CHAPTER II

HISTORICAL BACKGROUND OF FAMILY PLANNING PROGRAMME IN INDIA
Indian Family Planning Programme is the world's largest voluntary programme administered in a democracy. This programme is unique for the gigantic proportion of its mammoth size set in a vast spectrum of socio-cultural milieu that has transcended a variety of barriers of very complex nature. Perhaps it must be third largest operation after decennial censuses and general elections.¹

At the time independence, health care services were predominantly urban hospitals based and curative. General practitioners well versed in maternal and child health and pediatricians and obstetricians provided health care to women and children while they did not provide comprehensive, integrated, good quality services, technology for detection and management of health problems was limited and outreach of services was poor. The majority of population, especially those residing in rural areas, did not
have access to health care, as a result of which morbidity and mortality rates among them were quite high. Many women were died while illegal inducted abortions to get rid of unwanted pregnancy because they did not have access to contraceptive care. Contraception’s that were too early, too close, too many and too late and lack of ante-natal care to detect and treat problems in pregnancy resulted in high maternal and infant mortality rates. Antenatal, intrapartum, postnatal and intraceptive care was not readily available to women who required these services desperately.

Obstetricians who were daily witnessing maternal morbidity and mortality associated with high parity were willing to persuade their patients who had completed their families to undergo surgical sterilization. The fact that the techniques were simple, safe and effective and could not be done soon after delivery under local anaesthesia accounted for the popularity of postpartum bubal sterilization. The safety, simplicity and efficacy of vasectomy were also well recognized. For couples who had completed their family sterilization of one partner resulted in the reduction of maternal morbidity and mortality associated with high parity. To some extent this was responsible for decline in maternal mortality rates in urban areas during the 1950’s. However, these measures had not impact on the mortality or fertility or the population growth rate of the country as a whole because of poor outreach, especially in rural areas.²
After Independence, epoch-making events, followed one after another in quick succession in the field of population control. The Indian army took a lead in the matter. In 1949 with enthusiastic support of General K.M. Kariappa, family planning advice was included in the wealth and welfare scheme of the army. The programme has since taken deep roots in the defence services and is an important welfare service today.

An important landmark in this period was the first All India Conference on family planning organized by the Family Planning Association of India (FPAI) in 1951 in Bombay. The credit for this goes to Dhanvanth Rama Rao and her enthusiastic colleagues. S. Chandrasekhar drew the attention of the public towards this problem through his writings after careful and through deliberations the conference made several far-reaching and revolutionary recommendations.

The year 1951 which was also the year of the first decennial census in the country after Independence pointed out that the increase in population since the previous census was staggering. Shri. R.A. Gopalsami, the Census Commissioner, in his report drew pointed attention to the enormity of the increase, and the magnitude of the problem.³
FIRST FIVE YEAR PLAN: (1951-1956)

There is no doubt that the high rate of population growth affects not only the health of the mother and child but health of the economy as well. Ever since the First Five Year Plan of India was launched in 1951, Family Planning became an integral part of development planning, particularly in the context of health.4

Indian is the first country in the world to have a national policy and a programme of family planning. The National Family Planning was initiated in 1952 on a rather modest scale in the wake of First Five Year Plan as a part of the total efforts at socio-economic development in the post-independent period. The first plan had recognized that a rapidly growing population would jeopardize the programme of raising standard of living and hence, the programme of family planning was included in the plan.

The approach of this plan regarding family planning was exploratory. The effort was to make people aware of the problems and provide devices and services for planning, the family and was the first such effort made by a national government in the world. 5

It was spelt out in the First Five Year Plan that a programme for family limitations and population control should obtain an accurate picture of the factors contributing to the rapid population increase in India, discover suitable technique for family planning and device methods by which knowledge of these techniques could be widely
disseminated and make advice on family planning constitute an integral part of the service of the hospitals and public health agencies.  

The Planning Commission set up a panel on Health Programmes in 1951 which in turn appointed a committee to report on population growth and family planning with R.A. Gopala Swamy, Dhanvanthi Rama Rao, Gyand Chand, A.C.Bose and Sushila Nayar as members. In the same year, the government of India invited Abra Stone, World Health Organization (WHO) expert for conducting pilot studies on the rhythm method. Traveling widely throughout the country, Stone drew public attention to the need for controlling births. As a result of his visit two experimental centres, one each in north, Lodi Colony in Delhi and Ramanagaram in Mysore state were established to conduct studies on the rhythm method. These centres proved as the fore-runners for many subsequent research centres, to be established in the years to come.

The Family Planning Research and Programme Committee was appointed in 1953 with Major General G.K. Lakshmanan as its Chairman and C.G. Pandit and later T. Lakshminarayana as its Secretary. It included distinguished doctors of medicine, public health experts, demographers and Social Scientists in the country. The Committee made important recommendations on diverse aspects such as the scope of family planning location of centres and their
staffing pattern and accommodation training and field studies and research. In regard to methods of contraception the committee advocated the use of rhythm and the diagram and fully exhorted the sterilization schemes.

Marie Stopes had in the meantime advocated the use cotton pad and oil as a suitable method for India. Smt. Shakuntala Paranjape, who had earlier opposed the sterilization because of its being inexpensive, later became an ardent supporter of these techniques.

Thus, in the early days of the programme, the methods recommended were rhythm, diaphragm and jelly and later foam tablets. These were provided through clinics. During this plan period, 126 family planning clinics were set up in urban areas and 21 in rural areas.7

The entire first decade of India’s Family Planning Programme which had began with the adoption of First Five Year Plan (1951-1956) was period of very humble and cautious start. Although, following the model used by planned parenthood organization in the west, the setting up of family planning clinics for those who needed such services (what is known as clinic based approach) was visualized, the chief emphasis during this period was on natural method (e.g. Rhythm) while the first plan document declared that a “reduction in the rate of population growth must be regarded as a major desideration, a meager of Rs.65 lakhs out of total outlays of Rs.1,1960
crores (i.e., 0.033%) allocated to the Family Planning Programme over the five year period of which only about Rs.15 lakhs was actually spent.\textsuperscript{8}

Thus it is obvious that the first plan period progress was rather poor, even going by the mere expenditure figures.

The programme activities were confined to rendering advice on family planning in government hospitals and rural medical centres, conducting experiments on different methods of contraception and making research studies on the medical, technical and motivational aspects of family planning. During the plan period from 1951 to 1956 as many as 7,000 sterilizations were performed.\textsuperscript{9}

SECOND FIVE YEAR PLAN (1956-61)

In the second plan period it became abundly clear that population growth was more rapid than what was assumed in the first plan. The second plan therefore emphasized the urgency of arresting the growth rate of population. The Second Five Year Plan called for further development of the family planning programme on "systematic lines", and suggested integrating family planning and health education activities with community development. There had been a steady expansion of activities in the field of family planning during the second plan period. The family planning programme of this period included provisions for:
(i) Grants to state governments, local authorities and voluntary organizations for opening for family planning clinics.

(ii) Training of personnel.

(iii) Public education on family planning and population problems,

(iv) Research in human fertility and the means of regulating it and

(v) Demographic research including the study of inter-relationships between social, economic and population changes, reproductive patterns and attitudes and motivations affecting size of the family and suitable procedures for the rapid education of the people.\textsuperscript{10}

At this stage, the Planning Commissioner recommended the strengthening of the Central Organization for family planning and for augmenting the scope of the programme. A Central Family Planning Board was therefore constituted. Colonel B.L.Raina was appointed as an officer on special duty on September, 26, 1956 and later designated as Director. Family Planning from 1957, the programme further developed under the stewardship of D.P. Karmarkar, who had taken over as the Health Minister in the reconstituted Cabinet after the second general elections.
The programme now had four clearly identifiable components - education, service, training and research. Major activities included development and strengthening of the administrative machinery at the centre and in the states, liberalized and flexible assistance to voluntary organizations and local bodies' extensions of the training programme, inclusion of family planning in the medical Curriculum, people's participation in the programme follow-up support for sterilization schemes, research and measures to produce contraceptives within the country.

