in the decadal growth rate of population from 21.3 per cent in the period 1991-2001 to 16.2 per cent during the period 2001-2011. Efforts have been targeted toward addressing the unmet need for maternal and child health and contraception, particularly in states where mortality and child health and contraception have been lagging. In India’s policy planning, another landmark during the new millennium is the launch of National Rural Health Mission (NRHM) initially for the period 2005-2012. Its preamble notes ‘Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The mission adopts a synergistic approach by relating health

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217 Cited in Jejeebhoy et al., "Setting the Stage.," p. 16.
to determinants of good health viz. segment of nutrition, sanitation, hygiene in
safe drinking water.\textsuperscript{218} The National Rural Health Mission (2005 -2012) ‘seeks to provide effective healthcare to rural population throughout the
country with special focus on 18 states, which have weak public health
indicators and or weak infrastructure’ and ‘sets the target of reducing IMR to
30 and MMR to 100 and TFR to 2.1.’\textsuperscript{219} Very recently, Government of India
has introduced a Family Planning Insurance Scheme for acceptors of
sterilisation and indemnity cover for doctors performing sterilisation
procedures in both Government and accredited private/NGO/Corporate health
facilities. The Insurance Scheme will be operated by the Oriental Insurance
Company Ltd. (OICL). The Insurance Scheme provides (compensation) as the
following: death due to sterilisation in hospital (Rs. 1, 00,000); deaths due to
sterilisation within 30 days of discharge from hospital (Rs. 30,000); failure of
sterilisation (including first insurance of conception after sterilisation) Rs.
20,000; medical complication occurring within 60 days of sterilisation
operation (Rs. 20,000) (to be reimbursed on basis of actual expenditure
incurred, not exceeding Rs. 20,000).\textsuperscript{220}

\textsuperscript{218} GOI, "National Rural Health Mission (2005-2012)," (New Delhi: Ministry of Health and

\textsuperscript{219} Ibid., p. 2, 15.

Family Welfare Programmes - Retrospect and Prospects

While the beginning which India made is impressive, the goal of population decline even after four decades (now five decades) remains a distant dream. The population continues to grow at a faster rate than anticipated by India’s planners and policy makers and every decennial Census sends shockwaves to them and even made India’s ‘family planning programme suspect in the eyes of the common man.' These poor results stem from an inadequate understanding of the Indian society. Bose noted ‘we have got into a rut of mechanically fulfilling family planning targets without paying adequate attention to the qualitative aspects of the family planning programme’ and that ‘the programme has emerged as massive monolithic programmes’. The progressive increase in the importance attached to the policy of population control is well reflected in the successive plan allocations to the programme of family planning. It is to note that under the Indian Constitution, health comes under the State List (Item 6 on List II reads as Public Health and Sanitation; and Hospitals and Dispensaries) while the social and economic planning including family planning come under the Concurrent List.

223 Bose, From Population to People., p. 2.
224 Mathur and HCM Rajasthan State Institute of Public Administration., eds., The Family Welfare Programme in India., p. vi.
226 A series of scholars and analyst of repute have stressed and some even criticised the ‘over-inflating’ budget allocations to family planning in successive plans. See example Desai, "The Perspective of India's Population Policy.", p. 412., Mitra, India's Population - Aspects of Quality and Control., p. 639, Bose, From Population to People., and more recently Rao, From Population Control to Reproductive Health: Malthusian Arithmetic.
List (Item 20A of List III reads as Population Control and Family Planning).

In effect, family planning is placed under the Union list as it has always been a
cent per cent centrally sponsored programme. This created an anomaly. The
family planning programme has emerged ‘as massive monolithic programme,
centrally -financed, directed and monitored while the implementation of the
programme is left to the States. Several States take interest in family planning
only because the programme brings money from the central government. The
Planning Commission is of the opinion that if the States are asked to share
financial responsibilities, the family planning programme will collapse.

Bose quotes D. Banerji who said ‘health has been hijacked by family
planning’ and to this Bose aptly adds ‘the plane crashed killing both health
and family planning.’

Rao and Jain also support the same and argued that
over the years, concern in family planning have contoured health sector
developments. Elsewhere, Rao also noted that ‘the entire public health
infrastructure, neglected, starved of funds; almost dysfunctional has been
suborned for family planning. The entire primary health care (PHC)
system, then has become besmirched with population control concerns.’
Ashish Bose also found ‘divergence within the Plans in the basic
philosophy of family planning. Whereas the formulation of the plans was in
term of the family planning as an integral part of the development planning,

227 On this anomaly Bose submitted suggestions to Sarkaria Committee on Centre-State
Realtions on January 15, 1975. See Bose, From Population to People., p. 357.
228 Bose, From Population to People., pp. 11-12.
229 Bose, Beyond Demography- Dialogue with People., p. 207.
231 Rao, From Population Control to Reproductive Health : Malthusian Arithmetic., p. 15.
the formulation of the programme has been in terms of family planning as an integral part of health planning. This divergence had far reaching implications for the actual implementation of the family planning programme. He further contests, ‘by hitching the family planning wagon to the passenger train of public health and not to the express train of development’, the Plan blundered.’ It is rightly observed that the ‘family planning is easier advocated than accomplished.’ Davis even said ‘family planning is a euphemism for contraception.’ Davis aptly commented on the underlying assumption of family planning programme (and the probably reason for failure) that ‘family planning can solve the problem of population growth seems to be taken as self evident.’ Bose noted what is disturbing is that the totality of the health situation has worsened in spite of the fall in mortality rates and a rise in the expectation of life. Further, the above analysis clearly shows that there appeared no consistency in family planning programmes rather from Plan to Plan perspectives and strategies kept on changing whether it may be issue of relationship between socio-economic and demographic changes, or it may be adoption of new family planning and reproductive technologies. However, to add weight to this argument, let’s quote from Rao as his authority is less likely to be challenged than mine. Rao noted, ‘in past when family planning programme utilizing a particular approach ran aground- as it inevitably did -

233 A decade later Bose and other further argued to restore the problem of population more squarely into the focus of the problem of development. See Bose et al., eds., Population in India's Development - 1947-2000., p. vi.

234 S.Chandrasekhar, Hungry People and Empty Minds., p. 15.


236 Ibid., p. 371.

the way out of the impasse was adopting a new approach built around a new technology. Thus with the failure of the clinic approach began extension education approach. But before this would really get off the ground, the intrauterine contraceptive device (IUCD) was hailed as the magic bullet to defuse the population bomb, to use militarist metaphor! The IUCD approach having failed, it was vasectomies, and that being politically costly, attention turned to female sterilisation. Yet even this seemed to lead down a blind alley [italics mine]. \(^{238}\) Santha\(^{239}\) has noted that though the family planning programme has experienced growth and expansion over the past half century, pregnancies continue to be unplanned and the current need for contraception remains substantially high. According to Jejeebhoy and Santha\(^{240}\) a vast shift in orientation is evident in a number of policy documents and programmes. The National Population Policy, the Tenth Five Year Plan and the Reproductive and Child Health programme for example all stand testimony to the fact that there is a commitment at the highest level to the broader health agenda. Unfortunately, there has been a huge schism between the articulation of and commitment to the new paradigm at the highest levels and its operationalisation at the community and grassroots level. It is rightly observed that family planning efforts coupled with the socio-economic improvements seem to hold a greater promise for the decline in fertility in India.\(^{241}\) Bose further added, 'India's family planning programme will certainly succeed if

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\(^{238}\) Rao, From Population Control to Reproductive Health: Malthusian Arithmetic, pp. 16-17.


