CHAPTER - VI

UNMET NEEDS AND FAMILY WELFARE PROGRAMME IN INDIA

Since 1970s, India’s economic growth rate has risen, poverty has declined, and social indicators have improved. Nevertheless, over a quarter (28.6%) of India’s population currently lives below the national poverty line. Currently, India’s annual population growth rate is 1.74%. India is the second most populous country in the world, contributing about 20% of births worldwide.

India’s population crossed one billion mark by the year 2000. India is likely to replace China as the world’s most populous country some time before the middle of the twenty-first century. Soon after independence in 1947, the size and growth rate of the population were recognized as potential problems. Thus, from the early days a family planning programme was envisaged as an integral part of a comprehensive social development programme. India was the first independent country in the world to as adopt a policy of reducing population growth through a government-sponsored national family planning programme, as called for in the First Five Year Plan (1951-1956). India officially began to implement the programme in 1952 (Zodgekar, 1996).

Although the First Five Year Plan acknowledge the serious economic consequences of high fertility, 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 known about the attitudes of the masses or the views of religious and other leaders. Nevertheless, the declared
goal was a reduction in the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy.

The policy focus from the beginning had been on the limitation of family size. The principal means of implementing the policy had been the propagation of the family planning programme. The programme was directed primarily at building up a large infrastructure for providing family planning advice and services and creating public opinion actively in favour of the programme. Successive Five-year Plans have repeatedly stressed these objectives and approaches. The preoccupation with fertility control in every Five-year Plan was translated essentially into efforts to reduce the birth rate. This objective was further highlighted from 1966-1967 onwards, when the programme to reduce the birth rate was made target oriented. It was argued that, without a major improvement in the adoption of family planning, national development goals would be extremely difficult to realize. A rapid decline in both the birth rate and the population growth rate was considered to be of utmost importance. Unless a sense of national urgency could be introduced in the form of compulsive persuasion in that direction, an effective decline in the birth rate would take too long to foster if it were to be solely a consequence of economic and social development. This view prompted the Central Government to announce a detailed population policy introducing a number of new measures (Zodgekar, 1996).

**Family Welfare Programme in India: Objectives and Approaches**

The Family Welfare Programme in India was launched with the objective of reducing birth rates to the extent necessary to stabilise population at a level consistent with the requirements of the national economy. The programme has since evolved through a number of stages, and has changed direction, emphases and strategies. During the first decade of its existence,

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family planning was considered more a mechanism to improve the health of mothers and children than a method of population control (Visaria 2000; Visaria and Chari 1998). Clinic-centred family planning service delivery, along with health education activities, were promoted during this period. Over time however, the primary focus of the programme became the achievement of demographic goals.

With growing concerns about the rate of population growth, and its adverse effect on the pace of social and economic development, the Third Five Year Plan period (1961-66) marked a subtle shift in the emphasis of the programme from the welfare of women and children to the macro objective of population stabilisation (Visaria and Chari 1998). At the same time, an extension-education approach replaced the original clinic-centred approach, and the programme was integrated with health services. During 1965--75, the programme was further integrated with the maternal and child health programme. This period also witnessed the introduction of time-bound method-specific targets within the programme.

National family planning programmes are relatively new. The main goal is to promote the regulation of fertility through the spacing and limitation of the number of children born. They are concerned with one of the most complex aspects of human behaviour. The aims of national family planning programmes in general, are to achieve the widespread dissemination of knowledge of effective family planning methods, to increase the motivation of the population to accept and utilize those methods and to provide supplies and services.

The Family Welfare Programme in India is recognised as a priority area, and is being implemented as a 100% Centrally sponsored programme. As per Constitution of India, Family Planning is in the Concurrent list. The approach under the programme during the First and Second Five Year Plans
strengthened. The primary objective of the Fourth Five Year Plan (1969-74) was to reduce the annual birth to 32 in 1974 and "top priority" was given to family planning. Later, the targets to achieve zero population growth were reset in the 90s to be achieved by 2016 A.D. The programme was made an integral part of MCH (Maternal and Child Health) of PHC (Primary Health Centres) and their subcentres.

The 1990s witnessed dramatic changes in the Family Welfare policy and programme in the country. The passing of the 72nd and 73rd Constitutional Amendments and the Panchayati Raj and Nagar Palika Acts in 1992 set in motion the process of democratic decentralisation, and brought the Family Welfare Programme, legally, in the domain of Panchayati Raj institutions. In addition several factors, including stagnation in the Family Welfare Programme, organised pressure from multiple constituencies to bring issues of quality and choice into the programme, and the recognition of inherent constraints in the programme contributed to changes in policy approach (Visaria et al, 1999). The International Conference on Population and Development in 1994 and the Beijing Women's Conference in 1995 further catalysed the process of policy change. In 1996, the government took the radical decision of abolishing method-specific contraceptive targets that had been used to guide, monitor and evaluate the programme for decades, replacing it with what was initially called the Target-free Approach, where health workers’ case loads would be determined by needs identified at the community level, rather than centrally-assigned. Since 1996 there is a major shift in Family Planning Programme with emphasis on Community Need Based Assessment Approach under the comprehensive concept of Reproductive and Child Health Programmes.

In 1997, to avoid misconceptions and to direct the programme more towards addressing clients' needs, the Target-free Approach was renamed as
the Community Needs Assessment Approach, and decentralised participatory planning was initiated. The government has provided broad guidelines for conducting community needs assessment and has given states the responsibility for working out the practical details of implementation.

The Family Welfare Programme in India has experienced significant growth and adaptation over the past half century since its inception in 1951. During this period, financial investments in the programme have substantially increased and service delivery points have significantly expanded. Services administered through the programme have been broadened to include immunisation, pregnancy, delivery and postpartum care, and preventive and curative health care. The range of contraceptive products delivered through the programme has widened. Multiple stakeholders, including the private sector and non-governmental sector, have been engaged in providing contraceptive services. Of late, the programme has been integrated with the broader Reproductive and Child Health Programme. The couple protection rate has quadrupled from 10 per cent in 1971 to 44 per cent in 1999 (MOHFW, 2000). Notwithstanding these achievements, several issues continue to daunt the programme and many goals remain under-achieved: a significant proportion of pregnancies continue to be unplanned; the contraceptive needs of millions of women remain unmet; several sub-population groups including adolescents and men continue to be neglected and under-served; and contraceptive choice remains conspicuous by its absence, as is quality of care within the programme.

