

**PUBLIC POLICY ON POPULATION CONTROL IN
POST-INDEPENDENCE INDIA: A CRITICAL STUDY**

A THESIS SUBMITTED TO
THE UNIVERSITY OF HYDERABAD
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

BY

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UNDER SUPERVISION OF
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OCTOBER 2007

October 25, 2007

CERTIFICATE

This is to certify that the work entitled **Public “Policy on Population Control in Post-Independence India: A Critical Study”** submitted by **Darse Shalem Raju** in partial fulfillment of the requirements for the award of **Doctor of Philosophy**, has not been previously submitted for any other degree of this or any other university. To the best of our knowledge, this is a bonafide work of the candidate.

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ACKNOWLEDGEMENTS

I want to thank **the Almighty**, the creator and sustainer of universe.

It gives me immense pleasure to express my deepest gratitude for the help received from various sources in the course of the preparation of this thesis work.

I express my deep sense of gratitude and my extreme indebtedness to my guide **Prof. P. Eshvaraiah**, Department of Political Science, University of Hyderabad, for suggesting this topic as also for showing great patience and keen interest. I thank him for his constant and valuable guidance and encouragement throughout the research work. His insight into the subject helped me in understanding the methodology to be adopted and revising the plan of the thesis.

I am extremely grateful to **Prof. Sheela Prasad**, D.C. Head of Regional Studies Centre, for her valuable suggestions. She has been a source of inspiration for completion of this thesis. I express my thanks to **Prof. E.Haribabu** our beloved Dean of Social Sciences for his kind co-operation and attention

I express my gratitude and thanks to **B. Chandra Sekhar Rao**, Department of political science, **Prof. Sudarshanam**, **Prof. Arun Patnaik** and **Dr. Sandhya Madam**, Department of Political Science for sharing their thoughts and ideas. I take this opportunity to express my sincere gratitude to **Prof. Shanta Sinha**, for her suggestions.

It is an immense pleasure to acknowledge my sincere feelings and respect to **Dr. Arjun Rao** for his valuable guidance and encouragement extended to me in giving shape to this work. I express my gratitude and heartfelt thanks to **Dr. K.Y. Ratnam**, Department of political science, for his guidance.

I am grateful to **T. Devendra Reddy**, Managing Director of Gayatri Agro Industrial Power Ltd and Lakshmi Gayatri Iron & Steel Pvt. Ltd, Hyderabad, for his constant support throughout the research work and life. There are no words to express my gratitude. He is man of reasoning and symbol for humanity.

I express my sincere gratitude to all my Professors, Department of political science and Department of Regional Study Centre for their suggestions during the preparation of this work.

I may be failing in my duties, if I do not acknowledge the support of my family members for their encouragement, constant affection prodding and inspiration throughout my academic life. I will remain ever thankful to them. I am thankful to my wife **Dr. K. Sharon Rani, M.D.**, for encouraging me to complete my work. I should not forget happy moments of my daughter, **Shamma Shalem** and my son.

I express my heart-felt gratitude to my family members. I thank my eldest brother, **D. Samuel, Deputy Commissioner of Income Tax** and my sisters-in-law. I am thankful to my sister, **Vijaya** for her services and to **K. Venkaiah**, Engineer for his immense help. I will ever be grateful to my friend **Ananda Kumar M**, for his valuable suggestions. I am thankful to my friends

Dr. Ravindra, and K. Bhaskara Rao for their assistance and encouragement in many ways in completion of this thesis.

DARSE. SHALEM RAJU

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CHAPTER 1

INTRODUCTION

1.1 Overview of Population Growth in India

India has the second largest population among countries of the world, the first being China, with only 2.4 per cent of the world's geographical area. India's share of world population is 16 per cent. India is adding 17 million people every year, roughly the equivalent of the total population of Australia. According to the latest estimates based on fertility rates, in the world today, India ranks second in population numbers (Communist China tops the list with more than 750 million people) and seventh in land area. (Chandrasekhar., 1977: 246). India is expected to overtake China by 2050, when there would be 1,592 billion Indians to 1,392 billion Chinese. "India's population is very large and is growing very fast. This affects adversely the growth of economy and is highly unfavorable for the growth of output." (Agarwal ,1994:77).

India's population was 238 million in 1901. It increased by only 5.4 per cent by 1921 to 251 million. But during the next three decades the population increased by 11 per cent, 14.23 per cent and 13.31 per cent respectively. By 1961 the population was 431 millions, registering an increase of 21.64 per cent. (Khan and Gupta ,1985: 1). It was 548 million in 1971. According to the 1981 census, the population of India was around 685 million. It was 1027 million in 2001. It indicates that about 16 million people are added every year and even today, India's population is increasing day by day.

According to the Indian Journal of Public Administration “the figures of Indian population today are thoroughly alarming. The world population has gone up from 2.5 billion in 1950 to 5.3 billion, that is more than double in 1990. As per the first census the recorded population in India was 351 million. (IIPA., 1992 : 1). In the 1991 census, the population figures were 844 million, but, these figures were represent under-estimation and in fact the population was above 1027.0 million. In the 2001 census, the population figures that came out were 1027.0. From 351 million to 1027.0 million in 56 years, the growth rate is still above two per cent per annum” (Ibid: 1) Indians are adding one Australia every year to the Indian state population, the growth rate remains constant increase in absolute terms. Life expectancy has steadily risen now to 60 years.

By the year 2050 India will emerge as the most populous nation on the planet, having at last overtaken our neighbor China. Between 1995 and 2000 the world population grew at the rate of 1.3 per cent per year. The world populations touch 9 billion by 2054.

The growth of population has diluted much of the benefits of substantial economic growth that India achieved since Independence. For instance, widespread malnutrition, sending into society children with shriveled bodies, underdeveloped minds, urban slums, deforestation, desertification and despoliation of natural resources, precede apace, rural conflicts, social tensions and fuelling the growing proclivity towards violence.

India has made considerable progress in the last 60 years in industrial and agriculture sectors, but the green revolution now is not going to produce comparable

food grains to keep pace with the population growth. India exports food grains but people are still undernourished. "The pressures upon food are going to increase and the benefits of Indian economic development during the last 60 years have already been very largely diluted as a result of population growth" (Ibid, 2).

The nation has not paid enough attention towards this issue, and today it has become a serious issue. If not happened the rates of population growth will be higher in South-Asia. If no policy is taken seriously, the rate of population growth is very high in South-Asia.

1.2 The Magnitude of the Population Problem

The problem of fast increasing population is at the root of the socio-economic maladies of India. Presently the country has 16 per cent of the world's total population and only 2.4 per cent of the land areas. Population growth rates as well as population size are matters of concern as about 1.6 million persons are added every year in the country. The country is rich in natural resources and also has developed a remarkable infrastructure for industrial growth. But increasing population has turned into a major obstacle for equitable development.

The problem of population peril cannot be solved without a thorough understanding of different quantitative and qualitative aspects of the rapid population growth. The population growth was very slow till 1921. Before 1921 famines and plague took a heavy toll of human life slowing the increase in population. Due to this fact 1921 has been considered as the great divide.

The density of population has been increasing from one decade to another since 1901. In 1901 only 77 persons lived per sq.km. as against 216 in 1981. This

has affected the land man ratio and per capita land has come down considerably. With the increasing pressure on land in rural areas, there has been mass migration to urban areas. This caused higher density of population in the cities creating a number of problems in urban centers such as congestion, housing shortage, lack of basic amenities, insanitation and health hazard, etc. "These are hard realities which cannot be denied. Nonetheless the existing size of India's population and the current rate of population growth are definitely obstacles in the country." (Misra S.K. and Puri, V.K., 2000: 71).

The growth of population is the single most pressing problem and is, in a way, the mother problem which leads to many other problems. The current growth is still very high. If the population growth continues as at present, the country, will have alarming figures and also will have dubious distinction of overtaking China as the most populous country in the world. It hardly needs to be emphasized that large population would not only undermine all our efforts towards socio-economic development of the country but would also be virtually unmanageable. According to Ashish Bose the consequences of the unbridled population growth is going to become manifest much before. (Asish Bose, 1989: 59). The growth of population leads to a number of problems in India.

The states like Kerala, Tamil Nadu and Orissa recorded a lesser rate of decadal population growth as compared to other states. The states which need special attention from the viewpoint of population control policy are Assam, Rajasthan, Jammu and Kashmir, Haryana, Gujarat, Uttar Pradesh and Madhya Pradesh etc. which showed above the all India decadal growth rate. This indicates that it is difficult to tackle the problems of population growth at the national level. These

factors of population growth are to be studied in detail in each individual state with a view to achieve uniform results in different regions of the country.

The growth of population is the function of fertility, mortality, migration and several other factors. These factors are also governed by social, political, cultural, economic and biological factors of the region. The biological factors are more significant for fertility of human beings. The mortality factor of population growth is generally affected by geographical, biological, socio-economic and medical and sanitary conditions of the area concerned. The factor migration is generally affected by economic conditions and employment opportunities of a country. In under developed countries like India, the role of migration is also significant in India. Internal migration i.e., rural to urban migrations, is significant to affect distribution of population within the country.

The physical, mental and educational development of human resources is considered to be closely related with the rate of population growth. The rapid growth of population and higher levels of fertility retard the desired level of socio-economic development which in turn hinders the proper growth of the human beings.

There is a wide gap between the rate of growth of national income and per capita income. The consumption standard of the people indicates that the major chunk of India's population is still below the poverty line.

The population of a country needs food, clothing, houses, education, and transport. These are essential components for the human development. All these affect resource capital due to population explosion. Even the national income and per capita income of a common man in the country has not been adequately benefited by the efforts of planned economic growth mainly due to rapid growth of population.

The population pressure would further lead to growing urbanization as people from rural areas would migrate to cities in search of work, and provision of basic services in urban areas, which are most resource intensive, would be even more difficult. Above all, such a high population growth would play havoc to environment and may lead to ecological crises.

In respect of food grain which is the first and foremost requirement of population, it has been noticed that there has been a decline in per capita availability of food grains due to rapid growth of population. Per capita per day availability of pulses which are an important source of protein for the poor people declined due to rapid growth of population. Housing is also area of the essential needs of people which affects their health and all-round development. The high increase in population year after year has been placing a heavy to fulfilling the housing needs of the people.

As a result of rapid population growth the backlog of unemployment has been noted and higher rates of population growth create shortage of educational facilities and consequently lead to lower percentage of literate and educated persons in the population. Higher increase in population tends to reduce per capita income and consequently per capita expenditure on human resource development. The desired increase in wages is not achieved due to excess labor supply. Excess labor supply is due to the population explosion. Excess labor supply weakens the bargaining strength of the industries worked in India.

As Chandra Shekar writes: "The decline in death rate and increase in population is the result of health revolution in India". (Chandrasekhar, 1972: 253).

The fall in death rate in India must also be attributed to increase in agricultural production and development of better communications and transportation.

The government of India introduced the family planning programme to make cheap and effective contraception available to all categories of the population. Emphasis was also on raising the marriage age of girls. In a bid to reduce fertility (the average age of girls at marriage was 15.6 at the time), sterilization was promoted, and abortion was legalized for married women in the early 1970s. In the 2001 census, India's population totaled just over a billion people (1.027 billion).

Indian aims to accelerate the decline in birth rates, but the higher increase in the population is affecting the overall quality of life, development and conditions of India. Despite policies of the government, the birth rate continues to be high. The overall picture of population control in India shows little or insignificant decline in birth rate. If it continue further, "population growth can become a great threat and an insurmountable malady to our economic growth and thus to the promotion of man's welfare". (Varughese K V, 1993: 96).

The Indian government's concern to control population growth dates back many years which resulted in a population policy. Although population growth has slowed considerably, India has accumulated such potential for growth that the target of population stabilization has had to be regularly deferred. The population policy introduced in 2000 forecast stabilization by 2045.

1.3 Need for the Study of the Problems in the control of Population

If the Government of India wants to achieve a major breakthrough in population control and to prepare new population policies it needs to make attempts to

invent new devices to control birth rates. So far there is no government framed a policy to device an anti-pregnancy vaccine. For example "In the Indian programme, all couples of reproductive age have been receiving almost identical attention from programme personnel, regardless of their fertility potential. (Srinivasan K, 1989:272). This kind of the treatment is also to be studied by taking into age and fertility aspects of the people. Many are dependent very largely on operative techniques on vasectomies and tubectomies-which are very effective, but do impinge physically and psychologically upon the most sensitive elements of the human anatomy.

So far no Indian pharmaceutical companies have achieved a major breakthrough in contraceptive technology. The Indian government should have to see the Indian pharmaceutical companies have to develop a breakthrough in contraceptive technology and need to be urging the industrial and commercial community to interact with scientists on this aspect in order to ignite the minds of masses to aware of the population problem.

The government of India should frame a policy for Indians to concentrate much more than what has been done on female literacy. There is a very close correlation between birth rates and female literacy, when the latter goes up, the former goes down. This fact is so well established now that it is known throughout the world. It is the time to study the population problem very seriously.

There is a very close relationship among the following four aspects. These are: population growth, female literacy, female mortality and medical facilities. The author of contours of social and economic development policy issues concluded that "for lowering levels of female mortality, substantial improvements in socio-economic conditions were necessary, in addition to the provision of medical facilities". (Shenoi

P V, 1989:232-233). The socio-economic conditions will be improved when female literacy is at higher level. For example, in Kerala, which is not otherwise a prosperous state, because of lack of universal literacy and universal female literacy, the birth rate is much lower than it is in other parts of the country. (The Indian Journal of Public Administration. 1992: 3). There is an impact of higher literacy on birth rates. Women have been playing a pivotal role in reducing birth rates. So women must be associated at all levels in any family planning or population control programme.

The welfare of children, maternal and child health care are absolutely essential for ensuring lower fertility. It may appear to be a contradiction in terms, but lower the child mortality rate; lower is the growth rate. Where the mortality rate is high, the family tends to have many more children because they are not sure how many are going to survive. Wherever children are well looked after and the mortality rate of the child falls, the fertility rate also falls. It is must to know fertility levels in India. There should be a cross cultural study on fertility levels in the world to frame new policies to control birth rates. "According to the UN (1981) statistics there is some decrease in fertility in virtually all the large developing nations comprising over half the world population" (Ghosh, 1989: 32).

There is a need to study child health, mother's health and medical facilities. In this case integrated child health care programme is extremely important to curb the growth of population. This involves immunization to pregnant women and nursing mothers; nutritional inputs to infants; and a whole gamut of medical and childcare facilities up to the age of five. The growth of population is not an ordinary issue and it should be studied by all the sections of the Indian society. There should be a concern over population issues by many people in India. It is "concern over this rapid

rise in population rose from four quarters; Intellectuals, socio reformers especially those interested in improving the status of women, the Congress Party (the leading political party that spearheaded the movement for political independent) and government". (Srinivasan., K. 1989: 15). This area has become a hot topic among the political parties, politicians, social reformers and intellectuals.

The population control programme is still in the hands of the Government. Actually it is not something that can be done merely by government or by adopting policies in Parliament. What is required is a mass movement, a National Movement for Population Control (NMPC). This must involve the Central Government, state governments, local bodies corporations, municipalities, Zillah parishads and panchayats, because unless these bodies are deeply associated, the nation is not going to get the desired results. "So the message of the small family norm is to be conveyed to the masses through effective motivational and educational measures (Madan G R and Dr. Joshi M D., 1989: 50). The success of the family planning programme is based on motivational and educational measures.

Not only the Chambers of Commerce and Industry, but also the working class sectors along with the organized labor need to be involved in the population control programme. Labor could be an extremely effective instrument for motivating the working class in view of the concentration of people who can be easily reached. It is the time to have some progressive and enlightened industrial houses to population control and also involve non-governmental organizations, particularly women's organizations in family planning programmers. For example, the Family Planning Association of India, which has got branches of it all over the country and it, could play a very meaningful role in this context. Women are the key to the whole problem.

That is why in India “The National Council of Educational Research and Training has recently incorporated the population education component in the school curricula. (Bhende and Kanitkar, 1999: 472). The study of population control has become a subject in many universities. Apart from these, youth organizations, trade unions and co-operatives must be associated. The population values should be put into our educational system.

There is a need to renewal of national interest in population control. The term population control is replaced by term called family planning. Population control concept should be recognized as the wider concept in politics and demographic studies.

There is a need to study the national population polices made by the Government. So far the National Population Policy took a number of decisions never taken by any government anywhere in the world. Sometimes humanist policies and some times revolutionary policies are also used to be framed by the many state Governments in India. “Many states should pass laws that impose a two-child born norm for contestants to elections to the Panchyat Raj Institutions. (Development, Sexual and reproductive health and rights; Sociology for International Development (SID) Beverly Hills; Sage Publications., 2005: 22). All these aspects need to be studied carefully. The success of these policies depends on the consciousness of the people about the problem.

In fact, population control became a subject of national consensus. The damage that has been done to the national interest by making population control a subject of political controversy is absolutely impossible to compute. Hundreds of billions of rupees must have gone to create the entire infrastructure that is necessary

but the Government of India has reached such a huge figure that even if population growth rate begins to fall, it will at least take 25 years before our population to stabilize. The country faces a disaster situation and realized to reduce the population growth by eliminating the other associated problems. "Governments at the Cairo conference agreed that developing countries should cover two-thirds of the costs of a package of basic reproductive health and family planning services, prevention of sexually transmitted diseases and HIV / AIDS and related research, data and policy analysis". (Agarwal S P., Gupta, Mithelish. Sherwani, M.W.K., 2002: 102).

The Government of India made a number of new policies in democratic way and adopted towards economic growth and development should be matched by a parallel movement in the field of population control. Therefore the Government of India has recognized openly "Family Palnning is a multi faceted problem in India. (Bhande and Kanitkar, 1990: 526). There is a need to study this multi-faceted problem.

It can be understood from the above discussion that India is in a very difficult situation in controlling the birth rates, Some times it has selected difficult paths some times took soft options to allure people. Today, India is going through a multi-dimensional crisis due to population growth. Population problem has been recognized as an economic problem, social problem, political problem and a spiritual problem. This has affected every walk of life of Indians and also leading to a number of problems in India.

1.4 Understanding the necessity of the Population Policy in India

Population growth has long been a concern of the government, and India has a lengthy history of explicit population policy. In the 1950s, the government began, in a modest way, one of the earliest national, government-sponsored family planning efforts in the developing world. The Government planners optimistically believed that the population would continue to grow at roughly 2 per cent growth rate.

Implicitly, the government believed that India could repeat the experience of the developed nations where industrialization and a rise in the standard of living had been accompanied by a drop in the population growth rate. In the 1950s, existing hospitals and health care facilities made birth control information available, but there was no aggressive effort to encourage the use of contraceptives and limitation of family size. ([http:// countrystudies.us/India/32.htm](http://countrystudies.us/India/32.htm)).

By the late 1960s, many policy makers believed that the high rate of population growth was the greatest obstacle to economic development. The government began a massive program to lower the birth rate from forty-one per 1,000 to a target of twenty to twenty-five per 1,000 by the mid-1970s.

The National Population Policy adopted in 1976 reflected the growing consensus among policy makers that family planning would enjoy only limited success unless it was part of an integrated program aimed at improving the general welfare of the population. The policy makers assumed that excessive family size was part and parcel of poverty and had to be dealt with as integral to a general development strategy.

Education about the population problem became part of school curriculum under the Fifth Five-Year Plan. Cases of government-enforced raised many questions on the propriety of state-sponsored birth control measures.

During the 1980s, more family planning programs were implemented through the State Governments with financial assistance from the Central Government. In rural areas, the programs were further extended through a network of primary health centers and sub-centers.

By 1991, India had more than 150,000 public health facilities through which family planning programs were offered. Four special family planning projects were implemented under the Seventh Five-Year Plan. One was the All-India Hospitals Post-partum Programme at district- and sub district-level hospitals. Another program involved the reorganization of Primary Health Care facilities in urban slum areas, while another project reserved a specified number of hospital beds for tubal ligation operations. The final program called for the renovation or remodeling of intrauterine device (IUD) rooms in rural family welfare centers attached to primary health care facilities. (<http://countrystudies.us/India/32.htm>).

Despite these initiatives in promoting family planning, the 1991 census results showed that India continued to have one of the most rapidly growing populations in the world. Between 1981 and 1991, the annual rate of population growth was estimated at about 2 percent. The crude birth rate in 1992 was thirty per 1,000, only a small change over the 1981 level of thirty-four per 1,000.

However, some demographers credit this slight lowering of the 1981-91 population growth rates to moderate successes of the family planning program. In 1986, the number of reproductive-age couples was 132.6 million, of whom only 37.5

percent were estimated to be protected effectively by some form of contraception. The goal of the Seventh plan was to achieve an effective couple protection rate of 42 percent, requiring an annual increase of 2 percent in effective use of contraceptives.

The heavy centralization of India's family planning programs failed to take into account regional differences. Centralization is encouraged to a large extent by reliance on central government funding. As a result, many of the goals and assumptions of national population control programs do not correspond exactly with local attitudes toward birth control. (<http://countrystudies.us/India/32.htm>).

The common fertility pattern in India diverges from the two-child family that policy makers hold as ideal. Women continue to marry young; in the mid-1990s, they average just over eighteen years of age at marriage. When women choose to be sterilized, financial inducements and cultural factors are the principal incentives. On an average, those accepting sterilization already have four living children, of whom two are sons. The strong preference for sons is a deeply held cultural ideal based on economic roots. Sons not only assist with farm labor as they are growing up (as do daughters) but they provide labor in times of illness and unemployment and serve as their parents' only security in old age.

Surveys done by the New Delhi Operations Research Group in 1991 indicated that as many as 72 percent of rural parents continue to have children until at least two sons are born; the preference for more than one son among urban parents was tabulated at 53 percent.

A significant result of this eagerness for sons is that the Indian population has a deficiency of females. Slightly higher female infant mortality rates (seventy-nine per 1,000 versus seventy-eight per 1,000 for males) can be attributed to poor health care,

abortions of female fetuses, and female infanticide. Human rights activists have estimated that there are at least 10,000 cases of female infanticide annually throughout India. (<http://countrystudies.us/India/32.htm>).

The cost of theoretically illegal dowries and the loss of daughters to their in-laws' families are further disincentives for some parents to have daughters. Sons, continue to carry on the family line and bear its burdens. The 1991 census revealed that the national sex ratio had declined from 934 females to 1,000 males in 1981 to 927 to 1,000 in 1991. In only one state--Kerala, a state with low fertility and mortality rates.

The census found, however, that female life expectancy at birth had for the first time exceeded that of males. India's high infant mortality and elevated mortality in early childhood remain significant stumbling blocks to population control. India's fertility rate is decreasing, however, and, at 3.4 in 1994, it is lower than those of its immediate neighbors (Bangladesh had a rate of 4.5 and Pakistan had 6.7). The rate is projected to decrease to 3.0 by 2000, 2.6 by 2010, and 2.3 by 2020. During the 1960s, 1970s, 1980s, 1990s, and 2000s, the growth rate had formed a sort of plateau. Some states, such as Kerala, Tamil Nadu, and, to a lesser extent, Punjab, Maharashtra, and Karnataka, had made progress in lowering their growth rates, but most did not (<http://countrystudies.us/India/32.htm>).

All the factors listed in the preceding pages emphasize that the need to understand the population policy in India.

1.5 Hypotheses of the study

There is a positive relationship between economic development and birth rates in India. There will be positive attitude for acceptance of family planning programme if the government of India provides adequate incentives for acceptors of the same. Had the government of India improve the economic conditions of the people the adoption of family planning programme could have become successful.

There is an inverse relationship between economic development and birth rates. There is no sufficient economic development in India to adopt family planning programme. Most of the policies in the medical welfare and family planning are not reaching to the people. There is no political commitment to implement the programme. The programme has failed due to socio-economic-political factors. The maximum and minimum family size in India is determined by personal, social, political cultural, geographical, psychological factors along with economic factors. If economic conditions of the masses improve the adoption of family planning is easier. Most of the population control programmes are beyond the People's perception about the family planning programme. The family planning programme has a number of defects.

1.6 Review of Literature

The Family Planning programme was started in India in 1952. Since its inception, several studies have been conducted on different aspects of population control programme in India. The policy makers considered research to be an important support to programme action. The periodic compilation, documentation and dissemination of research findings were considered to be useful.

In this chapter since it is not possible to review all the studies some relevant studies only have been reviewed. These studies indicate the trends and differences, policy and implementation, methods and their uses, and knowledge, attitude and practices of the people with regard to family planning programme. Gopal Rao (1947) has undertaken over 550 studies and reviewed the literature in her book.

Saha (1971) carried out a study of rural area in Singur, West Bengal to evaluate the family planning programme executed in a rural health unit and training centre. The findings showed that percentage who desired to limit family size and the birth rate of the experimental area was much less than in the non-experimental area.

Chandra Sekhar (1972) mentioned that infant mortality is one of demographic aspect in which the urban rates are consistently lower than the rural. He has summarized the evidence that the higher the infant mortality rate. The reverse is also true, the higher the infant mortality, the more up springs are produced. The infant mortality rate too varies by level of income and education. It seems that both the higher and the infant mortality rates have effects on population growth rates.

Bhogle and Kaur (1972) have carried out a comparative study of two factories, one in Bombay and the other in Hyderabad. The study was conducted with a view to find out the knowledge, attitude and practice of family planning in two industrial settings so as to determine the influence of a sustained and organized motivational programme of family planning on the levels of knowledge, attitude and practice. A very High proportion of respondents indicated willingness to limit family size. Respondents preferred spacing and were unwillingness shows for abortion. On the whole adoption of family planning methods and small size family was better in Bombay than in Hyderabad.

Rao and Kanbargi have studied legal abortion between April 1972 and March 1975 in Karnataka state with a view to help improving the planning of abortion services at the State and national levels. The study has showed that age of women undergoing abortion, their family size, duration of pregnancy and age of new contraceptors after abortion have declined while proportions of women with less than primary education undergoing abortions and number of new conceptors after abortion have increased.

Ghosal (1973) carried out a study in Northern Calcutta with a view to assess the post-programme knowledge, attitude, practice and fertility levels of couples as compared to the baseline, assessing the reaction of the recipients to the programme and studying the obstacles in the use of contraceptives.

Misra (1973) studied 17 states of India to find out the levels of performance and variations in the family planning programme of Indian states. His findings showed good performance states to be more urbanized, had higher literacy levels and per capita income. They were also positively and significantly correlated with each other.