Research too long strides during this period, Medical Research was coordinated by the Reproductive Biology Committee of the Indian Council of Medical research with V.R. Khanolkar as Chairman and communication research by the Communication Action Research Committee with P.C. Mahalanobis as Chairman of these two committees, one concerned itself with population policy and the second with research and programmes relating to family planning.\textsuperscript{11}

In 1957, the Demographics Training and Research Centre were established in Bombay as a joint effort of the United Nations, the Government of India and Dorabjee Tata Trust. A few Communication Action and Demographist Research Centres were either established all over the country during the Second Plan Period. The research in these centres provided useful leads.\textsuperscript{12}
During the period of Second Five Year Plan Rs.275/- crores were allotted for the plan period. As a result, number of Medical Colleges increased from 41 in 1955-56 to 55 in 1959-60. The strength of Doctors increased from 7,000 to 80,700 during the same period. By the end of 1960-61, there were 32,000 nurses, 36,000 midwives, 17,000 health visitors and 12,000 dais and nurse dais.\textsuperscript{13}

In the course Second Plan the number of clinics increased to 549 in urban areas and 1100 in rural areas.\textsuperscript{14} In addition to these clinics, family planning services were provided at 1864 and 330 rural and urban medical health centres respectively. A number of sterilization centres were also established. The programme was guided by the Central and State Family Planning Boards. All the states had set-up special units for family planning work.\textsuperscript{15} As many as 152,677 sterilizations were performed during this plan period.\textsuperscript{16}

The Second Five Year Plan document also clearly identified, "an effective curb on population growth" as an important condition for important condition for improvement in the level of living, but by the end of Second Plan (1961) only 411 clinics were set up, all failing to attract expected number of clients and sterilization was not financed by Family Planning Programme till 1960. More than 50% of only Rs.5/- crore allocated to Family Planning Programme during Second Plan Period had remained unspent. The pace of increase in voluntary contraceptive acceptance by the end of Second Plan was slow and the
record of voluntary attendance in family planning clinic-based approach (in which people were expected to come spontaneously to the clinics for sterilization or other services and advice relating to fertility control) as back as early 1950 – when illiteracy rate was just overwhelming, transport and communication network was best as its infancy, and mortality levels were extremely high schools, of course a sheer immaturity of official understanding and perception of the reality. This in turn led to rethinking about the efficacy of clinic-oriented approach.\textsuperscript{17}

**THIRD FIVE YEAR PLAN (1961-66)**

The programme was recognized in the Third Plan after the publication of 1961 Census result which showed a higher growth rate than anticipated. It was towards the middle of the Third Plan that the emphasis was shifted from the clinical approach to the more vigorous extension educational approach for motivating the people for acceptance of the small family norm and for provision of services.\textsuperscript{18}

The Third Five-Year Plan (1961-66) document again expressed serious concern about an increasing growth rate of population, which had by then reached about 2 percent per annum (as was revealed by the 1961 Census). The plan document noted that "the objective of stabilizing the rate of growth of population over a reasonable period must at the very centre of planned development."\textsuperscript{19} In this context, the greatest emphasis has to be placed in the stand subsequent five year
plan on the programme of family planning. To tone up the family planning programme a special committee was appointed by the Ministry of Health and by Planning Commission's panel on health. The programme for family planning provided for

(a) Provision of services
(b) Education and motivation for family planning
(c) Training
(d) Supplies
(e) Communication and motivation research
(f) Medical and biological research
(g) Demographic research.20

It was indeed in the light of these results that the plan came out with the following 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, specially the rate of infant mortality and may for a time even tend to raise the birth rate. The objective of stabilizing the growth of population over a reasonable period must, therefore, be at the very centre of planned development. The programme of family planning involving intensive education provision of facilities and advice on the largest scale possible and wide-spread popular effort in every rural and urban community has therefore the greatest significance".21
Mr. Govind Narain summed up the philosophy behind family planning policy pursued so far as follows:

(a) The community must be prepared to feel the need for the services in order that these may be accepted when provided;

(b) Parents alone must be deciding the number of children they wish to have;

(c) People should be approached through the media they respect and through their recognized and trusted leaders;

(d) The service should be made available to the people as near to their door-steps as possible and

(e) The services will have greater relevance and effectiveness if they are made an integral part of medical and public health programme.\(^{22}\)

The main task in the field of family planning in the third Plan was to find effective solutions to certain basic problems and to mobilize all have available agencies for educational and extension work in support of family planning. To utilize such diverse agencies as private medical practitioners, indigenous doctors and village dais for family planning work along with the family planning clinics and the primary health centre needed careful planning at the local level. It was thought that facilities were needed to emphasis moral and psychological elements so that self restraint could be highlighted.
Policies like social policies, education of women opening of new employment opportunities for them and raising of the age for marriage were thought to be helpful in addition to advice on birth control. Family Planning Programme needed measures necessary to promote welfare of the family.23

Top prior importance give to the family planning programme continued with further intensification of the strategies adopted in the third plan. Instead of giving low priority to the programme, it was given high priority. The clinical approach was slowly included into what is called extension approach, increasingly broadening into what is called 'cafeteria approach' under which 'a number of family planning methods were simultaneously picks and choose any method of this choice. Extension services were established to educate and motivate people. A small amount of monetary intensive who also introduced to attract people to sterilization.24

There have been two district trends in the progress of the family planning programme since this period. One of these was to make it a community centre programme rather than a clinic centred one. The second one was to involve to a greater extend the man in the programme. The revised programme was named as the "extended Family Planning Programme", and it was discussed in a special workshop convened for the purpose in September 1963. The Government of India accepted it and an order for its implementation
was issued an October 4, 1963. Thus, the year 1963 was the turning point in the national family planning programme.

The main components of extended programme were:

(a) creation of a social climate in which the need is felt by individual families and by groups of people

(b) spreading the message of small family norm

(c) provision of readily accessible services, generally, as part of health services especially for health of mothers and children

(d) adoption of effective methods by all eligible couples

(e) stimulation of social changes affecting fertility such as education and employment of women, increasing age at marriage, etc and

(f) Research with emphasis an action research and feedback mechanism to use the findings in programme operation.

The year 1965 is of great importance in the history of family planning programme for two reasons. Firstly, the Indian Council of Medical Research (ICMR) cleared the intrauterine contraceptive trials in the preceding two years and it was included in the programme in July the same year. The other was the visit of the United Nations Evaluation Mission led by Colville Deverell the then Secretary General of the International Planned Parenthood Federation. Another notable event was the appointment of the Family Planning Programme and
Evaluation Committee by the Government of India. Both these teams toured the country extensively, interviewed family planning workers and visited training centres and research institutions. Both recommended considerable strengthening of the organization, stepping up of training activities and improving evaluation.

As consequences, the organization at the centre at the policy-making level as well as at the decision-making one was greatly strengthened. Its full implementation actually started in 1966.

During the Third Plan period research made steady progress at twenty two centres, seven demographic research centres, seven communication action research centres and eight centres conducting studies on bio-medical aspects established all over the country.\textsuperscript{25}

At the end of the Third Plan there were 3,676 rural family welfare planning centres, 7,080 rural sub-centres and 1,381 urban family centres, 7,641 personnel took regular course and 34,484 short-term courses. The Central Family Planning Institute was established at Delhi. The number of doctors, nurses and auxiliary nurses, midwives were recorded to the extend of 86 thousands, 4,500 and 3,600 respectively in 1956-66.\textsuperscript{26} Twenty Eight Regional Family Planning Training centres had also been established during this period. Besides sterilization and conventional contraceptives, Intra Uterine Device (IUD) (Lipp's Loop) was introduced on a large scale in 1965. A factory for producing loops and inserters was established at
Kanpur. The number of sterilization operations had gone up considerably 1.37 million operations were performed during the Third Plan as compared to 0.15 million in the earlier plan period.