Target setting became the main feature of the Indian family planning programme from the mid-1960s. Bose (1987) has also provided a good discussion on the implication of family planning targets. He came to the conclusion that target setting was merely a routine approach to streamline the programme. Unfortunately, over the years, the target has become an end in itself and not the means to bring about a decline in the birth rate (Bose, 1989).
A group, formed by the Government to come up with alternatives to using targets for monitoring the family welfare programme, suggested selecting good points of previous efforts for monitoring under a target-free approach (Murthy, 1999). A national meeting in March 1996 also discussed alternative, target-free strategies for the family welfare programme (Satia and Subramaniam, 1996). Based on various inputs such as the aforementioned, the Government produced the "Manual on Target-free Approach in Family Welfare" and widely distributed to the states to facilitate this change from target-oriented programme monitoring to target-free approach (Government of India, 1996). The basic idea behind the TFA was that the central government would no longer give method specific contraceptive targets. The states should develop their own system of performance planning and performance monitoring based on assessment of the community needs. A decentralised participatory planning process was to be adopted by the grassroots level workers to arrive at the needs of the community. These needs had to be aggregated at the PHC and then at the district level to form the action plans. The TFA manual gave various formats for this process. Such planning was to be backed up by reporting various data for monitoring of work done. For improving supervision and detecting quality problems, the TFA manual provided supervisors' checklists. Supervisors were to observe the work of the subordinate, interview the clients and check the records to fill up the supervisory forms. It was hoped that such a process would help improve quality of service.

Target-free approach was communicated in the Health Department through regular meetings and written communications of the Health Department. It was also discussed and explained during the regular meetings of Secretaries and Directors of family welfare at central level. In 1996, the states were asked to conduct a two-day workshop for state officers and similar workshops at district and sub-district levels for orienting the whole family
welfare infrastructure to the new approach. Unfortunately there was confusion regarding the approach because the central level left the methodology regarding how to calculate the work load at sub-centre level and how to set expected level of achievement to the discretion of the states. Even at the formulation stage, there seemed to be differential understanding among senior programme managers about the spirit, purpose and the mode of implementation of this approach which was reflected in the manual. For instance, the manual used various terminology such as “unmet needs”, "felt need of population", "area requirement", "service needs", "expected needs" and "norms", it was also not clear as to which features of the approach were critical: "target-free" or "decentralised participatory planning" (Government of India, 1996).

**Development of Reproductive and Child Health Project**

The Reproductive and Child Health (RCH) interventions that are being implemented by the Government of India (GoI) are expected to provide quality services and achieve multiple objectives. There has been a positive paradigm shift from the method-mix target based activity to client centred, demand driven quality services. The Government of India is making efforts to re-orient the programme and change the attitude of the service providers at the grass-root level, as well as to strengthen the services at the outreach level.

- Ante Natal Care (ANC) and Immunization Services
- Extent of Safe Deliveries
- Contraceptive Prevalence
- Unmet need for family planning
- Awareness about RTI/STI and HIV/AIDS
- Utilization of Government Health Services and user's satisfaction
The RCH Project, Phase I has been designed to meet women’s needs across their life span. The general objective of the project include empowering women and children through providing high quality care to them, empowering the community as a whole to demand better health services, and improving substantially the performance of the health care delivery system.

The broad objectives of the project have been:
- To improve the health status of women, adolescents and children
- To improve the quality of health seeking behavior of women
- To increase the credibility of service providers though improved quality of services

The strategy envisioned to achieving these objectives is summarized as below:
- institutional strengthening
- enhanced managerial capability
- strengthened monitoring system
- decentralized planning
- upgraded service delivery
- Demand creation for services through improved health care seeking behavior.

The overall expectation has been a decline in fertility, maternal and infant mortality and morbidity. These are expected to help reach the ultimate goal of zero rate of growth in population. (www.sambhavindia.org).

India’s National Rural Health Mission was launched in April 2005 with a strong commitment to reduce maternal and infant mortality and provide universal access to public health services. The second phase of India’s Reproductive and Child Health Program (RCH II) is an integral and important component of this mission. The World Bank prepared a US$360 million credit (Reproductive and Child Health II Project) building in the
lessons of RCH I to support this effort. When deficiencies in procurement in RCH I were uncovered, the Bank launched an investigation and worked with the Government of India to build a strong remedial plan.

The Government and the Bank agreed on a comprehensive Governance and Accountability Action Plan (GAAP) to address procurement deficiencies in India health sector projects. The action plan will apply to all centrally sponsored health and family welfare programs supported by the Bank in India.

The delivery of high quality health services is an extremely complex area involving a host of public and private, local and international players. The agreed plan articulates the specific roles and responsibilities of public, private, and civil society institutions engaged in the health sector to ensure timely supply of quality pharmaceuticals, health sector goods and services at a competitive price.

The Government’s plan to address weaknesses in pharmaceutical quality assurance and procurement processes include five specific measures:

- improving quality certification of pharmaceuticals;
- increasing competition and mitigating collusion;
- strengthening procurement implementation and contract monitoring;
- handling procurement complaints; and
- disclosing information and promoting oversight by civil society.

(www.worldbank.org)

The Government of India has adopted the 1994 Cairo agenda with speed and commitment at the highest level, recognising that improving reproductive health, including family planning, is essential to the development of the family welfare programme. The changes now being put in place signal a significant shift from a programme measured primarily by contribution to declines in fertility and population growth rates, to one which
recognises the need to satisfy the needs of individuals for a variety of high quality services, as well as contributing to demographic objectives.

The new agenda has tended to focus - at a programme level - on the range of services that should be available to deliver an RCH programme characterised by: "high quality, client-centered approaches that address a range of reproductive health needs, including safe motherhood and family planning, as well as other problems such as reproductive tract and sexually transmitted infections" (Measham and Heaver, 1996). Much of the preparatory work that has been undertaken has sought to define at which level of service delivery (community/sub-centre/primary/first referral units/district hospitals) particular health interventions should be available (Pachauri, 1996). In other words, the focus has been on missing inputs that would need to be added to the existing MCH and family welfare services to address the broader RCH agenda.

The second main characteristic of the GOI's new policy is generally referred to as the Target Free Approach (TFA). The name derives from the desire to replace centrally defined family welfare targets based on demographic objectives with locally determined measures of performance. However, the term also subsumes several new policy directions: a focus on quality and responsiveness to users; decentralisation of planning and management responsibilities; and new expressions of community involvement. These policy changes initiated in the context of the RCH programme coincide with structural changes in the organisation of government - notably a strengthened role for panchayati raj institutions. The TFA Manual attempts to explain and operationalise these policy changes, but is widely acknowledged to be a preliminary attempt and will require much additional work.
To shift in FP programme in the form of the TFA, the MCH programme, along with the FP programme, is being given a new shape in the form of the RCH programme, which is in line with the suggestions made at ICPD and the World Bank sector review in India to reorient FP programmes to RH approach. The programme witnessed a paradigm shift in its policies and implementation whereby ‘demographic orientation’ changed to ‘client centred’ approach and client’s reproductive rights, and reproductive need became priorities in the programme. This led disbanding with the ‘target’ approach and target-free decentralized PHC based planning approach started receiving advocacy for implementation, and vertical nature of the programmes changed into holistic approach. This is how the health got transformed into reproductive health concept. To bring due focus on child health in this concept, the Government of India has adopted the nomenclature popularly known as RCH (Gupta, undated). In October 1997, with the help of the World Bank and other donors, the Government of India launched a five-year programme with an expected expenditure of about 50 billion rupees (US$1.25 billion) to provide RCH throughout the country.