Panandiker *et al.* have attempted at analyzing the policy implications of the scheme of incentives and disincentives introduced in 1976. The book sharply focuses on the limitations of the scheme as well as its consequences on the morale of the people and the administration. The measures failed in attracting the people. It rather alienated them completely from the programme because of extensive use of coercion in its implementation. Four states namely Uttar Pradesh, Bihar, Madhya Pradesh and Punjab were selected for the study. The study examined the context of the new policy with a view to see how far it served as a viable population policy for the

country, and more specifically the policy implications of the scheme of incentives and disincentives incorporated in the new package. Thinking and motivation of the State Governments towards new policy were explored. Capability of the administration was assessed. Understanding and attitude of different classes of people were studied.

Barnabas, (1977), evaluated the population control policy in the last twenty years or so and particularly highlighted the administrative apparatus at work in the implementation of the policy. The effort is towards providing an overall view to the population control programme in India. The discussions are about the organizational arrangements, human and material resources, the evaluation and feedback system as well as training and research programmes. He has highlighted the insights gained while discussing the programme in general and implementation system in particular. Some thought has been given to the relationship between the levels of development and population growth. Details of the success and reasons for success of the programme in certain sectors such as the army, railways, posts and telegraphs etc.

Srinivasan (1977) has evaluated the family planning programme in the state of Karnataka, India, in a case study prepared for OECD Development Centre. The case study is in the application of certain selected techniques in evaluating the impact of family planning programmes on contraceptive acceptance and fertility. It was intended for the middle-level administrators in-charge of family planning programmes at the provincial or district levels, mainly for the purposes of monitoring and evaluating their own programmes at periodical intervals of time. A summary of indices for evaluative purposes at the district level is discussed. On the basis of the findings, implications are drawn for programme strategy and action, and on the need for collecting certain other types of data on crucial variables, mainly for the purpose

better evaluation. The study presented application of ten different but interrelated measures of evaluation of family planning programme.

Pillai (1977) *et al.* have studied the communication patterns between one hundred twenty seven satisfied adopters of male sterilization and two hundred fifty seven potential adopters of family planning. The influence of satisfied adopters relative to other family planning communication agents was evaluated.

Mahadevan (1979) has stated that age at marriage determines the duration of marriage and through the duration of marriage which in turn influences fertility. Age at marriage marks the beginning of social and biological entry of women into the married life though there are exceptions. The higher the age at marriage the greater will be the influence in decreasing fertility. The norm and practices of marriage are believed to serve as major determinants for the regulation of fertility either by blocking permanently or delaying entry into a marital alliance. Mahadevan says that all the customs of marriage independently may not contribute substantially to reduce fertility but their cumulative effect is likely to create differentiation in the total effective reproductive period among various communities leading ultimately to reduction in fertility. Some factor influences the age at marriage.

Seshachalam (1981), has studied the decision making process in family welfare programme organizations. Three districts of Andhra Pradesh were chosen on the basis of performance over a five year period from 1971-72 to 1975-76 to collect information about the decision making process of the personnel and the decision making norms of the organization at state, district and Primary Health Centers.

Rele and Kanitkar (1980) evaluated the existing estimates of the level of fertility in Greater Bombay based on field work concerning various facets of

reproductive behavior of married women. They have examined the levels and patterns of fertility, the influence of social, economic and cultural factors such as religion, mother-tongue, educational attainment of husband and wife, economic status, residence background, age at marriage, induced abortion, family size and child spacing and the knowledge, attitude and practice of family planning.

Rao (1983) has emphasized the need to take the inter-state disparities in birth and death rates, and rural urban variations into consideration, while formulating the population policy. In his view the first step to reduce the rate of growth of population is to bring down the combined crude birth rate which now varies from 40.1 per thousand in Uttar Pradesh to 25.6 in Kerala to the level of Kerala within the next 10 to 12 years.

According to Ravindra Kumar (1989), the population of India is growing faster due to low levels of income and education, higher infant mortality rate, unchanged status of women in the society and other social practices. In India more than three-fourth of population live in rural areas. The proportion of poor people in the country and the family planning mission's performance is not up to mark due to various reasons, in curbing the growth of population. The per cent of couples effectively protected by all family planning methods by the end of 1985 is only 31.9.

Mitra (1997) has explored the underlying reason for the widespread reaction against the policy and efforts to enforce it and suggested approaches to examine first the historical emergence of India's current population policy and economic feasibility of the national policy for reducing the birth rate and achieving the small family norm.

1.7 Major Objectives of the Study

The study attempts to outline the various issues relating to the population policy and administrative aspects of family planning programmes. The study examines the advantages and disadvantages of the Family Planning programmes from its inception.

Major Objectives of the Study

- To trace the evolution of population programmes in pre and post independent India
- To present an overview of the approaches to Family Planning
- To study the political aspects of population control in India
- The survey of two villages to ascertain the awareness levels, perceptions on family planning,; reasons for disapproval, social support, etc. identify barriers to Family Planning, etc.
- To critique the population control programme in India in relation to policies, political support, budgetary allocation and related aspects

1.8 Methodology of the Study

The present study employed the meta-policy approach as subsequently and the population policy has been analysed using both qualitative methods and quantitative methods, including case studies, survey research, statistical analysis among others.

But a discussion on the definition of a policy and the framework of analysis would not be out of place here. A policy is a deliberate plan of action to guide decisions and achieve rational outcome(s). The term may apply to government,

private sector organizations and groups, and individuals. presidential executive orders, corporate privacy policies, and parliamentary rules of order are all examples of policy.

Policy may also refer to the process of making important organizational decisions, including the identification of different alternatives such as programs or spending priorities, and choosing among them on the basis of the impact they will have. Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals.

Definitions of policy

Definitions of policy and research done into the area of policy is frequently performed from the perspective of policies created by national governments, or *public policy*. Several definitions and key characteristics of policy have been identified within the framework of government policy. While many of these are broadly applicable to other organizations such as private companies or non-profit organizations, the government-focused origin of this work should be kept in mind.

According to William Jenkins in *Policy Analysis: A Political and Organizational Perspective* (1978), a policy is 'a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions should, in principle, be within the power of those actors to achieve'. Thus, Jenkins understands policy making to be a process, and not simply a choice.

Policy Analysis

Policy analysis or policy studies can be defined as "determining which of various alternative policies will most achieve a given set of goals in light of the relations between the policies and the goals". However, policy analysis can be

divided into two major fields. Analysis of policy is analytical and descriptive, i.e. it attempts to explain policies and its development. Analysis for policy is prescriptive, i.e. it is involved with formulating policies and proposals (e.g. to improve social welfare). It depends on the area of interest and the purpose of analysis to determine what type of analysis is conducted.

Most policy analysts have graduated from public policy schools with public policy degrees. Policy analysis has its roots in systems analysis as instituted by United States Secretary of Defence Robert McNamara during the Vietnam War.[3]

Policy analysts can come from many backgrounds including sociology, psychology, economics, geography, law, political science, public policy, social work, environmental planning and public administration.

Different Approaches to Policy Analysis

Although various approaches to policy analysis exist, three general approaches can be distinguished: the analytic, the policy process, and the meta-policy approach.

The analytic approach focuses on individual problems and its solutions; its scope is the micro-scale and its problem interpretation is usually of a technical nature. The primary aim is to identify the most effective and efficient solution in technical and economic terms (e.g. the most efficient allocation of resources).

The policy process approach puts its focal point onto political processes and involved stakeholders; its scope is the meso-scale and its problem interpretation is usually of a political nature. It aims at determining what processes and means are used and tries to explain the role and influence of stakeholders within the policy process.

By changing the relative power and influence of certain groups (e.g enhancing public participation and consultation), solutions to problems may be identified.

The meta-policy approach is a systems and context approach, i.e. its scope is the macro-scale and its problem interpretation is usually of a structural nature. It aims at explaining the contextual factors of the policy process, i.e. what are the political, economic and socio-cultural factors influencing it. As problems may result because of structural factors, e.g. a certain economic system or certain political institutions, solutions may include the change of the structure itself.

The present study has employed the meta-policy approach as stated above. Policy analysis is methodologically diverse using both qualitative methods and quantitative methods, including case studies, survey research, statistical analysis.

The study examined the available literature or secondary sources which were collected from already available records and government documents from 1951 onwards till today. Along with them a number of web sites have become sources to extract the required information. The study focused on the selected books, articles, periodicals, the Government documents, census reports, fieldwork, different survey reports and a number of web sites. The information has largely been gathered by documentary evidence, which consisted of research studies, reports and articles in professional journals. The officials of the Central Government (few) who are at the helm of affairs were interviewed, particularly to get the information along with the respondents from the field.

1.9 Scope of the Study

The scope of the problem is wide and study of the problem is also too vast. The rapid growth of population has brought about tremendous problems particularly

by rendering the investment on economic growth and development. In spite of all these Five Year Plans, the per capita income has not shown any appreciable increase. It is not unusual to lay the blame on growth of numbers for this state of affairs. The Government of India is too attentive to solve. The problem is not only confined to demographic factors but also related to social, cultural economic, political and psychological. In spite of huge investment in family planning programmes since the inception of the program, there has been no significant decline in the birth rate. Perhaps, this shows that the family planning programme, both at the policy and at the execution levels, has some inherent defects which need to be rectified in the light of this study, and it is for this study to suggest new lines of thinking on policy and administration.

1.10 Scheme of Analysis or Chapterization

The organization of the thesis is as follows:

Chapter 1 gives an overview of the population growth in India, focuses on the magnitude of the population, problem and its implications for different sectors. This is followed by the rationale to undertake the study and a review of the available literature. The problem is stated followed by the objectives of the study. The methodology adopted for the study is discussed keeping in view the objectives of the study.

Chapter 2 reviews the evolution of population programmes in India during the pre and post independent period followed by the scrutiny of the Five Year Plans as also the National Population Policy with meta-policy approach.

Chapter 3 takes a peek into the political aspects of the Population Control Programmes in India.

Chapter 4 is devoted to ascertaining peoples' perceptions about family planning programmes under implementation in Andhra Pradesh particularly understanding of the Family Planning Programmes, perceived advantages and disadvantages, incentives preferred for adopting family planning programmes.

Chapter 5 is a Critique of the Population Control Programme in India.

Chapter 6 is a summary of the findings, discussion and recommendations.

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CHAPTER 2

EVOLUTION OF POPULATION CONTROL PROGRAMMES IN INDIA

The Evolution of population control programmes has been analyzed here to find out whether objectives intended were realized and to ascertain the appropriateness of design and implementation. This is an attempt to throw light on past experiences, identify and plug gaps, if any.

The major objective of the Government of India has been to stabilize the growth of population at a level consistent with requirements of national economy was pointed out in India's First Five-Year Plan. Indian planners stood divided on how to achieve this end. Some expected rapid economic development required to solve the problem. But the majority favored population control through the family planning programme and recognized a positive relationship between economic development and family planning in India.

2.1 Pre-independence period

2.1.1 Evolution of Positive Attitude in India Towards Population Control

In the west the writings of Sigmund Freud shed light on persons such as Charles Brad Laugh and Annie Besant to examine the subject of population control and to stem the growth of population. They preached the subject of population control even at the risk of being arrested in 1876. (Mahadevan K, 1989: 187). Marie Stopes began population control services in U.K. Margaret Sanger carried the same services for population control in the U.S.A. and fought with officialdom in that country to provide population control services for women.

Population as an important factor in determining the 'means of subsistence' originated with the great work of Thomas Malthus published in 1796 in "Principles of Population". His view that high fertility leading to high population growth is a great impediment to development and even meeting the basic needs of the people, that the population size has the potential to grow at geometric progression while food production can at best grow only at arithmetic progression, prevailed as a leading thought in the western world for over 100 years. (Bhende and Kanithkar, 2000: 109). If human beings do not control fertility, Malthus argued, nature would bring back the balance between food supply and population size by famines, wars, and epidemics or positive checks

India was shown as the typical case where Malthusian checks are likely to occur because population growth the means of production and unless population growth rates are controlled, the checks on it by hunger; famines and epidemics could not be avoided. (Ibid ,109) Being a devout religious Christian priest, Malthus considered the use of contraceptives morally wrong and advocated late marriage and abstinence within marriage as the means of controlling fertility and population growth. In this aspect Gandhiji, a century later, shared the views of Malthus with regard to the British, as colonizers attributed all the famines, epidemics and deaths in the Indian sub continent to its overpopulation, rather conveniently, without assuming any responsibility on their side. With the rapid growth of population in the world since 1850, mostly in the developed world. (Ibid, 109) neo- Malthusianism, which included the use of artificial methods of contraception (especially condom or the French Leather, as it was called) began in Europe and neo-Malthusian Leagues were

set up in many parts of Europe, particularly in England and also advocating promoting contraceptive use in developing countries. (Srinivasan K, 2006).

Most of the governments started taking serious notice of the population problem only after Second World War. It was recognized that achieving development and economic gains, population growth had to be curbed. As a result, governments of all countries started implementing legislation on population control with or without a formal population limitation policy. India was the first country to launch the nationwide Family Planning Programme in the world in 1951.” (Ghosh, 1992: 51).

2.1.2 Shri Pyare Kishan Wattal s' Contribution

The development of an intensive Population control programme in India is of recent origin. But the movement to control birth rate has been advocated for more than 50 years. In 1916, Shri Pyare Kishan Wattal published his book, *The Population Problem in India*. “Already as in 1916, the late P.K.Wattal has drawn attention to the danger of the population problem in India” (. Mahadevan, 1989: 187). It was the first expression of concern about overpopulation in India and Shri. Pyare Kishan Wattal in 1916 advocated family limitation. (Ramakrishna K, 1980: 29).

According to Srinivasan, K. (2006) population concerns have a long history in India. The growth of population in India was low until 1921, owing to famines, epidemics, and wars. According to Indian census reports, the population, within its present geographical boundaries actually declined between 1911 and 1921, from 252.1 to 251.3 million because of the high mortality inflicted by the influenza endemic of 1918-19. A million people succumbed during 1943-1944.

In 1923, Phadke had started the first non-governmental association (Population Birth Control League) to reduce the birth rate in Bombay (Ibid; 187). In

1925, Prof. Raghunath Dhondo Karve opened a birth control clinic in Bombay, an idea the general public were acquainted with. The British Government was indifferent and was out of line with the thinking of Mahatma Gandhi, who believed in limiting family size through self-control and sexual abstinence. Prof. Karve met with strong opposition; he even lost his job at the Christian Missionary College.

2.1.3 Rabindranath Tagore' Contribution

The great poet, intellectual and humanist, Rabindranath Tagore supported birth control. In a letter to Mrs. Margaret Sanger in 1925, he expressed his gratitude to her for championing the cause and stated: "I am of opinion that the birth-control movement is a great movement, not only because it will save women from enforced and undesirable maternity, but because it will help the cause of peace by lessening the number of surplus population of a country scrambling for food and space outside its own rightful limits." (Rabindranath Tagore, (1925) as quoted in Family Planning News, Vol: 1, No.12, Cover page: 3)

2.1.4 Neo-Malthusian League

The Neo-Malthusian League was formed in Madras in 1928. With the support of influential persons and medical doctors the League published several papers in the Madras birth control bulletin on the techniques of birth control. (Ramakrishna, k., 1980, 30). On June 11, 1930, The Mysore Government issued orders to open the first Government birth control clinic in the world. It was the first official birth control clinic in India (Ibid, 31). Neo- Malthusian Leagues were started in other cities in India, especially Poona and Bombay. Madras and Bombay seem to be the first two Indian cities where concern over the population problem gained momentum. (Srinivasan k., 1989).

The policies of the Mysore Government during this entire period were bold and enlightened steps. On June 11, 1930, the Government of Mysore issued an order

setting up birth-control clinics in the Victoria and Vani Vilas Hospitals in Bangalore and in the Krishnarajendra Hospital in Mysore. Dr. C.V. Natarajan was designated to look after this new service which did not last long. The intellectual and political support to the family planning movement was not entirely missing during this period. (Mahadevan K, 1989: 187). In 1930, Justice Vepa Ramesam advocated and propagated firmly the adoption of artificial means of birth control. The Syndicate of the University of Madras, in 1931, supported a proposal to provide instruction in contraception.

The All-India Women's Conference in its Lucknow session supported birth control. In 1935, the National Planning Committee set up by the Indian National Congress under the chairmanship of Shri Jawaharlal Nehru supported family planning. (Bhende and Kanithkar, 2000: 109).

Mrs. Margaret Sanger visited India during 1935-36. On December 1, 1935, the Society for the Study and Promotion of Family Hygiene was formed and supported birth control. Dr. A.P. Pillai who advocated the programme conducted a training course in 1936. In 1939, "Birth Control World-Wide" opened clinics in Uttar Pradesh and Madhya Pradesh. In 1940, Shri P.N. Saprú moved a resolution in the Council of State for the establishment of birth control clinics. Smt. Rana Dutta extensively toured India and advised on population control. In 1940, the Society for the Study and Promotion of Family Hygiene became the Family Planning Society, incorporating the Bhagini Samaj Birth Control Clinic in Bombay. (Ibid, 109)

The Health Survey and Development Committee (Bhore Committee) appointed in 1943 by the Government of India recommended provision of birth control services. In 1949, the Family Planning Association of India was formed under

the Presidentship of Shrimati Dhanvanthi Rama Rao. Around the time, she toured the country extensively with the objective of organizing birth control campaigns on behalf of the Family Planning Association of London.

2.1.5 Formation of National Planning Committee

The Indian National Congress under the chairmanship of Shri Jawaharlal Nehru who had considered this problem at length and among other things had stated formed the National Planning Committee:

“We agree with the view that the size of the Indian population is a basic issue in national economic planning, in so far as its unrestricted increase of proportion to means of subsistence affects adversely the standard of living tends to nullify social and ameliorative measures. In the interests of social economy, family happiness and national planning, family planning and limitation of children are essential and the State should adopt a policy to encourage these”. (National Planning Committee, 1971:223).

It is desirable to lay stress on self-control as well as to spread knowledge of cheap and safe methods of birth control. Birth control clinics should be established, and other necessary measures taken in this behalf and to prevent the use or advertisement of harmful methods... We consider that the raising of the marriage age and discouragement of polygamy are desirable in the interests of the limitation of the size of family. A eugenic programme should include the sterilization of persons suffering from transmissible diseases of a serious nature, such as insanity and epilepsy. (Ibid, 490-500).

2.1.6 Bengal Famine Enquiry Committee

According to Srinivasan, the report of the Bengal Famine Enquiry Committee constituted by the Government of India, which submitted its report in 1945 contained a

chapter on the potential dangers to the economy and life of people arising out of rapid population growth, especially a population living in abject poverty and deprived of the bare necessities of life.

The attitude of the Government towards birth control is reflected in the final report of the Famine Enquiry Commission which was set up by the Government in 1943 after the catastrophe in Bengal. The Commission was also known as Wood Head commission stated.

“At the present time a deliberate state policy with the objective of encouraging the practice of birth control among the mass of the population is impracticable...a fall in birth rate will tend to follow rather than precede economic betterment.” (The Government of India, Famine Enquiry Commission, Final Report, 1945: 3).

Before India got independence, the interest of Indians on the population problem waxed and waned periodically. Interest seemed to increase with the census, visits of distinguished advocates of family planning, or publication of research reports or recommendations of enlightened individuals, groups or committees.

According to Srinivasan, the Bhore Committee recommended a suitable health infrastructure for the country. It also stressed the need for a national programme of family planning for improving the health status of population. (Srinivasan K, 1989: 28-32).

The reports of the two committees, the Bengal Famine Enquiry Committee and the Bhore Committee, one for sheer survival and the other for an improvement on the health of the population, paved the way for the Government of India to adopt a National Programme of Family Planning after attaining its political independence in

1947. These two reports have helped the Government of India to frame National population policies at the central level. (Ibid, 28-32).

It was only the undeterred struggle of a few individuals and groups that kept the subject from going completely into oblivion. Gandhiji's views on birth control also need to be taken into account as he had a strong influence over the Indian masses not only in the political field but also in all the areas of human life. He declared "there can be no two opinions about the necessity on birth control. But the only method handed down from ages past is self-control". (M.K.Gandhi, Young India, 26th, 1950: April, as quoted in S. Chandra Sekhar, population and planned parenthood in India: 50).

2. Post-Independence India

Soon after Independence, notable events followed in succession in the domain of population control. The Indian Army took a lead in this area and in 1949 on General K.M. Cariappa's advice; population control was included in the health and welfare scheme of the army. He was considered as one of the pioneer who strongly advocated family planning in the armed forces. He posed a very serious question which drew attention to the paramount importance of family planning. (Mahadevan K., 1989,195-197). The programme has since taken deep roots in the defense services and is an important welfare service today.

S. Chandrasekhar, who had been drawing the attention of the public towards this problem since 1946 through his writings and speeches made several far-reaching and revolutionary recommendations to curb population growth. The first All-India Conference on Family Planning, organized by the Family Planning Association of

India in 1951 in Bombay under the stewardship of Shrimati Dhanvanthi Rama Rao and her colleagues.

The year 1951 was also the year of the decennial census in the country. The increase in population since the previous census was staggering and had a very sobering influence on the Government. Shri R.A. Gopalswami, the Census Commissioner, submitted his report which shocked the Government and influenced the politicians and planners of the Government to consider the population control programme as a part of the First Five-Year Plan itself. His strong plea to prevent improvident maternity became a slogan in his time. (Ibid).

In 1951, a few years after independence, the Indian government introduced its First Five-year Plan, which referred to "population problem". "Rapid population growth" was considered an impediment to the country's development. At the time, India had a 361 million population and annual growth rate of 1.25%. The Government of India had introduced a family planning programme to make cheap and effective contraception available to all categories of population. Emphasis was also placed on raising the marriage age of girls in a bid to reduce fertility. Sterilization was promoted and abortion was legalized for married women in the early 1970. (Jacques Véron, 2006).

"In 1952 the Government of India decided that a lower growth rate of the population was essential to facilitate social and economic development and thereby raise levels of living of its people." (Ghosh, 1992: 31). At the same time, the Government of India which had launched on the 'great adventure' of raising the standard of living of the people through planned development was now seized of the problem.

Birth control was included as a welfare programme in the First Five-Year Plan with an allocation of 6.5 million rupees for the first time. In 1951, the Government of India obtained through the World Health Organization services of Abraham Stone and set up and conducted pilot studies on the rhythm method. Many people were critical of his advocacy of the rhythm method.

Two experimental centers, one in the north, Lodi Colony in Delhi and the other in Ramanagaram in Mysore State, were established to conduct studies on the rhythm method, which were the forerunners of many research centers to be established and studies to be conducted in the country.

The population policy proposed by Dr. S. Chandrasekhar was comprehensive and as he considered all the relevant aspects. The primacy given by the Indian planners to population in the area of development is amply reflected by the Planning Commission which constituted a Population Policy Committee in 1952 to suggest a population policy. However, the committee failed in formulating any policy (Visaria, 2002: 3 and 24).

In 1953, the Family Planning Research and Programme Committee was appointed with Major-General C.K. Lakshmanan as its Chairman and Dr.C.G.Pandit and later Dr.T. Lakshminarayana as its Secretary. This commission had doctors, public health experts, demographers and social scientists in the country. This Committee recommended curbing the growth of population and also started centers, staff accommodation, training field studies and research.

The Committee also advocated the rhythm method extensively. Despite strong advocacy for giving support to these methods and the rising number of cases in hospitals, the Committee under the presidency of Rajkumari Amrit Kaur, the then

Health Minister felt necessary to defer the scheme and to collect basic information. "Except for the suggestion on the implementation of the sterilization programme," (Mahadevan K, 1989; 197). Natural method and rhythm methods have been advocated.

Dr. Marie Stopes advocated the inexpensive method of use of cotton pad and oil method for India. The programme has been propagated by many Indians and endorsed by another Indian expert, Sakuntala Paranjpye" (Ibid: 197). In the beginning of the programme, the methods recommended were the rhythm, diaphragm and jelly and later foam tablets. All these were supplied through family planning clinics. Sushila Gore was appointed as a Special Officer in charge of training. She led a touring team and trained a large number of family planning workers. (Ibid: 197).

Later, in 1957, Dr. Sushila Gore established Family Planning Training and Research Centre in Bombay. Research, largely medical, was undertaken by several institutions with Centre's financial assistance. "The Government has clearly recognized the urgency of the family planning programme to curtail population growth." (Bondestan and Bergstrom, 1980: 89).

India was perhaps historically the first nation to adoption of antenatal policy in the world to lower the growth rate of the population. The First Five-Year Plan consisted of many provisions related to family planning programme. However, only 21 rural and 126 urban clinics were opened. (Ghosh, 1989:51).

The First and Second Five-Year Plans recommended the measures for family limitation and spacing of children for securing better health for the mother and better care in bringing up the children" (Jolly K.G, 1986: 13). Its operative concern was, however, restricted to advice in government hospitals and rural medical centers, and

field experiments on different methods of collecting information on the medical technical and motivational aspects of family planning. The main emphasis was on the propagation of rhythm method and establishment of clinics. During this first plan "the aim of the family planning programme was to reduce the birth rate through the clinical approach". (Chandra S K, 1989: 69).

At this juncture the Planning Commission recommended the strengthening and promoting of the central organization for family planning and widening the scope of the programme. In 1956 a Central Family Planning Board was formed with Lt. Colonel B.L. Raina as Officer on Special Duty. Later, it was designated as Director, Family Planning. It has become an apex advisory body at the national level. (Srinivasan K, 1989:30).

The same programme was developed further under the supervision of Shri D.P.Karmakar, who had taken over as the Health Minister in the reconstituted Cabinet after the second general elections. The population control programme had four components - education, service, training and research. The programme envisaged extension of family planning advice and services, a broad-based programme of education, including sex education, establishment of training centers, research and evaluation. (Mahadevan K, 1989:198). Several activities for the family planning were included in the designed programme.

2.2.1 Entry of the Sterilization programme

Sterilization programme pursued in Madras State was included in the programme of the Government of India in 1958. The central assistance for sterilization schemes was made available from 1960. In addition to the use of already existing contraceptives, sterilization was accepted for the first time in 1958 by the

Government of India which began to finance it by 1960. Several efforts were made to increase the use of audio-visual aids to propagate the programme. (Ibid: 198). From 1958 to 1960 sterilization yielded good results and there was greater awareness on these policies in the country. (Srinivasan K, 1989: 31).

In order to strengthen the family planning programme the Government of India did its best and "in 1956 the United Nations Regional Demographic Training and Research Center was established in Bombay" (Ibid; 32). The objective was to produce and distribute large quantities of informational material. There was evidence that, wherever there were adequate inputs, the birth rate could be lowered.