The programme had achieved significant success but not to the extend expected. The expenditure was 248.6 million rupees against a provision of 270 million rupees which was more than eleventh times the expenditure in the Second Plan. During the same period, India had to face two wars with its neighbours and to a certain extend they gave set back to the programme for some time.\textsuperscript{26} At the end of the Third Plan Period, the birth rate stood around 41 per thousand, successful public health and curative measures had brought down the death rate to around 16. Thus the growth rate touched a high figure of 25 per thousand. This made the Government of India think hard and implement the programme vigorously.\textsuperscript{27}

**ANNUAL PLAN PERIOD (1966-69)**

A major change in this approach came about in 1966-67 family planning became “time bound and target oriented”. Method specific annual targets were fixed for the different fertility regulation methods.\textsuperscript{28} Since 1966-67 the annual targets began to be fixed for the number of acceptors of different methods of contraception. Infact, the responsibility of achieving the targets set by the central government on the basis of the desired decline of the birth rate was in turn passed on successive lower administrative units such as state, districts,
primary health centres and sub-centered and their functionaries. These services providers also were assigned quotas of work to be done. Indeed the 'tyranny of targets' afflicted the India Family Planning Programme for almost three decades until their removal in April, 1996. The introduction of Lippes Loop in 1965 necessitated a major structural reorganization of the programme leading to the creating of a separate Department of Family Planning in 1966 in the Ministry of Health. During the years of 1966-69 the programme took firmer roots.

The programme was geared towards bringing about changes in attitude and behaviour with the guiding principles to convince the individuals that the change is in their interest that it is socially accepted and that it desirable and is approved by their peers. The Cafeteria approach was made main plank for the provision of contraceptive services to the 100 million eligible couples in the reproductive age group. This met with an immediate success within a period of two years the numbers of acceptors had been nearly double, registering a record figure of three million in 1967-68. Next year the number of increased to 3.1 million. The sterilization figures rose steadily during this period and about 4.4 million operations were performed. During this period about 2.1 million IUD insertions were done. The distribution of Nirodh was stepped up as it was felt that probably this was the most widely used method of contraception. An
organization for Niradh marketing programme was set up. The first phase of massive continuous advertising and sales promotion programme was launched in selected areas on September 25, 1968. Local production of Condoms which had been encouraged during the Second and Third Plans was not able to cope with the demand. As a result, the Government of India floated a public undertaking, the Hindustan Latex Limited and the factory was established in Trivandrum, Kerala with an initial production capacity of 144 million Condoms every year.31

Another notable feature of this period was the mounting of massive programme of mass education and motivation. An abstract symbol, the inverted triangle, was adopted to take the message of family planning to every home. This symbol can now be seen in almost every nook and corner of the country. Not only this have many other countries also adopted the inverted red triangle as the symbol of family planning in their own countries. The recommendations flowing from the evaluation of the programme by the United Nations Team and Planning Commission helped in modifying the strategy of the programme at this juncture. The practice of fixing annual family planning targets was initiated during this period.32

The allocation of funds for family planning was increased to raise 83.00 crores though this amount was considered inadequate. Actual performance included 4.4 million sterilizations 2.1 million IUD
insertions and 1.3 million conventional contraceptive users. It aimed at reducing the birth rate to about 32 per 1000 population by 1973-74. The results were far from satisfactory.33

FOURTH FIVE YEAR PLAN (1969-74)

Considering the incongruities involved in the evaluation of the processes and impact of the family planning methods, methods specific targets in family planning were introduced during the Fourth Five Year Plan. Then the efforts were to integrate family planning with maternal and child health services.34 During the Fourth Five Year Plan (1969-74), the Government of India gave "top priority" to the programme.35 The 1971 Census showed that the population explosion was no longer a potential threat but a major problem that needed to be tackled energetically. The Government of India gave top priority to the family planning programme and provided substantial funds for several new initiatives. Sterilization, especially Vasectomy several services were made widely available. IUD and Condoms were made available through the Primary Health Centres (PHC). The hospital-based postpartum programme provided a contraceptive care to women coming for delivery.34

In this plan, the Government of India has recognized family planning as a key programme for the success of the country's side programme with objective of reducing the birth rate. Thus, the fourth plan stated that the India's objective of attaining socio-economic
betterment of the people can only be fulfilled if the rate of growth of population is controlled and human skill and resources are properly developed. In the opinion of the Planning Commission, the birth rate appears to have remained unchanged around 41 per 1000 population during the greater part of the past two decades up to 1965-66. It is proposed to aim at its reduction 39 per 1000 to 25 per 1000 population on with the next 10-12 years.

In order to get the desired results, same measures were suggested to follow in the plan period. They are

1. Group acceptance of small sized family
2. Personal knowledge about family planning methods
3. Ready availability of supplies and services
4. Provision for audio-visual equipment: technical equipment, mobile units etc., for promoting the acceptance of family planning programme as a way of life.
5. Recruitment and training of doctors and other workers
6. Special stress was laid on IUD as of its efficacy, reversibility and acceptability
7. The implementation of the programme on a coordinate basis involving ministers, voluntary agencies, local leaders, local bodies, labour organizations etc.,\textsuperscript{35}
During the fourth plan: the plan approach had been to integrate family planning services with those for health, maternal and child health and nutrition. In June 1977, a renamed Ministry of Health and Family Welfare issued. "A statement of policy" setting forth a new integrative approach to family welfare.

"Family planning has ....... To be lifted from its old and narrow concept and given its proper place in the overall philosophy of welfare. It must embrace all aspects of Family welfare, particularly those which are designed to be protected and promote the health of mothers and children. It must become a part of the total concept of positive health. At the same time, it must find meaningful integration with other welfare programme, viz., nutrition, food, clothing, shelter, and availability of safe drinking water, education, employment and women's welfare. It will be our endeavour to bring about this integration in a greater degree".36

On the eve of the Fourth Plan, five central training institutions and 43 regional family planning training centres were functioning and were preparing to train 10,000 medical and 1, 50, 000 para-medical personnel required to implement the programme vigorously. There were 4,326 rural family-welfare planning centres in operation. The fourth plan stated: "family planning will remain a centrally sponsored programme for the next ten years and the entire expenditure will be met by the Central Government. It will be ensured that performance does not lag behind the expenditure. The effort will be to achieve
enduring results through appropriate education and motivation. Central health services will be fully involved in the programme”.

The Fourth Five Year Plan outline referred to family planning as 'kingpin of the plan' and 'limitation of family' as an essential and escapable ingredient of development. The high priority given to family planning was reflected in the formation of a Cabinet Committee with the Prime Minister, Shrimati Indira Gandhi, as the Chairman. Similarly committees have been established in most states. A Department of Family Planning was formed within the Ministry of Health and Family Planning. A Cabinet Minister is in overall in-charge, with a Minister of State guiding the programme, and Secretary to the Government of India exercising administrative control.37

In the Fourth Plan Period, the Indian Family Planning Programme attempted some major initiatives which deserve a detailed discussion.

(1) The mass vasectomy camps with higher than usual incentives payment (about Rs.100) which began first in Kerala in late 1970 were subsequently held in almost all the states of India upto 1972-73. They were discontinued during 1973-74. According to different estimates between 66 and 82 per cent of the 3.12 million sterilizations performed during 1972-73 were undertaken in these vasectomy camps.38
The Medical Termination of Pregnancy (MTP) Act. 1977 went into effect on April, 1, 1972. It permits abortion upto 20 weeks on health grounds. It further provided that a pregnancy resulting from contraceptive failure may be presumed to constitute a grave injury to the mental health of the pregnant women. At the end of December 1980. Some 3,120 institutions in district (hospitals, family planning centres) provided facilities for abortions. Since April, 1972, 1.82 million abortions had been registered under the Act. About 65 per cent of these abortions have been performed in six states which together accounted for 48 percent of the estimated eligible couples in India as a whole. It is widely believed that the total number of unregistered abortions each year probably exceed several million.