The Government of India, Ministry of Health and Family Welfare upholds the legitimate right of its citizens to be able to experience sound Reproductive Health (RH). Accordingly, the Reproductive Child Health (RCH) programme mission is to provide need based, client centred, high quality services to all the citizens of the country. The RCH programme is more significant to contribute to the population stabilization to a level that should be optimal to meet the need of national development. For this, what is contemplated important, is conformity with small family size norm. The RCH programme, thus, envisages in this direction to facilitate the availability and accessibility of the available spacing and terminal methods of family planning to the couples on the one hand and provide high quality care to the mother and child as an assurance to good health and longevity of both on the other. The Government has taken the cognizance of the fact that for the
success of the RCH programme stabilization, its own efforts may not be enough, the involvement of NGOs and community is, therefore, equally important. Accordingly, the programme objectives have been laid down with such crucial concerns (Gupta, undated).

**Programme Objectives.**

The main objectives of the national RCH programme are:

- To integrate all interventions of fertility regulation, maternal and child health with reproductive health of both men and women.

- To make services client centred, demand driven, high quality and based on the needs of the community arrived at through centralized participatancy planning and the target free approach.

- To upgrade the level of facilities for providing various interventions and quality of care. The first referral units (FRUS) being ser-up at Sub-district level will provide comprehensive emergency obstetric and new-born care. Similarly RCH facilities in PHCs will be substantially upgraded.

- To improve facilities for obstetric care, MTP and IUD insertion in the PHC. Also IUD insertion in sub-centres.

- To improve the outreach of services primarily for the vulnerable groups of population who have till now been effectively left out of the planning process, e.g. (i) design special programmes for urban slums, tribal population and adolescents, (ii) Involvement of NGOs and voluntary organizations in a big way to improve the service outreach and make the programme people’s programme, (iii) Train Indian Systems of Medicine Practitioners (ISMPS) and to support research in this area in order to improve the range of RCH services, (iv) Make use
of the Panchayati Raj System in planning, implementation of RCH services and assessment of client satisfaction with services.

The key features of the strategy of the government's RCH programme are community participation in planning, client-centred approach, upgrading of facilities and improved training, emphasis on good quality care, absence of contraceptive targets and incentives, making services gender sensitive and multi-sectoral approach in implementing and monitoring services. The programme aims to reorient programme planning from top-down to bottom-up. It focusses on quality of care to produce client satisfaction leading to improved use of services. The key components of the programme are child survival and safe motherhood, FP, women's health including RTI, STD/HIV, and adolescent education. The programme espouses a life-cycle approach.

The expectation is that this programme will provide the resources needed to reorient the FP programme from a target-oriented approach to client-oriented approach and help improve the scope and quality of services. Thus it complements and takes further the changes envisaged under the policy shift of the TFA. The implementation of the RCH programme has started but is progressing somewhat slowly as it continues to evolve, and it is too early to assess its impact. When the RCH programme is fully implemented, it is hoped that the paradigm shift envisaged under TFA in the family welfare programme will be fully realised.

FAMILY WELFARE PROGRAMME THROUGH FIVE YEAR PLANS

First Five Year Plan (1951-56)

The First Five Year Plan stated: “The main appeal for family planning is based on considerations of health and welfare of the family. Family limitations or spacing of children is necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programme.” Thus the key elements of health care to women and children and
provisions for contraceptive services had been the focus of India’s health services right from the time of India’s independence.

**Second Five Year Plan (1956-57 and 1960-61)**

In the Second Five Year Plan period the Government had allotted nearly Rs.5 crores. This time the emphasis was laid on the use of contraceptives (mechanical and chemical) for family planning. The rhythm method was not successful because it was difficult to understand and difficult to practice. Contraceptives have limitations, because in the rural population, which is living in huts, privacy and bathroom facilities are both lacking which are very essential if contraceptives have to be properly used. Surgery (sterilization in women and men) has a place in the family planning programme by way of stopping further additions.

**Third Five Year Plan (1961-66)**

The approach to family planning in the Third Five Year Plan (1961-66) changed to extension education wherein the clinical staff were to work in the community and use an information-education communication (IEC) approach to (a) create a small family norm, (b) create acceptance of fertility regulations, (c) provide services within the reach of the people, and (d) spread knowledge about non-clinical methods, such as the rhythm method and condoms in the hope that people would influence each other and be given access to means to limit their family size.

**Fourth Five Year Plan (1969-74)**

In the Fourth Plan (1969-74), high priority was accorded to the programme and it was proposed to reduce birth rate from 35 per thousand to 32 per thousand by the end of plan. 16.5 million couples, constituting about 16.5% of the couples in the reproductive age group were protected against conception by the end of Fourth Plan.
Fifth Five Year Plan (1974-79)

The objective of the Fifth Plan (1974-79) was to bring down the birth rate to 30 per thousand by the end of 1978-79. The programme was included as a priority sector programme during the Fifth Plan with increasing integration of family planning services with those of Health, Maternal and Child Health (MCH) and nutrition, so that the programme became more readily acceptable. The years 1975-76 and 1976-77 recorded a phenomenal increase in performance of sterilisation. However, in view of rigidity in enforcement of target by 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 content of its objectives.

Sixth Five Year Plan (1980-85)

In the Sixth Plan (1980-85), certain long-term demographic goals of reaching net reproduction rate of unity were envisaged. The implications of this were to achieve following by the year 2000 AD.

- Reduction of average size of family from 4.4 children in 1975 to 2.3 children.
- Reduction of birth rate to 21 from the level of 33 in 1978 and death rate from 14 to 9 and infant mortality rate from 127 to below 60.
- Increasing the couple protection level from 22% to 60%.
Seventh Five Year Plan (1985-90)

The Family Welfare Programme during Seventh Five Year Plan (1985-90) was continued on a purely voluntary basis with emphasis on promoting spacing methods, securing maximum community participation and promoting maternal and child health care. In order to provide facilities/services nearer to the door steps of population, the following steps/initiatives were taken during the Seventh Plan period.

- It was envisaged to have one sub-centre for every 5000 population in plain areas and for 3000 population in hilly and tribal areas. At the end of Seventh Plan i.e 31.3.1990, 1.30 lakhs sub-centres were established in the country.