\(^{241}\) Pathak and Singh, 'Fertility Transition in India.', p. 180.
we inject in the programme, the health and education consciousness of Kerala, the people’s involvement as in Gujarat, the contribution of the organised sector as in Maharashtra and the rural prosperity and dynamism of Punjab. We do not have to look to Singapore or Taiwan or South Korea for success stories. Mohan Rao after looking over the Malthusian and neo-Malthusian red herrings, and undertaking an exhaustive review of Five Year Plans, concluded, ‘the problems faced by the Indian family-planning programme are thus not solely technical, administrative, or strategical. The neo-Malthusian understanding of the population issue lies at the heart of the programme’s failure to understand the issue differently.’

Truly, this more than half century chequered history of India’s family planning programme and unabated population growth even today, left us to have only pity with government. But it raises questions as why family planning programmes have not penetrated into the houses and hearths of masses? Why there is mass apathy to family planning programmes or more specifically, the contraceptives? Who are the adopters of family planning? What are their characteristics? Therefore without denying the significance of variety of social sciences researches hitherto done, here is a modest attempt to explore the determinants in the adoption of family planning/family welfare programmes.

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242 Bose, From Population to People., p. 69.
243 Rao, From Population Control to Reproductive Health: Malthusian Arithmetic., p. 117.
1.4 Social Work Education, Research and Family Planning

Family planning rests heavily on multi-disciplinary approaches and inputs, and ‘is no one’s sole domain’. Similarly, Pathak reviewing objectives of family planning in the country (India) and elsewhere noted that we can group them under four headings- demographic-economic objectives, welfare of the families and the children, health of the mothers and infants, and lastly, improvement of the women’s status; and thereafter, argued that family planning programmes do not exclusively belong to any one profession or discipline and that it is a multi-disciplinary field. More interestingly, ever since the very inception first global official family planning programme (in India), ‘it was felt that social workers could play a significant role in its success.’ Cogently clustering the history of social work and family planning in India, Indira Patel laments:

However, neither the Government nor the profession recognized it (family planning) as a potential field of social work practice and consequently social work profession remained outside the programme even till 1970. There has been a dynamic change in the attitude of social work educators

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towards the role of social work profession. From its mere ameliorative approach it has accepted the challenge of social change and the need of mobilisation of its knowledge and skills to the tasks of planned social development. It has come to recognize that family planning programme is one such programme of planned national change and development and consequently social work educators have cared to transcend the frontiers of their clinics and of the small group settings to visualize their role in this challenge of national attitude and behaviour modification [addition and italics mine].

During 1970s there seemed to be a spurt of social work initiatives in family planning. For example, the International Conference on Social Work Education organised a workshop on the theme ‘Family Planning and Population Dynamics’ at Manila in 1970 and focused the attention of social work educators all over the world in general, and in the developing countries in particular, to their role in the national family planning programme. In the same stream recognising the needs for national consideration of the challenge, the Association of Schools of Social Work in India (ASSWI) organised a five days workshop on the theme Social Work Education and Family Planning to help determine the role of schools of social work in promoting social change and development in India through focus on family planning programme. In his keynote address to the same ASSWI workshop, Gore noted, ‘we have, however, gradually come to realise, that in spite of campaigns of mass

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247 Ibid., pp. ix-x.

248 Basically, the decades 1960s-1970s are considered as the golden period of demographic studies in India, and even in third world countries, so it is no accident that there was an upsurge of initiatives to explore the role of Social work profession in family planning and the typology of relationship and need and necessity of social work research in this area.

249 Cited in Patel, "Introduction.", p. x.

250 Ibid., p. x.
vasectomy and free distribution of contraceptives, the results achieved are often marginal; something is still left undone, and there is something more to family planning than the mere availability of contraceptives at low cost. The user has to use the available method and this depends upon psycho-social factors. Family planning in turns has social consequences for the practising individuals and this is only being realised gradually [italics mine].

Lydia Rappaport in her attempt to quantify the social worker’s roles and functions in family planning, outlined the scope of family planning and stated:

One key concept is the regulation of fertility by preventing unwanted pregnancies by spacing the number of children desired. This gives families mastery over their reproductive functions and enlarge their capacity for choice and self direction in individual and private family goals......Family planning is also embedded in the health matrix and seeks to make an impact on foetal wastage, prematurity, maternal mortality and morbidity and child health. It is also rooted in concepts of social and psychological well being in its emphasis on strengthening the quality and stability of family life. Thus it becomes a measure for positive mental health. Family planning objectives include not only conception control but also help with problems of infertility, although this dimension is unplugged in actual practice. Thus family planning deals with the promotion, postponement and prevention of conception.

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251 Gore, "Key Note Address.", p. vi.

Rappaport assertion is taken forward by Florence Hasel Korn who highlighted 'the compatibility of the value base of family planning and social work in regard to the right to opportunity for self-realization and the right of self-determination regarding freedom of choice in decisions affecting one's own fate. Even at the level of more instrumental values in regard to enhancing, strengthening, and preserving of family life which are the chief concerns of social work, there is almost an emphatic convergence of interest between social work and family planning [italics mine].'\textsuperscript{253} In 1972, M.S. Gore observed that the interest of social workers in family planning flows from certain premises- 'family planning is a problem of critical importance to the country and to the world. Even with the relative plenty of food in the country today, the problem of population is still a pressing one. Unless a solution is found to the problem, it can spell disaster for all over development programmes. If the problem is of such a great importance, obviously social workers must make a contribution.'\textsuperscript{254} Visaria looked from another angle and argued, 'it is possible that people like to avert the risk of being left without any children and their behaviour might therefore be governed by the least encouraging experience they observe. If this presumption is valid, those who attempt to persuade the people to limit their family size have to make a very important distinction in their appeals, depending on the group to which they talk. The social workers who deal with the problem either on an individual or on a group basis would also do well to pay attention to this very important

\textsuperscript{253} Cited in Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education.", p. 32.

\textsuperscript{254} Gore, "Key Note Address.", p. v.
phenomena. He further noted, 'the humane concern of social workers with the quality of life and their awareness of the conflicts inherent in the process of social change can reasonably be expected to help accelerate the social engineering programmes which aim at or depend on the goals and values of the people.' Rao aptly argued, 'the existing gap in educational, motivational and behavioural change efforts and services in family planning can be filled up only when professions like social work contribute their knowledge and skills to improve programme.' Noting that the association of the profession of social work with the programme of family planning is of recent origin, Nanavatty noted, 'social work is basically meant to enable individuals, groups and communities to improve their social situations, to adjust to the changing conditions, and to participate in the tasks of development. Its interest in family planning and population control is in basic conformity with its objectives......... The contribution of social work to family planning can be manifold. It may relate to direct services, to areas of motivation and communication, to supportive services, to the determination of policy, to programme formulation, and to evaluation and research.' Later in 1988 Ashish Bose noted that the family planning programme must be debureaucratised and put in professional hands aided by dedicated social


256 Ibid., p. 54.

257 Rao, "Health and Educational Approach to Family Planning-a Review of Studies and Implications for Social Worker's Education.", p. 32.

workers, taking the maximum advantage of modern methods of communication.\(^{259}\)

Thus, the relationship of social work and family planning merits endurance for a plethora of reasons. The social work profession's basic objectives, core humanitarian values and client centred approaches on the one hand and family planning inertia among Indian masses on the other, all points to need, necessity, and significance of relationship between the two. Pathak convinced of the synchronised social work and family planning dyad, pondered over the researches in family planning and the space for social work research. He aptly puts together family planning and social work research as:

The environmental aspect has been neglected in both family planning research studies and the implementation of programme. Though there has been an increase in the number of research studies on communication in the family planning field during 1960s, most of these studies have been focussed on the message, object and channels of communication. The different researches have tended “to look at the communication process from the sources point of view, rather than the receivers.”\(^{260}\) Social work as a profession has always recognised the importance of motivation in human behaviour, has given great attention to this aspect in practice and has emphasized the importance of looking at the problem from the client's point of view. *It is my contention that social workers in India are more suited to conduct studies on motivation in family planning by virtue of their orientation, background and*


professional practice. It is true that they have not done research in this so far [italics mine].