The scheme of training multi-purpose workers was introduced during this plan period. A major advantage of the shift from unipurpose to multi-purpose workers schemes was the reduction in the time spent on travel and giving a measure of responsibility and confidence for the health staff by broadening the range of their activities.
The outlay proposed for the period of 1969-74 was Rs.437.50 crore, covering Rs.53.50 crore under Central, Rs.176.50 crores centrally sponsored Rs.188.20 crore under state and Rs.19.29 crore under Union Territories. But the total expenditure during the plan period was about Rs.343.91 crore. The mortality rate has declined from 27.4 per 1,000 (1949-50) to 15.1 per 1,000 in 1972-73. The bed population ratio has gone up to 0.491/1,000 from 0.32/1,000 during the plan period. The number of primary health centres and sub-centres rose to 52.50 and 3, 3000 ending 1973-74 against its number of 4.1999 and 22.826 respectively in 1968-69.41

FIFTH FIVE YEAR PLAN: (1974-1979)

The approach in the Fifth Five Year Plan was to integrate family planning services with those for health, maternity and Child Health and Nutrition. Efforts were made to convert more and more vertical programme workers into multipurpose workers who paid special attention to family planning motivational services. The principle of integration was extended to other fields and in particular to mass motivational efforts by making fuller use of existing channel like functional literacy workers education, health education special welfare and such other outlets.42

Emphasis was on community involvement by offering package of community incentives and awards. Practice of providing compensation to individuals for acceptance of family planning
continued. The efforts made towards involving organized sectors in family planning programme continued and was further intensified. Special stress was laid on work to be done socially backward regions including city slums and tribal areas. Efforts were directed towards new, simple and better methods of fertility regulation.43

The Fifth Plan document re-fixed the demographic goals. The family planning programme was giving the “highest priority” by the Central Government. The expenditure per year during 1974-78 was almost doubled that of the figure for the Fourth Plan, somewhat ironically, despite such proclaimed official priority for family planning programme the percentage share of the outlays on family planning programme was still merely 1.25 of the total, and the actual expenditure on family planning programme as a percentage of Gross Domestic Product (GDP) remained rather close to zero (0.12 per cent) during the Fifth Plan. Mass camps were organized with increased frequency in more states. In some land mark camps such as one in Ernakulam in 1972 as many as 65,000 vasectomies were carried out in a fortnight's time.44 Advocacy of spacing methods also began during this period. Incentives for adopters of family planning methods and motivators and service providers were introduced during the Fifth Five Year Plan period.45

The Fifth Five Year Plan had two basic objectives - to be economically self-reliant and removal of poverty. As regards
population growth the approach is to tackle it more effectively. "The high rate of growth of population constitutes of an important constraint on progress towards removal of poverty. It has an adverse effect on domestic saving which is detrimental to the growth of economy. There is in addition an adverse impact on the pattern of growth for the needs of sheer subsistence have to be given a greater weight. The higher the rate of growth of population the lower is the rate of growth and per capita income for all these reasons the objective of removal of poverty calls for more effective restraints on the growth of population. The family planning programmes need to be evaluated carefully with a view to evolving a package of practices that holds better promise. The provision of Rs.560 crores for family planning in the fifth plan should provide the means to put through a more effective programme". The Fifth Five Year Plan introduced a new concept "Minimum Needs Programme" mentioned below:

"The primary objective during the fifth plan is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups, children, pregnant women and lactating mothers. It will be necessary to consolidate past gains in the various fields of health such as communicable disease, medical education and provision of infrastructure in rural areas".48

The Fifth Plan aimed at reducing the birth rate further to about 30 per thousand by the end of the plan period and to 25 per thousand
by the end of 1983-84. The operational targets were laid to achieve the required reduction in the birth rate. The operational targets involved a little over 18 million IUD insertions and about 9 million Conventional Contraceptive Users (CC Users) by 1978-79. Against this the first four years of the plan 13.3 million sterilizations, 2.1 million IUD insertions were performed and the number of CC Users at the close of the period was around 3 million. 1977 about 26 million of the 106 million eligible couples were protected under various methods by the programme. It is estimated that over 33 million births have been averted since the inception of the programme and as a result the birth rate for 1975-76 is expected to have come down to around 33 per thousand of population.47

The Government of India announced new national policy on April, 16, 1976 which was totally different from the earlier population policy of the Government. Its main features were as follows:

(a) The Government proposed legislation to raise the age of marriage to 18 for girls and 21 for boys.

(b) As the acceptance of family planning by the poorer sections of society was significantly related to the use of monetary compensation, i.e., Rs.150 for sterilization if performed for men and women with two children, Rs.100 if performed with three living children and Rs.70 if performed with four or more children.48
One of the important decisions taken by the Government in the light of the new policy was to set up a Grievance Cell to deal with numerous complaints received in the Ministry and to ensure redressal of grievances. At the same time, the States Governments were requested to ensure prompt payment of the ex-gratia relief of Rs.5000 for the dependents of those who died as a result of sterilization.

The year 1975-76 and 1976-77 recorded a phenomenal increase in performance of sterilization. However, in view of rigidity in enforcement of targets by the field functionaries and an element of coercion in the implementation of the programme in 1976-77 in some areas, the programme received a set-back during 1977-78. As a result, the Government made it clear that there was no place for force or coercion or compulsion or for pressure of any sort under the programme and the programme had to be implemented as an integral part of "family welfare" relying solely on mass education and motivation. The name of the programme also was changed to family welfare from family planning. The change was not merely in nomenclature but essentially in the context of its objectives.

**SIXTH FIVE YEAR PLAN (1980-1985)**

The change of Government in January 1980, marked a turning point in the programme and helped to restore it to some extent with continuing emphasis on its voluntary nature. The Six Five Year Plan commencing 1980-81 underlined that family planning should be
interwoven with development plans especially with health, maternal and child care and nutrition. The Family Planning Programme was viewed as a part of total national effort for providing a better life to the people. The government led by Mrs. Indira Gandhi started rehabilitating the population policy and programme. She reiterated the Government's total commitment to voluntary family planning and emphasized that 'family planning must become a movement of the people, by the people for the people, and should be the centre of planned development. The 20 point programme was revived and modified which this time included family planning, special mention was made of the household as basic unit for poverty eradication, economic emancipation to enable children from poor families to go to schools to receive adequate nutrition and develop into useful citizens, education and employment of women to literate them dependence and insecurity and to improve their status, measures to implement the legal provisions for increasing age at marriages establishing linkages with basic needs.52

The Working Group on Population Policy set-up by the Planning Commission has recommended the adoption of the long-term demographic goal of reducing the Net Reproduction Rate a (NRR) to one by 1996 for the country as a whole and by 2001 in all states from the present level of 1.67. The implications of this are as follows:
(i) The average size of the family would be reduced from 4.2 children to 2.5 children.