- The Post Partum programme was progressively extended to sub-district level hospitals. At the end of Seventh plan, 1012 sub-district level hospitals and 870 Health Posts were established in the country.

- The Universal Immunization Programme started in 30 Districts in 1985-86 was extended to cover all the districts in the country by the end of the Seventh Plan.

- A project for improving Primary Health Care in urban slums in the cities of Bombay and Madras was taken up with assistance from World Bank.

- Area Development Projects were implemented in selected districts of 15 major States with assistance from various donor Agencies.

The achievements of the Family Welfare Programme at the end of the Seventh Plan were:

- Reduction in crude birth rate from 41.7 (1951-61) to 30.2 (SRS: 1990).

- Reduction in total fertility rate from 5.97 (1950-55) to 3.8 (SRS:1990).
• Reduction in infant mortality rate from 146 (1970-71) to 80 (SRS:1990).
• Increase in Couple Protection Rate from 10.4% (1970-71) to 43.3% (31.3.1990).
• Setting up of a large network of service delivery infrastructure, which was virtually non-existent at the inception of the programme.
• Over 118 million births were averted by the end of March, 1990.

The approach adopted during the Seventh Five Year Plan was continued during 1990-92. For effective community participation, Mahila Swasthya Sangh (MSS) at village level was constituted in 1990-91. MSS consists of 15 persons, 10 representing the varied social segments in the community and five functionaries involved in women's welfare activities at village level such as the Adult Education Instructor, Anganwari Worker, Primary School Teacher, Mahila Mukhya Sevika and the Dai. Auxiliary Nurse Midwife (ANM) is the Member-Convenor. A major new initiative undertaken during 1991-92 was the Child Survival and Safe Motherhood Project, an integration of Universal Immunization Programme with expanded/intensified MCH activities in high IMR States/Districts of the country.

**Eighth Five Year Plan (1992-97)**

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

World Bank assisted Area Projects which sought to upgrade infrastructure and development of trained manpower continued during the 8th Five Year Plan. Two new Area Projects, namely India Population Project (IPP)-VIII and IX, had been initiated during the 8th Plan. The IPP-VIII project
aimed at improving health & family welfare services in the urban slums in the cities of Delhi, Calcutta, Hyderabad and Bangalore, IPP-IX operated in the States of Rajasthan, Assam and Karnataka.

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

Recognising the fact that demographic and health profile of the country was not-uniform, 90 districts which had 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 district, was made for upgradation of health infrastructure in these districts from 1992-93 to 1995-96. This amount was 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 had been covered.

Realising that Government efforts alone in propagating and motivating the people for adaptation of small family norm would not be sufficient, greater stress was laid on the involvement of NGOs to supplement and complement the Government efforts. Four new schemes for increasing the involvement of NGOs were evolved by the Department of Family Welfare.

The Universal Immunisation Programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant woman with immunisation 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 involved sustaining the high immunisation coverage level under UIP, and augmenting activities under Oral Rehydration Therapy, prophylaxis for control of blindness in children and
control of acute respiratory infections. Under the Safe Motherhood component, training of traditional birth attendants, provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were being taken up.

The targets fixed for the 8th plan of a National level birth rate of 26 was achieved by all States except the states of Assam, Bihar, Haryana, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.

**Ninth Five Year Plan (1997-2002)**

Reduction in the population growth rate had been recognised as one of the priority objectives during the Ninth Plan period.

The objectives during the Ninth Plan were: (i) to meet all the felt-needs for contraception, and (ii) 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 were: (i) to assess the needs for reproductive and child health at PHC level and undertake area-specific micro planning, and (ii) to provide need-based, demand-driven, high quality, Integrated reproductive and child health care.

India started its family planning (FP) programme in 1952, becoming the first government-sponsored programme in the world. The programme evolved gradually moving from awareness and information activities initially, to clinical services, and later on to a time-bound target-oriented programme from 1966 onwards (Gupta, Sinha & Bardhan, 1992). The FP programme, along with Maternal and Child Health (MCH) services, is called Family Welfare in India. This programme is sponsored by the Department of Family Welfare in the Ministry of Health and Family Welfare at the central. At the state level, it is managed by the Department of Health and Family Welfare. At the central and state levels, there are various divisions within the Department.
of Health and Family Welfare that look after various programmes. But at the
district level and below, the same infrastructure provides both family welfare
and health services. Generally, the primary health centre (PHC, one for
30,000 population) and sub-health centre (one for 5,000 population) provide
the information, education and communication (IEC) services as well as
spacing methods of family planning. Sterilisation operations are done at some
PHCs, community health centres (CHCs, 1 for 100,000 population), at district
hospitals or at specially arranged camps in the PHC or in selected villages.
The PHC also provides MCH services, immunisation and services for control
of communicable diseases.

Under the target-oriented planning and monitoring system introduced
in 1966, the central government gave to each state method-specific
contraceptive acceptor targets, which were based on calculations to achieve
replacement fertility level by a certain year. These targets were then
distributed to the districts by the state governments, and the district
administrator or health officers passed them on to the PHC. In turn, each
paramedic working under the PHC was given a target of new acceptors for
each method. In most states the targets for family planning were also given to
non-health staff, such as staff of revenue, education and rural development.
The district administrator and the state level technocrats and bureaucrats
reviewed performance of health care organisation, at each level, based on the
achievement of the targets.

Over the years, the contraceptive prevalence rate (CPR) has increased
from about 10 percent in the early 1970s to around 45 percent in the mid-
1990s. The total fertility rate (TFR) has declined from 6 in 1950s to 3.3 in
1997, and is likely to continue on its downward trend. The birth rate declined
from about 42 in the early 1960s to 27 in 1997 (World Bank, 1995; Registrar
General of India, 1998).
Tenth Five Year Plan (2002-2007)

The Tenth Plan proposes to fully meet all the felt needs for Family Welfare services and enable families to achieve their reproductive goals with a paradigm shift from:

- Demographic targets to focus on enabling the 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 child health to integrated health care for women and children.
- Centrally defined targets to community need assessment and decentralised area specific microplanning and implementation of Reproductive and Child Health Care (RCH) programme to reduce infant mortality and reduce high desired fertility.
- Predominantly women centred programme to meeting the health care needs of the family with emphasis on involvement of men in Planned Parenthood.

The Tenth Plan envisages a reduction in IMR to 45/1000 by 2007 and 28/1000 by 2012, reduction in MMR to 2/1000 live births by 2007 and 1/1000 live births by 2012 and reduction in decadal growth rate of the population between 2001-2011 to 16.2.

Family Welfare Programme in India: Determinants for its Success and Failure.