He further added that the main weakness of present family planning programme is in the latter area i.e. motivation to practice family planning and effective follow-up in case of irregularity or complications. It is in this respect that social work can, make a very effective contribution. Bhendre is of opinion that family planning studies can broadly be categorised under the following heads: KAP (Knowledge, Attitude and Practice) studies, studies of acceptors of contraception, and communication studies and in her background paper on social work research she even suggested that social worker has legitimate claim to be involved in research in all the three areas. Gindy has raised the question why those fields of research should be of particular interest to social workers when those have already engaged the attention of sociologists, anthropologists, psychologists, and other social and behavioural scientists. The answer lies in the social worker's unique knowledge of the individual, his behaviour, feelings, values, attitudes, anxieties and family relationship all of which are major factors underlying any social work research carried out in the field of family planning.

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262 Ibid., p. 79.
264 Ibid., p. 140.
In view of *supra*, the relationship of social work and family planning is well established and grounded. However, in India it was a hot topic decades ago, does it still has enough warmth to be picked up for the social work research exploring the personal and familial characteristics in the adoption of family welfare programmes! Here, it is suffice to mention that in India of new millennium-high unmet need (for contraception) exists, contraceptive technology is available, post-Cairo new population policy clarion for informed choices, client centred target free approach but population growth is unabated and more pressing than of the time when there was spurt of studies and social work was no exception. Thus, the gravity of problem on one hand and paradigm shift with client centred approach on other, together provides not only much space to social work research but makes it inevitable for a profession that is heavily rooted in client centred humanitarian philosophy. Further, given the cultural diversity of country, as social workers we must, to borrow from Jeanne C. Marsh, 'give much consideration to effective social work practice in a multicultural society.'\(^{266}\) The consequent sub-chapters (on literature review and justification of study) and the next chapter (on research methodology) attempt to elaborate the need, necessity and rationale of undertaking present research, and the modalities of undertaking the same.

1.5 Literature Review

Bose\textsuperscript{267} review of progress in demographic research in 1970 not only observed increasing emphasis on fertility and family planning surveys in Indian demography (which at present is not our cause of concern) but did show the persistence of population studies in pre-independent (as already discussed) and in post independent India. His article mentioned Tara Patankar\textsuperscript{268} whose bibliography of fertility studies listed 200 such surveys while another bibliography prepared by Kapil and Saksena listed 245 studies on sterilisation and KAP (knowledge, attitude and practice of family planning) in India conducted since 1950. K.G. Rao\textsuperscript{269} reviewed 550 such KAP studies on fertility, family planning and contraceptive practice since the launch of national family planning programme but she seemed not very amused of the scope of these studies. As stated earlier one has to be very parsimonious (others may differ) with this literature of oceanic depth on the issue of population, fertility and family planning. One may ask if such is the gravity of available literature why is the present research! Leaving the answer to be answered later on, in the forthcoming paragraphs an attempt is made to review the major much quoted studies across each decade to understand the nature of these studies and accordingly the need for the present one.

\textsuperscript{267} Bose, "Studies in Demography."


\textsuperscript{269} K.G. Rao, Studies in Family Planning: India (New Delhi: Abhinav, 1974).
The Mysore Population Study\textsuperscript{270} (MPS) conducted in 1951-52, a joint venture of United Nations and Government of India provided valuable information on births, deaths, age at marriage and the motivational aspects of fertility regulation. The MPS collected data from about 10,000 households in rural and urban areas of the old Mysore State and was an experiment in the use of sample survey of households to measure the trends and characteristics of population and also to examine the inter-relationship between fertility behaviour and socio-economic development. A clear positive association between fertility and economic status in rural areas was observed. In the urban areas the lower non-manual groups and skilled manuals workers show slightly larger families than other occupational groups. The study found a curvilinear relationship, with fertility increasing with education and then declining with further education. In Bangalore city there was no appreciable difference in the fertility below the level of high school education, and in rural areas, the illiterate were less fertile than women who were literate or had attended the upper primary and middle schools. The lowest fertility was found only among women who had above high school and University education. More importantly, study found that the economic advantage of children to the parents either in the immediate future or in the old age was most important reason for having a large family. It was further noticed that the motive for having a large or small family size was mainly parent-oriented i.e. the motives were perceived advantages for parents and not for children. Some other reasons which are conducive for having more children were ‘to avoid community criticism’, ‘to follow the community pattern’, and ‘to follow the

example of friend or relatives’. The findings of the study indicate the importance of understanding the whole social milieu of the respondents before analysing their fertility behaviour.

The early years of 1970s witnessed the famous Khanna study in Punjab by Wyron and Gordon\textsuperscript{271}, and its re-study by Mamdani\textsuperscript{272}. The Khanna study, based on experimental design comprised three study areas, that is, one study population and two control populations in Ludhiana district of Punjab. The study population were to be served by a resident staff to make monthly household visits to acquaint each family in the sample with the advantages of family planning and to supplement the necessary material. One of the control areas was used to measure the influence of data collection while the other was used to obtain data on births and deaths. Participant observation was claimed to be the standard method of fieldwork in this phase of the study although it explored sexual and contraceptive practices. The definitive study lasted four years from 1956-60. For most of the first year, acceptance of contraceptive approximated the expected 25 per cent of all eligible couples. Towards the end of 1957, acceptance rates declined and never subsequently reached a figure that could have made a difference in the birth rates. However, both the authors observed that over population is a melody of society that produces wasted bodies, minds and spirits just as surely as other familiar scourges- leprosy, tuberculosis, cancer. These observations clearly smack of the authors master’s voice, the funding organisations which included Rockefeller Foundation and


their neo-Malthusian *mantra*. Fortunately, Khanna villages were revisited by Mamdani to refute the high hearted claims of Khanna study *in verbatim*. Mamdani sought an alternative understanding of the population problem-by locating the problem in a context, by way of understanding the living and working conditions of the population, the role of technology in a given social context, the importance of the family labour, and the influence of all these factors in shaping the desired family size. He argued that given the material conditions of the population studied, there existed a necessity for family labour, which in turn determined family size. There was, therefore, rationality in the given socio-economic context for the peasant’s desire for a large family. This desire then was not rooted in either ignorance or irrationality. Indeed, he concludes that by and large, for all section of the agrarian population, resorting to family planning would be ‘to court economic disaster’. Thus, unlike ‘super’ rationality of Khanna study, Mamdani’s plain logic proposes to see fertility in the prevailing socio-economic and demographic conditions. It may not be hyperbolic to say that large family size of the sampled population reflected nothing but the survival strategy of rural masses in an age of high mortality. Towards, the close of 1970s Khan\textsuperscript{273} came up with *Family Planning among Muslims in India*, based on a sample of 330 Muslim couples randomly chosen from the Muslim dominated localities of Kanpur city. This micro-exploratory study (as author claimed) is discussed here for two reasons, one it was a brilliant attempt to correlate and single out determinants of fertility (demographic, socio-economic, family and psychological variables) and contraception adoption using sophisticated statistical tools and secondly, it has

\textsuperscript{273} Khan, *Family Planning among Muslims in India.*
as its sample, a community, that is Muslims, who are much quoted as apathetic to family planning. Khan argued that total number of children dead, perceived child mortality and the sex preference of wife were negatively associated with contraception and also noted that looking at the set of regression equations for the total sample, it appears that the number of living children, husband-wife communication, husband-wife empathy and perceived burden of children are all equally important predictors of family planning acceptance. The study showed that just 50 per cent of the total sample had used contraception at one time or other and thus contradicts the general belief that Muslims does not accept family planning. However, the limitation with the study was that it became more quantitative (though author made liberal use of respondent ‘typical’ responses in their language) and therefore failed to highlight dynamic processes in the contraceptive adoption which move beyond the couple, around whom author’s indexes (for example husband-wife empathy index) and regression results revolved.