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

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

(iv) The population of India will around 900 millions by the turn of century and will stabilize at 1,200 millions by the year 2050 A.D.\textsuperscript{53}

(v) The percentage of eligible couples protected with family planning methods was planned to be increased from 22 in 1978 to 60 in 1984-85

To achieve the targets great emphasis was laid on the adoption of non-terminal methods like IUD, CC and Oral Pills (OP). These are being popularized among young couples through education, publicity and mass media. In addition cash prizes are given to the people who adopt family planning methods to curb the family size.\textsuperscript{53}

Keeping in view the long-term demographic goal of reducing NRR to 1 by 1995 as approved by NDC, the following targets have envisaged for the Sixth plan keeping in view the performance present capacity and future potential: the family planning targets are given in table 2.1
TABLE 2.1

FAMILY PLANNING TARGETS

<table>
<thead>
<tr>
<th>Years</th>
<th>Family Planning Expectations/Levels of Achievement (in millions)</th>
<th>Percentage of Couple protected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sterilization</td>
<td>IUD</td>
</tr>
<tr>
<td>1980-81</td>
<td>3.00</td>
<td>0.80</td>
</tr>
<tr>
<td>1981-82</td>
<td>4.00</td>
<td>1.10</td>
</tr>
<tr>
<td>1982-83</td>
<td>4.50</td>
<td>1.50</td>
</tr>
<tr>
<td>1983-84</td>
<td>5.00</td>
<td>2.00</td>
</tr>
<tr>
<td>1984-85</td>
<td>5.50</td>
<td>2.50</td>
</tr>
</tbody>
</table>


The table 2.1 analyzes the number of sterilizations which were around 3.00 million in the base year (1980-81) and went up to 5.50 million in the terminal year of the plan. The number of IUD insertions was to go up from 0.80 million in 1980-81 to 2.50 million in 1985. The percentage of effective couple protection envisages by 1985 was 36.56 against the past percent of 22.74. This called for a tremendous motivational effort backed by adequate infrastructural facilities. It needs mention that a total of 15.5 million sterilizations were required during the plan period 1980-85 for maintaining the birth rate at the existing level, assuming present levels of IUD and CC Users. This is because of the proportion of women in the reproductive age will be rising. Even if the age specific fertility rates are held constant, the birth rate reduction required a vigorous family planning
promotional effort. However the country has not been able to meet the targets as planned.

The performance under the programme during the VIth Five Year Plan is given in table 2.2.

**TABLE 2.2**

<table>
<thead>
<tr>
<th>Family Planning</th>
<th>1980-85</th>
<th>% age of target achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td>17.45</td>
<td>79.2</td>
</tr>
<tr>
<td>IUD</td>
<td>7.17</td>
<td>81.7</td>
</tr>
<tr>
<td>C.C and O.P Users(Couple Year Production)</td>
<td>32.50</td>
<td>85.4</td>
</tr>
<tr>
<td>Total Acceptors</td>
<td>57.12</td>
<td></td>
</tr>
</tbody>
</table>


The table 2.2 explains the performance of family planning during the sixth plan. In sixth plan period percentage of sterilization target achieved was 79.2 per cent whereas IUDs 81.7 per cent, CC and OP users were 85.4 per cent. Total acceptor of family planning in the sixth plan period was 57.12 per cent.

The allocation during the Sixth Five Year Plan was Rs.1, 078 crores but the expenditures were around Rs.1, 448 crores.54

**SEVENTH FIVE YEAR PLAN (1985-90)**

The Seventh Plan continued the tradition of target setting and population projections and it envisaged a reduction in the rate of growth down to 1.53 percent during 1996-2001. Despite a low key approach to family planning, the Seventh Plan witnessed a slow but steadily increases in the number of acceptors of female sterilization.
There was greater emphasis on reversible methods and younger couples were offered incentives not to have more than two children. The UIP started earlier, was replaced by the broader programme of Child Survival and Safe Motherhood (CSSM) to be implemented in collaboration with United Nations International Children Emergency Fund (UNICEF). However, note that the share of Family Welfare Programme in total outlays continued to be quite small as ever, and the envisaged magnitude of birth rate reduction remained quite far from realized. Although reported numbers of acceptors of IUD’s Condom and Oral contraceptives rose faster than ever before the accumulated evidence suggests that the data were manipulated at the grassroots level to create an impression that the prescribed targets for these methods were achieved.55

The Family Welfare Programme envisages the following goals for the plan:

1. Effective couple protection rate : 42.0 per cent
2. Crude Birth Rate per thousand Populations : 29.1 per cent
3. Crude Death Rate per thousand Populations : 10.4 per cent
4. Infant Mortality rate thousand Populations : 90.5 per cent
5. Ante-natal care : 75.0 per cent

To attain the above stated targets particularly 42 per cent couple protection the Seventh Plan stipulates 31 million sterilizations by its close 21.25 million IUD insertions and during the terminal year.
14.5 million CC Users. The Seventh Plan targets for family planning methods are understood:

(1) The efficiently and effectiveness of the programme infrastructure will have to be improved.

(2) Within the overall framework greater flexibility will have to be provided to each state with respect to programme inputs.

(3) Greater emphasis will be needed on spacing methods to increase the couple protection rate, especially of the younger age group.

(4) Special Information Education and Communication (IEC) campaigns would needed to be organized to remove the bias against girl-children.

(5) Efforts will be made for propagation and enforcement of the law relating to the minimum age of marriage.

(6) States which have the lowest couple protection rate would need special attention. Similarly within states areas and groups with lower acceptance rate will have to be given particular attention. The programme would have special focus on urban slums, backward and tribal areas as well as the rural poor.
(7) A special programme will have to be undertaken for cities with population over 10 lakhs in order to achieve a much higher couple protection rate.  

(8) Involvement of Voluntary Organizations in the programme has played a significant though limited or so far. The need for providing greater support to such voluntary efforts has been recognized. The existing scheme for providing assistance to voluntary organizations are being augmented and continuous efforts need to be made to streamline the mechanism for implementing these schemes. More innovative schemes have to be developed to secure further involvement of voluntary organizations.

(9) Experience has shown that involvement of women’s groups and youth groups around some common, social and economic activities have been quite useful in promoting family welfare programmes. Village Health Committees and Mahila Mandals are to be actively involved in the programme.

(10) Increase emphasis is to be given to population education formal and non-formal.

(11) MCH services are to be providing based on the 'High Risk Approach'. A scheme of Universal Immunization of all
eligible infants and pregnant mothers has been taken up in the country.

The strategy has been worked out keeping in view the long-term demographic goal of reaching net production rate of 1 (one) by the year 2000 A.D., as spelled in our National Policy.

Ministry of Health and Family Welfare in its reports 1987-88 has come out with the need of extensive and coordinated approach. It states that

"Population control can no longer be the responsibility of one Ministry or Department. It has to be the total government approach and effort reflecting the total and complete political and administrative commitment of the government across the board embracing all governmental agencies developmental and non-developmental. The entire planning process must be geared towards controlling population. Every action of government must be evaluated in terms of its impact on population. All Ministries, Departments and agencies must accept population stabilization as one of their main objectives and reflect in it their programmes in their message in their extension work and in their normal day-to-day activities. The Planning Commission must review the performance of states in terms of their efforts to stabilize the population and evaluate the activities of various departments in terms of their contribution towards holding population growth. The planning and development process of this
country must indicate the adoption of small family norms as the objective of all programmes. The governmental agencies must also communicate to non-governmental agencies in the country the need to spread the message of small family norm. National apex institutions such as NDC, Reserve Bank of India (RBI), Planning Commission, JCM and apex bodies set-up in the various ministries to advise and direct activities should reflect the national concern in the area of population control.\textsuperscript{56}

Table 2.3 explains budget break of a total sum of amount Rs.3256.26 crores pertaining to family welfare programmes. By which we came to know that this plan gone more importance for effective implementation of family planning.

\textbf{TABLE 2.3}

\textbf{SEVENTH PLAN OUTLAYS: FAMILY WELFARE PROGRAMME}

<table>
<thead>
<tr>
<th>S.No</th>
<th>Programme</th>
<th>Rs. Crore</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Services and Supplies</td>
<td>1356.92</td>
</tr>
<tr>
<td>2</td>
<td>Training</td>
<td>60.90</td>
</tr>
<tr>
<td>3</td>
<td>Information, education and communication</td>
<td>105.00</td>
</tr>
<tr>
<td>4</td>
<td>Research and evaluation</td>
<td>25.00</td>
</tr>
<tr>
<td>5</td>
<td>ICMR</td>
<td>50.00</td>
</tr>
<tr>
<td>6</td>
<td>Maternity and Child Health</td>
<td>888.44</td>
</tr>
<tr>
<td>7</td>
<td>Organization</td>
<td>125.00</td>
</tr>
<tr>
<td>8</td>
<td>Village health guide scheme</td>
<td>370.00</td>
</tr>
<tr>
<td>9</td>
<td>Areas projects</td>
<td>275.00</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3256.26</td>
</tr>
</tbody>
</table>

Source: 7\textsuperscript{th} Five Year Plan, Government of India.