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. Since the formal beginning of the early 1950s, it has gone through many structural, administrative and implementation strategy changes. There is no doubt that that the facilities and services made available
for family planning have increased substantially over time (Zodgekar, 1996). In the rural areas, at the beginning of April 1991 there were 130,978 sub-centres, 22,059 primary health centres, and 1,923 community health centres (Department of Family Welfare, 1990:257-263). However, there are some doubts about the full utilization of these services and the quality of service standards being provided by these centres (Singh, 1989:39). The programme has contributed to large-scale awareness about family planning, contraceptives and available facilities (Mahadevan et al., 1989). There are reports of an increasing number of sterilization operations, IUD insertions and use of other contraceptive methods (Raina, 1994:172), all of which have increased the couple protection rate.

Since the goal of the family planning has always been established in terms of demographic targets, it is logical that its performance would have to be evaluated in terms of its impact on the reduction of the birth rate. The various fertility indicators certainly do show some trends towards declining fertility in India. The crude birth rate seems to have declined from about 45 per thousand in the 1950s to 28.5 per thousand in 1993. The total fertility rate has also declined from about 5.2 children per woman (1970-72) to 3.7 (1990-92). This amounts to a nearly 28 per cent decline in fertility during the period 1970-1990. A number of other demographers (Jain and Adlakha, 1982; Rele, 1987; Visaria and Visaria, 1994) also reported a reduction in fertility during the last few decades (Zodgekar, 1996). It almost came to halt in the 1980s (Jain, 1989; Raina, 1994).

During 1968-69 the decline in the birth rate came down. In 1961 the birth rate which was 41.7 per thousand came down to 39 per thousand in 1969. The target was to reduce the birth rate to 32 per thousand by 1972-73 during the Fourth Five Year Plan (1969-74), fell short by seven points. At the end of 1974, the birth rate was 38 per thousand. It came down to 37.2 (1981) to 32.5 (1986), to 30.5 (1989). When the percentage increased during 1941-51
it was 13.3; it increased to 21.5 (1951-61), to 24.8 (1961-71) to 24.6 (1971-81) to 23.5 (1981-91). In all the fields the achievement of the target was a disaster such as the number of sterilization has fallen, decline in the number of IUD (loop) insertions, fall in the use of number of conventional contraceptives.

Various cultural and religious beliefs and traditions are generally involved in shaping individual reproductive behaviour. In fact, the rational approach to procreated is often rational only within the upper and lower limits of reproductive norms established by the society (Freedman, 1966; Caldwell, 1980). Hence the motivation for smaller families and that of the use of birth regulation methods are not always linked and Family Planning Programmes need to adopt the view that gaps between the expressed desire not to have children and the lack of contraceptive use can be accounted for, at least in part, by both normative and rational, behaviour.

The factors like education, age, income background, husband's occupation, woman's (working) status influence the attitude of a woman towards family planning. In term of age, it has been found that the percentage approving of family planning decreases as the age group increases.

The study conducted by Gautam and Tekhere (2005) reveals that there are various determinants for male contraceptive acceptance. Based on qualitative/quantitative investigations the following important issues emerged from the study which were listed as follows:

- Limited option
- Rampant failure rate of vasectomy
- Psychological (misconceptions, fear, sexual pleasure)
- Socio-culture (tradition, mores, values, taboos, etc.)
- Educational (educational attainment, literacy)
- Availability of services, attitude and skill of providers and their staff
• IEC (information, education and communication)
• Economic (availability, accessibility and affordability)
• Religious

Limited option: It was also realized' through qualitative and quantitative data that males have only two options of contraceptive, one is temporary or spacing method—condom and second is terminal method i.e. vasectomy. While females have more options viz. IUD (intra-uterine device), OP (oral pills), EC (emergency contraceptives) as spacing methods while tubectomy, hysterectomy as terminal methods. Because of limited choices male contraceptive acceptance is less than females.

Rampant failure rate of vasectomy: Failure rate of vasectomy is a major barrier in the way of male contraceptive acceptance. It was observed that there were poor follow up, and rarely semen test is done after the vasectomy.

Psychological: The third determinant in the way of male contraceptive acceptance is psychological; which is called as 'pre and post vasectomy syndrome'. Many misconception related vasectomy were observed. There are many psychological barriers related condom use, e.g., lack of natural sexual pleasure among, both the spouses, fear to let condom stuck inside female organ, fear of being leak/burst during intercourse and ultimately suffering will go to the part of the women.

Social-cultural: In the year of 1952, when the family planning programme was launched, as national programme, it was completely a new experiment with the people, and a new experience of the people. Country like India which is known for its diversity, the socio-cultural barriers can't be generalized; but certainly there are many mores, values, traditions and taboos which resist in promoting the contraceptive acceptance e.g., son preference. The son preference is one of the major cause of not accepting the
contraceptives until or unless, the couple get at least one son. In case of getting son the graph of male contraceptives either increases or decreases.

**Educational:** It is observed that if a person having better educational attainment, the misconceptions are fewer in his mind. They adopt condom as a spacing method, because they know better that the OP (oral pills) and IUD may harm the women by side effects. The educated people are well convinced that vasectomy is a minor surgery, having no or very less adverse impact rather than the tubectomy. They have no fear of failure of the vasectomy and trauma followed after it.

**Availability of services, attitude and skill of providers and their staff:** Vasectomy acceptors are rarely cared for follow-up actions, even sometimes semen test is not done.

**IEC activity:** Today television is a good source of communication; it directly affect the society and -brings changes according to the goal of the family planning programme. The accord media in the study area which is influencing positively is the programme in radio, the third is, banner, posters, hoardings, etc. In today's society school is a good platform for IEC activity, and communication can be established from children to parents, but in contraceptive programme it can hardly communicate.

**Economic (availability, accessibility and affordability):** Economic factor is an important factor which is influencing the male contraceptive acceptance in adverse manner. In Indian society, male are prime earner of the family and rest of the members are dependent on him, that's why it is the responsibility of other members to take care of the chief earner. If any complications arise after vasectomy the whole family becomes disorganised and unstable economically.
Religious: It is recognized that religion has limited impact on contraceptive acceptance but it can not still be ignored. Still there are some resistance groups in the name of religion.

The aim of family planning programmes must be to enable couples and individuals to decide freely are responsibly the number and spacing of their children, and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. The success of population education and family planning programmes in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities (United Nation, 1994).