The Government of India could not concentrate on research in the First Plan but during later five year plans research took long strides. Medical research was coordinated by the Reproductive Biology Committee of the Indian Council of Medical Research with Dr. V.R. Khanolkar as its Chairman, communication action research by the Communication Action Research Committee with Professor P.C.Mahalanobis as its Chairman and demographic research by the Demographic Advisory Committee with Professor V.K.R.V.Rao as Chairman. The members of these committees were able to place research activities on a firm base. International agencies, especially the Population Council and the Ford Foundation supported research activities. (Mahadevan K, 1989:198).

2.2.2 The Mysore Population Study and other studies

The Mysore Population Study conducted in 1951-52 under the joint auspices of the United Nations and the Government of India and Mysore was published during this period and it was a first methodological study. It yielded much valuable information on the population of Mysore State. The national Sample Survey

Organization collected a great deal of information for the entire country in its several rounds. (Srinivasan K, 1989:32).

In 1957, the Demographic Training and Research Centre (now called the International Institute of Population Centre) was established in Bombay as a result joint effort of the United Nations, the Government of India and the Sir Durable Tata Trust. . (Mahadevan K, 1989:199). Communication action and demographic research centers had been established or were in the process of being established all over the country. This research provided useful information. During the Second Plan period about Rupees 21.56 million fifteen times more than the First Plan allocation was spent.

The Government constituted a committee to review and study the experiences for drafting the Third Five Year Plan. After the third general elections, Dr. Sushila Nayar, the Health Minister emphasized on providing family planning services. 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 the available agencies for educational and extension work in support of family planning. The State Governments were also advised by the Health Minister to provide the services. (Chandra S K, 1989: 57).

2.2.3 The Directorate of the Family Planning Board (DFPB)

The DFPB had recommended two major shifts in the emphasis in the programme based on performance in the field and research findings. One of these was to make it a community-centered programme rather than a clinic-centered one and sought greater involvement of man in the programme. The revised programme

was named as the Extended Family Planning Programme and was implemented from October 4, 1963.

The main components of the extended programme were: (1) creation of a social climate in which the need is felt by individual families and by groups of people; (2) knowledge that a small family norm is valuable to each individual permeating into every mind; (3) provision of readily accessible services, generally, as a part of health services especially health of mothers and children; (4) adoption of effective methods by all eligible couples; (5) stimulation of social changes affecting fertility such as education and employment of women, increasing age at marriage, etc.; (6) research with emphasis on action research and feed back mechanisms to use the findings its programme operation; and (7) evaluation. Several other techniques were also adopted by the Government of India. (Mahadevan K., 1989:199). "Besides sterilization and conventional contraceptives IUP was also introduced on a large scale in 1965" (Jolly K G, 1986: 14).

Realizing the importance of abortion as a method of birth control" a committee was constituted in 1964 under the chairmanship of Shantilal Shal which submitted its report in 1966. The Central Family Planning Unit, in October 1967, headed by Shantilal Shah accepted the recommendations of the abortion committee. (Ibid: 200). The year 1965 is of great importance in the history of family planning programmes for two reasons--the Indian Council of Medical Research cleared the intra-uterine contraceptive device for mass use on January 5, 1965 after extensive trials in the preceding two years and it was included in the programme in July, the same year.

2.2.4 The work of United Nations Evaluation Missions

The later development in the evolution of population control was the visit of the United Nations Evaluation Missions led by Sir Colville Deverell, the then Secretary---General of the International Planned Parenthood Federation. Another notable event was the appointment of the Family Planning Programme Planning and Evaluation Committee by the Government of India. Both these teams toured the country extensively, interviewed family planning workers and visited training centers and research institutions. Both recommended considerable strengthening of the organization, stepping up of training activities and improving evaluation. As a consequence, 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. (Ibid.197).

Research was making steady progress at different research centers, and studies on bio-medical aspects. "The strategy of the programme was shifted from the clinic approach to the community -raised extension approach" (Ibid; 200). Research is an important item of the community extension approach.

With a view to developing a multi-disciplinary agency that would serve as a technical resource to the national family planning programme, the Family Planning Institute was established under the Directorate-General of Health Services in Delhi in October 1962 as a Government institution. Later, realizing that for the development of research and training, the intellectual climate should be permissive and conducive to the growth of new ideas and free exchange of thought, the Institute was declared as autonomous in March 1965 and was redesigned as the Central Family Planning

Institute with full support from the Government. The Institute acts as the Secretariat for the Demographic and Communication Action Research Committee.

At the end of the Third Five Year Plan all these centers have provided services and advised needy couples on family planning methods. Regional family planning training centers had also been established. A factory for producing loops and inserters was established at Kanpur. The number of sterilization operations had gone up considerably and the programme met with success. The Government of India spent a lot of amount even though the national conditions were not very conducive. The amount earmarked for the Third Plan was Rs.270 million but during the same period, India had to face two wars with neighbours which came as a set-back to the programme. (Ibid; 199)

In order to allure the public towards the issue, the Government of India began propagating by setting up different symbols." The symbol of an inverted and triangle representing the message of family planning was introduced. It continues to be the family planning logo in the country" (Srinivasan K, 1989: 134).

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. During this period "Non-clinical approaches were increasingly exposed" (Barnabas A., 1977: 6). The Government has planned to expose non-clinical devices to promote the programme.

The problem high rate of population growth was to be solved by applying different approaches. At the time of the beginning of Third Five Year Plan the growth rate reached a high figure of 25 per thousand. This forced the Government to implement the programme vigorously. Further during the Third Five Year Plan "the

Family Planning Programme was viewed not simply as a social welfare measure for improving women's health and status, or in helping couples to space and limit their children according to their desires, but as a positive policy instrument for achieving the country's demographic goals' (Ibid; 34) by the Government.

As a result of rethinking on the part of the Government of India, the family planning programme gained momentum since 1966. To start with a Cabinet Committee of five Union Ministers was designated as the agency for evolving policy. For about two years, the Prime Minister herself had taken over the leadership of this Committee.

In order to strengthen the programme the Department of Family Planning was established in April 1966 within the Ministry of Health and Family Planning. (Jolly, K.G, 1986: 14). The department has two wings-the secretarial wing headed by a Joint Secretary and the technical wing headed by the Commissioner for Family Planning and maternal and Child Health. Six regional offices at Ahmedabad, Bangalore, Bhopal, Calcutta, Chandigarh and Lucknow, each with a regional director at its head maintain liaison between the Central and State Governments. During these years the focus was to strengthen the family planning at the state and district levels, including urban and rural family planning centers and sub-centers(Ibid.19).

At the ministerial level, two notable changes took place in 1967. Dr.S.Chandrasekhar who was associated with studies in population problem and family planning for a number of years both in India and abroad was appointed as the Minister of State for Health and Family Planning in March, 1967. In November the same year, the stewardship of health and family planning was elevated to cabinet rank and Shri Satya Narayan Sinha was appointed the Union Minister for Health, Family

the one best suited to their requirements, was made the 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 number of acceptors had been nearly doubled, registering a record figure of three million in 1967-68. Next year, the number increased to 3.1 million.

The sterilization figures rose steadily during this period and about 4.4 million operations and 2.1 million IUCD insertions were done. The sterilization programme was successful. Commercial activities also were begun in the market and "Commercial distribution of condom under the name 'Nirodh' was launched in 1968" (Ibid; 14). 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 Nirodh marketing programme was set up to promote the sales of condoms through existing commercial channels. This was based on the study conducted by the Central Family Planning Institute in Meerut district within the Department of Family Planning.

In order to reduce the birth rate "the practice of fixing annual family planning targets was initiated during this period" (Ibid; 14). Targets were fixed only from the Third Plan. The first phase of a 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 pieces every year.

An important act of the program was that "In 1968, the target for the crude birth rate (CBR) was fixed at 25 to be realized by 1975-76, but it was again revised in 1968 stipulating CBR of 23 by 1978-79" (Ibid; 36). Another epoch making feature of this period was the launch of a massive programme of mass education and motivation. An abstract symbol, the inverted red triangle, was adopted to take the message of family planning to every home. Not only this—many other countries have also adopted the inverted red triangle as the symbol of family planning in their own countries. In order to reach the goal of the programme the Government has decided to spend a large amount. "During inter-plan period the average annual expenditure as well as performance of the programme increased by as much as five times that of the third time year plan" (Ibid; 14). Even at inter-plan periods also the Government viewed the problem so serious and allocated a large sum of amount to reduce the birth rate in India.

Family planning was retained as a centrally sponsored programme for the next ten years and the entire expenditure was to be met by the Central Government. It was ensured that performance does not lag behind the expenditure. The efforts were kept to achieve the assumed results through appropriate education and motivation. General health services were also becomes part and parcel of the programme.

The Fourth Five-Year Plan described the family planning programme as 'the kingpin of the population policy and emphasized the limitation of family is an essential and an inescapable ingredient of development.

Top priority was given to curb the growth of population and family limitation. It was reflected in the formation of a Cabinet Committee with the Prime Minister, Shrimati Indira Gandhi as the Chairman. Similar Committees have been established

in most States. A Department of Family Planning was formed within the Ministry of Health and Family Planning. (Mahadevan K, 1989:200).

The major aim of the programme in 1978 is to reduce the growth rate of 2.5 per cent per annum to about half. This is based on an assumed course of mortality starting with an initial expectation of life at birth of 41.9 years for males and 40.6 for females centered in 1956, an increase of 0.9 year every year till 1970 and 0.75 per year thereafter. Under these mortality assumptions, the birth rate is expected to be reduced to 23 per 1000 by 1978-79. During this period the family planning programme has been integrating with other aspects. This plan has aimed at "consolidating the structure and components of the programme developed in the past and placed increasing emphasis on the integration of family planning programme with maternal and child health care" (Jolly K.G, 1986: 14).

2.2.6 Related strategies conducive to Population Control

At all the levels the family planning programme became an integral part of the existing medical and health services. The contraceptive methods require the services of medical and health employees. The implementation of the programme should be through the health services. The integration of family planning with maternal and child health services has strengthened the programme by capitalizing on the skills of the workers at every level and by the fact that the community already accepts these workers. If medical and health personnel in the integrated programme tend to dilute the effort required for family planning, the remedy lies in educating these persons to involve themselves more in the programme so that the limitless opportunities available in the antenatal, post-natal and pediatric clinics are utilized fully, and in

strengthening the basic health services. The focus is on interdisciplinary collaboration.

Health service centers are called family welfare planning centers. All effective and safe methods are made available, the individual having the freedom of choice of the method. Emphasis, however, is laid on sterilization, IUCD and condoms. A scheme for the highly subsidized sale of condoms through normal trade channels was launched in 1969. Large-scale field trials on pills are in progress. Services are provided as close to the people as possible. To make the programme successful the Government of India made some acts even on pregnancy. For example during this period "The medical terminations of pregnancy act of 1971 came into force in 1972" (Jolly K.G, 1986: 14).

Nearly 40 per cent of our population consists of 0-14 age group that will continuously enter the reproductive span. Voluntary agencies decided that this group should be properly 'indoctrinated' at this stage, through population education in the schools, colleges, teacher's training courses, and adult literacy classes. Specialized campaigns organized amongst those in this group, who do not get opportunity to go to the schools. This is a vast-and as yet uncharted-area for the voluntary sector to make a signal contribution of a lasting nature to the solution of the population problem.

Besides population control measures, there were some more notable measures like increasing the age of marriage and liberalization of abortion. The State Act (the Child Marriages Restraint Act) enacted in 1930 and subsequently amended in 1949 and in 1956 rose the age at marriage for girls from 14 to 15 years and then to 16 years. The present age at marriage is estimated to be about 21 years, and varies in different States.

In India performing an abortion has been legalized only for the purpose of saving the life of the woman. It is not clear to estimate the incidence of abortion in the country. It is estimated that annually there may be over six million abortions in the country.

The Ministry of Health appointed a committee to study the possibilities of legalizing abortions. The committee considered that the legal provisions are too restrictive and recommended, among other things, that the provision for abortions should be liberalized to allow for the termination of pregnancy by a qualified medical practitioner, not only for saving the pregnant women's life but also when the continuance of the pregnancy is likely to affect the woman's health either before or after child birth. It has also been suggested that the woman or her husband should be persuaded to undergo voluntary sterilization to ward off the danger of repeated abortions and further pregnancies except when the medical practitioner does not consider it necessary.

The Employment of Children Act, 1938 and the Factories Act, 1948 and later amendments to them prohibit employment of children below 14 years of age. This was also against the growth of population. Measures to remove children from the labor market will strengthen fertility control.

A study on social change in three groups, pre-industrial, partially industrial, and industrial, showed that all the three groups were requested to adopt basic education to their children and wanted their children to have a better standard of living and made them in favor of new technology. This is an encouraging trend. This kind of educational facilities and compulsory school education become 'vital sector'

not only for economic development, but also even in the matter of achieving the small family norm.

An important point is to curb the growth of population is education for girls. It is estimated that while 90 to 95 per cent of the boys are attending elementary schools, hardly 60 per cent of the girls go to school. According to the census report female literacy in India ranged from 11 to 59 per cent. There seems to be a definite correlation between education and fertility. The NSS 16th round has shown that the number of children born per woman was two if she had passed the intermediate examination (that is, two years in a university), 4.6 if she was a matriculate, 5.0 if she had middle school education, and 6.6 if illiterate or of primary school education. So education for girls is important to reduce the growth of population.

Legal and constitutional provisions for maternity benefit to women workers are regulated under a number of State Acts and several central Acts-Plantation Labor Act, 1951, the Employees' State Insurance Act, 1948, the Employees' State Insurance (Amendment) Act, 1966, and the Maternity Benefit Act, 1961. Maternity leave is granted to non-industrial employees of the Government of India through specific provisions in government rules.

The Maternity Benefit Act, 1961, among other benefits, provides for the payment by an employer of the average daily wage for the period of actual absence immediately following the birth of the child the maximum period being restricted to 12 weeks. Some State Governments have limited the grant of maternity benefit to their non-industrial employees to three children.

The government initiated a number of various measures such as land and taxation policy to study the real conditions. Division of large holdings into smaller

ones, land tenure credit system, peasant proprietorship, and legislation concerning inheritance, and security in old age may have an appreciable bearing on fertility behavior. Unemployment insurance and old age pension are being considered; in fact, some States have already introduced old age pension to certain categories of persons.

The government of India constituted the Small Family Norm Committee which has made several recommendations with regard to future policy. A bonus of a month' salary is suggested for those women workers who get themselves sterilized after the second child. Special facilities for health, welfare and other social services may be provided for children of persons who undergo sterilization after two or three children.

The Life Insurance Corporation of India Introduced a new redeemable 18 years after marriage and carrying special benefits for those who have limited the family to one, two or three children. Education on Family Planning was included in the curricula of educational institutions. All the government and non-government agencies were encouraged their employees and persons within their sphere of influence to have small families. Efforts made in this direction were recognized and rewarded by the government.

The policies of government were aimed for higher agricultural production, development of an efficient transport system, expansion of public health and medical facilities, and improved civil administration which tended to reduce mortality. The policies of the government on Industrialization in it's woke brought about changes in the value system.

The present programmes, focused on administrative and operational research at all levels, to clarify organizational problems and gave chance to find solutions for

these. The solutions to these problems led to have a stronger base for future health programmes. Efforts in these directions could lead to the achievement of the World Health Organization objective promote maternal and child health and welfare and fostered the ability to live harmoniously in a changing total environment.

The policies of government dealt with problems like political unrest and also frustrating man's hopes for better life. All these policies are caused to build social and cultural environment which preserves and also promotes the dignity of individuals. All the available knowledge, skill experience, humanity can gain control to obtain objectivity. This stage is set for moving beyond to the levels of human civilization.

The structure of ten five year plans of the country indicate that family planning as a measure of population control was given a high priority in each five-year plan. The financial allocations for the family planning programme in each successive Plan are also indicative of the growing importance accorded to the family programme. All the five-year plans consisted of a number of policies framed to control the increasing birth rates in India. Here below we give a chronological and detailed account of working of the population control policies under Five Year Plans.

2.3.1. Highlights of First to Third Five Year Plans

The Government of India evinced keen interest in solving the population problem from the First Five-Year Plan onwards. During this period, the Planning Commission has considered the growth of population as one the most serious problems accorded it top priority (Bhende and Kanitkar, 2000: 492).

The draft outline of the First Plan, published in July 1951, contained a section on "Population Pressure: Its Bearing on Development", which recognized that India had a population problem. A sum of Rs. Sixty five lacs was allocated by the central Government in the plan of the Ministry of Health for family planning programme (Chandra S K, 1989:51). The Commission expressed the view that "The increasing pressure of population on natural resources (which must inevitably be limited) retards economic progress and limits seriously the rate of extension of social services, so essential to civilized existence. If there is no population policy there will not be progress". (GoI, Planning Commission, 1953: 23).

The document referred to a family planning programme with different terms i.e. Family Limitation and Population Control, terms. Those terms may be considered objectionable on humanitarian grounds to some sections of the Indian society. And also concentrated on field research with a view to identify values, norms, customs, sentiments and beliefs related to childbearing issues.

During the second five year the Planning Commission had pointed out that the rate of population increase was one of the key factors in development and underscored the fact that "a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall ". (GoI, Planning Commission, 1956: 7).

Another important point is that the Planning Commission had never considered a population control programme as an alternative to socio-economic development. Now it recognized it as socio-economic problem. While recognizing that with improved public health programmes and lower death rates, the population pressure was likely to increase, it accepted the need for curbing the birth rates. "This

highlights the need for a large and active programme aimed at restraining population growth, even as it reinforces the case for a massive developmental effort.”(*Ibid*,7).

Further, the Second Five-Year Plan included education, provision of services, training and research in the programme activities. Facilities for voluntary sterilization and increased availability of conventional contraceptives were provided to the people. Again, in the Second Five-Year Plan the approach was clinical. (Chandra S K, 1989:72). In order to strengthen the family planning programme, the Government of India has allocated Rs. 50 million, which registered an eight-fold increase over the earlier plan period. (Mahadevan K., 1989: 198).

The Government of India for the first time has recognized that the problem will not be solved in a short period. The Third Five Year Plan considered the population problem not as a short term but a long term goal and stated that. (Planning Commission, 1961, 12).

This time the Government of India has long-term objectives in order to achieve the goal. Accordingly the short-term objectives were replaced by long-term objectives. The government officials and the members of planning commission had begun to set long term objectives on the bases of the census reports. Unlike the earlier plans, the Third Five Year Plan was specific about the goals and direct and indirect measures to be considered for promoting this programme. The amount earmarked for the Plan was Rs. 270 million. (Mahadevan, K, 1989: 199).

2.3.2. Highlights of Fourth to Tenth Five-Year Plans

During this period this problem has been viewed in a different way that the population problem was not only from the point of view of economic development,

but also from that of much needed social change. The family planning programme found its place in the Fourth Five-Year Plan as a programme of highest priority and it was said under the present Indian conditions, the quest for equality and dignity of man requires as its basis both a high rate of economic growth and a low rate of population increase. (Chandra S K, 1989:52).

In the Fourth Five-Year Plan also 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 the Plan. ([Http // www // mohfw.nic.in/ evolfw.htm](http://www.mohfw.nic.in/evolfw.htm) IV FYP).

Even far-reaching changes in social and economic fields will not lead to a better life unless population growth is controlled. The limitation of family is an essential and inescapable ingredient of development.” (Planning Commission, 1969, 22). The framing of the family planning policies are based on social, economical and cultural factors. The Government of India wanted to improve the conditions of the people. The amount earmked for the family planning during this plan was Rs. 2, 858 million. (Mahadevan, K, 1989: 2000).

During the Fifth Five-Year Plan the family planning programme was included as a part in the National Minimum Needs Programme. It accorded a high priority to population control, and based the demographic projections for the Plan period on certain assumptions regarding a reduced growth rate, a birth rate declining much faster than the death rate and an effective family planning programme.

The programme said: “If family planning is less of a success than assumed above, the total increase in population would be even larger. It is of the utmost importance that family planning must

from Family Planning. The change was not merely in nomenclature but essentially in the content of its objectives. ([Http // www // mohfw.nic.in/ evolfw.htm](http://www.mohfw.nic.in/evolfw.htm) V FYP).

The Janata Government started in March 1977 made it explicitly clear that it was firmly committed to the programme of population in the programme did not arise. Some of the measures announced in the National Population Policy in 1976, especially those relating to compulsion, were dropped, while some others were retained. The Government that came in power was also committed to the programme of population control and also ruled out any element of compulsion in the programme.

The Government of India for strengthening the family planning programme granted the earmarked Rs.10, 100 million. The long-term demographic goal was recommended by the Working Group on Population Policy which was approved by the National Development Council included involves reducing the net reproduction rate (NRR) to one by 1996 for the country as a whole and by 2001 in the states.

The long term goals are set up during this period. For instance -The average size of the family would be reduced from 4.2 children to 2.3 children. The birth rate per thousand population would be reduced from the level of 33 in 1978 to 21. The death rate per thousand population would be reduced from about 14 in 1978 to 9 and the infant mortality rate would be reduced from 129 to 60 or less. As against 22 per cent of the eligible couples protected with family planning, 60 per cent would be protected. The population of India would be around 900 million by the turn of the century and would stabilize at 1,200 million by the year 2050 A.D. (Planning Commission, 1985: 281). Certain long-term demographic goals of reaching net reproduction rate to a uniform level were envisaged. 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% were the adapted goals.

During the Seventh Five-Year Plan the outlay for the family welfare programme was Rs.3, 256 cores. It was pointed out that in view of the progress made in the Sixth Plan, the goal of reaching a net reproduction rate of unity could be reached only by 2006-2011, instead by the year 2000 A.D. The goals for the year of 1990 were-Effective couple protection at 42 per cent, Crude birth rate 29 and Crude death rate 10.4 and Infant mortality rate at 90.0 to be achieved by 1990. (Government of India, Planning Commission, *Seventh Five-Year Plan, 1985-90*, Vol.II, New Delhi: 1985).The Seventh Five-Year Plan has included a number of new points related to the family planning adoption and family planning welfare.

The Family Welfare Programme 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 doorsteps of population, the following steps/initiatives were taken during the Seventh Five-Year Plan period. Establishment of one sub-centre for every 5000 population in plain areas and for 3000 population in hilly and tribal areas. By the end of the plan i.e.31.3.1990, 1.30 lakhs sub-centres 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 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 approach of family welfare adopted during the Seventh Five-Year Plan was continued during 1990-92. For effective community participation, Mahila Swasthya Sanghs 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, Unaware 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. ([http // www // mohfw.nic.in/ evolwv.htm](http://www.mohfw.nic.in/evolwv.htm) VII FYP).

During this period Rs.6500-00 cores was allocated for the Family Welfare Programme. Keeping in view the level of achievement in the previous five year plans, the long-term demographic goals for the country have been revised. It has been stated in the Eighth Five-Year Document that the net reproduction rate of one would now be achievable only in the period 2011-16 A.D. and not by the year 2000 A.D., as envisaged in the National Health Policy declared in 1983.

Accordingly, the goals of the crude birth rate, crude death rate and natural population growth rate to be achieved by the end of the Eighth Plan Period (i.e., 1997) were also revised. The revised goals to be achieved by 1997 and 2000 A.D. respectively were: crude birth rate: 26 and 21; crude death rate: 9 and 9; the goal for the effective couple protection rate by 1997 was 56 per cent and by the end of 2000 A.D. it continued to be 60 per cent. (Family Welfare programme in India, Year Book 1995-96; 1997; 10). The latest report of the Technical Group on Population

Projections constituted by the Planning Commission has estimated that the replacement level of NRR-1 is achievable by 2026 A.D. and beyond. (Family Welfare programme in India, Year Book 1996-97:1998: 19).

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 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.

Recognizing the fact that demographic and health profile of the country is 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 up gradation of health infrastructure in these districts from 1992-93 to 1995-96. This amount was 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 had been covered.

Realizing that Government efforts alone in propagating and motivating the people for adaptation of small family norm would not be sufficient, greater stress had been laid on the involvement of NGOs to supplement and complement the

Government efforts. Four new schemes for increasing the involvement of NGOs had been evolved by the Department of Family Welfare. These NGOs did laudable work.

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 was strengthened and expanded into the Child Survival and Safe Motherhood (CSSM) Project. It involved sustaining the high immunization coverage level under UIP, and augmenting activities under Oral Dehydration 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 are being taken up.

The targets fixed for the Eighth 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. . ([http // www // mohfw.nic.in/ evolw.htm](http://www/mohfw.nic.in/evolw.htm) VIII FYP).

During this Ninth Five-Year Plan population stabilization had become an area of top priority for sustaining the process of economic development in the country. This has been the focus of successive Five Year Plans. The Ninth Five-Year Plan (1997-2002) had outlined the following objectives/ strategies: Reduction in the population growth rate, meeting all the felt needs of contraception through improved availability, access and quality of contraceptive care. Reduction of infant and maternal morbidity and mortality. So that there is a reduction in the desired level of fertility. Assess the need for reproductive and child health at Primary Health Centre (PHC) level and

undertake area specific micro planning. (Government of India, Family Welfare programme in India, Year Book, 1997-2002)

Provided need-based, demand-driven high quality, integrated reproductive and child. Improve access to family planning services and to reduce the number of unwanted pregnancies. Focus on measures for providing essential obstetric care; undertake initiatives to promote institutional deliveries and also to promote safe home deliveries in poorly performing States. (Ibid, 1997-2002)

Prevention, detection and management of Sexually Transmitted Infections/ Reproductive Tract Infections in women is a priority area in essential Reproductive and Child Health (RCH) programme care at all levels of health care Pulse Polio Programmed launched in 1995, in addition to the routine immunization for polio under Universal Immunization Programme so as to achieve zero polio incidence by 2000.. The rate of decline in population growth is likely to be further accelerated during the next decade. (Ibid, 1997-2002)

With regard to the socio-economic indicators though an improvement has to be registered. There are wide inter-state, male-female and rural-urban disparities in outcomes and impacts to be minimized studies. At least 9 States and Union Territories have already achieved replacement levels of fertility i.e. a TFR of 2.1 i.e. Goa, Kerala, Nagaland, Delhi, Tamil Nadu, Pondicherry, Andaman & Nicobar Islands, Chandigarh and Mizoram.

However, 5 states i.e. Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh which currently constitute nearly 44 per cent of the total population, are projected to contribute an anticipated 55 per cent increase during the period 1996-2016 so as to constitute 48 per cent of the total population in 2016 (Source : M/O

Health & Family Welfare). Demographic outcomes in these states would determine the timing and size of the population at which India achieves population stabilization. With a view to providing a reliable and relevant policy framework for improving family welfare services and for monitoring the delivery. (Ibid, 1997-2002)

Reduction in the population growth rate has been recognized as one of the priority objectives during the Ninth Plan period. The objectives during the Ninth Plan were to meet all the felt-needs for contraception and 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 are to assess the needs for reproductive and child health at PHC level and undertake area-specific micro planning and to provide need-based, demand-driven, high quality, integrated reproductive and child health care.