Table 2.4 explains the target and performance of seventh plan.

The target fixed for sterilization was 31.00 millions and achievement
was 23.70 million. There is a shortfall of 7.30 millions. Whereas IUDs are concerned target fixed was 21.25 million and fulfilled 21.28 million. There is complete achievement of target. CC and OP users are concerned achievement exceeds the target.

**TABLE 2.4**

**TARGET AND PERFORMANCE OF SEVENTH PLAN**

(In millions)

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Target</th>
<th>Achievement</th>
<th>% of Achievement</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sterilization</td>
<td>31.00</td>
<td>23.70</td>
<td>76.50</td>
</tr>
<tr>
<td>2</td>
<td>IUD</td>
<td>21.25</td>
<td>21.28</td>
<td>100.14</td>
</tr>
<tr>
<td>3</td>
<td>CC and O.P. Users</td>
<td>14.50</td>
<td>15.94</td>
<td>109.93</td>
</tr>
</tbody>
</table>

Note: Indicate terminal year targets and achievement
Source: 7th Five Year Plan, Government of India.

Table 2.5 analyzes the year-wise performance of seventh plan.

The highest 5.0 million (84%) achievement of sterilization was in the year 1986-87 whereas IUDs are concerned it was 3.9 million (105%) in the same year.

**TABLE 2.5**

**YEAR-WISE PERFORMANCE OF SEVENTH PLAN**

<table>
<thead>
<tr>
<th>S.No</th>
<th>Year</th>
<th>Sterilization</th>
<th>IUD</th>
<th>CC and OP Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1985-86</td>
<td>4.9 (88)</td>
<td>3.3 (101)</td>
<td>10.7 (103)</td>
</tr>
<tr>
<td>2</td>
<td>1986-87</td>
<td>5.0 (84)</td>
<td>3.9 (105)</td>
<td>11.6 (100)</td>
</tr>
<tr>
<td>3</td>
<td>1987-88</td>
<td>4.9 (82)</td>
<td>4.4 (103)</td>
<td>13.4 (104)</td>
</tr>
<tr>
<td>4</td>
<td>1988-89</td>
<td>4.7 (87)</td>
<td>4.8 (97)</td>
<td>14.3 (94)</td>
</tr>
<tr>
<td>5</td>
<td>1989-90</td>
<td>4.2 (76)</td>
<td>4.9 (93)</td>
<td>15.9</td>
</tr>
</tbody>
</table>

Note: The figures in brackets indicate percentage achievement
Source: 8th Five Year Plan, Government of India.
EIGHTH FIVE YEAR PLAN (1992-1997)

To impart new dynamism to the Family Welfare Programme, several new initiatives were introduced and ongoing schemes were revamped in the Eight Plan (1992-97). The broad features of these initiatives are as under

World Bank assisted Area Projects which seek to upgrade infrastructure and development of trained manpower have been continued during the 8th Five Year Plan. Two new Area projects namely India Population Project (IPP) VIII and IX have been initiated during the 8th plan. The IPP-VIII projects aims at improving health and family welfare services in the urban slums in the cities of Delhi, Calcutta, Hyderabad and Bangalore. IPP-IX will operate in the states of Rajasthan, Assam and Karnataka.

An US AID assisted project named "Innovations in Family Planning Services", has been taken up in Utter Pradesh with specific objective of reducing TFR from 5.4 to 4 and increasing CBR from 35% to 50% over the 10 years project period.

Recognizing the fact that demographic and health profile of the country is not uniform 90 districts which have CBR of over 39 per thousand (1991 Census) were identified for differential programming. Enhanced allocation of financial resources amounting to Rs.50 lakhs per year per districts was made for up-gradation of health infrastructure in these districts from 1992-93 to 1995-96. This
amount is being used for providing well equipped operation theatres, labour room, a six-bedded observation ward and residential quarters for paramedical workers in 5 PHCs of each district per year. All the block level PHCs of these 90 districts have been covered.

Realizing that Government efforts alone in propagating and motivating the people adaptation of small family norm would not be sufficient. Greater stress has been laid on the involvement of NGOs to supplement and complement the Government efforts four new schemes for increasing the involvement of NGOs have been evolved by the Department of Family Welfare.

The Universal Immunization Programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases. From the year 1992-93 the UIP has been strengthened and expanded into the child Survival and Safe Motherhood (CSSM) Project. It involves sustaining the high immunization coverage level under UIP and augmenting activities under Oral Rehydration Therapy (ORT), prophylaxis for control of blindness in children and control of acute respiratory infections.57

Restricting population growth is one of the most important objectives of the Eight Plan. The plan aims at bringing down the birth rate from 29.9 per 1000 in 1990 to 26 per 1000 by 1997. This is a modest target and should be realizable, provided the government is
able to carry out its strategy in the coming years under the eighth plan, for population control there is stress on decentralized planning and implementation. The advantage of area specific strategies is that it would allow scope for flexibility of approach.

The table 2.6 explains budget break of a total sum of amount of 6500.00 crores pertaining to family welfare programmes. It came to know that excess of 2244.74 crores were allotted to eight plan as against the seventh plan.

**TABLE 2.6**

**EIGHTH PLAN OUTLAY-FAMILY WELFARE PROGRAMME**  
(Rs. in crores)

<table>
<thead>
<tr>
<th>S.No</th>
<th>Programme</th>
<th>Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Services and supplies</td>
<td>3086.00</td>
</tr>
<tr>
<td>2</td>
<td>Training</td>
<td>59.00</td>
</tr>
<tr>
<td>3</td>
<td>Information Education and Communication</td>
<td>127.00</td>
</tr>
<tr>
<td>4</td>
<td>Research and Evaluation</td>
<td>89.00</td>
</tr>
<tr>
<td>5</td>
<td>Maternity and Child Health</td>
<td>1982.00</td>
</tr>
<tr>
<td>6</td>
<td>Organization</td>
<td>71.00</td>
</tr>
<tr>
<td>7</td>
<td>Village Health Guide Scheme</td>
<td>140.00</td>
</tr>
<tr>
<td>8</td>
<td>Area Projects</td>
<td>400.00</td>
</tr>
<tr>
<td>9</td>
<td>Other Schemes</td>
<td>46.00</td>
</tr>
<tr>
<td>10</td>
<td>Provision for settlement of arrears payable to states</td>
<td>500.00</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>6500.00</strong></td>
</tr>
</tbody>
</table>

Source: Eighth Five Year Plan Draft, Government of India.

The Central Government’s role in now being limited to general policy planning and providing technological inputs. Thus the approach of the government is to make family planning programme one of “peoples operation with government cooperation”. Another important aspect of the strategy is to make the younger couples, who are productively most active, the focus of attention. The younger
couples will now have to be prepared to accept a small family norm as a social responsibility. In the future targeted reduction in the birth rate will be the basis of designing and implementing the family planning programme against the existing approach of couple protection rate. From this point of view the out reach and quality of family planning services will be improved. So far, the system of cash incentives to adopters of sterilization programme has failed to make any impact on the population growth. Therefore, the entire package of incentives and awards has to be restructured to make it more meaningful. The possibilities of introducing certain disincentives to the non-adopter of family planning programme, the role of the education, information and communication is widely recognized. These are now being considered as critical inputs by the planers and will thus be strengthened and expanded in the eighth plan. The research and development of methods aimed at regulation of fertility both in males and females will also be given a new thrust.