Recognition of the changes worldwide and the challenges that are faced by the programme has led to the development of several new policy initiatives. Recently, the programme focus has shifted away from vertical family planning services towards the provision of comprehensive integrated reproductive health care at all levels of the health sector (Pachauri, 1995). Providing a backdrop of the changing policy environment, this paper reviews and synthesises recent evidence on contraceptive use dynamics and the unmet need for contraception in India. While discussing some of the barriers that hindered the success of the programme, the paper sheds light on new initiatives to address these and assesses their impact if any. However, it may be mentioned that it is too early to make any definitive assessment of the impact and data for making such an assessment are limited. The review concludes with a discussion of critical programmatic and research issues to be addressed in order to improve quality of services and meet clients' needs- This review draws on national surveys and small-scale studies, carried out primarily in the 1990s, and as far as possible new information and data are incorporated.
During the last three decades, the developing world has experienced what might be called a reproductive revolution. In this short span of time the percentage of couples using contraceptives has increased five fold, from less than 10 per cent in the 1960s to more than 50 per cent in the 1990s. A landmark study published in 1990 indicated that the family planning programmes were responsible for averting over 400 million births. However, family planning practices vary considerably from country to country. In many developed countries, contraceptive prevalence exceeds 70 per cent, while in developing regions, such as sub-Saharan Africa, it remains below 15 per cent. Regional variation in contraceptive use reflects fundamental differences in religious views, desired family size, women's status, their knowledge of contraceptives, and the strength of organized family planning programmes (Ashford and Noble, 1996).

According to the World Bank, the future challenge for family planning programmes will be to meet the needs of those not currently being served as well as to improve the quality of existing services. The use of a non-use of contraception reflect the motivation to control fertility and the propensity to contracept among those who are motivated. Women can be motivated to control fertility either because they wish to postpone with next birth. According to the 1991 Indonesian Demographic and Health Survey (Indonesia, 1992), by the definition of unmet need, approximately 20 percent of the married women in Indonesia have an unmet need to limit fertility and another 20 per cent have an unmet need to space their births. Of those women that want to have no more children and stated that their need for contraception is unmet, the higher need is for women with no schooling (33 per cent compared with only 11 per cent among the highest educational level) (Sumbung, 1996).

**Family Welfare Programme in India: The Critique**

Inspite of successes of increasing CPR and declining birth rate, there has been criticism of the Indian family planning programme within and
outside the country (Conly and Camp, 1992), for its highly centralised, inflexible, target-oriented monitoring which both limited choice for couples in selecting FP methods and did not ensure quality. The target-oriented monitoring also encouraged some degree of inflation of the results reported in terms of clients served, as well as created a feeling of alienation in the community toward the programme. The workers and the staff also felt pressured for non-achievement of targets. The programme neglected several systemic problems, such as lack of proper infrastructure, poor logistics and supplies, weak supervision and training (Mavalankar, 1998).

The major impetus for change seems to have come from three sources. First, during the late 1980s and early 1990s, some research studies, evaluations and assessments indicated various problems faced by the family planning programme as mentioned above. Second, the programme performance reached a plateau as the pace of increasing contraceptive prevalence and decreasing birth rate slowed down inspite of increasing efforts. Third, over the years, several women's groups, women activists and NGOs had also criticised the target-oriented FP programme as being insensitive to women's needs (Visaria et al., 1998).

This situation led to rethinking about the strategy and the programme at several levels within and outside the government. The Government of India set up two committees, one headed by the Chief Minister of the state of Kerala and another headed by an agricultural expert and bureaucrat to review the population policy and the family welfare programme. The latter committee, which gave its report in May 1994, recommended moving away from target-oriented approach (The Futures Group International, 1998).

In 1994, the Government of India participated in the International Conference on Population and Development (ICPD) held in Cairo and
presented a country paper which considered family planning in the broader context of health and development (Government of India, 1994). The ICPD Programme of Action (POA) emphasised quality of care, voluntary choice in family planning and action to help couples meet their reproductive goals. It talked about reproductive health (RH) in the context of reproductive rights, thus moving away from demographic, macro level goals to a client focus as endorsed by ICPD-POA, 1994.

In 1994-95, the World Bank reviewed the family welfare sector in India in collaboration with the Government of India and a report was published in May 1995. The report focussed on how the programme can carry out the commitment given at the ICPD to implement a client-centred approach that responds more effectively to the RH and FP needs of women and men in India. The overall recommendation of the report was "reorient the family welfare programme, as quickly as possible, to a reproductive and child health approach that meets individual health needs and provides high quality services". One of the key policy recommendation of the report was "eliminate method-specific contraceptive targets and incentives. Replace them with working with universities broad reproductive and child health goals and measures. Increase emphasis on male contraceptive methods and broaden the contraceptive method mix". The report also recommended increasing the budget for reproductive and child health to meet critical gaps and enhance service quality (World Bank, 1995).

The Government of India started doing away with using specific, quantitative targets for monitoring the programme in the early 1990s, ICPD provided a final push in this direction. Meanwhile, some states had already initiated steps to experiment with alternate strategies for the FP programme. For instance, in the state of Tamil Nadu in the early 1990s, one district collector had removed targets from non-health functionaries and involved
ANMs (auxiliary nurse midwife) in target setting. Beginning in 1992, the state of Rajasthan also started experimenting with alternate ways to plan and monitor the FP programme. Following the recommendation of its expert committee and consensus at ICPD, in April 1995, the Government asked each state to identify one or two districts and make them target-free for family welfare. Two states, Kerala and Tamil Nadu, where fertility had declined to near replacement level, opted to make the whole state free of targets. Other states experimented with removing targets in one or two districts as per central guidelines. Targets for condoms were discarded from April 1995 onwards for all states. After one year of piloting this approach, the Government decided to make the family welfare programme in the whole country target-free from April 1996. Several state administrators and family welfare directors were concerned that in the absence of targets the programme performance in terms of number of acceptors recruited for sterilisation would decline and suggested a slower process of removing targets (Murthy, 1999).

The field staff generally found the formats for planning, supervision and reporting suggested in the TFA manual too complicated and removed from what really was happening on the ground. Consequently, they were not used systematically. In the absence of proper understanding of the programme, its purpose and approaches, the target-free approach in many states was interpreted as, the "work free approach". Many activities, such as FP extension work, IEC work, sterilisation camps, etc., which were performed under the family welfare programme, possibly under the pressure of targets, stopped in several states after targets were dropped. Some workers thought that as there was no pressure of targets they did not need to put in even the usual effort. Even though the target-free manual had suggested a series of indicators for performance measurement and quality assessment, no systematic effort was made in many states to collect data on these indicators and use them for monitoring and improving the programmes. Some states,
such as Maharashtra and Rajasthan, did try to focus on unmet needs, access and quality of care. Field observations in two districts of Gujarat showed that the TFA became an exercise to prepare sub-centre, PHC and district action plans without understanding the purpose and meaning of the whole exercise.

Because of the lack of pressure following removal of targets and the lack of close monitoring in some states (especially in central and north India), the number of sterilisations performed dropped somewhat in the year 1996-97, the first year of implementation of the TFA. This was especially true for Uttar Pradesh and Bihar where sterilisation performance went down substantially between 1995-96 and 1996-97. In several states, there was a gradual decline and a continuation of the previous trend beginning before the TFA for certain states. Only in one or two states, there was a marginal increase in sterilisation acceptance. The decline worried the programme managers at the state and central levels, and some states informally or formally reintroduced the targets at state or district level.