The Tenth Five Year Plan (2002-2007) outlines efforts in three broad areas. Meeting the unmet need for contraception. Reducing infant and maternal mortality. Enabling families to achieve their reproductive goals. With regard to addressing the unmet need for contraception, the government is focusing particularly in areas where fertility declines have been lagging. Issues such as adolescent reproductive health, unintended pregnancy and access to safe abortion are addressed. Counseling, access to and provision of good quality services and follow-up care are emphasized. Health and family planning workers are required to regularly visit households in their assigned areas in order to provide information related to health and family planning, counsel and motivate women to adopt appropriate

2.3.3 National Population Policy 2000 and Mortality Influencing Policy Health for All- 2000 A.D

The Department of Family Welfare has drawn up the National Population Policy (NPP) 2000 to achieve replacement level of fertility by 2010 and of population stabilization by 2045. The major goals for 2010 include providing universal access to quality contraceptive services in order to lower TFR to 2.1 and attaining two-child norm, full coverage of registration of births, deaths, marriage and pregnancy, reduction in the IMR to below 30 per thousand live births, universal immunization of children against vaccine preventable diseases, elimination of polio by 2000 and near elimination of Tetanus and Measles, reduction in MMR to less than 100 per one lakh live births, promoting delayed marriage for girls and universalisation of primary education and reduction in dropout rates at primary and secondary levels to below 20 per cent for both boys and girls.

A number of promotional and motivational measures have been adopted by the Department of Family Welfare for achieving the goals e.g. Community Incentive Scheme under which Panchayats and Zila Parishads are to be rewarded for exemplary performance, the Balika Samridhi Yojana of Department of Women and Child Development is being continued, a Family Welfare- linked Health Insurance Plan is being undertaken, the National Maternity Benefit Scheme is now being implemented through the Department of Family Welfare, crèches and child care centers to be opened in rural areas and urban slums, facilities for safe abortions be strengthened, strict enforcement of Child Marriage Restraint Act 1976 and of the Pre-Natal Diagnostic Techniques Act 1994 etc. Ministers of all states and UTs, and the Central

Ministers in charge of concerned Ministries/Departments, reputed demographers, public health professionals and NGOs as members, have been constituted.

Aware of demographic inertia, the Indian government set different kinds of targets in the population policy introduced in 2000: an immediate target of meeting needs for contraception, healthcare infrastructure, staff and services to improve reproductive health; a medium-term target of fertility at the replacement level (2010); and a long-term target of population stabilization (2045). (Jacques Véron, 2006).

To facilitate the attainment of the goals set out under NPP 2000, an Empowered Action Group (EAG) was constituted in the Ministry of Health and Family Welfare for preparation of area specific programmes with special emphasis on states that have been lagging behind in containing population growth to manageable limits. A detailed database for these EAG states i.e. MP, UP, Bihar, Rajasthan, Orissa, Chattisgarh, Uttaranchal and Jharkhand has been compiled by the Department so as to help guide and direct the States for better plan formulation and monitoring.

Change Strategies for the EAG states have also been constituted in October 2001 to develop specific strategies focusing on community services. It has been made to develop appropriate structures, capabilities and systems in these states. It developed strategies for family welfare. As a follow up to the deliberations of the National Commission on Population, the Prime Minister has announced the creation of a Population Stabilization Fund with an initial contribution of Rs.100 core.

On the 11th of May 2000, at the threshold of crossing the stupendous figure of a billion people, India had the National Population Policy 2000 (NPP 2000). The policy document is a mere framework within which the strategies and programmes are incorporated. Having regard to the imperatives and the choices before the nation, the

NPP2000 is fundamentally an antenatal policy, which seeks to achieve replacement levels of fertility in three stages immediate, medium-term and long-term, to reach a stable population by the year 2045.

A set of fourteen National Socio-Demographic Goals and twelve Strategic themes with intended Action Plans form the matrix of the policy. It is basically a framework broadly outlining the current country-wide demographic perspective and proposed thrust areas to achieve the desired – population stabilization by the year 2045. Decentralization of planning and programme implementation has been emphasized with convergence of services at the unit level. Although the regional differentials in population have been highlighted, specific strategies to meet the particular needs of the regional or State differentials in the area of population and development have not been advanced. The regional differentials in the population and development have been the major stumbling blocks in the advancement of the country in the sphere of development. (Ramakrishna R M, 2006)

In June 1981 a joint meeting of the Central Health Council and the Central Council of Family developed the mortality-influencing policy and Health for all by 2000 A.D. This development was viewed as an outcome of the Declaration on Health issued at the International Conference on Primary health jointly sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at Alma Ata (U.S.S.R.) in 1978.

In this Declaration, popularly known as the Alma Ata Declaration it was stated: "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organizations and the whole world community in

the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.” (World Health Organization, UNICEF, “Declaration of Alma-Ata,” in *Primary health Care*, Alma-Ata USSR, 6-12 September 1978, Geneva: World Health Organization, 3).

India is a party to the universal commitment to secure Health for all by 2000 A.D. Health indicators/targets for achievement by 2000 A.D. were also worked out for immunization status for infants and pregnant women, coverage by vitamin A prophylaxis (0-5 years) and nutritional supplement for expectant mothers and children up to 12, coverage of population with protected water supply and found human excreta disposal. “Targets were also worked out relating to various communicable disease, blindness, dental health, mental health and school health” (The Government of India, Report of the working group on health for all by 2000AD. 30-34).

2.3.4. Swaminathan Committee Report

The Government of India appointed in July 1993 an Expert Group for drafting a national population policy for consideration of the Government and adoption by Parliament. This report contains some basic directional shifts in the goals of population stabilization programs, organizational modifications at various levels and setting up of new institutions, for effective programme implementation.

The report has a number of popular clichés such as it is pro-nature, pro-poor and pro-women in its direction and thrust that the population program should move from negative to positive goals: that population growth is depleting non-renewable natural resources, especially the underground water at an exponential pace and if not checked in time, can lead to serious deficiencies of water in the country; it is assumed

that development that is not equitable is not sustainable; and that gender equity is essential for development and is an integral component of development itself.

Only broad goals were set for achieving reductions in selected demographic parameters by the year 2010, such as in the TFR values from the existing level to 2.1, IMR to less than 30, maternal mortality rate to less than 100 per 100,000 live births, negligible incidence of marriage below age 18 for girls, and rapid improvements on a number of other social indicators such as female education, abolition of child labor, and accessible quality primary health care. (Ibid).

The Committee recommended some new structures such as setting up a Population and Social Development Commission at the center with the Prime Minister as Chairman and also similar commissions at the state level; integration of the Department of Family Welfare at the central level with the Department of Health Services and a Population and Social development Fund to direct the flow of funds for population and related programmes. Many of the recommendations of the Committee whose report was submitted in May 1994 and the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in September 1994, were discussed and debated over the next six years in various committees and National Population Policy 2000 was launched in that year (Ibid).

2.3.5. Population Issues at International Conferences

The International Conference on Population and Development (ICPD), organized by the United Nations at Cairo in 1994, was in its deliberations, by and large, dominated by women's groups. The Programme of Action formulated at the end of Conference. India as a signatory, postulated that population policies were to be

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viewed as an integral part of programmes for women's development, women's rights, women's reproductive health, poverty alleviation and sustainable development.

Women's concerns dominated the discussions at the Cairo conference, which felt that population policies, which are based on macro demographic considerations and acceptor-target-driven programmes, are unnecessarily and unevenly burdening women with the task of regulating reproduction to suit macro level policies. They argued that, henceforth, population policies should not be viewed with the sole concern of reductions in fertility rates considered desirable by planners and demographers, but by considerations of reproductive health, reproductive rights and gender equity. It was argued that developmental programmes, which, are not engendered, are not only sustainable but also endangered.

The Programme of Action adopted by the ICPD recommends a set of qualitative and quantitative development goals. They are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity, equality and empowerment of women; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health.

The Government of India, which was a signatory to ICPD Programme of Action, promptly followed up on the recommendations by abolishing the acceptor based family planning targets since April 1995, in the country. It had already experimented with the 'target-free approach in a few selected districts in the previous year but the effectiveness of the approach was not properly assessed.

Since 1997, officially, the Reproductive Health Approach has been adopted as the national policy of the Government of India. The official RCH programmes include



the conventional maternal and child health services including immunization of children, contraceptive services to couples, treatment of reproductive tract infections (RTIs) and sexually transmitted diseases, provision of reproductive health education and services for adolescent boys and girls, and screening of women near menopausal age for cervical and uterine cancer and treatment, if were required.

The budget required for these additional services, intended to be covered under reproductive health are quite high. It was feared that the emphasis on contraceptive services would get diluted when budgets are not adequately increased to cover the wider goals of RCH programmes. (Ibid). Population concerns go beyond reproductive health, though the latter is an important contributing factor for population stabilization. (Ibid)

2.3.6. Recent Policies

According to the writings of the eminent scholars K.Srinivasan at present three policies seem to be in operation in the country having a direct impact on population issues and availability of family planning services. These are the National Population Policy 2000 (NPP 2000), the National Health Policy (NHP 2002) and the recently launched National Rural Health Mission (NRHM 2005). The last one is really a policy document in the statement of vision and objectives, setting up of goals, formulation of strategies and programmes and launched by the Prime Minister of the country in May 2005.

National Population Policy 2000 (NPP 2000) and the National Health Policy 2002 (NPP 2002) were framed within a gap of two years. Following discussions with various committees, starting with the M S Swami Nathan committee on population policy, the NPP 2000 was announced on February 2000, after almost six years. Since

1994, after ICPD, several discussions were held on the appropriate and revised population policy by various committees set up by the Planning Commission.

The final policy document, approved by the Group of Ministers and Planning Commission was launched by Sri. A.R. Nanda, the then Secretary, Department of Family Welfare; later approved by the newly set up National Commission on Population under the Chairmanship of the Prime Minister in its first meeting held in July 2000; and approved by the Parliament in 2001. Parliamentary approval became mandatory since the policy recommended a continuation of a Constitutional Amendment made in 1976 that froze the seats in Parliament and State Legislative Assemblies on the basis of 1971 census until 2001.

In 2001, on the basis of the recommendations of NPP 2000, the Parliament extended this constitutional freeze of seats until 2026. Since independence, the population policies formulated from time to time, beginning with the policy in 1976, aroused a high level of political interest and popular discussions. This may be because of the long held mistaken view that population problem is the mother of all the problems in the country. (Ibid).

No other country in the world including China had so many population policies as India. China had only one policy, the one child policy, and just went ahead and implemented it. NPP 2000 and NHP 2002 typify the impact or goal obsessed approach to policy rather than the inputs- processes- outcome oriented approach to policy.

Knowing fully well that NPP 2000 and NHP 2002 goals are impossible to be realized, they find a place in the policy documents under the assumption that stating the goal is in itself reaching half way. NPP 2000 has laid down three objectives,

immediate, medium and long term and 14 quantitative goals, called the national socio-demographic and put them in the document (Ibid).

For example the goal for IMR stipulated in all the three policies: reach IMR of 30 by 2010 in NPP 2000 and NHP 2002 and by 2012 in NRHM 2005. Recent trends in IMR indicate that the level has declined only by 14 points in 11 years (80 in 1990 to 66 in 2001) or at 1.3 points per year. During the subsequent two- year period, 2001 to 2003, the decline has been more rapid, with the IMR declining by 6 points from 66 to 60 or 3 points per year. If the IMR trend line observed in 1990, 2001 and 2003 is extrapolated the future expected IMR in 2010 would be 51.

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CHAPTER 3

POLITICAL ASPECTS OF POPULATION CONTROL IN INDIA

This chapter is an attempt to study the politics of the Government towards the population control programme in India. The study carries out to examine a number of political aspects involved in the family planning programme. Important aspects among them are: Impact of the eminent decision maker's views on family planning programme. The chapter also deals with the constitutional provisions and examined how they were connected to the population control programme. The same study examined the politics of population control programme during different Government under different Prime ministers. The study has even focused on the external pressure to reduce the birth rates, and examined the politics of the population control during the time of Emergency. It examined the incentives and disincentives of the family planning programme and their contribution in solving the problem.

After independence the Government of India played a pivotal role in controlling population growth. As Ghosh writes "The family planning programme occupied a principal position in the arsenal of policy-makers in India for achieving reduction in birth rates commensurate with the development goals". (Ghosh, 1992: 51). Initial policies of the Government did not emphasize upon to a population policy to control birth rates. At the outset the Indian Government's had no firm commitment to design a population policy to control births rates. Later it has become an important issue to the decision makers of the Indian Government. The policy makers had recognized it as a socio-economic-political problem and committed themselves to

address the problem as soon as possible. In this regard, from the inception of the programme to till date a number of divergent opinions emerged among the politicians.

Most of the policies of the Government indicated that the policy formulation is essential for controlling population growth. Discussion was held among the pioneers of the family planning programme and on the issue of motivation to the acceptors and to the promoters of the family planning programme. According to Barnabas 'The same discussion was directed towards making leading actors, interest groups and political organizations participate in the policy formulation to control population growth.' The discussions were held with officials of the Family Planning Departments at the center and in the states'. (Barnabas, A.P, 1977:5). The problem of population growth has been considered a national problem and the officials of the both central and state governments have begun to discuss the problem. Discussion has become the first step for policy formulation.

These discussions enabled the policy makers to get a clear understanding of the necessity for the policy formulation to curb the growth of population and later developments emerged in the policy formulation process. The leaders of the nation and state politicians took part in it. There are a number of sources from which different opinions were derived regarding the views of prominent political leaders, cabinet members, interest groups, intellectuals and government officials towards policy formulation to population control. The attitude of the Government has changed from time to time.

3.1 Views of Eminent Leaders

Mahatma Gandhi, hailed as the Father of the Nation for his sacrifices for India's independence, was India's hero. Gandhi realized the need for birth control as

early as in 1925; he firmly believed that abstinence from sex was the only method that should be adopted for birth control. Gandhi wrote in *Young India* in 1928 there could be no two opinions about the necessity of birth control. But the only method handed down from the ages past is self-control or *Bramhacharya*. Gandhi considered sterilization inhuman. He was in favor of sterilization for men rather than for women.”(Mahadevan K, 1989: 193). He believed that male aggression would increase if women alone were sterilized. He contributed no direct inputs in formation of India’s population policy. Many leaders have agreed with his views on population control in later ages. Gandhi was not in favour of sterilization and believed in abstinence from sex. Gandhi influenced some ministers.

Jawaharlal Nehru, India’s first Prime Minister, decided to constitute a Planning Commission to design a plan to control the birth rates with the help of eminent people. Jawaharlal Nehru, who was also the Chairman of the Planning Commission, believed that population problem could be solved within the framework of economic development.

Though not fully convinced of the need for a policy of population control, Nehru bowed to the views of some of the influential educated elites in the country and gave his assent to family planning programme on a limited scale.

In a message to the third international conference on Planned Parenthood at Bombay in 1951, Nehru indicated that the Planning Commission had made definite policy on birth control which the Government had not yet officially accepted.

Nehru was very clear and forthright in his strong advocacy of family planning. He said, “The first aspect to be considered in planning is what will be the population

for which we are planning? How much food they would require? How much housing? How much money for other things like education, health? It does not become a theoretical concept . . . if our population grows rapidly; the necessity of limitation of that growing population becomes an urgent necessity for us.” (Mahadevan K, 1989: 195).

On another occasion he emphasized that the approach for the family planning should be scientific and should be for social good. He said any approach must not be inhibited by pre conception or conviction held already. He wrote to Lady Rama Rau; “You know I am wholly in favor of family planning. Certainly one of its principal objects is to lessen the rate of population increase. But there are other aspects also; to give fuller life to the family planning and more particularly to mothers and children, He devoted a section to population in his book, *Discovery of India*. He wrote that this eastward sweep of technology accompanied by education, sanitation and better public health is continuing and will cover many of the countries of Asia. Some of these countries, like India, far from people needing a bigger population, would be better off with fewer people” (Ibid; 195.). He was in favor of family planning and decided to promote the programme through scientific and other modern methods.

Nehru’s prominent colleagues in the union cabinet, notably Morarji Desai and Krishna Menon were the chief spokesmen of several Government policies for a decade. They influenced the Government’s population policies in many ways. Morarji Desai, Krishna Menon, Gulzari Lal Nanda, the members of the Planning Commission were the core of the Indian Cabinet in the 1950s. Their views were expressed through other leaders who were their followers.

Morarji Desai was a Gandhian and “advocated a true Gandhian type of policy not in favor of rigorous Government support.”(Ibid; 195). Like Gandhi, he believed in family limitation through abstinence from sex. He was not enthusiastic about the family planning policy. However, he went along with the majority opinion. He lost his power and status after 1963.

Gulzarilal Nanda, the then Planning Minister and a Gandhian, was more complacent than enthusiastic towards a population control policy. He was also against to any kind of artificial contraception on ethical and religious grounds. He was very much interested in protecting the people by introducing new policies related to their family planning. He was not interested in artificial contraceptive methods. He disfavored the methods on ethical and religious grounds.

Krishna Menon, the then Defense Minister and a member of the Planning Commission, viewed such a policy with disfavor and his attitude could be attributed to his leanings towards Marxism according to which rational control of human fertility is iniquitous. He believed and often stated that India is a rich country with poor people. According to him the population of India could be supported with a rapid all round development of the country, exploiting the vast resources available in India. With so much indifference prevailing at the top towards birth control at that time, it is surprising how the policy came into being so early in whatever form that it did. One plausible explanation is that the opinion of educated elites carried a lot of weight.

India is a traditional society and there is a great reverence for educated elites from times immemorial. Gopaldaswami, Mrs. Rama Rau, Dr. Gyan Chand, Dr. A.C.

Basu, et al were the educated elites who influenced the Government of India for making a population policy at initial stages.

The role of the educated elites in the field is notable. Gopaldaswami, the former Registrar General and Census Commissioner of India, played an important part in arousing the interest of the political leaders and the Government towards population control.

Gopaldaswami drew attention of the Indian people and the members of the Government to the problem of population growth and the likely future problems of growth as in 1941-51. He gave top priority for a population control policy. He suggested, "the incidence of improvident maternity should be reduced from the present level of over 40 percent to fewer than five percent within next 15 years."(Ibid; 42). This was accepted by the government of India. This suggestion had been treated as a guiding principle by the members of the Government while they were making policies to reduce the population growth. There were different opinions among the eminent people about the population control programme. Such divergent opinions created ambiguity among the policy makers to formulate a population policy.

3.2. Politics of Population Control Programmes from Inception

3.2.1 Constitutional Provisions

The constitution of India has declared in its Preamble that it aims of providing all its citizens: "Justice, social, economic and political; Liberty of thought, expression, belief, faith, and worship; Equality of status and of opportunity; and to promote them among all fraternity, assuring the dignity of the individual and the unity of the nation". (Basu D.D., 2006: 24)

In the Directive Principles of the State Policy, the constitution provides that: The State shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall prevail and shall inform all the institutions of the national life. (Art. 38). (Ibid, 2006)

The State shall, in particular, direct its policy towards securing: that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;

That childhood and youth are protected against exploitation and moral and material abandonment. (Art.39). (Ibid, 2006)

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties. (Art.47) (Ibid, 2006)

Guided by these Directive Principles, the Government of India and the state Governments have adopted planning for development as the main strategy for the fulfillment of the constitutional obligations. The two fundamental approaches underlying the planning are: 1. To increase the production of goods and services and 2. To reduce the growth in the number of people demanding goods and services. The Government realizes the limits in rapidly increasing the production of goods and services and therefore on reducing the rate of increase in population. (IIPS, 1973: 265-270)

Government realized that while the birth rate remained same, death rate was declining, contributing to the steep rise in population. This realization was reinforced by the decennial census of 1961 and 1971.

To bridge the gap between birth and death rates, the Government has adopted a number of approaches such as clinical to the extension education, cafeteria and camp campaign. There have been shifts from the clinical to the extension approach to cafeteria approach. Recently, the campaign approach is becoming popular. . (IIPS, 1973, 265-270) The Government of India used to change its approach from time to time.

Realizing the importance of family planning in India, the Government had made a policy to establish a separate Department of Family Planning in April 1966. There is also the Central Family Planning Council, which co-ordinates the efforts of the Government at the Central, state and voluntary body levels. There are also other co-coordinating bodies at the Cabinet and Secretariat levels both at the Centre and in most of the States.

The Government of India is financing the programme although the bulk of the administration work is done at the state and district levels. As regards the family planning programme, the Government's objectives are: - To prepare the community to feel the need for family planning and use the services available for the purpose under the auspices of the Governmental and non-governmental organizations. (IIPS., 1973: 265-270)

To sensitise the people through various media and through several leaders to accept individually suitable methods of family planning without offending the religious values and moral susceptibilities:

To make available the services to the people on demand at their residence or at the nearest to their residence.

To make the services under the family planning programme integral parts of medical and public health services and more particularly of mother and child health programme.

Government, therefore, feels that appropriate modifications in the policy and administration of the family planning have to be made to resolve the paradox. One of the ways by which this could be done is to ascertain the factors adversely affecting adoption of family planning practices by the less developed areas or communities and from such knowledge, make suitable modifications in the methods of reaching the people for the purpose. Government felt it necessary to adopt a differential approach to reach areas and communities in the light of the ascertained knowledge about differences in propensities towards the adoption of family planning programmes. (IIPS, 1973: 265-270)

The Indian Government fully realized that the activities of the Department have only a limited possibility of reaching the people without a fuller and more active participation of the community in the decision making process and without the cooperation of organization and leaders outside the Government.

With a view to achieve involvement of the people in the decision making process, and to mobilize the cooperation of organizations and leaders outside the Government, the Government of India was keen to encourage the political parties and representative bodies at the national, state and local levels to discuss thoroughly the pros and cons of the family planning policy in their respective forums.

The Government of India (GOI) was also eager to ascertain the views of the public about entrusting the administration of the family planning programme to an autonomous organization at the centre and in the states so that the organization may have greater freedom and initiative to experiment with several methods of approach in the people and getting them to accept the ideas of limiting the size of their families.

The Government of India (GOI) has converted the family planning programme into a family welfare programme. The Government of India has begun to take an overall view of the needs and conditions of the families and provide social security services and social welfare services so that the fears arising out of the limitation of the size of the family would be mitigated by the services available under the various programmes.

The GOI was also eager to encourage the voluntary organizations which it felt have a great role to play in mobilizing the citizens of India to identify their individual aspirations with the national objectives. (IIPS, 1973: 265-270)

The constitution of India distributed the powers between center and state governments. In this process, the provision of family planning programme is allocated and given to administer by the Ministry of Health in all the states. (Barnabas A.P., 1977: 33) The provision for the family planning and welfare is given to the state governments. Even if the provision is in the state list Union Government has got full powers to make policies on any provision in the state list. Policy formation in India is subject to the restraints and demands of diverse groups in the society. (Basu D.D, 2006: 199)

3.2.2. Politics of Governments Under Different Prime Ministers

During the time of the Prime Minister Lal Bahadur Shastri, the Government was not firmly committed to reduce the birth rates. Shastri followed the policies made by the earlier governments. The members of the cabinet were interested in formulating a new policy to stop the growth of the population. But the then prevailing conditions were not conducive to formulate a new policy. The intervention of the Government with the problem was so minimal.

3.3 Tyranny of Targets

The Government of India had intensified the efforts for the family planning. (1966-74). On the one hand the Ministry of Health was renamed as the Ministry of Health and Family Welfare, and a separate department of Family Welfare with a Secretary in charge was set up. On the other hand the 'cafeteria' approach started broadening the range of contraceptives offered (pills and IUD), Mass sterilisation camps were started and the MTP Act was passed. However, the ambitious target of reducing birth rates was not achieved. The Minimum Needs Programme was integrated with the Family Planning Programme but this was also the period of apparent anomalies. While the Indian Health Minister raised the slogan of "Development is the best contraceptive" at the Bucharest conference, forced sterilization camps were conducted at the behest of Sanjay Gandhi during the Emergency. As everyone knows the Emergency excesses in the field of sterilizations were one of the main reasons which brought the Government down.

After 1977, Family Planning (now the department was renamed as Family Welfare) became a low-key activity but soon after Indira Gandhi came back to power, the voluntary sterilization camps re-started with the new technology of laparoscopic sterilization. Women, then were the main targets for contraceptives - especially sterilizations - and vasectomy figures became negligible. Method specific targets were also introduced for the temporary methods but there were incidents of gross mis-reporting because these figures were difficult to follow-up. Performance in Family Planning programmes also became a key indicator of ranking states and districts and it was included as an important feature of the Twenty Point Programme.

After Indira Gandhi became Prime Minister, the family planning programme reached a peak and became a vital aspect of the Indian politics. Indira Gandhi was more comprehensive in her approach to the control of population. She gave a top priority to the allocation of resources for this programme. There were ups and downs in formulating policies. Whatever happened, there was an overall promotion of the family planning programme during her tenure in the office and it was somewhat encouraging to the policy makers. For this reason the United Nations gave Mrs. Gandhi its first award for the promotion of the family planning programme in the developing world. The external pressure had begun from this occasion onwards to curb the growth of the population.

During this time, the road to population stabilization was long, arduous and full of pitfalls. But it was worth to recall that the Twenty-Point Programme put forward by Indira Gandhi after imposing Emergency in 1975, did not include a clear structure to population control. However, family planning was included in Sanjay Gandhi's Four-Point Programme that unfortunately resulted in coercive methods and

even body snatching in the name of fulfilling sterilization targets. This was totally unacceptable to Indian voters, especially those in the northern states that were under the strong influence of Sanjay Gandhi. This was largely responsible for the exit of the powerful government of Indira Gandhi in 1977 after the general election.

Addressing the delegates of the first conference of the Asian Forum of parliamentarians on "Population and Development" in 1984, Mrs. Gandhi said: "In India, family planning is part of our plan of economic development and occupies a crucial place in our Twenty-Point Programme that is meant to raise the standard of living of the poorest. We are trying to create a favorable climate for family planning with the help of the mass media, folk media and interpersonal communication by trained personnel. Parents are more likely to restrict their families if they have reasonable assurance of the healthy survival of their two children. (Mahadevan K, 1989: 196).