In 1980 Desai\textsuperscript{274} came up with brilliant sociological critique of family planning studies and fallacy of programme approach. He reviewed and quoted from major preceding pioneering works, (for example Agarwal\textsuperscript{275}, Mukherjee\textsuperscript{276}, Banerji\textsuperscript{277}, Kavoori\textsuperscript{278}, Dandekar\textsuperscript{279}, Mitra\textsuperscript{280}, and many

\textsuperscript{274} Desai, \textit{Urban Family Planning in India}.


\textsuperscript{276} Ramkrishna Mukherjee, \textit{Family and Planning in India} (New Delhi: Orient Longsman, 1970), p. 15


\textsuperscript{278} Kavoori, "Reconstruction of the System.", p.21.

more), who have highlighted the limitations of family planning programme and reasons for debacles in the successive Five Year Plans but did emphasize the importance of programme and the need to curb population growth. Desai in the same fashion lambasted on government’s much focus on ‘population control’, targets and strategies and finally made a very strong ‘submission’ for programme failure and argued that, ‘unless the family planning programme examined in the context of socio-economic development that is taking place in India as a consequence of planning based on capitalist mixed economy path, the above mentioned shifts can never be understood.

It is puzzling that our established scholarship, while pointing out some of the limitations of family planning movement have never systematically laid bare the basic relationship between the path pursued for national development and the “population control” assumption adopted for the family planning movement [italics mine]. Thus, he blamed the very path of developmental planning for the family planning debacles and

280 Mitra, India’s Population- Aspects of Quality and Control.

281 All these studies made cogent analysis of necessity of curb on population growth, common man rationality of having large families and wrong premises of family planning programme which per se is not bad. These scholars have also dwelled heavily on limitations of researches on family planning. Mitra’s, for example, exhaustive account of limitations in researches undertaken also include the ‘overlapping and repetitive nature of KAP studies undertaken since 1950-52.’ Mukherjee lamented the lack of perceptual data to explain why people have not taken to family planning as a self generating process.

282 For example Mukherjee observed ‘the family planning to reduce couple-children ration appears to be needed on two main counts- 1. The population growth rate affects adversely the present rate of economic growth, as measured by, say, GNP per capita. It thus does not lead to economic development. 2. The rapid increase in population creates difficulties to produce adequate education, health facilities, social and cultural amenities, etc; in order to bring the people on par with those in the ‘developed’ countries. It thus affects the course of ‘social development’ [italics mine].’ (p. 17).

283 Desai, Urban Family Planning in India., p. 146.

284 More recently the Indian model of development is again questioned by Ravindra as being ‘a major cause of its current economic conditions i.e. it seeks increased productivity rather than an equitable distribution of resources, and subsidies in public health and education for the poor. See T.K. Ravindra, “Women and the Politics of Population Development in India,”
towards the end of the book he became very critical (even pessimistic) and opined that 'India's approach brings to mind Barry Commoner's words in *The Closing Circle*: “war is a means of solving a social issue, not by social means but by a biological process, death.” The same is true, I believe, of enforced population control.  

In this decade (1980s) a very large scale field study was carried out in five districts of Uttar Pradesh by Mishra and others to understand the functioning of family planning programme and the reasons for the poor response it received. This study utilizes what is described as an open system framework to emphasize the interrelatedness of factors-economic, social, demographic and organisational- which govern family planning acceptance. The study covered a massive sample comprising 45 primary health centres (15 each in poor, average and well performing PHCs selected at random) and 3000 couples selected at random. The significant findings that emerged were that the mean household size and land ownership are positively related. The landless poor thus have the smallest household size. Infant and child mortality were extremely pervasive with the majority of families experiencing the death of at least one child; of those who had more than two live births, the majority had seen at least one child die. Possibly because of its pervasiveness, infant and child morality data is not presented in relation to income and landholding. Given the nature of agrarian economy, it is not surprising that a substantial proportion of the population felt that children

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286 B. D. Mishra et al., *Organisation for Change: A System Analysis of Family Planning in Rural India* (New Delhi: Radiant Publishers, 1982). On similar pattern were empirical studies in other states on India for example R. Anker and M. Anker, *Reproductive Behaviour in the Households of Rural Gujarat* (New Delhi: Concept, 1982).
played an important role in the household economics—although this data is not provided by income or landholding categories. The study concluded that socio-economic conditions act as a barrier to fertility reduction. On this Rao\(^{287}\) noted the ‘neo-Malthusian thinking turned on its head!’ According to Rao, while the critical importance of socio-economic factors is glaring the authors themselves do not give this the attention it deserves. Thus, much of the data—education, age at marriage, desired family size and so on—is not presented in relation to landholding or income strata. The study does note that income, caste, education, and landholding are closely related. Towards the close of decade Bose\(^ {288}\) presented a very exhaustive account of family planning programme, its inherent fallacies and unavoidable promoters (donor agencies) in his two volumes *From population to people*. The title itself reflects the coercive family planning promotion during emergency and urgent need of people’s participation\(^ {289}\). Overall both volumes are an excellent critique— one dwells more on family planning programme, family planning

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\(^{289}\) A full fledge study was undertaken in two major states of India i.e. Madhya Pardesh and Gujarat to explore the possibility of people’s participation in family planning. The study examined two models i.e. NGO model and Panchayati Raj model and find that peoples are much ready provide effective mobilisation and in the same NGOs were more successful. V.A. Pai Panandiker and Ajay K. Mehra, *People’s Participation in Family Planning* (New Delhi: Uppal Publishing House (under the auspices of Centre for Policy Research), 1987).
inertia among masses and ways out of impasse while the second volume highlights unfruitful contribution of donor agencies, target centric bureaucracy and family planning initiatives in other countries, from where our policy makers frequently draw much inspiration, so Bose helps them out!

During the 1990s, one of the major qualitative and empirical work was the ethnographic study of fertility behaviour in Rajasthan by Patel, published in 1994. The study attempted to understand fertility behaviour as an integral part of the village society and highlights the view that instead of measuring directly the impact of socio-economic factors on fertility, substantial insight are gained in exploring and analysing the specific institutional mechanism through which socio-economic factors operate. The findings reflected the socially prevalent prescriptions and proscriptions about—when to begin fertility career and when to end, and how many children (socially optimum number) and of what sex. The cosmology and even social onomastics reflect and reinforced fertility practices, as well as social management of pregnancy and childbirth. The study also documented the pervasive occurrence of infant and child deaths, with every woman in the study village having lost a child or more and noted that social norms of fertility and the repository of experiences of past and present fertility and mortality continue to influence people’s behaviour in favour of high fertility. The study also appreciated indigenous fertility control measures (their effectiveness immaterial), and that the sterilisation is ridiculed in village society while modern temporary methods like condoms, pills and IUD are

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290 Patel, *Fertility Behaviour*. 