Table 2.7 indicates that during the Eighth Plan the CBR and IMR declined to 27.4 and 72 against the target of 26 and 70 respectively. The Couple Protection Rate (CPR) increased to 45.4 per cent against the target of 56 per cent during this period. The target of IMR is achievable; target for CBR may be difficult to achieve: the target for CPR has not been achieved.
TABLE 2.7
EIGHTH PLAN TARGET AND ACHIEVEMENTS

<table>
<thead>
<tr>
<th>S.No</th>
<th>Indicator</th>
<th>Targets</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crude Birth Rate</td>
<td>26</td>
<td>27.4 (SRS 1996)</td>
</tr>
<tr>
<td>2</td>
<td>Infant Mortality Rate</td>
<td>70</td>
<td>72 (SRS 1996)</td>
</tr>
<tr>
<td>3</td>
<td>Couple Protection Rate</td>
<td>56</td>
<td>45.4 (March 1997)</td>
</tr>
</tbody>
</table>

Source: Five Year Draft, Government of India.

Even though the targets set for IMR and CDR are likely to be achieved, it is noteworthy that maternal parental, neonatal, mortality rates continue to remain high. This is because the components of antenatal, intrapartum and neonatal care programming are not aimed at universal screening of risk factors for identification and appropriate referral of the at risk individuals. Improvement in the contents and quality of antenatal and pediatric care at primary health care level will receive focused attention during the Ninth Plan.58

NINTH FIVE YEAR PLAN

During the Ninth Plan period the family welfare programme will be geared up to meet the unmet demand for contraception with the twin, objectives of reducing maternal morbidity and mortality and achieving rapid decline in birth rates. During the Ninth Plan period, the Department of Family Welfare implemented the recommendations of the NDC sub-committee centrally defined method specific targets for family planning was abolished. The emphasis shifted to
decentralize planning at the district level, based on assessment of community needs and implementation of programmes aimed at fulfillment of these needs. State specific goals for process and impact parameters for maternal and child health and contraceptive cases were worked out and used for monitoring progress. Efforts were made to improve the quality and content of services through training to upgrade skills for all personal and building up a referral network. The Department of Family Welfare set up a consultative committee to suggest appropriate restructuring of infrastructure funded by the states and the centre and revises norms for reimbursement by the centre and has started implementing the recommendations of the committee. Monitoring and evaluation has become a part of the programme and the data used for mid-course corrections.59

OBJECTIVES DURING THE NINTH PLAN

(1) To meet the felt-needs for contraception.

(2) To reduce the infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility.

THE STRATEGIES DURING THE NINTH PLAN WILL BE

(1) To assess the needs for reproductive and child health at PHC level and undertake area specific micro planning.

(2) To provide need-based demand driven high quality, integrated reproductive and child health care.
THE PROGRAMME WILL BE DIRECTED TOWARDS

(a) Bridging the gaps in essential infrastructure and manpower through a flexible approach and improving operational efficiency through investment in social, behavioral and operational research.

(b) Providing additional assistance to poorly performing districts identified on the basis of the 1991 census to fill existing gaps in infrastructure and manpower.

(c) Ensuring uninterrupted supply of essential drugs, vaccines and contraceptives, adequate in quantity and appropriate in quality.

(d) Promotion makes participation in the Planned Parenthood movement and increasing the level of acceptance of vasectomy.

Efforts will be intensified to enhance the quality and coverage of family welfare services through:

(a) Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM and H:

(b) Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral co-ordination and community:

(c) Involvement of the industries, organized and unorganized sectors, agriculture workers and labour representatives.
During the Ninth Five Year Plan the Department of Family Welfare has drawn up the National Population Policy 2000 (NPP 2000), which aims at achieving replacement level of fertility buy 2010. A National Commission on Population was constituted in May 2000, in line with the recommendations of the NPP 2000.\textsuperscript{61}

**REVIEW OF PERFORMANCE OF THE FAMILY WELFARE PROGRAMME DURING THE NINTH PLAN**

The decentralized planning and initiatives taken up under the RCH programme during the Ninth Plan were expected to lead to substantial improvement in the coverage and quality of services. In order to achieve this, the Department of Family Welfare was given additional outlay to enable it to provide adequate financial inputs to the states. Goals for the Ninth Plan were projected on the basis of these newer initiatives and additional inputs provided. Goals set for the Ninth Plan current status regarding these are in the following tables.\textsuperscript{63}

Table 2.8 indicates the present status of CBR is 25.8, TFR 2.85, Couple Protection Rate 46.2 per cent, MMR 540 and Neo-National Mortality Rate is 68. The goals set for Ninth Plan was 24, 2.9, 51, 300, 56 respectively.
TABLE 2.8
GOALS FOR NINTH FIVE YEAR PLAN

<table>
<thead>
<tr>
<th>S.No</th>
<th>Indicator</th>
<th>Present Status</th>
<th>Ninth Plan (2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crude Birth Rate</td>
<td>25.8</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>Total Fertility Rate</td>
<td>2.85</td>
<td>2.9</td>
</tr>
<tr>
<td>3</td>
<td>Couple protection Rate (%)</td>
<td>46.2</td>
<td>51</td>
</tr>
<tr>
<td>4</td>
<td>Maternal Mortality Rate</td>
<td>540</td>
<td>300</td>
</tr>
<tr>
<td>5</td>
<td>Neo-natal Mortality Rate</td>
<td>68</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: Tenth Five Year Plan, Government of India.

A review of the performance during the Ninth Plan suggests that the health systems in the states needed more time to adapt to decentralized planning and implementations of components of the RCH programme. In an attempt to improve coverage under specific components of the RCH programme, some state embarked on campaign made operations which took their toll on routine services.64

Table 2.9 explains the year wise allotment of budget and actual expenditure for family welfare programmes. A sum of amount 1468.70 crores were allotted during the Ninth Plan and the department executed the expenditure was 13951.25 crores. The highest outlay of 4210.00 crores was made in the year 2001-02.

TABLE 2.9
YEAR-WISE OUTLAYS AND ACTUAL EXPENDITURE DURING THE NINTH PLAN

<table>
<thead>
<tr>
<th>S.No</th>
<th>Year</th>
<th>Outlay</th>
<th>Actual expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1997-98</td>
<td>1829.35</td>
<td>1822.00</td>
</tr>
<tr>
<td>2</td>
<td>1998-99</td>
<td>2489.35</td>
<td>2342.75</td>
</tr>
<tr>
<td>3</td>
<td>1999-00</td>
<td>2920.00</td>
<td>3099.76</td>
</tr>
<tr>
<td>4</td>
<td>2000-01</td>
<td>3520.00</td>
<td>3090.11</td>
</tr>
<tr>
<td>5</td>
<td>2001-02</td>
<td>4210.00</td>
<td>3596.63</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>14968.70</td>
<td>13951.25</td>
</tr>
</tbody>
</table>

Source: Tenth Five Year Plan (2002-2007)
Independent surveys have shown that several states have achieved goals set for some aspect of the RCH programme during the Ninth Plan demonstrating that these can be achieved within the existing infrastructure, manpower and inputs.

- Andhra Pradesh, Punjab, West Bengal and Maharashtra have shown substantial decline in birth rates and the latter three states are likely to achieve replacement level of fertility, ahead of the projections.
- Punjab has achieved couple protection rate and use of spacing methods for ahead of all other states.
- Tamil Nadu and Andhra Pradesh have achieved significant reduction in home deliveries.
- Kerala, Maharashtra, Punjab and Tamil Nadu improved immunization coverage.
- Tamil Nadu and Andhra Pradesh and achieved improvement in coverage and quality of antenatal care.\textsuperscript{65}

**TENTH FIVE YEAR PLAN: 2002-2007**

During the Tenth Plan, the paradigm shift which began in the Ninth Plan will be fully operationalised. The shift was from

- Demographic targets to focusing on enabling couples to achieve their reproductive goals.
➤ Method specific contraceptive targets to meeting all the unmet needs for contraception to reduce unwanted pregnancies.