Rajiv Gandhi promoted the family planning programme with the same vigor. In 1985, Rajiv Gandhi wanted to restructure the Family Welfare programme. He gave a greater thrust to the allocation of finance, appointment of technocrats and innovativeness in accepting new strategies. He doubled the amount to the family planning programme to stem the growth of population. This act shows his greater commitment to this programme. It was more visible at the time of delivering the inaugural speech at the second National Conference of parliamentarians on "Population and Development" in 1985, Rajiv Gandhi said, "The issue is a very crucial one, not just for India, but the whole world. It is more important to us in India because we see the rate at which we are growing, is affecting our economic growth.... It must be linked with every other facet to see how we can attack this problem from all sides. We have taken very major steps in directing family planning. We are taking a major programme for education. This has to be the basis of any

family planning programme. We have expanded television network and we are covering a very large proportion of our people today. We have to ensure women get adequate education, right from primary school level to university level. We have to see that adult education is given enough importance. Women's welfare is a very crucial part of any family planning programme. The status of women must be raised in our society." (Mahadevan K, 1989: 196)

Rajiv Gandhi accepted the real condition and decided to formulate a policy to stop the prevailing bad conditions in the country. But he soon got engulfed in political turmoil and his tragic death ended the story of restructuring the programme.

The coalition government of UPA put population control issues on the back burner given the political exigencies. The Common Minimum Programme had blundered in referring to the need for "a sharply targeted population control (Ashish Bose, 2005: 2). To be launched in 150 high-fertility districts. 'Target' is now a dirty word in political demography and the experts who drafted the Common Minimum Programme realized that their statement was not politically correct.

An office memorandum quietly issued by a Director in the Department of Family Welfare on December 10, 2004, modified the words "population control programme" and inserted a clumsy sentence as follows: "The UPA Govt. is committed for population stabilization programme focusing on high fertility states learning from the successful experience of southern states and in other states it should be promoted through strengthening comprehensive primary health care." (Ashish Bose, 2005: 4).

On the 50th anniversary of India's Independence, Prime Minister Gujral promised to announce a National Population Policy in the near future. During November 1997 Union Cabinet approved the draft National Population Policy with

the direction that it should be placed before Parliament. However, this document could not be placed in either House of Parliament as the respective Houses stood adjourned.

It is wise to move from population control to primary health care. But the tragedy is that there is almost a total collapse of primary health care infrastructure almost all over India. One should not be impressed by statistics on the large number of Community Health Centers (CHCs), Primary Health Centers (PHCs), Sub-Centres (SCs) reported in Health Ministry documents because most of these are not fully functional. It was therefore in the fitness of things that Prime Minister Man Mohan Singh took upon himself the responsibility of launching National Rural Health Mission (NRHM) on April 12, 2005. He also reconstituted the unwieldy National Commission on Population and at the very first meeting (The Hindu July 23, 2005) and declared "I sincerely believe that coercion of any kind to achieve population stabilization is unacceptable in a free society".

The political structure in India intervenes with the family planning plans. Policy making process is politicized and is subject to the same public scrutiny, debate, bargaining and compromises that characterize Indian politics in general. The issue of the family planning has been politicized at all the levels in India.

3.4. Changes in the approach to Family Planning Services Delivery Since ICPD

The International Conference on Population and Development (ICPD, Cairo, 1994) marked a radical shift in thinking and action around population and development issues. Family Planning lost its pre-eminent place in service delivery to the concept of comprehensive reproductive health services across the life cycle. As a

result of ICPD the focus of family planning programs shifted from fulfillment of national demographic goals to fulfillment of reproductive goals of individuals and couples. The respect for human rights, the concern for gender equality and equity and the need for universal access to services which enable the enjoyment of the highest quality of physical and mental health were now the key guiding principles for reproductive health related service delivery. In concrete terms these translated into voluntary and informed choice addressing unmet needs.

3.5 Politics of Population Control during Emergency Period.

The Government of India declared constitutional or internal emergency in June 1975 that continued up to March 1977. The Central Government permitted the state governments to pass legislation for the compulsory sterilization of couples with a minimum of three living children. The state governments were also asked to introduce a series of measures by which their employees and other citizens were eligible for preferential allotment of houses, loans, etc., if they accepted family planning. Necessary changes in the service conduct rules of the central government employees were also contemplated.

During the emergency period, several target oriented, time-bound and coercive measures were resorted to. Bills for compulsory sterilization were drafted by the states of Maharashtra, Punjab and Haryana, but were not implemented. A world record was achieved with a reported 10 million sterilizations during this short period. The goals, which could not be achieved during the previous 19 years, were attained during this short period of time. However, many medical personnel neglected post operative care in their over enthusiasm. Community health services suffered a loss of credibility

and the sterilization method became grossly unpopular. (Mahadevan K, 1989: 203-205).

A comprehensive policy formulated by Karan Singh, came into being in 1976. It was largely due to the direct and indirect influence of the 1974 Bucharest conference and the 1971 Census findings that showed a phenomenal increase in population. It was also because of the political support from Indira Gandhi and Karan Singh and the imaginative administrative and technical guidance of A. Chandrasekhar and Sarala Grewal, the then secretaries of the central Health Ministry, and Family Welfare, and K. A. Pishaoti, the then Director of the Gandhigram Institute of Rural Health.

The policy envisaged the definite goal of reducing the birth rate from 35 per thousand population in the beginning of the fifth five year plan, to 25 per thousand by the end of the sixth plan, in order to realize the aim of bringing down the growth rate of the population to 1.4 per cent in 1984. In order to achieve this target, a package of policy measures consisting of five major dimensions, viz., certain political measures; fiscal measures; administrative measures and social change strategies were proposed, leaving compulsory sterilization to the discretion of individual states. The proposed measures were: Freezing the population base at 1971 census for representation in the Lok Sabha and state legislatures. Devolution of taxes and duties and grants-in-aid on the basis of 1971 Census figures. Central assistance earmarking 8 per cent against performance in family planning. Full rebate in income tax assessment for money donated for the family planning programme. Considering the small family norm as an integral part of the activities of every ministry. Highest priority for women's education above the middle level as well as non- formal education. Rising minimum

setback because of administrative and political factors and the after-effects of the emergency. For instance, the number of sterilizations dropped from 10 million in 1976-77 to just 0.8 million in 1977-78" (Mahadevan, K., 1989: 55-59).

3.6. Changes in the Family Planning Policies and Programmes Since 1990

The decade of the 1990 was marked by many changes in the way the National Family Welfare programme was designed and delivered. With release of the Eighth Five Year Plan in 1992, the family welfare programme entered into a reflective phase. The plan document expressed concern about the poor realization of family welfare goals and questioned the wisdom of centralized planning and target setting. (Planning commission, 1990:300-365).

India was very quick in implementing some of the recommendations of the Cairo Conference notably the withdrawal of contraceptive targets. In 1995, contraceptive targets were removed in one or two districts in all states and in April 1996 the entire country entered into a new era of the Target Free Approach (TFA) to Family Planning. Subsequently the Reproductive and Child Health Programme was launched and in the year 2000, India announced its National Population Policy. The new approach included very laudable components like - quality of care, bottom-up planning, and community-need based service provision which were all in line with the ICPD recommendation and also genuinely addressed the existing lacunae in the Family Welfare Programme.

3.7 Transition in the Indian population politics during the period of Indira Gandhi.

India's National Population Policy implemented during the nation's political Emergency illustrated how policies targeted to bring demographic changes collided

with human rights when democracy was suspended. There was a dynamic relationship between policy and reproductive rights as human rights and also the political climate in which the Emergency and National Population Policy of 1976 arose.

The management of the population affairs in India had become a political and economic issue. During emergency time it had become an issue of health and human rights. A sterilization drive focused on males was implemented in India under the auspices of the 1976 National Population Policy. There is no better situation to explore the relationship between health and human rights.

In India the population management issue became a political issue between 1971 and 1976 and found a close relationship between poverty and economy. In 1971, India's population growth rate was 2.25 percent a year (Panandiker and Umashankar, 1994 89-104) and campaigning on a platform of *garib hatao*, or end poverty, Indira Gandhi of the National Congress Party became the Prime Minister of India. Yet, India's efforts to reduce poverty have failed. At that time India had faced three important problems. The first problem is the Bangladesh War. The second problem is poor harvests. The third problem is an oil crisis. By 1974, inflation was rising (Park, 1975) and the poor were no better off than in 1971.

On June 26, 1975, Prime Minister Indira Gandhi declared a state of political Emergency on the premise that it would "prevent economic deterioration, political disruption, social disturbance, and general chaos" (Palmer, 1977, 161). But, it had created more problems to the Government and to the people. The Emergency allowed Parliament to amend all aspects of the Constitution except for India's status as a federal democracy (Malhotra, 1989), suspend civil rights, and censor the press (Wolpert, 2000). Shortly after declaring the Emergency, Indira and the Congress Party

announced anti-poverty Twenty Point Program (Dhar, 2000). The twenty point programmes brought a number of changes in the field of family planning programme.

The future of the Congress Party was at stake during the Emergency, and Indira and Congress Party leaders believed that the survival of their political careers depended on continuing Indira's political dynasty, which began with her father, Jawaharlal Nehru, the nation's first Prime Minister. The Twenty Point program failed to meet the needs of India's citizens, but assisted in the success of Indira's plan to make her son Sanjay a political heir (Malhotra, 1989).

In this, Sanjay was given political privileges including permission to develop national policies. It was proposed that unplanned population growth would pose a threat to the Twenty Point Program (Panandiker and Umashankar, 1994: 89-104). Using Malthusian reasoning, Sanjay's policy agenda led for more effective population control programs. Sanjay Gandhi, believed that twenty-point programme could not be implemented if the growth of population was increasing.

In 1976, with India's population growing rapidly and the Emergency extended for another year, the Minister of Health and Family Planning, Karan Singh, announced a National Population Policy aimed to deter population growth and events. The Policy hoped to help solve the nation's economic hardships, established how incentives would be allocated to those who participated in population management efforts, and sought to reduce the nation's birth rate from 35 to 25 per 1,000 by 1984 (Frank, 2001). The policy also acknowledged that India's population growth concerns could not wait for increased development and education to result in a drop in fertility (Cassen, 1978).

During this period the Ministry of Education came to lime light. The Union Ministry of Education has encouraged the state governments to give attention to girls' education, introduce family planning into school curriculums, and scale up rural health projects. During the same period, Sanjay Gandhi convinced political leaders to support and implement the Policy's programmes by promoting the idea that population growth curbed the development India needed to improve the welfare of its citizens (Gwatkin, 1979). Thus, there was a great amount of pressure to pursue the Policy's goals. In turn, a chasm between the good political interventions in family planning and recognition of human and reproductive rights was formed. Whereas, programmes implementation focused on individual fertility behavior rather than structural determinants of population growth. (Khadija Turay, 2006)

The political climate created by the Emergency, the manner in which the Policy was framed, and the way Sanjay implemented the sterilization drive, jeopardized the rights to reproductive health and a secure existence. Generally, in India, public health services were overseen by states and not by the central government. The Population Policy stated that the central government did not wish to legislate compulsory sterilization, but, if a state legislature felt prepared to pass a policy making sterilization compulsory, then it could do so (National Population Policy, 1976).

Maharashtra was the only state that tried to pass a compulsory sterilization bill, but eventually failed to do so (Gwatkin, 1978). However, by vaguely defining the terms 'force,' 'abuse,' and 'coercion' (Malhotra, 1989) in the Policy statement, misconceptions of its goals were common and it was unclear to the citizenry and those carrying out the program just how vigorous enforcement should be (Viczianny, 1982)

Intense bureaucratic pressure led some states and vasectomy camps to falsely believe that they were more prepared for an increase in volume than they really were.

Hence, a number of deaths occurred as a result of infection from unhygienic procedures. (Gwatkin, 1979) Inconsistent incentives were offered to those performing and receiving vasectomies, as well as government officials overseeing the drive. Encouraged dishonest reporting of quota performance (Cassen, 1979) and made it difficult to evaluate the program's effectiveness.

For many citizens, efforts used to reach the goals of the Population Policy did not balance reproductive rights with concerns for India's development (Cassen, 1978), but represented "the conversion of the government's administrative resources into an engine of oppression, corruption, and fraud (Mirta, 1977, 298)."

Questionable and sometimes coercive implementation practices combined with strong political will proved to leave most socio-economic rights unprotected as well, allowing acceptance of the sterilization drive to be guided by one's economic status (Gwatkin, 1979), specifically regarding fewer children as the norm. Citizens living in poverty found it difficult to agree with the political leadership that a reduction in population growth depended on people making "the rational decision that it is in their own economic self-interest and that of their children to have smaller families (Rouyer, 1987, 454)." Yet population control efforts like sterilization were still pushed on poor males because officials knew that incentives would be hard to refuse (Vicziány, 1982).

Regarding intervention in population control and the qualitative composition of India's population-- during the Emergency the Population Policy furthered the inimical rift between Hindus and Muslims by legitimizing traditional enmities (Basu,

1997) and increasing concerns about protecting 'vote banks' (Stein, 1998) in the Government.

To ebb the possibility of violent uprisings or any more divisions in the wake of the Bangladesh War, the government assured via policy action that parliamentary seats and the allocation of central funds would not be affected by a state's population control performance (Cassen, 1978). However, this did not secure the right to social protection.

The protest, which signaled the downfall of the 1976 Population Policy, occurred in part because under Sanjay's direction the government demolished a poor, predominately Muslim neighborhood near Jama Masjid in Delhi, relocated its citizens, and mandated that rehousing be conditional on submitting to sterilization (Cassen, 1978).

The impact of population policy on reproductive rights, secure existence and social protection for people illustrate how interconnected human rights are and how broad the reach of population politics can be. Citizens understood this and became more forceful in their demands for change; making it difficult for Indira to balance civic demands from her constituents and political demands of the Congress Party (Kohli, 1988).

The number of sterilizations performed during the period measures the effectiveness of the Population Policy of 1976, which was declared as a successful legislation. But the figures were proved to be a wrong reporting; about 8.25 million people were sterilized between 1976 and 1977 (Gwatkin, 1979). However, it came to light from a right-based perspective, that the effectiveness of the policy was measured by deaths, violence, and rights and goals of the Population Policy and declared that it

was unsuccessful. (Khadija Turay, 2006). Failure was reflected in the fact that the sterilization drive lacked sustainability and was counterproductive to improving and protecting the nation's health. For instance, it concentrated in one place when the country's health professionals were being used to reach sterilization goals rather than provide other services (Cassen, 1978), on only one aspect of sterilization neglecting other health services. Compensation for sterilization operations rose to ten percent of the total health budget and the government allocated medical services to sterilization rather than patient welfare. (Vicziány, 1982)

Widespread fear was associated with the sterilization campaign. The people were even deterred from utilizing other social services such as the World Food Programmer's nutrition centers (Cassen, 1978). In part, convinced by the abundant reports of forced male sterilization, Indira realized that the positive aspects of the Emergency were waning and that it would be politically beneficial to fully restore democracy; and in 1977 she called for General Elections. With democracy fully restored the press was uncensored, making government actions more transparent, and the Opposition leaders was released from prison. (Khadija Turay, 2006)

In theory, Indira could have won the 1977 elections because the opposition believed that it was too late to effectively organize (Malhotra, 1989) and Indira had in fact legitimized the Emergency by changing the Constitution. In reality, negative sentiment attached to the conditions created by the Emergency and the poor responsiveness of authorities to rights violations accompanying the Population Policy significantly decreased her chances of victory.

Indira Gandhi wanted to legitimize her political standing and regain the credentials of a democratic leader (Malhotra, 1989) and the most legitimate way to do

this were through an electoral process. Indira won in 1971 and 1972 by transcending regional and caste lines with a platform based on economic issues. However, in 1977 people desired social change and accountability, and the election became a referendum on the Emergency (Malhotra, 1989).

According to Klieman, the Indian voters were disenchanted with Indira's leadership because it did not protect social freedoms awarded by democracy and the human rights that complement them. She lost the election and results reflected disapproval of methods used to implement the sterilization drive and Population Policy rather than the Emergency's suspension of democracy (Klieman, 1981).

According to Malhotra the Indian voting patterns stated that the states near Delhi suffered most from repercussions of the way the Policy was implemented (Malhotra, 1989). People in northern India concluded that the implementation of the sterilization drive under the Population Policy was a violation of their independence as men and self-worth (Ibid, 1989).

It is very clear to be believed that India's 1977 elections were the first in the world in which fertility behavior was a deciding factor (Cassen, 1978). The leadership that succeeded Indira immediately transitioned the National Population Policy to one of family planning with a focus on voluntary participation and protecting health (Bhagat, 2002); thus causing programs to have more implications for women's reproductive rights than men's as seen with the sterilization drive. India has revised its National Population Policy several times since 1976, each time with a stronger focus on family planning and health rather than population control.

In the 1980s, Prime Minister Rajiv Gandhi had initiated an effort to revise the strategy of the family welfare programme, but little came of it. In 1992, the Karunakaran Committee, set up by the National Development Council (NDC) partly in response to the 1991 Census results, recommended the formulation of a National Population Policy. A draft prepared by an expert group under the chairmanship of M.S. Swaminathan in 1994 was circulated widely and its successive variants were considered by the cabinets of three different coalition governments. The drafts underwent several revisions until finally the NPP 2000 was announced by the present government in February after its approval by the Cabinet. The policy is now expected to be discussed in Parliament so that a broad political consensus can be evolved on the subject. (Pravin Visaria, 2006).

After the International Conference on Population and Development in Cairo, a global political intervention, the culture of India's population politics has begun to reflect a shift towards maternal and child health, resulting in efforts like the Reproductive and Child Health (RCH) Program, which was launched in 1997 and promotes essential and emergency obstetric care as well as improved immunization efforts. (Khadija Turay, 2006)

However, some claim that programs like RCH are still only for population control rather than to promote improvements in health because of their focus on clinical rather than social reproductive health services. Nevertheless, there is a clear need for such policy sponsored programs because currently approximately 1.2 million babies die within their first month of life in India (Mudur, 2003). Derivatives of RCH I and II such as the National Rural Child Health Mission serve to legitimize the nation's commitment to upholding rights and standards of living conducive to

improving public health. Such programs are also creating sustainable policy and practice solutions to improve health and acknowledge the human rights mothers and children have regarding special care and assistance (Khadija Turay, 2006)

According to Bhagat, the most recent National Population Policy does not abandon concerns about uncontrolled population growth, and aims for a Total Fertility Rate of approximately two live births per woman by the year 2010 (Bhagat, 2002). India's current economic situation and culturally diverse and extraordinarily large population make it a paragon for examining relationships between human rights, political intervention in fertility behavior, and health.

Although efforts have been made on a policy level to protect reproductive rights via protecting health, traditional beliefs and values still pose a barrier to fully realizing human rights for women and in turn optimal health for children in India. Customs such as son-preference remain prevalent and are believed to contribute to a lessened quality of health care and thus increased mortality risk for female babies (Clark, 2000). Therefore, it appears that today, at national and state levels, India is faced with reconciling public health needs and policies with rights such as freedom of belief, religion, and thought, in addition to reproductive rights; especially with recent technological advances.

India has illustrated that political intervention in family planning and fertility behavior can be brought into harmony with human rights if certain conditions are in place. In India, this would include: 1) a fully functioning democracy, because the Emergency illustrated that political intervention in fertility behavior cannot be successfully pursued when legislative and executive frameworks are impaired, and 2)

that political intervention and the methods by which it is implemented be focused on family planning and health rather than population control. (Khadija Turay, 2006)

The Government of India during the Ninth Five Year Plan gave a top priority to population stabilization for sustaining the process of economic development in the country. This has also been the focus of successive Five Year Plans. Thus ninth five-year plan had decided to bring reduction in the population growth rate. This plan has made all efforts to develop, improve and strengthen the contraceptive care and also emphasized on reducing infant and maternal morbidity and mortality so that there is a reduction in the desired levels of fertility. (Ninth five year plan, Government of India, Planning commission, 1997-2002, 300-5).

The Government of India wanted to improve access to family planning services and to reduce the number of unwanted pregnancies. This plan period has also focused on measures for providing essential obstetric care, undertake initiatives to promote institutional deliveries and also put different efforts to promote safe home deliveries in poorly performing States.

The Government of India has made some special arrangements to prevent, detect and manage Sexually Transmitted Infections/ Reproductive Tract Infections in women which have become an essential element for Reproductive and Child Health (RCH) programmes at all levels of health care. Pulse Polio Programme was launched in 1995, in addition to the routine immunization for polio under Universal Immunization Programmed so as to achieve zero polio incidences by 2000.

The Department of Family Welfare has drawn up the National Population Policy (NPP) 2000 with a view to provide reliable and relevant policy framework for improving family welfare services. One of the major objectives of the Policy is the

achievement of replacement level of fertility by 2010 and of population stabilization by 2045. Another important goal of the plan was universalisation of primary education and reduction in dropout rates at primary and secondary levels to below 20 per cent for both boys and girls. (Bhende and Kanitkar, 2000).

The Department of family welfare has adopted a number of promotional and motivational measures for achieving the goals of this policy e.g. Community Incentive Scheme under which Panchayats and Zila Parishads are to be rewarded for exemplary performance, the Balika Samridhi Yojana of Department of Women and Child Development is being continued, a Family Welfare- linked Health Insurance Plan is being undertaken, the National Maternity Benefit Scheme is now being implemented through the Department of Family Welfare, crèches and child care centers to be opened in rural areas and urban slums, facilities for safe abortions be strengthened, strict enforcement of Child Marriage Restraint Act 1976 and of the Pre-Natal Diagnostic Techniques Act 1994 etc. (Local self-governments)

The National Commission has been constituted with the Chief Ministers of all states and UTs, and the Central Ministers in charge of concerned Ministries/Departments, reputed demographers, public health professionals and NGOs as members. The Commission will oversee and monitor implementation of the NPP and to facilitate the attainment of the goals set out under NPP 2000

An Empowered Action Group (EAG) has been constituted in the Ministry of Health and Family Welfare for preparation of area specific programmes with special emphasis on states that have been lagging behind in containing population growth to manageable limits. A detailed database for these EAG states i.e. MP, UP, Bihar, Rajasthan, Orissa, Chattisgarh, Uttaranchal and Jharkhand has been compiled by the

Department so as to help guide and direct the States for better plan formulation and monitoring.

A Core Group on Behavioral Change Strategies for the EAG (empowered action group) states has also been constituted in October 2001 to develop state specific strategies focusing on community service providers and opinion leaders, to develop appropriate structures, capabilities and systems in these states to plan, develop and manage strategies for behavior change for family welfare, etc. As a follow up to the deliberations of the National Commission on Population, the Prime Minister has announced the creation of a Population Stabilization Fund with an initial contribution of Rs.100 cores." (Ninth Five-Year Plan, Government of India, Planning Commission, 1997-2002, 300-5).

In 1996-97, the Department of Family Welfare requested the states to undertake a PHC based need assessment and attempt to meet the felt needs of contraception. A comparison of performance for the period before and after abolition of method specific targets indicates a reduction at the national level in the acceptance of sterilization, IUD and conventional contraceptives, in contrast to acceptors of oral contraceptives that have shown an increase.

The Eighth Five Year Plan target of 100 per cent immunization coverage for all the six Vaccine Preventable Diseases (VPD) has not been achieved even by 2000. The immunization coverage has been stagnating at roughly the same level throughout the nineties in most States with some States even reporting a declining trend. (Planning commission, 1997-2002).

There has been a substantial decline in the reported cases of VPD over this period. The goal of elimination of polio and neonatal tetanus by 2000 has not been

achieved. A review of the Pulse Polio Immunization (PPI) Programme in 1998 and 1999 revealed that though the number of reported polio cases had declined significantly since 1995, the reduction was not such that would enable achievement of the target of eradication of polio by 2000 AD in the country. Coverage under routine immunization for polio was about 90 per cent but for some States such as Bihar it was as low as 40 per cent. The States of Uttar Pradesh, Bihar, West Bengal and Delhi accounted for over 80 per cent of the cases of polio reported in the country. Identification of areas of low coverage and near 100 per cent coverage of children for providing OPV both during routine immunization and PPI is critical to achieve and sustain the goal of elimination of this disease. Appropriate storage of the vaccine with adequate cold-chain facility is also important." (Ganguly, 2002; .49-59).

The Tenth Five Year Plan has outlined its efforts in three broad areas. The first one is the meeting the unmet need for contraception. The second one is to reduce the infant mortality. The third one is to reduce the maternal mortality. With regard to addressing the unmet need for contraception, the government of India has focused particularly in areas where fertility declines have been lagging. Issues such as adolescent reproductive health, unintended pregnancy and access to safe abortion are addressed. Counseling, access to and provision of good quality services and follow-up care are emphasized Health and family planning workers are required to regularly visit households in their assigned areas in order to provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and deliver other selected services. "(Planning commission, 2003, 201-301).

However, many states set local goals based on the previous year's centrally assigned targets. Women's involvement in decentralized decision-making has yet to be fully operationalized at the grassroots level. In many states, the involvement of the community and other stakeholders, including Panchayati Raj Institutions, in needs assessments is reported to be minimal. Contraceptives are supplied through the government's network of health care facilities and with the assistance of NGOs. There is also a good social marketing programme of condoms and oral contraceptives."(Planning commission, 2003, 201-300).

3.8. Politics of Incentives and Disincentives for adoption.

The National Population Policy favours voluntary informed choice for contraceptive acceptance. However some states have provisions for incentives and disincentives, notably – Andhra Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh, Orissa and Himachal Pradesh. When disincentives are applied at the level of the health service providers, the health functionaries start applying pressure on the community, and engage in coercion. The quality of family planning services which is not too good to start with becomes worse. This poor quality has tremendous implications in terms of core health concerns like maternal mortality and morbidity. When disincentives are applied to the community, the impact is squarely upon the women. Men persuade or force women to undergo sterilisation operations. The woman also stands to be deserted if she has a third child. If a woman with three children becomes a widow she could have to face the burden of disincentives (no job, no loans etc.) even though she is already extremely vulnerable.

The impact of disincentives is also disproportionately borne by the dalits, OBCs/ STs who are already vulnerable - because they have more children. So instead

of creating opportunities for the vulnerable which is the mandate of the state. (according to the Indian Constitution) a scheme of disincentives ends up doing just the opposite. The impact of incentives is a little more complex to understand. Most incentives that are being provided are linked with undergoing sterilisation after two children. This is similar to promoting a two-child norm, in a less coercive way. The impact of such an incentive could be promoting sex selective abortion, as well as the pressure on the woman to undergo sterilisation operation. At another level when people are economically very vulnerable, incentives become coercion because people cannot afford to refuse the incentive. This point of view has been clearly elaborated by the Supreme Court. It is clear that whichever way one looks at it incentives and disincentives end up being disadvantageous to women.

3.9. Action Plan Incentives and Disincentives

According to the Action Plan, incentives and disincentives could be built for the state governments and communities for encouraging the small family norm. There are some set of incentives and disincentives. These are a consensus may be evolved for linking the central assistance for States/UTs to their performance in controlling the actual birth rate.