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unmanageable. However, it seems that Patel herself was overwhelmed by her attempt to have integrated view of fertility behaviour and overlooked the plights poor reproductive trajectory of women (though she noted and shared bitter pregnancy experiences of women and their clarion for ‘injectables’ to restrict fertility) and high unmet need for modern contraceptives as the traditional methods are of doubtful value. This study proved to a large extent that fertility behaviour is culturally determined rather than by socio-economic variables. However, like the macro socio-economic fertility studies this study reached the same end by its quest to find answer in micro cultural practices.

After Patel’s empirical study, came an edited volume *The Family Welfare Programme in India* by Hari Mohan Mathur, containing a good mix of critiques and empirical studies written by great and goods of time. Bose in his introductory chapter presented the changing paradigms of family welfare programme, while Talwar analysed the demographic transition in India and was supplemented by Pathak and Singh’s chapter on fertility transition in India. Mathur himself brilliantly presented the social and cultural influences in fertility (moving close to Patel) and argued that there is a need to understand the people’s beliefs and tradition to replace them with new ones. In 1996, Zodgekar reviewed the basic philosophy of the family welfare programme and the role of development and population-influencing factors. Citing a number of studies showing programme contribution to, ‘large scale awareness about family planning, contraceptives and available facilities’; ‘increasing

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291 Mathur and HCM Rajasthan State Institute of Public Administration, eds., *The Family Welfare Programme in India*.

292 Zodgekar, "Family Welfare Programme and Population Stabilization Strategies in India."

number of sterilisation operations, IUD insertions and use of other contraceptive methods. Zodgekar raised the basic question ‘whether the decline has been sufficiently large to merit applause for the efforts of family planning programme’ and is of the view that ‘birth rates and total fertility rates are still too high’. With regard to number of acceptors of family planning and their demographic characteristics he observed that, ‘though the couple protection rate has increased from 10.4 per cent in 1971 to 44.1 per cent in 1991, most of this increase has been achieved through sterilisation. Also there has been some inconsistency between the couple protection rates and total fertility rates observed among various States. This raises a question concerning the accuracy of reporting the non-reversible methods used and the effectiveness with which they have been used. The demographic characteristics of the couples concerned also are not very conducive to a steep decline in fertility. The mean age of acceptors is above 31 years. These couples on average have at least 3.3 living children. This profile has hardly changed over the years. This means that the programme has not been very successful in recruiting younger couples with lower parity. He further argued that ‘it is essential to net “high-risk” couples in order to ensure the future success of the programme. Such couples naturally will be young and of lower parity. Because they would not be suitable candidates to recruit for sterilisation, attention certainly must be given to the

need for expanding the use of reversible methods.' On the issue of development and population influencing factors, Zodgekar made two very significant observations. One that 'unless significant progress is achieved in improving the status of women (i.e. education, health and labour force participation) in India, a further reduction in fertility is highly unlikely [addition and italics mine].'^297 Secondly, on socio-economic conditions and family planning he was emphatic enough to conclude- ‘there exists a threshold above which socio-economic development has to rise in order for the small family norm to prevail in society [italics mine].'^298 The contribution of socio-economic conditions has also been validated by a good number of previous studies. Based on an analysis of 94 countries, Mauldin and Barelson^299 observed that, although programme efforts are important, programmes in countries with a better social setting are more successful. Bongaarts and others^300 have observed that socio-economic development and family planning programmes “operate synergistically, with one reinforcing the other [italics mine].” Even almost two decades before Bongaarts, Asok Mitra lamented that ‘few have stressed that economic growth and population control are the two sides of the same coin.’^301 Kulkarni and Rani comparative study of fertility declines in China and India also lends support to the good mix of strong programme and moderate socio-economic conditions for better results.

297 ibid., p. 21.
298 ibid., p. 22.
They concluded that 'the comparison of the fertility transitions achieved in China and some parts of India reveals that the decline in China has been more impressive than that of India and the decline has been achieved in a very short time. It is true that the socio-economic conditions in China were more favourable to a fertility decline than those, existing in India, but China’s superiority was not overwhelming enough to attribute the difference in the declines to socio-economic factors. The Indian State of Kerala, which has a social setting comparable to that of China, has also experienced a large fertility decline but at a slower pace. Clearly, China’s birth control campaign has played an important role in speeding up the fertility transition.'

There took place two very significant events in 1990s which gave a lot of raw material to hungry researchers that is National Family Health Surveys conducting during 1990-92 (NFHS-I) and 1998-99 (NFHS-II). These NFHS surveys offer some extremely interesting data on demographic differentials and some of their determinants. Chaudhury on the eve of NFHS (1992-93) examined the interstate variations in fertility in relation to certain aspects of female status and the survival status of children. Female status is measured in terms of a woman’s access to work outside the home and education. The survivorship status of children is determined by two indicators: (a) infant mortality rate and (b) child mortality rate. The bi-variate relationship is examined by using the technique of Parsonian correlation coefficients which

lend support to the hypothesized relationship between total fertility rate on the one hand and female status and child survival status on the other (i.e. higher the proportion of women in a State who are working outside the home for someone else, the lower is the fertility rate of that State; higher the proportion of women in a State who are formally educated, the lower is the fertility of that state and lastly, higher the infant/child mortality levels of a State, the higher is the fertility of that State). Further, the results of multiple regression analysis confirm child mortality as the single most important variable affecting fertility, followed by the work status and education. Chaudhury very rightly argued that the ‘female labour force participation will not result in lower fertility *per se* unless there is greater incompatibility between the roles of mother and woman.'^306 On the basis of this macro level analysis he also concluded that the ‘higher the proportion of women in a state completing less than primary education, lower is the fertility of the state. The implied female education elasticity at the point of sample mean is 0.125 for total fertility. The point estimate implies that, at the sample mean, with a 1 per cent increase in the perception of women in a state with less than a primary level education is associated with a 0.83 per cent decline in fertility, and this decline is significantly different from zero.'^307 The NFHS-II found that contraceptive prevalence had increased from 41 per cent in 1992-93 to about 48 per cent in 1998-99, with female sterilisation being, of course, the mainstay of the programme. Unmet need for contraception is highest—about 27 per cent among women below the age of 20 years, this need is entirely for reversible and spacing methods. Unmet need is also high among women in the 20-24 years

^306 Ibid., p. 60.
^307 Ibid., p. 67.
age group, with about 75 per cent of this group needing spacing methods. The NFHS for 1998-99 also reveals that the TFR reflecting socio-economic deprivation is 3.15 for Scheduled Castes (SCs), 3.06 for Scheduled Tribes (STs), 2.66 among Other Backward Classes (OBCs) and 3.47 among illiterate women as a whole. In contrast, it is 1.99 among better of women educated beyond class 10. The NFHS reveals that the IMR among the SCs, STs, and OBCs was 83, 84 and 76 respectively compared to 62 among others. About 72 per cent of births among the SCs women and 81 per cent of births among the STs took place at home, compared to 59 per cent among others. Conversely, only 21 per cent of births among SCs and 18 per cent among STs women took place in a medical institute. Of the total home deliveries among SC and ST women, more than 40 per cent were attended to by the TBA or a dāī. Only 36 per cent of women among SCs and 23 of women among STs received the attention of public health personnel. Thus, the NFHS data clearly reflects socio-economic conditions and variations in other indices whether that may be mortality or contraception adoption. However, the unmet need for family planning is substantially higher among the poorer groups. This again refute the poor logic of neo-Malthusians that poor profligate.