In many states, instead of central determination of targets on population, the PHC and workers were asked to calculate their expected level of achievement based on a formula given by the state government (as happened in Gujarat and Tamil Nadu) or based on unmet needs determined by survey of eligible couples (as happened in Rajasthan and Gujarat during second year). In effect, in many states, the target-setting exercise was decentralised to the periphery, which was a positive move, but in only one or two states consultation with clients was undertaken as the basis for estimating the unmet need for family planning. In other states, when the peripheral workers came up with lower need than expected by the higher level managers the targets were increased.

The other component of the TFA, which was focussed on improving quality of care and generating community participation, did not systematically
take place in many states, partly because there was no emphasis on these activities in the manual and at any of the other communications including workshops and meetings. Secondly, no additional resources were allocated for such activities. Thirdly, the health system had not emphasised community participation or quality issues in the past and hence lacked adequate skills on how to do them. There is no evidence to suggest that the quality of service or community participation improved in the programme. The state of Rajasthan seems to be an exception, as some innovative community participation activities and IEC efforts did take place (Mavalankar, 1998).

The experience to-date highlights the implementation difficulties of such a paradigm shift from “demographic orientation” approach to “client-centred” approach in a large country like India. The pace and direction of change as implemented shows a high degree of variability. For a rapid transition, implementation efforts need to be substantially enhanced through strengthening management resources for bringing about the change, accelerating the pace of learning, simplifying strategy and communication and providing more resources for improving quality of care. Much also remains to be done to increase community participation, especially women's participation.

Nevertheless, this policy change has begun the process where administrators and technocrats at various levels and service providers have begun to think of what they should do and how to meet client needs. The service providers have generally welcomed such a change and feel less pressured, and the performance of other services such as MCH may have begun to improve.

The success of this great effort to reform the family welfare programme will highly depend on the kind of leadership that will be available at the central and state level and the perseverance of the key managers in ensuring that the original vision is not lost over time. Effective partnership
with donors, NGOs and researchers will be essential to carrying on the
paradigm shift that has started in the Indian family welfare programme.

According to Bose (1995) India set the goal of Population stabilisation
in the very first Five-Year Plan (1951-56) which was formulated soon after
India attained independence in 1947. In spite of the completion of nine Five-
Year Plans, the goal of population stabilisation remains distant. The
population continues to grow at a faster rate than anticipated by India's
planners and policy makers and every decennial census sends shock waves to
them.

Demography must look far beyond decimal points, otherwise
demography will remain a dismal science of population, dominated by
doomsday predictions based on mechanical projections which can now be
worked out in a matter of minutes on an electronic computer. Statistical
competence is not enough to understand the population problem and to solve
it mere competence in reproductive biology and contraceptive technology is
not enough. It is unfortunate that in most discussions on family planning, the
family is never discussed: the obsession is with contraceptive technology. The
poverty-stricken masses in India still rely on the solidarity of the family for
their survival and are disillusioned by the Government's anti-poverty
programmes and the growing leakage's in the delivery of these programmes.
In short, state intervention in curbing the birth rate has not inspired India's
masses to take to the small family norm. Events during the short-lived
Emergency in India (1975-77) have amply demonstrated the power of the
people in a democracy: a mighty Government was humbled and the issue was
family planning. As someone then commented: "Coercion in family planning
is likely to bring down the- government faster than the birth rate".

The Planning Commission clearly recognised the need for population
control right at the beginning of the planning exercise. To quote the First Plan
(1951-56):
The recent increase in the population of India and the pressure exercised on the limited resources of the country have brought to the forefront the urgency of the problem of family planning and population control. It is, therefore, apparent that population control can be achieved only by the reduction of the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of national economy. This can be secured only by the realisation of the need for family limitation on a wide scale by the people (Planning Commission, 1952).

The Planning Commission did not, however, spell out in statistical terms the implications of the goal of "stabilizing India's population". No doubt the plan made an impressive start by advocating family planning as a state policy and India proudly claims that she was the first country in the world to have advocated family planning as a state policy, but our record of the last forty years in the field of family planning is far from impressive. Pandit Jawaharlal Nehru had the right perception of India's population problem when he described the problem not as one problem but 400 million problems! He further spelt out that the problem was of providing food, clothing, shelter, education, medical aid and employment to every person. In other words, he perceived the problem essentially as a problem of development.

India's first Health Minister, Amrit Kaur started the family planning work very cautiously. The emphasis was on the rhythm method and the family planning programme was a part of the health programme. In 1966, a new Department of Family Planning was created. The accent was on communication, financial incentives for the practice of family planning, particularly sterilisation, and high-powered advertising of new methods of family planning like the IUCD. A new methodology was evolved to monitor the family planning programme. Detailed targets were set for each family.
planning method by the Department of Family Planning. There is no doubt that during this period, there was a tremendous increase in the infrastructure of health and family planning and foreign advice and aid played an important role.

The Janata Government which came to the helm in 1977 changed the nomenclature of family planning into 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. The Janata Government fell in 1980 and Mrs. Indira Gandhi came back to power. The new Government did not change the Janata nomenclature of family welfare. Mrs. Gandhi proclaimed in her new 20 point programme that family planning was to be promoted on a voluntary basis as a people's movement. She also made a sincere effort to fill the family welfare basket with nutrition and maternal and child health programmes.

Professor Nicholas J. Demerath, an American sociologist, who worked as a family planning expert in India in the 60s, and wrote a critique in 1976. He observes that "the first reason why family planning fails in poor countries is the obsession of the experts with techniques of contraception- The belief that just about any problem can and will be fixed by some new tool or techniques is as Anglo-American as apple pie. He goes on to say: "Instead of employing proven psychological and social principles of motivation, family planning training courses typically exclude them. It is the mechanics and forms of bureaucratic administration that are emphasised along with a little demographic and reproductive physiology. It is thought that the more advanced the management system, the better meaning, the more quantified, computerised and routinised" (Demarath, 1966).

Under the Indian Constitution, health is on the State list while social and economic planning including family planning is on the Concurrent list.
But in effect, the family planning programme has operated as if the subject was on the Union list as it has always been a 100 percent centrally financed programme. The programme has emerged as massive monolithic programmes, centrally financed, directed and monitored while the implementation of the programme is left to the states. Several states take an interest in family planning only because the programme brings money from the Central Government. There is a feeling in the Planning Commission that if the states are asked to share financial responsibility, the Family Planning Programme will collapse. In fact, when the Community Health Workers Scheme (currently called the Health Guide Scheme), launched in 1977 as a centrally sponsored programme, was subsequently modified by the National Development Council in terms of 50:50 sharing by the Central and State Government, the scheme virtually collapsed in several states. Only when it was made a Centrally Sponsored Scheme again, the scheme revived but as the money was disbursed from the family planning budget,' the administration of the programme at the Central level was transferred from the Department of Health to the Department of Family Welfare. In spite of frequent recommendations in international and national seminars and conferences for the integration of health and family planning, our historical experience shows the continued lack of integration of health and family planning all along the line, right from the Central Government to the grass roots level. To make matters worse, there is quick money in the family planning programme for motivational work but there are no such incentives for health work. A suggestion that the Government award for good family planning performance may be given for the combined performance of maternal and child health (MCH) and family planning was quickly shot down by the bureaucracy.