Several thousand crores of rupees are made available to the states and Union Territories every year for rural development, poverty alleviation programmes, etc. Considerable portion of this money is released to the rural development agencies directly. Keeping a certain base year, a system of incentives and disincentives was worked out, so that additional money is made available to districts and Panchayats on the basis of their performance toward the control of birth rate. (Ministry of Health and Family Welfare: 2000:6)

The strong son preference in many parts of the country is coming in the way of adoption of small family norm. People, in turn, link this to the requirement of social security as sons are expected to look after their parents in their old age. Innovative schemes, which have been started in Maharashtra and Gujarat of giving long-term financial bonds on the basis of sterilization after the birth of one or two daughters, encouraged widely and the requisite financial support given for them in the Eighth Five-Year Plan. (Ibid: 6).

For putting across the message to the people that there is a political consensus in regard to population control and the nation is serious towards adoption of small family norm, legislation was brought before Parliament indicating that no person, who has more than two children, could hold an elective office from the Panchayat to Parliament in future". (Ibid: 6).

Further, the Fourth Asian and Pacific Population Conference arranged by UN ESCAP was held at Bali during August 19-27, 1992. The Indian delegation comprising three persons, was one of the smallest and India could not play a leading role that it was expected to play. Even the Registrar General and Census Commissioner of India, the major producer of census and other data, were not included in the Indian delegation. As Srinivasan writes: "Keeping in view the above one, planned for containment of population growth through active people's co-operation and any effective scheme of incentives and disincentives" (Srinivasan, K., 1989: 62).

Population growth is both a dependent and an independent variable. In the same way population control policy is also a dependent and an independent variable. The population policy depends upon the given economic culture. An economic

culture and political culture of a developed economy of industrialization, urbanization, individualism, etc., is bound to create an attitude to the size of the family that is unlikely to create the problem of excessive population growth. On the contrary, it may create a problem of slow birth rate and labor shortage. It is in the formation of this economic culture that long-term family planning can be made a continuous and a growing programme.

Historically, birth rate has responded very slowly to even those variables such as modernization, industrialization, urbanization, etc. because there were not population policies followed by the governments in the 18th and 19th centuries. Similarly, in the absence of modernization, industrialization and technological development, the birth rate is going to respond very slowly to government's population control policies in India. But modernization and industrialization are vastly influenced by political structure and the role of active political variables is great in these fields. The process of industrialization has been going slowly. Hence the decline in fertility that accompanies industrialization has also been slow. (Misra, S.K and PurI, P.K., 2000: 67).

Population growth is becoming a threatening political issue apart from its economic and social effects on the programmes of development. The political parties and their leaders in their professed programmes, election manifestos and policy statements seldom include any definite approach to the population problem. They are constantly being subjected almost everyday to the growing demands of a fast growing population.

Political leaders in India have taken up seriously the need for a population policy. There are a number of surveys to show that the political leaders at the local

levels, where politics could have an immediate impact on the size of the family, have been extremely reluctant to impress upon their constituents the need for having small size families

“Though it is a major policy issue, so far no follow up action has been contemplated to translate this policy into reality. Therefore, imaginative strategies must be urgently evolved to translate the policy into action” (Mahadevan, K., 1989: 202). The fault is not merely with the local leaders.

There is also the problem of superannuated leadership sticking around politics and carrying it on with all there past predilections and prejudices. The old leadership neither had a chance to practice nor had a belief in having planned families of limited size. The view of old leadership is differs from young in implementing the family planning programme. “Their credibility with the people could not be very high if these leaders preached restraint on the number of children produced. The new leadership which is comparatively younger has no urgency to look upon population control as an important policy”. (Ibid; 207).

Recently, another political prejudice has developed against population control. It is complained that as a result of the State vigorously pursuing a population control policy it has reaped serious disadvantages. The State is being punished just because it has been successful in following the vigorous population control policy.

These disadvantages accrue in two ways. One, since a large amount of Central Government’s fiscal policies in respect of share of taxes, grants-in-aid and subventions are based on per capita basis, the States with lower birth rates get less. Secondly, the number of seats allotted to a State in Parliament is also related to the number of voters. When the number of voters declines, the number of seats declines

too. This is a clear disadvantage although the change cannot be very large even over a decade. Regarding this the government of India has added many new provisions in the population stabilization bill 1999 and population policy 2000. "For instance, one of them, the population stabilization Bill 1999 and the population control bill 2000, not the idea of a one child norm along with a number of incentive and disincentives, including disqualifications of persons with more than one child from contesting elections" (Mohan Rao; 2005: 23).

There is no reason for any State to feel upset about its long-term share in the political power structure on grounds of population control because of two reasons. There is bound to be impact of one State upon the other and no national programme of family planning can run to different extremes in different States. The population ratio of different States is changed very much these days by considerable migration of people from one State to another "There were also wide fluctuations in the performance of the programme among different states" (Jolly, K.G., 1986: 156).

The payment of incentives to couples undergoing sterilization or getting an intrauterine device (IUD) inserted has been debated at length in India. Eminent persons such as J.R.D. Tata and K.S. Sanjivi were persuaded that the payment of sizeable incentives to prevent births would be in the national interest. Such incentives seemed justifiable on grounds of their cost-benefit ratio relative to alternative investments or public expenditures. Some argued that since these payments go to the poor, there is no reason to dispense with them.

When sterilized persons were asked whether they would have accepted sterilization even if no incentives had been given. Almost 4.5% reported that incentives were not given to them in their area. Of the rest, 89% reported that they

would have undergone sterilization even without any incentive. The validity of responses to a hypothetical question can always be doubted. Yet, the lesson clearly seems to be that incentives probably influence only about 10% of the acceptors or users of contraception. (Pravin Visaria, 2006).

The money spent on incentives can be used to improve the 'quality of services', although the concept of quality is sometimes criticized as elitist and conditioned by the previous experiences of the population. The incentives given to the acceptors of sterilizations and IUDs (intrauterine devices) led to widespread petty corruption and adversely affected the fundamental orientation of the entire programme, and absolved the service providers of their responsibility to ensure a high quality of service. The Expert Group had, therefore, proposed a discontinuation of incentives in cash or kind given by the central and state governments for the acceptors of contraceptives as well as to motivators and service providers.

The NPP 2000 refers to five schemes that involve incentive payments. For individuals, these include: (1) The Balika Samridhi Yojana run by the Department of Women and Child Development to promote survival and care of the girl child, with a cash incentive of Rs 500 given at the time of birth of a girl child of birth order 1 or 2. (2) The Maternal Benefit Scheme run by the Department of Rural Development awards an incentive of Rs 500 for the birth of the first child after 19 years of age and is limited to the first and second births only. The cash award is now to be linked to 'antenatal check up, institutional delivery by a trained birth attendant, registration of birth and BCG immunization.' (Pravin Visaria, 2006).

(3) A Family Welfare-linked Health Insurance Plan is to be established to offer health insurance (for hospitalization, not exceeding Rs5000) to couples (and their children) below the poverty line, if the couple undergoes sterilization with no more than two living children. The spouse undergoing sterilization would also get a personal accident insurance cover. (4) Couples below the poverty lines, which marries after the legal age at marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, are to be rewarded.

A fifth scheme provides for group incentives that will reward panchayats and *zila* (district) parishads for 'exemplary performance in universalizing the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.' While it would be a mistake to judge these schemes from the point of view of small sums of money they provide for, the real costs of proving one's eligibility and actually receiving the awards far exceed what is recognized in our metropolitan centers. The proof of age and of the fulfillment of prescribed conditions is difficult to obtain in most areas.

Also, the group incentives can generate misreporting of the level of fertility as well as mortality and it would be a mistake to award them until a system of complete registration of births and deaths, marriages and pregnancies is actually established. Overall, it is difficult to believe that the incentive schemes will make any material difference to the promotion of fertility decline. (Pravin Visaria, 2006).

The question of disincentives for a large family has often been discussed. Neither couples with large families nor localities that have a high birth rate or a high

level of fertility can be penalized, because more often than not, on grounds of equity, they need greater support to ensure the welfare of the future citizens of the country. It is argued, however, that they have a symbolic role in communicating to the people in the social or national interest.

During the past few years, Haryana and Rajasthan have passed laws that prospectively debar persons who do not adopt the two-child norm from contesting elections for panchayats, zila parishads and nagarpalikas. In Rajasthan, the High Courts have upheld the rationale of the laws. The population policy document of Rajasthan proposes to consider an extension of the law making candidates with two or more children ineligible to contest elections to 'other elected bodies like cooperative institutions.' It may also be made a 'service condition' for state government employees.

The Population Policy of Madhya Pradesh also states that, 'Persons having more than two children after 26 January 2001 would not be eligible for contesting elections for panchayats, local bodies, mandis or cooperatives in the state. In case they get elected, and in the meantime they have the third child, they would be disqualified for that post.'

The policy in Rajasthan proposes 'legal registration of marriage,' compulsory observance of minimum age of marriage for availing of 'government facilities and services' and 'stiffer penal provisions for violation of the legal age of marriage.' Madhya Pradesh also lays down that, 'From 26 January 2001, persons marrying before legal age at marriage will not be eligible to seek government employment.'

The linking of family size to the right to contest elections is presumed to demonstrate a degree of political commitment that is considered essential in a country

likely to become the most populous nation on earth within the next 50 years. The argument that it would adversely affect the interests of women or the disadvantaged sections of society does not seem convincing, particularly in a setting where people themselves have realized the need to regulate family size. However, feminists have been vociferous in their opposition to this bill and it is unlikely to be passed. (Pravin Visaria, 2006).

3.10 International Conferences and Politics of Population Control

The UN has held a series of conferences which have had an important bearing on the evolution of ideas of family planning programme. The first one, which was not strictly on the issue was the International Human Rights Conference held in Teheran in 1968, which introduced the concept of the rights into the realm of contraception and family planning. The first conference devoted exclusively to the issue of population was the World Population Conference in Bucharest in 1974. In this conference the dominant view was that development of the best contraceptive and importance was given to socio-economic development as a major force in reducing population growth. The next population conference was held ten years later in Mexico City. By this time, women's health activists managed to include some women's issues within the World Population Plan of Action – emphasising linkages between high fertility and lack of education, health care and employment opportunities for women and their low status. But this document also stated that government should make family planning measures widely available, shifting the focus to family planning programmes.

The International Conference on Population and Development held in Cairo in September 1994. Delegations from 179 nations took part in the negotiations which

finally led to the adoption of the Programme of Action (PoA) on population and development for the next 20 years. This document endorsed a new strategy which emphasised the linkages between population and development and focused on meeting the needs of individual women and men rather than on achieving demographic targets. Empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment were key features of this new approach.

The ICPD PoA stressed the importance of reproductive rights and reproductive health for men and women and emphasized the need for equity in gender relations, responsible sexual behaviour, and the need to enhance access to appropriate information and services. Special efforts were also made to emphasize men's shared responsibility and active involvement in responsible parenthood, sexual and reproductive behavior. The PoA also highlighted the nature of state action and International support that would be necessary for it to succeed. The period between 1984 and 1994, when the ICPD was held, was a period of great challenges to the traditional thinking on population. Women's health activists all over the globe drew attention to the effect of these programmes on women's health and their presence in large numbers in Cairo ensured that the Cairo Programme of Action reflected many of their concerns. The change in thinking that the Cairo process had brought about is being hailed as a 'paradigm shift'-- the shift from population control to individual well-being which has been outlined earlier.

These International conferences have played a major role in many countries' to formulate population policies. While the discussions and debates in these conferences reflect those which are going on in official circles within different

countries, the parallel NGO meetings are increasingly providing spaces to activists to react and interact with official delegates and get their concerns heard. Once the official document/recommendations get ratified, individual countries are expected to change their own policies in line with the principles of this agreement. In case of the ICPD, the document is known as the Programme of Action (PoA) and it is to form the guidelines for countries for the next twenty years. Some of the major goals from the ICPD PoA are as follows:

- By 2015, the PoA advocates for a universally available Family Planning programme for everyone in the world.
- By 2005, all countries should attain life expectancy at birth greater than 70 and by 2015 all countries should attain life expectancy at birth greater than 75.
- By 2015, all countries should achieve infant mortality rate below 35 per 1000 live births.

These conferences too have made important recommendations about the family planning programme. There is a lot of impact on the Indian policy makers.

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CHAPTER 4

PEOPLE'S PERCEPTION ON FAMILY PLANNING PROGRAMME IN A.P.: A CASE STUDY OF KATTEVARAM AND DANTHALUR VILLAGES OF TENALI MANDAL IN GUNTUR DISTRICT

This chapter deals with the people's perception about population control programmes initiated by the Government of India, and this advantages and disadvantages. Peoples' views about the family planning programme and changes in the programme during the recent past are also presented. In this process, the levels of awareness, knowledge and adoption of the family planning methods, perceptions of the momentary and material incentives of male and female respondents.

The major objective is to examine the people's perception on incentives, disincentives, awareness, attitude and knowledge of family planning methods, where there is no graded incentive schemes. People's attitudes towards schemes such as incentives and disincentives, situational exigencies, politicians, religious leaders, etc. are in a fluck but it is to understand whether people hold any emotion changed opinion regarding such changes.

4.1 Location of the Study:

The study was conducted in Kattevaram and Danthalur villages in Tenali Mandal, having population as mentioned in Table 4.1

Table 4.1

S.No	Name of the village	Total Population
1	Kattevaram	6500
2	Danthalur	6000

2 Method for the Selection of Respondents and Use of sample size method:

The following steps/criteria were adopted for the selection of the respondents from both the villages. All the wards of the selected villages were divided into the following three categories.

1. Wards with a **population less than 150**, (Consists of high class, high salaried, rich people and highly educated).
2. Wards with a population **between 500 to 2500**, (consists of middle class, middle class salaries people)
3. Wards with a **population from 2500 to and above**. (Poor, lower salaried, uneducated, low class people).

In both Kattavaram and Danthalur villages, two wards from each of the above three groups of population were selected at random. Within each of the selected wards two to three blocks were chosen at random. All the households of the selected blocks in each ward were enumerated, and the names of the head of the households, together with their detailed addresses were collected.

All the selected households were contacted for

1. **Basic information about family planning programmes.**
2. **Awareness, attitude and knowledge of the programme**
3. **Impact of the government policies.**
4. **About the incentives and disincentives of the programme.**

From each of the selected block of the villages 20 **eligible couples** were selected and interviewed and **25 eligible couples** were taken as an extra sample as

1. **The selected households were found to be locked.**
2. **The households were inaccessible**
3. **No eligible couple in the household, ..and**
4. **And Refusals.**

Finally, **114 calls in Kattavaram and 118 calls in Danthalur** i.e. a total of **232 interviews were conducted** against a target of **240 calls**. The details of the targeted

sample size, calls attempted, calls achieved and the details of the respondents are presented in Table 4.2.

Table 4.2 Targeted sample size, number of calls attempted, calls achieved

Selected Area	Place of Residence	Target sample	Calls Attempted	Calls received	Age of respondents	
					Male	Female
Kattevarm	Ward type (1)	40	44	40	28-48	25-40
	Ward type -2	40	42	38	25-45	20-35
	Ward type-3	40	46	36	21-35	15-35
	Sub-Total	120	132	114	--	--
Danthalur	Ward Type-1	40	42	40	28-48	25-40
	Ward type-2	40	48	40	25-45	20-35
	Ward type-3	40	54	38	21-35	15-35
	Sub-Total	120	144	118	--	--
	Grand Total	240	276	232	--	--

4.3 Population Explosion as a Problem for the Country's Development

To ascertain whether people perceived population explosion as a national problem, a list of ten problems including population growth was read, one by one, to each of the respondents. Respondents were asked to select two problems which they considered the most serious problems. Their answers are presented in Table 4.3. The data indicates that 90 households out of 120 in Kattevaram and 88 out of 120 in Danthalur perceived population growth as a serious impediment for the country's

development. Another 104 households in Kattevaram and 98 households in Danthalur perceived that the price rise is the most serious problem. In other words, a majority of the respondents considered population growth either as the first or the second most serious problem to the country's development.

Table 4.3 Perceived most serious problems for the country's development

Problem	Kattevaram				Danthalur			
	Ward 1 (40)	Ward 2 (40)	Ward 3 (40)	Total (120)	Ward 1 (40)	Ward 2 (40)	Ward 3 (40)	Total (120)
Population growth	40	35	36	106	40	38	30	108
Poverty	18	34	36	88	22	32	38	92
Price rise	24	37	37	98	24	38	36	98
Illiteracy	20	24	12	56	19	11	10	40
Unemployment	22	34	6	62	32	30	4	66
Castism	No answer	14	18	32	--	12	16	28
Corruption	24	28	4	56	22	30	6	58
Violence	8	16	20	44	10	12	26	48
Political instability	16	26	No answer	42	14	24	--	38
Dowry	--	30	--	30	--	4	28	32

4.4 How did people understand the term Family Planning?

To find out people's understanding of Family Planning each of the respondents was asked to answer a number of questions. For instance, "tell me what do you mean by

family planning?" A content analysis of the answers is prepared in table 4.4. It can be observed that the respondents had no clear answer. For instance in Kattavaram only 32 households' respondents perceived vaguely that "small family is a happy family". A significant number of respondents both in Kattavaram and Danthalur villages perceived the utility of family planning methods should not reduce the growth of population but favoured eligible couples undergoing operation.

Table 4.4 Family planning as perceived by the respondents

Questions on family planning/ Perception of Family Planning	Kattevaram				Danthalur			
	Ward 1	Ward 2	Ward 3	Total	Ward 1	Ward 2	Ward 3	Total
Small family is a happy family	18	10	4	32	20	12	8	40
To get operated	10	30	38	78	12	32	36	80
To have small family	22	14	8	44	20	12	6	38
Welfare of family	28	18	8	54	24	16	8	48
Having 2 or 3 children	20	14	--	34	20	12	--	32
To reduce population growth	16	18	--	34	16	18	--	34
Distribution of Family planning methods / loop, insertion, nirodh etc.	26	16	--	42	24	14	--	38
Asunder husband from wife	--	10	30	40	--	8	28	36
Protection of mother and child health	24	22	--	46	24	20	--	44

The analysis of the responses reveals that respondents are unaware of the objectives of the family planning programme. The philosophy behind the programme-

prevention of unwanted pregnancies, limiting the number of children, reducing the growth of population, welfare of family are still not known to many respondents in particular and people in general. The findings indirectly guide politicians and scholars to launch educational campaigns to explain the concept and philosophy of family planning to the masses.

4.5 Perceived advantages and disadvantages of Family Planning:

What are the advantages and disadvantages of family planning?

The success of any welfare programme depends largely on peoples' perception of the programme and the perceived consequences of accepting it. Keeping this in view, each respondent was asked to state the perceived advantages and disadvantages of family planning. Their answers are presented in Table 4.5 and 4.6.

A careful analysis of Table 4.5 indicates the pattern of perceived advantages of family planning in both the villages. For example, a large number of the respondents in both the villages have expressed that there are no advantages of family planning. Similarly two thirds of respondents from the wards of both the villages said "don't know" to this question. A further analysis indicates that the respondents from both the villages perceived no personal benefits or welfare to family embracing in family planning. It is interesting to note that a small percentage of the respondents from both the villages had mentioned no advantages of family planning in terms of societal benefits. The reason for such an attitude or answers is not very clear.

Table 4.5 Perceived advantages of family planning

Advantages	Kattevaram				Danthalur			
	Ward 1	Ward 2	Ward 3	Total	Ward 1	Ward 2	Ward 3	Total
Reduction in Population growth	26	14	8	48	22	12	10	48
Removal of poverty	18	12	--	30	20	10	4	34
Reduction in unemployment	22	28	--	50	22	26	--	48
Less financial burden on family	28	22	--	50	26	22	--	48
It makes family small and happy	30	24	--	34	30	22	--	50
Welfare measure	16	18	--	34	18	18	--	36
No advantage	--	22	38	60	--	20	34	54
Good increasing of children	14	24	--	38	12	24	--	36
Good Education	16	22	--	38	18	22	--	40
Mother and Child health	18	24	--	42	18	22	--	40
Development of country	18	18	--	36	16	18	--	34

Table 4.6 Perceived disadvantages of family planning

Disadvantages	Kattevaram				Danthalur			
	Ward 1	Ward 2	Ward 3	Total	Ward 1	Ward 2	Ward 3	Total
Operation makes people weak	6	22	18	46	8	20	36	44
Operation causes stomach ache / back ache	16	28	38	82	18	34	38	90
Operation causes complication	12	30	38	80	16	30	38	84
Operation and wife becomes pregnant	24	18	--	42	20	22	4	46
No disadvantages	10	18	--	28	10	16	--	26
Family Planning Methods harm full	18	34	38	90	16	32	38	88
Unable to perform family duties	14	24	36	74	16	30	36	82

4.5.1 Perceived disadvantages

It can be observed in Table 4.6 that a large number of respondents from both the villages listed a number of disadvantages in adopting family planning. Very few respondents perceived that there are no disadvantages of family planning. The reasons for such a high percentage of respondents from both the villages perceiving disadvantages in adopting family planning are not clear. However, the excesses committed during the emergency for sterilization and the negligence in post-operative care might have created such perceptions.

The Table indicates that a large number of respondents were confused about family planning activities promoting sterilizations among people. It is significant that there were still respondents from both the villages who said that the government was compelling people to adopt family planning programmes. A few respondents said that the government was conducting operations free of cost, and giving money to the operated people. The figures further reveal that a majority of the respondents were aware of the various activities of the family planning programme. A larger number of respondents did not answer these questions, as they were not aware of the family planning method they adopted. The reasons for such unawareness are not clear.

One of the reasons could be that the respondents failed to identify the programme as government's programme and hence expressed their unawareness. It is also possible that the respondents had expressed their unawareness just to avoid further questioning on family planning. However, a closer look of the data shows that the respondents were not aware of various family planning activities of the government.

4.7 Opinion on whether government shall run Family Planning Programme or not:

Each respondent was asked whether in his/her opinion the government shall run family planning programme or not, and if 'Yes', Why? Their answers are presented in Table 4.8.

In both the villages, most of respondents did not answer the question on government run Family Planning Programme . However, there were a few respondents who said that the programme should not be run by the government.

Table 4.8 Reasons why government should run family planning programme

Reasons	Kattevaram				Danthalur			
	Ward 1	Ward 2	Ward 3	Total	Ward 1	Ward 2	Ward 3	Total
To reduce unemployment	16	20	8	44	14	18	10	42
To reduce population growth	18	14	6	38	20	16	8	44
For welfare of the country	14	10	--	26	16	12	0	24
To make small family is happy family	18	14	8	40	20	16	6	42
Difficulty to rear many children	16	10	10	36	18	12	8	38
Programmes make un aware people aware of family planning	14	12	8	34	16	10	8	34
To lessen financial problems	18	10	--	28	20	10	--	30
To give better education	14	10	--	24	16	10	--	26
Could not give any reason	8	10	10	28	10	12	10	32
Government should return family planning programme	--	--	--	--	--	--	--	--
Did not know many thing about family planning	--	--	6	6	--	--	10	10

The table further indicates that the respondents from both the villages said that they did not see considerable societal benefits like decline in population growth, welfare

of the country and reduction in unemployment by continuing the family planning programme.

4.8 What are the advantages of family planning methods?

The study was conducted to identify the key factors responsible for the acceptance of the family planning methods. The answers are presented in table 4.9. However, before undertaking this exercise it is necessary to first establish the acceptance of the family planning methods. Table 4.9 discloses the number of users of family planning methods in both the villages.

Table 4.9 Users of different Planning Methods

Methods	Kattevaram				Danthalur			
	Ward 1	Ward 2	Ward 3	Total	Ward 1	Ward 2	Ward 3	Total
Tubectomies	10	12	8	30	12	8	6	26
Vasectomy	18	14	--	32	20	16	--	36
Condom	4	10	--	14	6	10	--	16
IUD	4	8	--	12	6	6	--	12
Pills	8	12	--	20	6	10	--	16
MTP	4	4	--	8	4	4	--	8
Rhythm	4	4	--	8	4	4	--	8
Abstinence from sex during heat period	10	8	--	18	12	8	--	38
Never users	--	--	14	14	--	--	18	18
Not responded property	--	--	4	4	--	4	4	8

Table 4.9 shows that the contraception methods popularized by government are adopted by a number of respondents of both the villages. The number of users of these

methods in both the villages very slightly. The data confirms that people are willing to accept the method. However, the respondents from the ward 2 and 3 of both the villages are more interested in adopting tubectomies. Respondents from ward 3 of both the villages did not show interest in vasectomy. Besides this, they are not aware of many family planning methods like I.U.D., Pills, MTP, Rhythm and abstinence from sex during heat period. Most of the respondents replied more positively and also showed keen interest to know about the methods.

Tubectomy was the most popular Family Planning method in both the villages, followed by vasectomy. The couple which did not want to accept sterilization mostly preferred one or the other traditional methods rather than the modern contraceptive.

A few of the respondents have adopted other practices. Some of them hesitated to reveal method they adopted. Some of them had no faith in these practices. These facts perhaps indicate that the family planning methods are either not easily acceptable to the masses or are not easily accessible to them - a fact which calls for an urgent and careful analysis of the reasons why all these methods are not so popular. It should also be examined whether some social or cultural barriers are attached to those methods or whether these methods have been mainly rejected because of fear of physical discomfort in terms of both side effects and sexual dissatisfaction.

There is a need for a more serious thinking on how these family planning methods, which are socially and culturally more acceptable to the masses, may be engaged and integrated in the national family planning programme. Perhaps, family planning methods have played a significant role in reducing the birth rate in various developed countries. All these facts suggest the need for enhancing people's understanding of the family planning methods with a view to avoid wanted / unwanted pregnancies in the country as a whole.

Incentives and Disincentives

During the past six decades, the developing countries have launched national programmes on family planning either with the objective of lowering high birth rates or with the public health and social welfare objective of improving the health of women to prevent unwanted pregnancies. In order to accelerate the acceptance of family planning methods, governments of various countries from time to time have offered incentives or compensations in cash and or kind to accept the various methods of family planning. In some countries, incentives are also offered to motivators, that is those who motivate couples to accept a family planning method, to medical personnel who perform sterilizations, insert IUD's or prescribe oral pills and to paramedicals who assist medical personnel at the time of providing service. In other countries, group or community incentives are also offered. The nature and size of incentive, very from country to country, within a country, from time to time depended on the extent to which a government presented the need for promoting a particular planning method. And also on the extent to which the offer of incentives was considered effective in promoting this method.