Among the studies of the present decade, is the empirical study of the two districts of Andhra Pradesh undertaken by Neeraja on a sample of 800 fecund women. The study mainly focused on correlating the maternal, child health and family planning services and concluded that types of services extended by the multi purpose health worker (female) is the lone variable

which has shown a significant influence on the family planning adoption. Overall a very poor adoption of contraception was observed in the study area and the reasons ranged from fear of side effects, need of more children to unwillingness of husband. However, study failed to look beyond the service delivery system in contraceptive adoption and other dynamics and determinants of family planning. In year 2004, came the brilliant critique (that reminds us of Bose 1988 humorous accounts) of hitherto population studies and family planning interventions by Mahon Rao\textsuperscript{309} a much-awaited volume in wake of Cairo conference. The author has brilliantly tried to engage with ideas, exploring the contexts and the contradictions. His primary purpose has been to locate and critique the family planning programme in India, its assumptions, unstated biases, and implications. Author noted since everyone who matters agrees that population is the biggest social problem in the country, how is it that the family planning programme, one of the largest public health initiatives in the world, has consistently fallen short of its objectives? Even if one were to agree that the issue is bringing down growth rates for the good of the nation, are we approaching the problem as we ought to ensuring health and security to peoples lives? If not, why not? Accordingly to Rao we have posed the question incorrectly, and have thus come up with answers that have been seriously misleading, putting the metaphorical cart before the horse, in a country where the vast majority of people have, of course, neither cart nor horse. What has occurred therefore is that issues of health have not received the central attention they ought to have. Health has become divorced from levels of living, of condition of work, of access to food,\footnote{Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic}.}
of striving for quality, and justice; it has come to be equated with doctors, hospitals, and technical interventions. Looking over the exhaustive and systematic criticism of changing (but unfruitful) strategies of family welfare programmes, especially under foreign influence, it seemed that author has negated the very relevance and utility of family planning. However, probably sensing the same, Rao himself (towards the end) noted, 'I am not arguing that family planning technology is not important, that people do not need it, that women in particular, do not seek it. On the contrary, my argument is that contraception is a right. It is a right as much as, and closely imbricated with, a right to health, a right to development, a right to security of our lives and our children's lives, and indeed a right to hope for the future?'³¹⁰ Author also pondered over the question- why some groups have more births than others? Could this have something to do with high death rates? What is the distribution of births and deaths among different segments of the population? When I looked for data on births, deaths and family size by socio-economic groups, I found very little that was worthwhile, reliable, and consistent. The truth of the matter, of course, is that we have not looked for better data, since we have not imagined it [italics mine]. Visaria and Visaria³¹¹ came up with a more demographically sound and analytical paper outlining changing population dynamics since independence- be that population composition, fertility rates by age, household size, female headship, participation of women in economy, contraceptive prevalence, and more importantly population momentum (youth distribution in population) which impedes fertility decline.

³¹⁰ Ibid., pp. 269-70.
³¹¹ Visaria and Visaria, "India's Population."
Santha attempted to understand the dynamics of contraception adoption and made a thorough analysis of the NFHS-II data and outlined the areas of future research which includes among others- gaining a better understanding of how much women and men make choices and negotiate trade-offs among methods, research to understand why women discontinue use, and more importantly research on the attitude and practice of men regarding fertility regulation.

There is another very important and recent empirical study (published in 2006) which has used the Amartya Sen concept of ‘well-being’ in studying the family planning adopters in rural Mexico and findings of the study are worth important to quote here. This rural Mexico study, based on a sample size of 300 women distributed across six communities of Chiapas in rural Mexico used structured questionnaire and some open questions about their pregnancies history, with their use of contraceptives, and their opinion of traditional gender roles and life expectations. The study has brilliantly dwelled on the process of sterilisation adoption- main reasons of adoption, extent of participation in decision-making, complications and also post-operation satisfaction or frustration to sterilised women. Their analysis demonstrated that women who positively assess their paid work outside the home and actually perform such work (the willingly employed category), generally have

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312 Santha, "Contraceptive Use Dynamics."
314 Amartya Sen (1985) suggests that ‘well being’ is a combination of doings and beings that is functioning’s that may large from being well-nourished and healthy to having self respect, human dignity and the ability to participate in community life. He assigns paramount importance to the freedom to choose between alternative functioning, which he terms as the ‘capability to function’ (Sen, 1988), that is, the freedom a person has for leading the life s/he values and achieving valuable functioning. Sen further stresses that we must pay attention to both the achievement of well being (achieved functioning) and well being freedom. See Amartya Sen, "Well Being, Agency and Freedom- the Dewey Lectures 1984," Journal of Philosophy 82, no. 4 (1985), Amartya Sen, "Freedom of Choice, Concept and Content," European Economic review 32 (1988).
fewer children than those who greatly value their roles as mothers and wives (the willingly home-based category). Authors noted that choosing the contraceptive option is central to women's well-being. On the one hand, there can be conflict in the decision-making process between women’s personal interests and those of the household, as well as in the distribution of benefits derived from such decisions. Finally, they concluded, our analysis demonstrate that there is no state forward relationship between the adoption of contraceptive methods promoted by state family planning programs, and an increase in the women’s well being as defined by Sen. Several factors intervene in women’s contraceptive choices, such as their educational levels, their assessment of paid work and their actual chances of getting such work. The contribution of these factors enhances the possibility of contraceptive use in increasing the women’s well-being. In this sense, an examination of life options that rural communities offer to women is a key element in understanding women well being. Our analysis shows that local opportunities for education and paid work outside the home translate into stronger possibilities of women achieving well being. However, the study though pondered over the process and determinants of contraceptive adoption, fails to take full cognisance of the intra-house dynamics of communication and power relation (of which participation in decision making is one aspect) and cumulative effect of determinants other than employment pattern and education of women.
1.6 Justification of Study

The United Nations estimated the population of the Indian sub-continent (consisting of India, Pakistan, and Bangladesh), on 1 July 2000 as 1299 million, 1.1 per cent higher than 1284 million for China (including Hong Knog). Two of the oldest civilizations of the world together accounted for almost 43 per cent of the world population (6.1 billion) and 53 per cent of the population of the less developed countries (4.87 billion) and India is expected to exceed China’s population some time during 2045-46, according to United Nations projections.\(^{315}\) The 2001 Census of India counted down the total population of country as 1027 million.\(^{316}\) It is also noted that decadal growth of population in India is more than the population of Brazil and that the population of one of its States, that is Uttar Pradesh (UP) is more than the population of near neighbour Pakistan.\(^{317}\) With this brief demographic profile, the justification of the present research on personal and familial characteristics in the adoption of family welfare programmes begins with a question J.N. Sinha raised more than a quarter ago. Sinha\(^{318}\) observed that the situation was well within control so long as the Malthusian devils of famines, epidemics and

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\(^{315}\) Cited in Visaria and Visaria, "India's Population.", p. 61. However, on the eve of 2001 Indian Census completion, the Census Commissioner speaking at ‘Population Trends in India: Migrating Towards New Realities’ claimed that by 2050 India’s population is estimated at 1528 million and will be larger than China’s 1477 million population (Times of India, New Delhi, December 4, 2001). This reducing in the target year (from 2050 to 2045) in which India’s population will exceeds that of China, further reflects the high growth rate of Indian population.


wars were in action. But what is the price that we have to pay for chaining these devils? He further cautioned at present many physiological and cultural factors keep Indian fertility below the biological limits. Malnutrition, early maternity, neglect of women, ban on widow remarriage, prolonged lactation after child birth and the practice of young wife staying with her mother all inhibit fertility. What of future? The answer to this question today, nor at any time, definitely does not lie either in unleashing Malthusian devils or in any recourse to past practices just mentioned. It is here that Davis very carefully and cogently noted that there is no reason to abandon family planning programme, contraception is a valuable technological instrument. It is this increasing importance of contraception that paves the way for the present research. The historical data abounds the explanation for the fertility differentials between different social groups. With Malthusian pessimism the very notion of positive relationship between population growth and nation’s development was put under the heaps of dust. What spread like wild fire is the assumption that the poor are prone to profligacy and high fertility – an impediment to growth and development of society? Thus the generations of scholars and researchers devoted themselves in understanding the various shades of fertility determinants. The fertility calculus was put to social and occupational differentiations. In India ‘since the early 1960s

319 According to Visaria and Visaria an important post-Independence change in the composition of the population as regards marital status has been the decline in the incidence of widowhood, because of the decline in mortality. The percentage of widows enumerated by the Census has declined from 10.8 per cent of all women in 1961 to 6.5 in 1991. See Visaria and Visaria, "India's Population.", p. 71.