A major drawback of our centralised family planning programme has been the lack of adequate appreciation of the problems created by regional disparities in the demographic situation planning programme has a 'cafeeteria
approach' and the people are free to choose whatever method they want, in effect, the programme is basically a sterilisation programme and (in recent years a female sterilisation programme). At the grass roots level, the only concern is to get more cases for sterilisation, regardless of the impact of such sterilisation on the birth rate.

The major weaknesses of India's family planning programme are: (a) unrealistic foreign orientation based on contraceptive technology, (b) monopoly of bureaucrats, (c) monopoly of the Central Government, and (d) sole concern for quantitative targets and their achievement irrespective of the impact on the birth rate.

Bose (1995) lists the major problems facing India's family planning programme as follows:

- No Government programme can overcome what we call demographic fundamentalism, which is a deep-rooted phenomenon in India society. By demographic fundamentalism, we mean the craze for sons and the relentless efforts to try and get a son even when five or six daughters are born. On the basis of empirical data from primary health centres all over India, we have observed that two living sons is the cut-off point. Therefore, a family planning programme, which is wanting a couple to have only two children, by definition, would imply that couples should have only sons and no daughters. Therefore, this introduces an element of contradiction in the policy as formulated by the government and the requirement of the masses in terms of their own perception. It is doubtful if a bureaucratic programme can dilute the force of demographic fundamentalism merely by putting posters and banners that "sons and daughters are the same". It calls for social transformation. This task can be entrusted only to enlightened social reformers.
One of the reasons why our family planning programme has not succeeded is the obsession with technology and the neglect of the geographical socio-economic context. For example, it was thought at one time that the Ernakulam Experiment of mass vasectomy camps in Kerala would pave the way for a drastic reduction in the birth rate. Similar camps in Uttar Pradesh led to tetanus deaths and the camps were abandoned. Obviously, U.P. is not Kerala. Then came the much advertised IUG (Lippie's Loop). It was soon abandoned by our women, we now have a new technology called copper T. Then came the laparoscopic method of female sterilisation. Here was a high-tech method, which saved time and money, and this was seen as a revolutionary step in the Indian family planning programme. However, the most callous use of this technology by our medical doctors brought a bad name to this technology. The failure rate is high, the pregnancy rate is high and there have even been deaths as a result of this operation. The latest in the field of technology is amniocentesis or sex determination before birth. Interestingly enough, this modern technology, which was originally used for detecting genetic disorders, is being misused in India for a massive programme of female foeticide. As soon as a couple is told that the pregnancy will result in the birth of a girl, abortion is resorted to. Amniocentesis raises moral, medical and ethical issues, which have to be sorted out. It is unlikely that a mere legal ban will succeed in weeding out this technology.

A related problem is that our family planning programme has got booked to technology. The whole issue of population control centres around sterilisation, or the terminal method of family planning. To make matters worse, under misguided foreign advice, we started paying money as compensation to acceptors of sterilisation. This immediately put a premium on sterilisation. Now we have come to
grief. It is clearly recognised that the use of money power has led to widespread corruption. Further, this has discounted the use of non-terminal methods. Worst of all, this has put the whole family planning programme upside down. Instead of starting with marriage and immediate practice of contraception after marriage, our focus is on the "exhausted generation" of women at the fag end of their reproductive life. This is one of the main reasons why we have not been able to make a dent on the birth rate. By and large, poor people have gone for sterilisation only after they have had two living sons: in short, only after their family building process was completed. They went for the operation to get some money. This is the state of their poverty. Rs. 160 cannot buy even a good shirt or nutrition for children for a month. The money was therefore put to an interesting use; the husband of the sterilised woman bought alcoholic drinks and drank it all. This is the economics of the compensation money as understood by our people. We do not blame the people because it is manifestly foolish to try to entice people by giving Rs. 160. We are familiar with the standard argument that this money is not incentive money. But anybody who is familiar with the field situation will tell you that there is no difference between condensation and incentives in reality.

To assess the achievement of the family planning programme one has to look at the trend of the birth rate. A source of data is Sample Registration System (SRS) under the Office of the Registrar General in the Ministry of Home Affairs. The SRS data are more reliable than the Family Planning performance data. In any case, we are more interested in the trend rather than in the yearly figures as such. The SRS data reveal that the birth rate has been stagnating, both in rural and urban areas, for over a decade. The stalling of the birth rate has generated considerable debate among demographers.
The Health and Family Welfare Ministry has argued that success should be judged by the number of births averted and not merely by the trend of the birth rate. They argue that but for the government programme, the birth rate of India would have been higher.

The Planning Commission is not impressed by this argument. As the Approach Paper (May 1990) to the Eighth Five-Year Plan (1990-95) puts it: "The measure of the success of any family planning programme should be targeted at the reduction in the birth rate and not the number of births averted" (Planning Commission, 1990).

The credibility of the family planning programme in large parts of India and especially in the states of Bihar, Haryana, Madhya Pradesh, Rajasthan and Uttar Pradesh is near zero. The illiterate masses have still not fully recovered from the shock of the crude body-snatching sterilisation programme during the Emergency. In India, sex is sacred because marriage is sacred. The assault on the sex life of couples in the name of family planning is totally unacceptable to the masses. In particular, women (who are half the number of voters) were incensed by such a body-snatching programme in the name of their welfare.

The politicians have burnt their fingers on the family planning issue. The mighty government of Indira Gandhi was swept out of power in 1977, mainly on the issue of family planning. In Uttar Pradesh, the most popular state of India, the ruling party could not win even one seat in parliament out of the 85 seats in that state. Such was the fury of India's illiterate masses. Today the politicians tend to blame the bureaucracy (even Indira Gandhi blamed the over-zealous bureaucrats for making a mess of the family planning programme). On the other hand, the bureaucracy blames the politicians for their singular lack of political will when it comes to family
planning motivational work which should be a priority concern for the elected representatives of the people. Some of our politicians and parliamentarians are more eager to visit China, Indonesia, Singapore, Thailand etc. to learn about family planning than visit Bihar, Uttar Pradesh or Rajasthan to study for themselves where we have gone wrong.