Simultaneously, in few countries, schemes of disincentives have also been introduced to motivate couples to restrict the family size. The disincentives sometimes euphemistically called beyond family planning measures are in a sense direct measure, aimed at restricting fertility and have taken different forms in different countries. For example, normal maternity benefits given to employed mothers have been curtailed after the forth pregnancy. Priority in the allotment of sites or have under public housing schemes, have been given to those who adopted sterilization.

Countries like India, from time to time, tried various schemes of incentives and disincentives. In India, for example, incentives in cash and or kind have been offered to the acceptants of family planning method in the past 50 years.

individuals perceive incentives (and disincentives) and how such perceptions structure their motivation and affect their decisions.

Table 4.11 shows the respondents' awareness and knowledge of incentives given by government for family planning acceptors.

The data collected from both the villages are analyzed and presented in table 4.11.

Table 4.11 Respondent's awareness and knowledge Table of incentives given by Government for F.P. accepted

Area	Number of respondents	Awareness of scheme			Awareness of mature of incentives			Knowledge of exact amount of incentives		
		No response	Not aware of any incentive	Aware of incentive	Aware of cash	Aware of other benefits	Both cash benefits	Knowing exact money	Not knowing money	Not clear
KATTEVARAM										
Ward 1	40	4	4	8	6	8	6	--	--	22
Ward 2	36	14	20	--	--	--	--	--	--	30
Ward 3	34	32	34	--	--	--	--	--	--	30
Total	112	50	58	8	--	--	--	--	--	82
DANTHALUR										
Ward 1	40	6	4	8	8	8	6	--	--	20
Ward 2	40	20	22	--	--	--	--	--	--	28
Ward 3	36	32	36	--	--	--	--	--	--	30
Total	106	58	62	8	8	8	6	--	--	78

Table 4.11 reveals that 50 respondents from Kattavaram village and 58 respondents from Danthalur did not respond. Fifty percent of the respondents did not respond positively. Of the 240 respondents from both villages 58 from Kattavaram and 62 from Danthalur were not aware of the programme. Only 16 respondents were not aware of the incentive scheme. Only those from ward one from both villages are aware of incentives. Respondents from Ward Nos. 2,3 of both the villages did not give answers, indicating the lack of awareness. The fact appears to be that people do not know clearly of the incentive schemes.

The attitudes of the respondents towards cash incentives and their opinions on specific amounts offered by the government are analyzed in the same table 4.11. It is interesting and informative to note that more than 70% of the respondents did not approve the incentive schemes offered/proposed by the government. About 10 percent of the respondents i.e. from the ward of the both villages have expressed their approval. A majority said that the incentive money was inadequate taking into account and the people's socio-economic background. The data reveals that the incentive scheme given to the respondents of both the villages favour increase in the quantum of incentives.

What kinds of incentives preferred by the respondents?

Table 4.12 gives data pertaining to the types of incentives preferred by respondents.

Table 4.12 presents data on the nature of the incentives that would promote the family planning. About 70 percent respondents suggested provision of cash or piece of loans as incentive to promote family planning. Those who preferred a house or house site, as incentives are marginally higher than the others. However, after probing specific suggestions, a meagre proportion did not respond or disapproved the scheme in both the villages. On the other hand, 34 respondents from Kattavaram and 34 respondents from

Danthalur indicated free loan as a possible incentive scheme to promote downsizing the family. The data indicate that the incentive scheme to promote family planning methods. Majority respondents have shown interest in long-term incentives or permanent benefits. It is interesting to note that incentive scheme was made for all people irrespective of their backgrounds. This data reveals that the motive of incentive scheme should be permanent.

Table 4.12 Type of Incentives preferred by Respondents

Type of Incentives	Kattevaram				Danthalur			
	Ward 1	Ward 2	Ward 3	Total	Ward 1	Ward 2	Ward 3	Total
Cash	10	20	34	64	12	22	36	70
Land	30	24	34	88	28	22	34	84
House/ Site	34	26	34	94	32	30	32	94
Good follow up service	30	30	--	60	30	28	--	58
Free Medical Service	32	34	--	66	34	34	--	68
Old age pension	24	22	--	46	22	26	--	48
Free Education	28	30	--	58	26	32	--	58
Free Loan as a possible Incentive	4	9	21	34	4	10	20	34
No response	10	--	--	10	8	--	--	8

Table 4.13 shows respondents awareness and attitude to sterilization and also opinion on sufficiency of cash incentives to the acceptors of family planning methods.

Area	Total no. Of Respondents	Approval of cash incentives			Opinion on sufficiency of cash incentives			
		Approve	Disapprove	No opinion response	More than enough	Enough	Less than enough	No opinion response
KATTEVARAM								
Ward 1	40	6	22	8	--	--	30	6
Ward 2	40	--	28	12	--	--	28	4
Ward 3	40	--	30	6	--	--	32	6
DANTHALUR								
Ward 1	40	8	20	10	--	--	28	4
Ward 2	40	--	30	4	--	--	34	4
Ward 3	40	--	28	8	--	--	32	4

Majority of the respondents revealed that they disapprove the incentive schemes and but incentives offered by the government are not enough. It is interesting to note that the knowledge of incentive schemes is higher among the respondent of the ward 1 in both villages. But in ward 2 and ward 3, respondents of the both villages had no knowledge about the incentive schemes and also expressed no opinion. This data suggests that the incentive scheme has not been popularized between the ward 2 and ward 3 of the both villages. For questions on the sufficiency of cash incentives to acceptance of family planning, most of them have expressed that the incentive amount should be increased. It is found that the respondents of the ward in both villages have a marginally higher

awareness of the incentive scheme than the respondents of the other wards. The disapproval of the incentive scheme is significantly higher among the respondents of the ward 2 and ward 3 of the both villages. This table reveals lack of awareness among the respondents on the incentive schemes. Also there are wide differences in awareness, knowledge and incentive schemes among respondents. The extent of awareness and favorableness' of affidavit to the incentives schemes appear to be lower or nil among the respondents of the ward 2 and ward 3 of the both villages.

Incentives for family planning acceptors and disincentives for non-acceptors have resulted in an explosion of controversies, some arguing in defense of them and other against. But these controversies are based largely on personal perceptions of individual analysts rather than on people's perceptions. In this paper an analysis of the perceptions of 240 households from selected villages Kattevaram and Danthalur in Tenali Mandal, regarding family planning incentives and disincentives has been presented. More than 75 per cent of the respondents from both the villages were not aware of the incentives for family planning acceptors. The respondents of the ward one of the both villages were aware of such incentives in cash. It is interesting to note that very few of the respondents were aware of both incentives in general and cash incentives.

More than 80 per cent respondents from both the villages wanted to have permanent incentives like house / house site / job for family planning acceptors. About 75 per cent of respondents from both the villages felt that incentives given were insufficient and wanted an increase in the quantum of incentives.

expected that these findings will be useful in promoting family planning in areas with similar socio-economic and cultural backgrounds, where the progress has not been satisfactory. The use pattern of family planning methods indicates that although the acceptance of contraceptive in the two wards of the villages did not differ much, there is difference between ward 1 and ward 2 and 3 of the villages.

The study reveals that there were significantly less disparities in respect of knowledge, attitude and awareness of the family planning methods and its incentive schemes among respondents in two villages. Even in demographic characteristics, the population of the two villages did not differ significantly. Also, the family size norms in the two villages did not indicate any significant difference. In both the villages, respondents wanted to have one incentive for family planning acceptors. There is a strong preference for the son in both the villages. Half of the respondents have expressed a desire for additional children and pointed out that family planning work was poor in both the villages. More than half of respondents have reported that family planning workers visited them. However, the work carried out by family planning workers to promote family planning seems to be an under estimated. This study finds that the efforts of the government very valuable but failed to contribute significantly to the promotion of family planning in the two villages. On the other side, in both the villages, the utilization of government health services was less extensive, follow-up services were not so well organized and there was a wide gap in the accessibility and utilization of health position between the respondents of ward 1 and ward 2 and ward 3 of both the villages. The living conditions are far from satisfactory. On most matters, they did not show keen interest on incentive schemes offered by the government.

In both the villages, especially respondents from ward 2 and ward 3 did not get more than one hour leisure time during the whole day. Even during this period, they were engaged in work which had considerable value for the welfare of the family. For example, during their leisure time they were busy making things, mostly for their family, childcare and teaching. Integrating all these bits of information can be pointed out that

they spend little time to know family planning methods. There is no equitable distribution of the benefits on the bases of socio-economic background. Through out the study, it is observed that there is no accessibility to essential services and modern amenities. The study shows that the health and family welfare programmes are not properly organized. As mentioned earlier accessibility to utilization of, health and family welfare services are not encouraging.

Knowledge and awareness of vasectomy was popular only in ward in 1 both the villages. Respondents from both the villages i.e. of ward 2 and ward 3 said that they never heard of vasectomy as a good family planning method for males. But majority of the respondents said that they heard of vasectomy as one of the birth control techniques. Almost 75 per cent respondents are not aware of vasectomy. A few of them had specific knowledge of vasectomy as a surgical operation and did not know how vasectomy was performed and what changes take place in the male in order to prevent women from getting pregnant. This table shows that majority of the respondents had no specific knowledge of vasectomy. The respondents of both the villages were asked why did they not have knowledge of vasectomy? Their answer was no family planning worker visited them.

A comparatively higher percentage of respondents had awareness and some knowledge of tubectomies. More than half of the ward 2 and ward 3 respondents are aware of the tubectomies. Some of them know how tubectomies were performed. In spite of awareness and knowledge of tubectomies among the respondents, actual adoption of tubectomies was negligible among the ward 3 of both villages. There is no clarity on reasons are not so clear for the lower rates of adoption of tubectomies. Indeed momentary and material incentives for family planning acceptors are now an accepted phenomenon. The incentives offered by government for acceptors of family welfare method are not crucial to decide to undergo family planning methods. In general, it may be pointed that monetary incentives prove hostile in making quick adoption of sterilization. But, the study reveals, majority of the respondents have not been attracted by family planning acceptors.

This study highlights that there were hardly any satisfied adopters of family planning. Most of these respondents may have undergone operations and were willing to speak on the role of government. More than half of respondents of both the villages informed that they did not receive enough medical attention after the operation. A considerably higher percentage of respondents from both the villages said that they did not receive adequate postoperative care. It was rather surprising and discouraging to note a majority of respondents have expressed their dissatisfaction with the type of follow up care they had required. At present, both the villages have no government doctor to look after the physical and psychological well being of the respondents. When asked about their past operative health condition, almost 75 per cent reported no change in their general health before and after the operation. But 65 per cent of the respondents said that their general health condition had deteriorated after the family planning operations. Very few reported improvement in their health after the operation. When respondents were asked, whether they would undergo family planning operations or recommend your partner or friend or sister or neighbor? Majority of the respondents did not respond positively.

There were number of reasons for not adopting family planning methods. More than 75 per cent respondents said that they wanted to have children, especially male babies. Very few of the respondents said that they wanted to have additional girl child. More respondents from both the villages were planning to have more children than the respondents from ward 2 and 3 of the both villages. More than 65 per cent of respondents from both the villages said that they had heard rumors about the after effects of sterilization operations. As a result they said they did not plan to adopt sterilization as a method of family planning. Very few respondents from both the villages said that they planned to adopt sterilization in future. Current practice of other contraceptives was another reason. Table 4.15 gives information on why people are not adopting sterilization operations.

compensation for time lost from work during the sterilization operation is adequate. When asked whether incentives were given for adoption for sterilization were a kind of donation from the government, almost 50 per cent of respondents from both the villages disagreed with the statement. A small percentage of respondents from both the villages agreed with the statement that incentives were a way a buying the poor. A considerably large percentage of respondents from both the villages questioned whether giving monetary incentives were a way of facilitating the decision to undergo sterilization operation or not. Almost 70 per cent of the respondents have not agreed with the question and 30 per cent of the respondents did not respond.

However, a large percentage of respondents from both the villages have expressed their preference for cash incentives for adopters of sterilization. But the employees from government and private sectors favoured at least one week's wages as their incentives for adoption of sterilization operation. Whereas non-employed and agriculture coolies have not been protected by any incentive schemes of the government. Majority of the respondents have expressed that adopter of sterilization operations, should be given compensation, which could be cashed when they are in old age. Very few respondents said they were given materials like clothes and radios etc. Some of the respondents indicated their preference for food for their children as an incentive from ward 2 and ward 3 of both the villages. 45 per cent of the respondents said that food be made available for children of the accepted of sterilization operations. Some respondents from both the villages have agreed that the people with large families could not access free education of children, medical facilities and old age schemes. A majority of respondents were in favor of incentives and old age schemes. Awareness to vasectomy was almost nil among the respondents from ward 2 and ward 3 of both the villages. Respondents from both the villages had no specific knowledge of vasectomy for family limitation. Adoption of vasectomy was nil in 2nd and 3rd wards of both the villages. Adoption of vasectomy was found only in wards No. 1 in both the villages. Almost two thirds of respondents said that the government had not conducted any type of special family planning camps. A very large percentage of respondents said that they did not receive adequate incentives. Some respondents said that their general health condition had

deteriorated as a result of sterilization operation, fifteen percent of respondents expressed a feeling of inadequacy as a result of sterilization operation. Majority of the respondents have expressed dissatisfaction with the operations and also attributed inadequate pre and post operative care on the part of the motivators as well as the doctors regarding the operation. As regards incentives, it was observed that a large majority of the respondents favored cash payments for undergoing sterilization. A study of socio-economic characters indicated that the social, economic and living conditions of the respondents here positively and significantly related to higher adoption of sterilization operations. Respondent's level of exposure of family planning communications media and their attitude toward a small family norm did not have any significant relationship with adoption of sterilization operations.

The Government of India introduced various schemes under which incentives are being given to those who accept family planning. The systems of cash prizes has induced some people to go in for sterilization. Family Planning is completely voluntary in this country, coercive method, have been generally avoided. There is widespread resentment among the respondents and this was a setback to voluntary family planning under the existing situation. Small cash incentives failed to motivate people for the family planning. More ever, most of the respondents did not agree with the provision that those who reject family planning may be denied certain facilities.

The field study was carried out to investigate socio-economic cultural conditions of the people and also to study knowledge on incentives, attitude and practices regarding family planning. Acceptors of family planning methods were slightly more in wards 2 and 3 in both villages. The increase in the number of acceptors in the ward 1 is not better than the other respondents from the villages. Despite large number of camps for public, there was no sharp improvement in the number of sterilization cases. The relationship between sterilization and use of conventional contraceptive also attract attention of the people. The variations in percentage of acceptors for sterilization and conventional contraceptive users complement each other. There is a slight increase in the number of

sterilizations leading to a corresponding decrease in the acceptance of conventional contraceptives. The fall in the use of conventional contraceptives could be because sterilization being a terminal method does not require use of any other method after.

Most of the respondents from both the villages have expressed that the acceptance of family planning methods is the result of policy or government intervention. Family planning was included in the highest national priorities and also new incentive schemes like immunization and prophylaxis against nutritional anemia were launched, about which people are not aware. The population policy of 1976 also offered a large number of incentives and disincentives to people to encourage them to adopt family planning. The study finds that the offered incentives are not adequate to adopt family planning methods. Some policies and measures, framed by government were not appreciated by the respondents. But half of the respondents have no proper education.

The study shows the lowest percentage of acceptance of family planning by the respondents. There are a number of reasons like lack of enough incentives, desire for son, lack of economic development, lack of education, shortage of lady doctors, lack of staff mobility and reluctance of acceptors and other complications such as bleeding, pain and other minor ailments.

CHAPTER 5

PROBLEMS OF POPULATION CONTROL PROGRAMME IN INDIA

This chapter examines some of the persisting problems of policy and politics of population control programme in India. Included are the problems like negative thought and apathy of the leaders, coercive elements particularly during the emergency period, failures of the committees appointed for implementation of family planning programmes etc.

5.1 Negative thought of the Indian Leaders

During the time of Nehru, a number of intellectuals, administrators and industrialists came together to frame population policies. Though family planning was a taboo-topic then Nehru started Family Planning Programme in the world as early as in 1952. J.R.D. Tata, Durgabai Deshmukh, Lady Dhanvanti Rama Rao, R.A. Goplaswamy and other members of several sub-committees influenced Nehru on the issue. But a conservative Health Minister, Rajkumari Amrit Kaur, delayed adoption of sterilization as a method of family planning. She favoured natural methods, like abstinence, safe period, as she was perhaps influenced by Gandhiji. Family planning could not be promoted. In this regard the late Raghunath Dhando Karve was forced to give up his official position for advocating family planning” (Mahadevan, 1989: 187).

5.2 Coercion of Family Planning Programme During the of Period Indira Gandhi

Indira Gandhi's era was the golden period for promotion of population policies and programmes in India barring some setbacks due to the excesses committed during the emergency. She appointed S.Chandrasekhar, a demographer, as

a Minister of State in her Cabinet. It was during her tenure that the most comprehensive population policy was adopted in 1976.

“Mrs. Indira Gandhi was more comprehensive in her approach to the control of population” (Ibid; 195). She gave full freedom to Health Minister, Karan Singh, receptive to new ideas to evolve a comprehensive policy. He depended heavily on the then Director of Gandhigram, K.A. Pisharoti, as well as on dynamic secretaries like A. Chandrasekhar and Sarla Gruel and many others for finalizing a national population policy.

The policy of providing contraceptives, and opening family planning clinics was not sufficient to bring down fertility. By the mid- 1970s it was clear that family planning had failed. The population was growing at a rate of 2.2% per year (at that rate, a population will double in 32 years). In 1975, the Prime Minister, Indira Gandhi, imposed emergency rule and, in 1976, a “national population policy” was introduced and made a national priority. Although the average number of children born to each woman had started to fall, population was still increasing at the same pace. Compulsory sterilization for mothers of three or more children was considered. The zeal of some states resulted in 8.3 million sterilizations in 1976- 1977, compared with a forecast of only 4.3 million. (Jacques Véron, 2006).

The Congress Party’s electoral defeat in 1977, due partly to the unpopularity of forced sterilizations, appeared to signal the end of an active population policy. The “family planning” programme became a “family welfare” programme, and reversible methods of contraception were encouraged. The new government was as concerned as its predecessor about the population problem, and the change in attitude was only apparent a return to power in 1980. Indira Gandhi asserted that, in order to achieve

the target of family limitation, “persuasion” was preferable to “coercion”. “Family planning must come from the people by the people and for the people,” she declared. (Ibid)

Between 1970 and 2000, the percentage of couples of childbearing age practicing birth control raised five fold, from 10% to 50%. Strikingly, although the use of oral contraceptives and intrauterine devices was officially encouraged, three-quarters of couples opted for sterilization. The number of sterilizations increased sharply from the start of the 1980s, and then stabilized between 4 million and 5 million per year. Over the same period, sterilization has become female-only (98% in the late 1990s) (Ibid)

Despite a decline in fertility from the 1960s onwards, albeit less sharp than in China, India’s population multiplied by 2.8 between 1951 and 2001. In 2000, India introduced a new population policy, with new targets of replacement-level fertility by 2010 and population stabilization by 2045. But those targets, like the previous ones, were thwarted by demographic inertia.

5.3 Medical Termination of Pregnancy Act and Marriage Act

Indira Gandhi made two major changes in the state politics by amending the Constitution. They are the MTP Act of 1972 and Age at Marriage Act of 1978 which legally increased the girls’ age at marriage to 18 and that of boys to 21. The MTP Act of 1972 underestimated the social and cultural structure of the Indian society. The Marriage Act of 1978 increased the age at marriage from 18 years to girls and 21 years to boys. In 1988 the Government of India reduced the age of voters from 21 years to 18 years through the 61 Constitutional Amendment. A man who was not

eligible for marriage was eligible to elect the governing body of the country. The Marriage Act of 1978 became a subject of discussions

But the MTP Act of 1972 and the Marriage Act of 1978 could not contribute much to fertility reduction because of the poor follow-up measures of the Government of India. No other major policy was adopted in India until the recent past, viz., "Action Plan for Revamping the Family Welfare Program in India".

5.4 Failures of the Committees on Population Control Programme

Several committees were appointed from time to time by the Central Government to provide expert advice on promoting the health and Family Planning Program. The most important among them are the Bhore Committee, the Mudaliar Committee, and the Mukherji Committee. The Bhore Committee supported promotion of family planning to prevent risks to the life of mother and child and to promote contraceptive availability in the country. But it was not achieved.

"The pioneering health survey and development committee under the chairmanship of Sir Joseph Bhore differed on the state undertaking a general program for promotion of birth control". (Ibid; 189). However, this committee did not favor governmental participation at a large level in promotion of contraceptives. The recommendations of this committee were farsighted and did not facilitate family planning program. The committee suggested Governmental control over the manufacture and sale of contraceptives. Because of liberalization, the Government lost overall control the manufacturing companies of the contraceptives. One more suggestion of the committee was Public assistance in research for a safe and effective contraceptive. This also failed due to inadequate budget allocation.

The Mudaliar Committee, 1959, made a number of recommendations which were not helpful for family planning. For instance, instead of suggesting expansion of service facilities in rural areas, it gave priority to consolidation of existing institutions and giving greater inputs to hospitals and medical institutions. The fact that the Chairman of the committee was a clinical expert and the absence of social scientists might have led to this one-sided recommendation.

The Mukherji Committee, 1965, made a few recommendations for strengthening infrastructural facilities for family planning program, the appointment of one additional doctor to the Primary Health Centre and one health assistant for every 20,000 population. There should be one mobile health and family planning unit per district. Voluntary family planning education programs should be conducted at the field level. No suggestion of the committee materialized and they have become outdated today.

The most important recommendation was to constitute a program implementation committee at the district level with the Collector as chairman. This recommendation is still valid and a high priority management issue. But this suggestion does not function well in several districts because of the poor managerial skill and commitment of a generalist administrator, like the Collector. If Collectors are given orientation in population control and directions to give high priority to this program, it can be promoted successfully. Many other recommendations of this committee are outdated today because, for instance, we need one worker (female) for every 3,000 population today and not for 20,000 populations.

In addition to these three committees, several other committees were constituted for the program, research and policy formulation. An 'expert committee'

was formed in the 1980s, which debated the target and fixed the NRR-I as a goal of the National family planning program for the 1990s. This committee did not revise the 1976 Population Policy, with more imaginative and high priority policy issues.

This committee classified the Indian States into three categories based on their performance in family planning and recommended differential future inputs. But they failed to take into the account inter and intra-district differential in performance of the family planning program within a state. The defective composition of the members of this committee affected its utility and dynamism. Because of the failure of the expert committee, in 1992, another committee was constituted to support population research.

The committee did not meet once even after six months of its constitution and failed to update the population policy. It did not give proper administrative directions for proper functioning of the family planning program. The committee did not use research and evaluation findings for effective implementation of the program. The committee failed in its responsibility for helping the government for strengthening research programs in India and to take up certain international agency backed.

Some committee members contributed to the strengthening the family planning program. Such contributions were translated into action after a very long incubation period. These committees could not influence the policy makers, who were UN dynamic politicians and rigid generalist administrators. Such obstacles adversely affected timely utilization of expert advice for strengthening this program in India.

5.5 Lack of Political and Mass support to the Family Planning Programme

“The planners realized the seriousness of damages involved in the demographic revolution that was gathering momentum in India” (Varughese K.V., 1993: 103). The population programme has been implemented for several decades under the several Five-Year Plans with varying political support, financial inputs, infrastructure, administrative efficiency, contraceptive mixes, diverse strategies and utilization of research findings. As a result, the goals set during one Plan period after the other have been altered, and could not be fully realized for one reason or another.

Political support, Political Parties and their leaders for the population control program has not always been readily available during the rule of several Prime Ministers and the ruling parties in India. It is also true of most states in the Indian Union. While some leaders gave relatively greater priority to this program, others just ignored it altogether.

The ministers' in-charge of this Program at the national and state levels did not support and promote it on a large scale. In addition, very often the ministers concerned were not leading men of their respective parties and, therefore, did not wield enough importance to get adequate funds for its implementation. There was no political commitment which hampered the progress of the Family Planning Program. This attitude of the politicians led to political turmoil in the Indian politics over the problem. (Ghosh, Bahmisikha, 1988: 1-52).

Only rarely have any of the Prime Ministers made any serious contribution to strengthening this program. In fact, it suffered a serious setback during the short period of the Janata Government headed by both Morarji Desai and Charan Singh. The then Health Minister, Raj Narayan, derailed the program by removing committed

bureaucrats like A. Chandrasekhar and renamed the family planning programme as the Family Welfare programme.

During the term of Rajiv Gandhi there was higher financial allotment for family planning program. He showed interest in it at the beginning of his tenure. He announced the right policy of creating three PHCs in every CD Block instead of the existing one. But this recommendation was not realized. His successors, viz., V.P.Singh, Chandra Shekhar, P.V. Narasimharao and Vajpayee and their Health Ministers did not give any priority to the family planning program.

Most of the major political parties did not even include family planning in their manifestoes during the 1992 parliamentary election and subsequent elections in 1997 and 2002. This speaks of the lack of political will to support this program. The government headed by Narasimha Rao proclaimed high priority to the family planning programme by allocating more amount. But the program failed to yield fruitful result. Political support at the state level is equally important, since family planning is being implemented by the State Government.

The family planning programme was given high priority and continuous political backing coupled with bureaucratic cooperation in a few states, viz., Kerala, Tamil Nadu and Maharashtra, but major states like Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan lagged behind in this respect. In the other states also, it did not receive adequate support. These differences in political support extended to the programme in the several states inevitably affected its progress. "The family programme did not make uniform headway in most of the states in India". (Mahadevan, K., 1989: 211). The financial allocation made for the population control programme under all the Five-Year Plans was far less than the real requirements.

5.6 Meagre Allocation of funds to the Programme

The percentage of budget allocation for family planning and health together never exceeded 10 per cent of the total Plan outlay. In fact, it should be at least 25 per cent of the total expenditure as successfully experienced in Malaysia and many other Asian countries.

The sector wise allocation for family planning alone was very meager; it never exceeded three per cent, while a poor country like Bangladesh has been spending three per cent of its budget for this program.

The investment of the Government in education is equally valuable for success of family planning. But the budget earmarked for it too has been inconsistent and insignificant. The minimum investment in education in a backward country like India must be 20 per cent. Although the external aid from international agencies for family planning remained stagnant or even decreased during certain Plan periods, the percentage of external assistance." The family planning programme in India is by and large financed, by internal resources". (Branabas, A.P, 1977: 22).

The decline of the family planning program was at peak between 1977 and 1980, which marked the last phase of Indira Gandhi's political career. The maximum internal allocation of finance was made, so far, only during the Seventh Plan period (Rs.3, 256). During the First Five-Year Plan period, even the meager outlay was not fully spent. However, the trend reversed in the subsequent Plan periods. These facts reflect the red tapism in financial management. They also reflect the poor coordination and cooperation between the Finance Ministry and Health Ministry.