321 For example Arsene Dumont noticing widespread differences in fertility between different social groups attributed them to what he called la capillaire sociale. In this social capillary theory he made the fundamental observation that the prosperous groups in order to raise socially and to enable their children to do so, tended to have fewer children while peasant
there has been a spate of empirical studies on fertility determinants.\textsuperscript{322} However, Rao\textsuperscript{323} excellent bibliography of 550 studies on fertility, family planning and contraceptive practice during 1951-74 lamented that only a miniscule (11) number are informed of the importance of social differences in fertility. Of these 11 studies, the majority uses the caste or education as the basis of stratification. The much ill famous Khanna study\textsuperscript{324} visualized high fertility and ‘over population as malady of society that produces wasted bodies, minds and spirits.’ Mamdani who also studied the same area as the universe of Khanna study justified the ‘large families of peasants as rational given the socio-economic conditions.'\textsuperscript{325} Nadkarni observed the persistence of ‘large families among cultivators than non cultivators but among cultivators, the size of family among poor is smaller.'\textsuperscript{326} Ansari in his study also qualified the same by analyzing the households as both unit of consumption and production and those that are only unit of consumption. ‘The size was largest in units where production held the family together 4.71, while it was lower in household units which are primarily units of consumption: 4.54.’\textsuperscript{327} Similarly Mysore study\textsuperscript{328}, Uttar Pradesh study by Mishra\textsuperscript{329} et. al and Rao\textsuperscript{330} study of families not only lacked these negative inducements against children but felt a positive inducement for them. Similarly Alfred Marshall pointed out that different occupation groups within the labouring classes differed markedly in their behaviour and thus pioneering the so-called labour theory of fertility. For details see Rao, \textit{From Population Control to Reproductive Health : Malthusian Arithmetic.}, p. 125.

\textsuperscript{322} Patel, \textit{Fertility Behaviour.}, p.1.

\textsuperscript{323} Rao, \textit{Studies in Family Planning: India.}

\textsuperscript{324} Wyon and Gordon, \textit{The Khanna Study : Population Problems in the Rural Punjab.}, p. 21.

\textsuperscript{325} Mamdani, \textit{The Myth of Population Control : Family, Caste, and Class in an Indian Village.}

\textsuperscript{326} M.V. Nankarni, ""Overpopulation" and the Rural Poor," \textit{Economic and Political Weekly} 11, no. 31-33 (1976).


\textsuperscript{328} U.N., "The Mysore Population Study."
Karnataka, all have found higher birth rates among the primarily exploiting and higher socio-economic groups, namely landlords and rich peasants. Rao categorically argued that it is not cultural factors or traditions that determine levels of fertility but objective socio-economic factors such as the nature of livelihood and chances of child survival. The National Family Health Survey (NFHS-II), though concludes high fertility among poor, too recognizes that household with a low standard of living have infant and child mortality rates two or three times higher than households with high standard of living. What is common in majority of these studies is monotonic, uni-variable and uni-directional linkage between fertility and its determinants. Sen rightly argues that 'Malthusian pessimism takes attention away from investigating what prompts people to make the fertility decision they make and how these choices depend on the large number of material and other conditions within which they live and work.' Khan very rightly noted that all human behaviour is governed by the social and cultural milieu and reproductive behaviour is no exception. It is also regulated by persisting norms, values, customs and taboos of society. Rao also argues that the 'major problem with plethora of studies is that they tells about certain

335 Rao, *From Population Control to Reproductive Health: Malthusian Arithmetic.*
associations ignoring other factors that are equally significant.' Thus, the major limitation of these studies is inability to cross classify multiple determinants of fertility. More recently Patel\textsuperscript{336} highlights the major gap in past studies and stressed heavily on exploring the specific institutional mechanism through which socio-economic factors (so called major determinants of fertility) operate, and linking the objective conditions of life with people's subjective orientation to understand the most intimate of human behaviour i.e. fertility behaviour.

Furthermore, it is interesting to note that almost all the major Indian studies on fertility and family planning abruptly ends at fertility decisions, failing to take cognisance of further interplay of intra-house dynamics of communication and power relation in the contraceptive adoption. There is much more to explore and to understand the interplay of forces in between i.e. after the 'rational' fertility decision, and before the contraceptive adoption. Further, given the collective nature of Indian society every actor and his actions are socially conditioned of which contraception is no exception and hence an urgent need to review and explore the personal and familial characteristics on one hand and intra house dynamics of communication of power relation which together conditioned the process of contraceptive adoption. More interestingly, the champions of family planning (irrespective of differences in their shades) all dovetailed to indiscriminately focus on 'enlightened individual wisdom'\textsuperscript{337} to

\textsuperscript{336} Patel, \textit{Fertility Behaviour}.

\textsuperscript{337} Interestingly, there are studies such as those of Hawthorn who in their attempt to explain the social determinants of fertility, stresses that the explanation of fertility behaviour must begin with the individuals. He believes that the attempt to explain the fertility pattern have suffered by too little concern with individual reasons for their behaviour and too much
make use of multiple innovative family planning and reproductive technologies and thus to contribute in population control and nation’s development and in this race completely ignored Indian social matrix. G.R. Bannejee\(^{338}\) renowned social work scholar observed that western society is far more individualistic, whereas, role-definition in India requires a person to be ‘duty’ oriented towards their family, community and only least at all, to themselves. Noted sociologist Kingslay Davis also qualified the above observation and noted:

> Unfortunately, the issue is confused by a matter of semantics. “Family planning” and “fertility control” suggest that reproduction is being regulated according to some rational plan. And so it is, but only from the standpoint of the individual couple, not from that of the community. What is rational in the light of a couple’s situation may be totally irrational from the standpoint of society’s welfare. The need for societal regulation on individual behaviour is readily recognized in other spheres—those of explosives, dangerous drugs, public property, natural resources. But in the sphere of reproduction, complete individual initiative is generally favoured even by those liberal intellectuals who, in other spheres, most favour economic and social planning [italics mine].^\(^{339}\)

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The present research aims to revisit family welfare programmes but from their roots i.e. Indian social milieu. The study thus attempts to fill this gap and to overcome such inherent limitations of studies on fertility and family planning. The study focuses on the multiple determinants of fertility and adoption of family welfare programmes and the social institutions through which these determinants operate and put to practical and subjective realms. The family is taken as the most pervasive of all social institutions, given the collective nature of Indian society in which family regulates the seamless but subtle relationship between individual and the society. It is rightly noted that a family in India, as elsewhere, is a corporate group whose members act together to meet their common purpose. Each person learns the fundamentals of his culture and society from his family. Mandelbaum further cogently noted ‘every social system, whether relatively complex or simple, rests on these natural systems (i.e. biology and ecology). These natural systems can be called parasocial system in the sense that they constantly and directly impinge on social relations. As for biological factors, the consequences of the new social controls over diseases have been much discussed in the demographic literature and need only to be mentioned here. These controls

340 For example Desai noted that among the institutions that compose rural society, the family is the most important. It has been its very foundation. It plays a decisive role in the material and cultural life of the rural aggregate and in moulding the psychological characteristics of the rural individual as well as the rural collectively. He, however, also commented on the undergoing qualitative transformation and the fact the rural society is acquiring quite a new gestalt. A.R. Desai, *Rural Sociology in India*, (Reprint 2006) Fifth ed. (Bombay: Popular Prakashan, 1978), p. 31, 37.