➤ Numerous vertical programmes for family planning and maternal and child health integrated health care for women and children.

➤ Centrally defined targets to community need assessment and decentralized area specific micro planning and implementation of a programme for health care for women and children, to reduce infant-mortality and reduce high desired fertility.

➤ Quantitative coverage to emphasis on quality and content of care.

➤ Predominantly women centre programmes to meeting the health care needs of the family with emphasis on involvement of men in planned parenthood.

➤ Supply of driven service delivery to need and demand driven service; improved logistics for ensuring adequate and timely supplies to meet the needs.

➤ Service provision based on provider’s perception to addressing choices and conveniences of the couples.66
The population growth rate continues to be high due to

- The large size of the population in the reproductive age-group (accounting for an estimated 60 per cent of the total population growth)

- High fertility due to unmet need for contraception (contributing to around 20 percent of the population growth) and

- High wanted fertility due to the prevailing high IMR and other socio-economic reasons (estimated contribution of about 20 percent population growth)

The Tenth Plan will fully operationalise efforts to

- Assess and meet the unmet needs for contraception

- Achieve reduction in the high desired level of fertility through programmes for reduction in IMR and maternal mortality ration (MMR) and

- Enable families to achieve their reproductive goals.

If the reproductive goals of families are fully met, the country will be able to achieve the NPP goal of replacement level of fertility by 2010. The medium and long term goals will be continue this process to accelerate the pace of demographic transition and achieve population stabilization by 2045. Early population stabilization will enable the country to achieve its development goal of improving the economic status and quality of life of the citizens.
Reduction in fertility, mortality and population growth rate will be major objectives during the Tenth Plan. Three of the 11 monitorable targets for the Tenth Plan and beyond are:

✓ Reduction in IMR to 45 per 1,000 live births by 2007 and 28 per 1,000 live births by 2012
✓ Reduction in decadal growth rate of the population between 2001-2011 to 16.2.

During the Tenth Plan the pace of implementation of the programme will be accelerated through streamlining of infrastructure, focus will be on improving quality, coverage and efficiency of services so that all the felt needs for family welfare services are fully met. Special attention will be paid to improving access to good quality services to the underserved population living in urban slums, remote rural and tribal areas.

During the Tenth plan, every effort will be made to:

• Ensure 100 per cent registration of pregnancies, deaths and births so that reliable state and district level estimates of MMR are available on a sustainable basis:

and

• Improve ascertainment of the cause of death through SRS and hospital records so that it becomes possible to assess time trends and changes in cause of maternal mortality.
During the Tenth Plan attempts will be made to enhance the quality and coverage of family welfare services through the involvement and participation of the organized and unorganized sectors of industry, agriculture and labour representatives. The problem solving approach of the corporate sector can be used to improve the operational efficiency of the health care services.67

The following table provides information of present status of process and impact indicators, the goals set for these in Tenth Plan and NPP 2000 (for 2010).

Table 2.10 envisages reduction in IMR to 45/1000 by 2027 and 28/1000 by 2012, reduction in MMR to 200/1000 live births by 2007 and 100/1000 live births by 2012 and reduction in decade growth rate of the population between 2001-2011 to 16.2.

**TABLE 2.10**
**GOALS SET FOR TENTH PLAN AND NATIONAL POPULATION POLICY 2000**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Indicator</th>
<th>Present Status</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tenth Plan</td>
</tr>
<tr>
<td>Target year</td>
<td></td>
<td></td>
<td>2007</td>
</tr>
<tr>
<td>1</td>
<td>Crude Birth Rate</td>
<td>25.8</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>Total Fertility Rate</td>
<td>2.85</td>
<td>2.3</td>
</tr>
<tr>
<td>3</td>
<td>Couple protection Rate (%)</td>
<td>46.2</td>
<td>65</td>
</tr>
<tr>
<td>4</td>
<td>Maternal Mortality Ratio</td>
<td>540</td>
<td>200</td>
</tr>
<tr>
<td>5</td>
<td>Infant Mortality Rate</td>
<td>68</td>
<td>45</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>DELIVERIES</th>
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</thead>
<tbody>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
</tbody>
</table>

Source: Tenth Plan Five Year Plan 2002-2007
The steep reduction in mortality and fertility envisages are technically feasible within the existing infrastructure and manpower as has been demonstrated in several states and districts. It is imperative that the goals set are achieved within the time frame as these goals are essentially prerequisites for improving the quality of life and human development. In view of the massive differences in the availability and utilization of health services and health indices of the population, a differential strategy is envisages so that there is incremental improvement in all districts. This in turn, is expected to result in substantial improvement in state and national indices and enables the country to achieve the goals set for the Tenth Plan.\(^{68}\)

The above table 2.11 explains plan-wise budget allotment for family welfare programmes. A sum of 0.65 crores were allotted in the first plan (1951-56) and it was increased to 27.125 crores during the Tenth Plan period (2002-07).

The agenda for population stabilization is multi-sectoral which necessitates decentralization and convergence across sectors. In cooperation with state Governments the Department of Family Welfare, is bringing about convergence between the NGO’s the SHGs (run by the Department of Rural Development) the Zilla Saksharta Samitis (run by the Department of Education) the social marketing organization (overseen by Department of Family Welfare) and the
Panchayat Raj Institutions, to improve integrated service delivery at community and household levels.

TABLE 2.11

PLAN WISE OUTLAYS UNDER FAMILY WELFARE PROGRAMME

<table>
<thead>
<tr>
<th>Period</th>
<th>Year</th>
<th>Outlays (Rs. in crores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Plan</td>
<td>1951-56</td>
<td>0.65</td>
</tr>
<tr>
<td>Second Plan</td>
<td>1956-61</td>
<td>5.00</td>
</tr>
<tr>
<td>Third Plan</td>
<td>1961-66</td>
<td>27.00</td>
</tr>
<tr>
<td>Annual Plan</td>
<td>1966-69</td>
<td>82.90</td>
</tr>
<tr>
<td>Fourth Plan</td>
<td>1969-74</td>
<td>285.80</td>
</tr>
<tr>
<td>Fifth Plan</td>
<td>1974-78</td>
<td>285.60</td>
</tr>
<tr>
<td>Annual Plan</td>
<td>1978-80</td>
<td>228.00</td>
</tr>
<tr>
<td>Sixth Plan</td>
<td>1980-85</td>
<td>1309.00</td>
</tr>
<tr>
<td>Seventh Plan</td>
<td>1985-90</td>
<td>2868.00</td>
</tr>
<tr>
<td>Annual Plan</td>
<td>1990-92</td>
<td>1424.00</td>
</tr>
<tr>
<td>Eighth Plan</td>
<td>1992-97</td>
<td>6195.00</td>
</tr>
<tr>
<td>Ninth Plan</td>
<td>1997-02</td>
<td>14170.00</td>
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<td>1997-98</td>
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<td>Annual Plan</td>
<td>1998-99</td>
<td>2239.35</td>
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<td>Annual Plan</td>
<td>1999-00</td>
<td>2720.00</td>
</tr>
<tr>
<td>Annual Plan</td>
<td>2000-01</td>
<td>3220.00</td>
</tr>
<tr>
<td>Annual Plan</td>
<td>2001-02</td>
<td>3830.00</td>
</tr>
<tr>
<td>Tenth Plan</td>
<td>2002-07</td>
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<tr>
<td>Annual Plan</td>
<td>2002-03</td>
<td>4930.00</td>
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<tr>
<td>Annual Plan</td>
<td>2003-04</td>
<td>4930.00</td>
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</table>

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11. Ibid.


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68. Ibid.