341 George Peter Murdock, for example, concludes (in *Social Structure*) on a sample of 250 societies that 'the family's functions for society are inseparable from its own functions for its individual members. It serves both at one and the same time and in much the same way.' For this and more critical views on the institution of family see chapter 8: The Family in M. Haralambos and R.M. Heald, *Sociology- Themes and Perspectives*, Twenty-ninth impression (first published in 1980) ed. (Oxford: Oxford University Press, 2006), p 331.

have been made possible by the mega social system of medical science and have been mainly implemented by governmental agencies. Their success makes necessary new social adaptations of many kinds, a principal one being for greater controls over the biological forces of procreation [addition and italics mine]. Family, thus, can provide the threshold energy needed for this social adaptation by promoting small family norm and contraceptive adoption. The 'Indian family' is the unique social institution in which and through which socio-economic determinants of fertility decision and family welfare programmes adoption operate. Unfortunately, even in all the government programmes on family planning, now family welfare, focus remains on individual 'couple' instead of 'family'. Desai survey of literature has shown that 'the government has acknowledged “small family norm” for family planning programmes, without at all defining what is a family. The world family is nowhere defined [italics mine].' Interestingly, the item 3.1 of the Report of the Committee on Small Family Norm states 'the responsibility of the couple to their children and society at large has to be invoked. In large measure, appeals about the happiness and welfare of the family and children

343 Ibid., pp. 405-409.
344 For example Patel noted that there are socially prevalent notions about when to begin, when to end, and how many children of what sex are ideal to have. The response of the significant others means a lot to the mother, as does her fertility performance to the family and the community. See Patel, Fertility Behaviour., p. xxvii.
345 Similarly, Bose noted that the population control programme is called mistakenly as the family planning programme because the family is nowhere in the picture. See Bose, From Population to People., p. xiii.
346 Desai, Urban Family Planning in India., pp. 8-9. He even argued that 'the adoption of the concept 'couple', based on individual per se is most convenient and handy one for the ruling class, which is not interested in developing family planning programme basically to make it acceptable by families for either enhancing the efficiency of the family to perform its specialised functions properly or to enhance family welfare. ....The government finds the concept ‘couple’ instead of family shorn of its social attributes very convenient in its family planning programme because it provides an excellent weapon in the hands of the government, to directly encroach on the private life of the individual’. (pp. 147-148).
have to be made so that individuals may perceive a small family to be in their personal and familial interests. In the very year in which 'small family norm committee report, saw light of day (1968), the eminent sociologists, Bell and Vogel, unlike our policy makers, have defined family in terms of family’s relation to larger society and as an institution preserving the value system of society. According to them, 'the nuclear family’s internal activities and functions they serve are always internally related to the position of family in society.' They spelled out in detail 'the interaction and intercourse of family (nuclear family) on the one hand and economy, polity, community and value system in general on the other.' They further wrote that 'the significance of the nuclear family, with regard to the society’s value system stems from the fact that the nuclear family is the smallest social unit responsible for the preservation of the value system.' Ramkrishna Mukherjee, very rightly suggested to 'examine the issue of family planning in the conceptual and empirical perspective' and also observed that 'the concept 'couple' chosen as a unit and identified with the concept 'family', for family planning movement, ignores the role of family as a sociological entity.' He warned that such a concept is of dreadful implications and pointed that even some of important 'studies did not usually take into account the possible consequences of difference in the unit of sampling and unit of observation.

349 Ibid., p. 10.
350 Ibid., p. 19.
The unit of sampling is family and unit of observation is a couple.\(^{352}\) Thus, it is unfortunate that in most discussions on family planning, the family is never discussed.\(^{353}\) Such an understanding and heavy reliance on individual couple in as intimate a matter as family planning, clearly smacks either the foreign influence\(^{354}\) (read pressure) or poor understanding of Indian society by the 'enlightened elite Indians', who are the vanguards of policy and planning. It is indeed like 'putting the metaphorical cart before the horse.'\(^{355}\) It is this limited understanding (rather misunderstanding) of family-couple gestalt that has resulted in the programme failure, irrespective of high value results of KAP (Knowledge, Attitude and Practice) studies\(^{356}\). It is rightly said that 'there is no reason to abandon family planning programs; contraception is a valuable technological instrument. But such programs must be supplemented with equal or greater investments in research and experimentation to determine the required socio-economic measures.'\(^{357}\) Talwar\(^{358}\) also argued that since the wide practice of family planning method is the only solution to bring about

\(^{352}\) Ibid., p. 16.


\(^{354}\) It is observed that the philosophy behind the programme was based on a western model (under the influence of the donor agencies). See Bose, From Population to People., p. xiii.

\(^{355}\) The phrase borrowed from Mohan Rao's eloquent description of Indian government approach to deal with health and family planning. See Rao, From Population Control to Reproductive Health: Malthusian Arithmetic., p. 14.

\(^{356}\) A great many reviewers have made sarcastic observations of KAP (surveys) 'gap'. Hauser even opined many of the KAP 'facts' are erroneous. He supported his judgement 'by the gap between the 70 per cent plus response to KAP survey question on "interest in learning" about birth control and relatively small percentage of "accepter" of clinic services offered \textit{gratis} by present action programs- frequently at levels of 7-10 per cent. This gap certainly raises serious questions about both the validity of the survey response and the assumption of rational behaviour.' See Philip M. Hauser, "On Non-Family Planning Methods of Population Control," in Studies in Demography- Essays Presented to Professor S. Chandrasekhar on His Fifty-First Birthday, ed. Ashish Bose, P.B. Desai, and S.P. Jain (London: George Allen and Unwin, 1970), pp. 356-357. Equally critical of KAP surveys were other contemporary and even present researchers. For details of each type see, Mitra, "Population in India's Development.\(\), and Rao, From Population Control to Reproductive Health: Malthusian Arithmetic.


\(^{358}\) Talwar, "Determinants and Consequences of Rapid Population Growth.\(, p. 57.\)
substantial changes in the birth, the obvious questions is – how can the use of family planning methods be increased. More recently outlining the key research areas Santha\textsuperscript{359} noted ‘gaining a better understanding of how women and men make choices and negotiate trade-offs among methods could provide useful insights for policy makers, programme managers as well as clients themselves. Future research should explore the context in which women and men exercise choice, including the power dynamics of relationship, and the interface between clients and the service system.’

In the light of discussions in this chapter it may safely be inferred- that population growth needs to be urgently curtailed; that government has experimented a dozens of strategies in more than a half century endeavour; that both unmet needs for contraception and mass inertia to family planning exists; that contraception is a valuable technology; that individual/couple centric approach is indigestive in rural milieu; that a plethora of studies have pondered over socio-economic determinants of fertility behaviour and family planning adoption; that few have explored the cultural context and constraints; that communication studies of contraceptive adopters have focused too much on source rather than the object (our subject).

The more specific questions to cogently circumnavigate these issues are- who are the adopters; how they trade-off the journey from fertility decision to contraceptive adoption; how the intra-house dynamics of communication and power relations matters in the process of adoption. In this backdrop,

\textsuperscript{359} Santha, "Contraceptive Use Dynamics.", p. 43.
understanding and exploring the dynamics of personal and familial characteristics in the adoption of family welfare programmes is the central objective of the present study.