Inadequate allotment of finance and under-utilization of the earmarked finance, resulting from bureaucratic mismanagement, have seriously affected the progress of Indian family planning program. There was no greater financial autonomy in the field of family planning program. Like in China, the Government of India did not create a high-power autonomous Family Planning Commission to promote the program

5.7 Very Limited Trained Personnel Available for the Programme

India is in the forefront of nations in creating institutions for trained manpower in the field of health and population. There are over 600 medical colleges, five central FP training institutions, two UN aided Population and Development Institutes, 55 Regional Health and FP Centres, 30 Population Research Centers, and 50 University Departments exclusively for population studies. The result of the program is too insignificant.

Internationally, Indian population scientists have emerged as experts, who not only guide population control programmes in several other countries, but also do research in India. Unfortunately, they have not been adequately utilized in India as in China or other Asian countries. The major reasons are that many of the experts are confined to theoretical and mathematical research and give a secondary place to action research in their studies. In addition, they are kept at a distance by the bureaucrats who are generalists with no expertise in such a difficult field as FP.

It would appear that the politicians would like to perpetuate their monopoly of power, and therefore, they do not care to involve experts in this program regularly. More than anything else, in the present administrative and organizational set-up itself, very negligible positions exist for experts at the top level. The important positions are

shared by generalists on the basis of promotion. For instance, the post of Commissioner of Family Planning is a technical one, but it has been filled in with bureaucrats. It should have been given to a trained policy and management expert on population studies.

The apex body at the center is the Cabinet Committee with the Finance Minister as Chairman. Besides the committee, there is central Family Planning Council under the chairmanship of the Union Health Minister. (Ibid; 17). The post of Director in this Ministry, which is also an important position, is given to a raw statistician. In fact, it should have been given to a demographer. Even at the peripheral level, doctors and trained Para-medical persons are not appointed in sufficient numbers to optimize the outreach of the family planning program, even though trained persons are readily available throughout India. One peripheral worker for every 2000 population should be created in the inaccessible and backward states like Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan. The organizational structure of the family planning program is not supportive to the family planning program.

The management of Primary health centers where real family planning service takes place is not in order in India. Very often, in many backward areas, there are no required numbers of doctors. In addition, keeping all the three to four doctors appointed at the same Primary health centers at the peripheral villages without decentralizing their work keeps them idle and utilization of the Primary health centers by the people becomes very meager. There is little coordination at the Primary health centers between the chief doctor and the other doctors and among the other staff. Either there are no suitable transport facilities or they are inadequate.

There are many trained doctors available in India now, but are not inclined to work in rural areas. There are no incentives to doctors in rural areas and there are no educational facilities offered to their children. They are reluctant to work in the rural areas. No lady peripheral workers have been appointed in view of the fact that acceptors of family planning are mostly women and the success of this program in future is not clear.

5.8 Poor Contraceptive Technology

“Contraception refers to measures which are taken in order to prevent sexual intercourse of coitus from resulting in conception. A contraceptive method is sometimes termed as birth control method, though ‘birth control is used in a broader sense to include intentional abortions, sterilizations and complete abstinence from coitus which are not usually considered to be contraceptive methods” (Asha A Bhande and Kanitkar, 2000: 237).

India has acquired the necessary technology of indigenous production of all the major contraceptives, like condom and IUD, and has also developed expertise on different procedures of male and female sterilizations and induced abortion. However, at the initial phase of the development of condom, the quality was not good enough to attract men. Similarly, Lippy’s Loop had more side effects than the Cooper-T and stainless steel variety of loop but for sometime the latter was not available in sufficient quantity.

The stainless steel variety is not used in India, though it is the most successful method used in China. There has been considerable delay in creating an acceptable method of contraception in India, which has adversely affected the program. In addition, despite knowing that sterilization of women is becoming increasingly popular all over India, the necessary facilities are not provided for this program.

There are additional weaknesses in promoting the use of contraceptives, such as the poor marketing of temporary contraceptive in rural areas. Other problems are inadequate facilities for induced abortion and hospital delivery.

The Indian family planning programme, in its early phases, relied on the clinic and cafeteria approach coupled with emphasis on abstinence, safe period, and coitus interrupts jelly and foam tablets. These strategies were in conformity with the pious policy of Gandhiji, who laid emphasis on the former two methods. They continued till 1966, when the Central Government recognized the urgent need for FP and established a separate department for this programme. During the first three Five-Year Plan periods, the government failed miserably in promoting serious family planning in terms of strategies, contraceptives and creation of infrastructure. India lost 15 years of valuable time in promoting this program after Independence.

After 1966, many changes were introduced in the promotion of this program. The major steps taken in this direction were the creation of a separate department for family planning, adoption of the extension approach and appointment of family planning extension educators, diversification of contraceptive methods, particularly acceptance of sterilization and IUD and condom, offer of incentives in the form of compensation and wages during the sterilization and post-sterilization periods. All these did come into being.

There were financial constraints, resulting from widespread drought which adversely affected the program for sometime. There was no momentum to mobilize resources and public opinion for this program which gave a rude shock to all the politicians and scholars.

The 1971 census reports revealed an all the time high rate of population growth in India. Consequently, greater priority was given to family planning by the then Prime Minister, India Gandhi. "These steps have contributed indirectly to creating greater awareness of family planning among people, but their direct contribution to reduction of fertility has been negligible, because the mean age at marriage of girls reached 18 years only during 1981-91 period and most of the induced abortions take place among the high parity women even today" (Sai Prasad, K.K., 1991: 70). The next five-year plans also devised new strategies, like disincentives and the camp approach, which could not succeed in promoting sterilization in a big way.

During the implementation of camp approach, the incentive amount was increased and different types of incentives, like money in cash, goods, increments in salary, bonus, etc., were also introduced. "Another important aspect of the strategy was the integration of family planning with maternal and child health program based on the experience of Gandhigram. Action Research Programme" (Pisharoti, K.A., 1974: 202). During the Sixth Five-Year Plan, the family planning strategy was further expanded and integrated with the total National development Programmes like the 20-point programme. But still the program was not successful.

For the first time, population control was specifically mentioned as one of the plan objectives. The 20-point programme, which was adopted, stressed the need to reduce poverty, and to provide the minimum needs of life to all the rural population. But, since then, no new strategies were devised for promoting this programme resulting in stagnation. Therefore, fertility continued to remain stagnant.

“Indian Population Scientists have contributed considerable body of knowledge to policy formulation and the improvement of performance”. Although a large number of studies are repetitive and relate to low priority areas of research, only a few of them were programme oriented and valuable for FP. “As early as the 1950s, the Central Government adopted the small family norm as a goal of this programme, based on the Mysore Population Study”. The studies of different people and surveys also could not help the family planning programme. “Later on, during the 1980s, S.Krishnakumar made efforts to modify the population control policy based on the findings of a national study” (Mahadevan, K., 1989: 132). Several studies did not influence the decision makers. The Indian population policy has got only limited innovative and distinctive feature compared with the population policies of China.

Yet another flaw of the population policy is that no rigid target or goals are contemplated for the program. Greater involvement of the NGOs is under estimated the family planning program. There is no inter-sectoral co-ordination.

5.9 Lack of sufficient Social Security and Educational Measures

The 1976 population policy document is not comprehensive. It does not cover details of the administrative changes required at different levels for success of the program. It also has not specified what type of social security measures are to be adopted to minimize the excessive preference for sons by couples, which has been the greatest barrier against acceptance of small family norm. China has succeeded to a great extent in overcoming this barrier by providing five types of social security programmes, viz., food, clothing, shelter; medical care after-death facilities.

India has not planned anything, so far, in this regard. In fact other measures like old age pensions, insurance, and old age rehabilitation for childless couples or

couples with girl child/children alone. Another major lacuna of this policy is that family planning should also have been integrated with all other ongoing welfare and developmental program. It is silent on its coverage in formal education and non-formal education. No provision is made for promoting the idea of small family norm among children, adolescent and adult youth.

Yet another major omission in the policy is that other family planning measures, such as induced abortion and age at marriage, have been ignored. Past experience has confirmed the need for the development of women through formal and non-formal education in a big way in order to make them accept family planning, reduce mortality and to improve the quality of life in our society. This idea has not been given adequate emphasis except a passing reference in the last item of the policy.

5.10. Involvement of Voluntary Agencies: Pros and Cons

The role of voluntary agencies has been well recognized but they have to work under many handicaps. The feeling of aloofness and lack of mutual understanding hampers proper integration of the work between official and non-official agencies. Inflexibility of the grant-in-aid pattern and the tardy methods of release of grants create misunderstandings between the official and non-official agencies. The organizations which receive the government grant are engrossed with the accounting of the grant that the real purpose is lost and the program suffers considerably.

The voluntary agencies are also uncertain about the continuation of their work for lack of timely release of the funds. Grants for the most part are earmarked for the salary of staff and equipment. The grant admissible for administrative purposes is much less than the administrative expenditure of governmental agencies. In theory 25

per cent of the grant sanctioned is to be released early in the year and another 25 per cent later. The balance 50 per cent, however, is to be released only after the audited statements for the year are produced with a utilization certificate for the full amount due. But this is only on paper. In actual practice, sometimes the whole year passes by without grants. The majority of the institutions find it difficult to function under the present circumstances. At present only 500 Family Planning Welfare Centers are being run by voluntary agencies, and they are under heavy financial strain.

Some of the organizations have been "so limited and diffused, their workers so few, their funds so meager Family Planning has to become a national movement and it must involve mass participation not by the 'Mass Camps' technique, but the voluntary organization functioning at the smallest area and population levels.

The decision to limit the size of the family and to adopt a particular method of the people, people have to become aware of the programme. In urban areas many voluntary organizations are functioning to enroll peoples' participation. In rural areas, the two organizations through which people's participation can be ensured the panchayats and cooperative societies. The performance of panchayats is not uniform in the country. The study finds that not much progress has been made in the involvement of the village leaders. The leaders have no favorable attitudes.

The Family Planning Department is part of the bureaucratic system of the country. The question of innovation in the Department of Family Planning is related to the larger question of innovation in the bureaucratic system as a whole.

The communication system, the organization of mass camps, the introduction of the intensive district scheme, the setting up of a feedback system, are indicative of

the efforts to attain higher levels of performance through changes. However, these changes operate within the constraints of overall bureaucratic system.

There has been some discussion as to whether the programme can be handled better by voluntary organizations. No voluntary organization is in a position to take up the programme of the magnitude that is being carried on at present. One possibility might be that a particular region might be allocated to a voluntary organization. It can be tried out on an experimental basis in one or two areas.

The involvement of the social scientists in family planning programmes is rather recent and very limited. There is little training available in the universities for undertaking these studies. To add to this overall problem, there are more specific ones with regard to demographic centers which restrict their contribution.

The Family Welfare Programme has been successful in spreading the message of the small family norm, improving contraceptive acceptance and reducing fertility rates but its achievements have been modest. While contextual and structural factors (meager incentives, economic problems high levels of illiteracy, poor access to sources of knowledge, limited knowledge, limited informed choice, poor quality services, limited access to family planning services, poverty, and gender- and non-gender-based disparities) are partly responsible, the direction, emphasis and strategies followed hitherto in the Family Welfare Programme have largely contributed to the limited success of the programme. (Santhya, McGrory and Haberland. 2001).

5.11 Hindrances to Meeting Contraceptive Needs

The Indians accept the small family norm. They have general awareness of contraception. However, that awareness of reversible (modern or natural) methods is

Balaiah conducted a study of men in rural Maharashtra and found that 92 per cent were aware of condoms, only 29 per cent knew about its correct use (Balaiah, 1999). A small-scale study conducted in Karnataka by Rajaretnam and Deshpande in 1994 reported that while 56 per cent of women and 61 per cent of men interviewed were aware of reversible methods, a much smaller proportion—31 per cent of women and 52 per cent of men—was aware of at least one service outlet for reversible methods (Rajaretnam and Deshpande, 1994).

Qualitative studies also report that in many cases, men and women who were aware of contraceptive methods did not have timely knowledge, especially during the initial years of their married life (Santhya, McGrory and Haberland 2001). For example, in-depth interviews with first-time pregnant women and first-time recently delivered mothers in Vadodara; and Kolkata reveal that they did not have contraceptive knowledge prior to becoming pregnant; had they had such knowledge, they may have delayed the first pregnancy.

Moreover, several studies report that misconceptions are common among women and men, particularly related to the side effects of contraceptive methods (Balaiah, 1999).

There is clearly a need to increase correct and timely knowledge about contraceptives among women, men and community leaders through clinic- and community-based programmes. Information, education and communication (IEC) efforts need to be strengthened, and integrated within the training of all health providers. (Santhya, McGrory and Haberland, 2001).

The Reproductive and Child Health Programme recognizes the importance of IEC efforts in promoting a demand for services, including family planning services,

but the lack of adequate collaboration between the health sector and IEC units is reportedly rendering these efforts ineffective (Population Council 2002).

Similarly, the experience of a scheme to involve Zilla Saksharata Samitis in IEC activities pertaining to the Reproductive and Child Health Programme shows that operationalisation at the ground level is a huge challenge. Under this scheme, these samitis are encouraged to utilize local resource persons and institutions from the district to design and deliver IEC programmes on reproductive and child health in the local language. This scheme is currently in different phases of implementation in 227 districts in the country and 22 Zillah Saksharata Samitis have completed these activities. An evaluation of the scheme in a number of districts in Gujarat shows that the involvement of Zillah Saksharata Samitis and IEC functionaries, who are to play a vital role in this venture, is completely missing. These educational activities are mainly organized by the staff of the primary health centers with some support from the local Panchayat (Santhya, McGrory and Haberland. 2001).

5.12 Problems of Gender inequalities and Patriarchal Value

India has a patriarchal set up in which, women have relatively little power. Young women are particularly powerless, secluded and voiceless in matters relating to their own lives, and are constrained from exercising choice in sexual and reproductive matters. Nationally, data from NFHS-2 shows that only one in two ever-married women participated in decisions about their own health care (IIPS and ORC Macro 2000). It is confirmed by IIPS report.

The role of the husband has been noted in several studies of decision-making related to the use of contraception, especially during the early years of marriage (Homeland, McGrory and Santhya 2001:35). Most couples do not discuss with each

other when to have their first child, birth spacing or contraception (IIPS and ORC Macro 2000)

Nationally, for example, less than one in five currently married women reported discussing family planning with their husbands (IIPS and ORC Macro 2000). Studies also show that most men approve of nine Zillah Saksharata Samitis as independent, autonomous bodies registered under the Societies Registration Act to help in implementing the National Literacy Mission at the district and village level. Contraception only after having a second or third child (Khan and Patel 1997), and that husbands' approval of a particular method is critical (Parveen et al. 1995).

Given that men dominate in reproductive health matters, promoting shared responsibility and the active involvement of men in safe and responsible sexual relationships, family planning, safe motherhood and responsible parenthood is critical. The National Population Policy and the Reproductive and Child Health Programme recognise this synergy, but men's roles have not been properly defined in government programmes (Santhya, McGrory and Haberland, 2001).

There have been some efforts to promote the use of male methods such as vasectomy and condoms, and initiatives to re-popularize vasectomy, including IEC campaigns and training of surgeons in "no-scalpel" vasectomy, in several states. Though these efforts have proved successful in some districts in Andhra Pradesh, a similar change has not occurred in most other states (Planning Commission 2002).

According to Prakashamma (1999) the male health workers could play an important role in promoting male involvement in reproductive and child health. However, two-thirds of primary health centers in India do not have a male health worker (IIPS 2001b). Moreover, the Reproductive and Child Health Programme

document offers no clear guidelines on the role and responsibilities of male health workers. (Prakashamma, 1999).

Murthy et al (2002) has conducted a number of surveys in different places. His Karnataka's experience shows that involving male health workers in the community needs assessment process can be problematic. Male workers in the state, who traditionally focus on malaria and tuberculosis screening and follow-up, viewed reproductive and child health as the domain of the female worker. (Murthy et al. 2002).

Limited efforts to involve men in reproductive health matters have been carried out by a few NGOs. These NGO experiences have demonstrated that men are potentially interested in becoming more supportive and involved in reproductive health programmes. There should be a concerted effort to incorporate what NGOs have learned in the design and implementation of public programmes.

Many studies report that reproductive decision-making often is beyond the control of young women and their husbands (Barua and Kurz 2001; Piet-Pelon, Rob and Khan 1999; Ravindran) and it is the extended family's decision on what is permissible that influences the husband/couple's decision. Access to appropriate contraception is frequently thwarted by the family and peer pressure. Hence, it is also important to engage other gatekeepers, including senior men and women in the family and influential people in the community, in reproductive health programmes. Santhya, McGrory and Haberland. 2001).

5.13 Availability of Choice of Methods

According to C.P.Puri (1998) the public sector provides five contraceptive methods—two forms of tubectomies (laparoscopy and minilap), vasectomy (including “no-scalpel” vasectomy), IUDs (CopperT200) oral pills (combined) and condoms. Efforts to broaden the basket of choices have been under way, including clinical trials to assess the safety and efficacy of available methods such as estrogen-progestogen combination injectables, vaginal rings and long-acting IUDs, and the development of new methods of male and female fertility regulation.

The government has introduced emergency contraceptive pills in the Reproductive and Child Health Programme. However, most women and men, particularly those who rely on the public sector—76 per cent of current users of modern methods relied on this sector (IIPS and ORC Macro 2000)—do not have access to a wide range of contraceptives.

Methods that are perceived for the family planning by the Government of India are less effective, including pessaries, spermicidal and diaphragms and they are controversial, including injectables and implants. These are dropped and not introduced in the public programme. These are given low priority by health workers. The recently introduced emergency contraceptive pills are currently available through medical officers only at the district and sub-district level (Mallik, 2003) these are not installed in all the medical stores. There is limited choice.

Several small-scale studies of Barge and Ramachandar ICMR Khan, Patel and Chandrasekhar, Khan, Gupta and Patel; Khan, Patel and Gupta; Murthy, Ravindran, Roy and Verma, Verma and Roy, and Visaria conducted in the early 1990s reported

that most women were informed about female sterilization and only a minority were told about reversible methods .

Rajaretnam and Deshpande, 1994 conducted a small qualitative study in rural Karnataka and reported that the eligible couples were not intimated about family planning methods and reversible methods. There was very limited information about the family planning and reversible methods.

According to IIPS and OR survey report a large majority (65 per cent) of women who intend to use contraception reported that they intend to use female sterilization (IIPS and ORC Macro 2000).

There is a misconception among the people for adopting family planning methods. There is female sterilization and there is hardly male sterilization. Only 22 per cent of users of any family planning methods were informed of its possible side effects at the time of accepting the method.

Most of the people across the country did not have enough knowledge about family planning methods and its side effects. They do not have even knowledge to solve the problems emerging out of the family planning methods. The same matter is proved by the small study conducted by Foo and Koeing. According to Foo and Koeing that pre-acceptance counseling of clients on how the method works, what the expected side effects are and how to manage the side effects is typically lacking or limited in the Family Welfare Programme across the country (Foo and Koenig 2000). The counseling should be concentrated on this matter.

According to IIPS the Reproductive and Child Health Survey-1 report only one-third of sterilization users (35 per cent), less than one-half of IUD users (46 per

cent) and fewer than one fourth of pill users (23 per cent) were informed of the side effects before accepting the method. The provision of pre-acceptance counseling was lacking or limited even in those states where contraceptive prevalence was relatively high such as Kerala and Tamil Nadu (IIPS 2001a).

Small-scale studies of Bhat and Hasalkar, Henagar and Sheshadri Rao Schaap and others on the reasons for contraceptive discontinuation conducted in various parts of the country, including Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Orissa and Uttar Pradesh, also reiterate these findings (Bhat and Hasalkar 1996) In most of these studies, more than half of women discontinued use of IUDs and oral pills reported side effects as the reason. There is, however, evidence that if women are informed earlier about the side effects they might experience in the first few months of method use, continuation rates will improve significantly. (Santhya, McGrory and Haberland, 2006).

According to Rajgopal and Ravichandran the acceptability of family planning methods were so limited. They reported that many of the reversible methods are not currently being promoted and also these are not acceptable to women in rural and urban areas (Rajgopal. 1989; Ravindran 1995).

According to Ravindran the desirability of including the diaphragm method among other contraceptive methods is 8 per cent. Participants accepted the diaphragm, and all users, irrespective of their educational level, reported that they thought the method was not appropriate and not easy to accept it. (Ravindran 1995).

According to Baveja many married adolescents accepted the diaphragm as compared to older women. Women do make an informed choice overriding provider bias. For example, in a study where 8,077 potential clients were provided with

detailed information on various methods, including IUDs, oral pills, condom and sterilization. (Baveja. 2000).

The Government of India's decision to remove Centre-driven targets for family planning has been perceived by many as a small but right step towards furthering informed choice, and thereby reproductive rights. Facilitating informed choice is envisaged as a strategic measure in the Reproductive and Child Health Programme and the National Population Policy 2000. Though the new policy formulations are path breaking in bringing the language of choice and rights into national discourse, the mechanisms to translate the rhetoric into action are not clearly defined, and the strategies delineated contravene the ethos of choice and rights. (Santhya, McGrory and Haberland. 2001).

A more recent study conducted by Population Council in Andhra Pradesh, Madhya Pradesh and Maharashtra also reports that women were rarely told about a range of methods—fewer than one in ten women in Andhra Pradesh, and one in five women in Madhya Pradesh and Maharashtra, reported having been informed about more than two methods. Women who do not have any children were not told about any method. Moreover, even though most of the providers are trained to provide counseling for condoms, oral pills, IUDs and female sterilization, few providers informed clients how a method works, how to manage side effects and the danger signs that warrant medical attention.

The information of all these studies surveys and concluded that there is limited choice and limited knowledge about contraceptive methods and the related. So the implementation of policies is not successful.

5.14 The handicaps special to the north India

In the densely populated states of the north – Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan – population growth is still rapid, with annual rates of increase above 2%. Those four states, home to 365 million people in 2001, represent a large share of the national total and account for the apparently slow pace of demographic change in India. The annual rate of natural increase is the highest in Bihar (2.3% in 2002). In Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan, birth rates were above 30 per 1,000 in 2002, and fertility was around 4 children per woman, compared with a national average of 3 children per woman. Women in Uttar Pradesh, India's most populous state (166 million people in 2001) gave birth to an average of 4.4 children in 2002. In the northern states, a combination of factors is delaying demographic transition: a lower level of education, in particular among women; less favourable gender relations; higher infant and child mortality; lower coverage by healthcare services; and less political commitment to family planning programmes [4].

5.15 Limited Number and availability of services

According to the Planning Commission Report of 2000 there has been considerable expansion and strengthening of the health care infrastructure, and family welfare services are now an integral part of services provided by primary, secondary and tertiary care institutions across the country. Currently, about 137,271 subcentres (1/ 4579 population) and 22,975 primary health centers (1/27364 population) in rural areas, and 871 health posts and 1,083 family welfare centers in urban areas provide family planning services at the grassroots level (Planning Commission 2002). Access to family planning methods has increased significantly, and only a negligible minority of women (4 per cent as per NFHS-2 data) perceived availability, accessibility or cost

as major impediments to adopt family planning. Yet, in practice, access to and availability of services are critical issues of concern. Gaps in infrastructure, manpower, equipment and supplies at the primary health centre level remain. (Planning Commission 2002). (Santhya, McGrory and Haberland. 2001).

A recent survey of IIPS on health facilities across the country reported that most primary health centres were not adequately staffed: almost one in ten was functioning without any doctor and 80 per cent did not have a female medical officer. The situation was particularly grim in Orissa, Rajasthan and Uttar Pradesh where 95 per cent or more primary health centers did not have a female medical officer. Nearly one-half of primary health centers did not have an auxiliary nurse-midwife; in states such as Orissa, Uttar Pradesh and Bihar, 87-94 per cent did not have an auxiliary nurse-midwife (IIPS 2001b).

According to Foo and Koeing family planning may not yield good results if family planning health workers are generally poorly trained and have little knowledge of the methods they are to provide (Foo and Koenig 2000; Jejeebhoy and Kulkarni 1996). The facility survey of IIPS 2001b reveals that only 16 per cent of primary health centers had physicians trained in conducting sterilization, and only two-thirds had at least one paramedical staff trained in IUD insertion (IIPS 2001b).

Visaria who had mentioned in writings about the female health workers and reported that they had received training in IUD insertion, the majority did not feel confident about actually inserting an IUD in field settings or showed little awareness of the precautions to be taken (Visaria, 2000).

Roy conducted a survey in Maharashtra 1991 and reported that that only one-third of the 80 health workers had correct knowledge of oral pills and only 43 per cent

could give adequate advice on a method convincingly (Roy, 1991) It is encouraging that the Reproductive and Child Health Programme has laid greater emphasis on skill up gradation and gender sensitization training, and a nationwide reproductive and child health training programme has been launched to upgrade the skills of health providers and managers to deliver the reproductive and child health package of services.

However, it is a matter of concern that a mid-term review of the training component of the Reproductive and Child Health Programme notes that that the modules and training focus more on the technical areas of service delivery and give little importance to the newer focus areas, such as gender sensitivity, lifecycle approach, client focus and quality of services, which are the pillars underlying the paradigm shift (Mavalankar, 2002). It has also been pointed out that lack of state ownership of training programmes, and inadequate technical support by the collaborating centers, have significantly affected the quality and pace of training (World Bank 2000).

The draft Programme Implementation Plan of the Reproductive and Child Health Programme-2 also recognizes the limitations of the existing training programme. Health or family planning workers are required to regularly visit each household in their assigned areas to provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and deliver other related services. However, data from NFHS-2 indicate that only 13 per cent of women had received a home visit from a health or family planning worker during the 12 months preceding the survey, and women without any children were least likely to receive a home visit. Only 11 per cent of

women who were visited at home reported that they received family planning services. (Santhya, McGrory and Haberland. 2001).

State-level data show that fewer than 2 per cent of women in several states, including Punjab, Haryana, Delhi, Arunachal Pradesh, Nagaland, and Jammu and Kashmir, received a home visit from health or family planning worker in the 12 months preceding the survey. Only in four states—Gujarat, Mizoram, Tamil Nadu and Maharashtra—had at least a quarter of women received such a visit. (IIPS and ORC Macro 2000).

Several small-scale studies also reveal significant shortcomings in the frequency and regularity of outreach services, the time devoted by workers to such activities and the length of time spent with clients (Foo and Koenig 2000). Additionally, outreach services are reported to be almost nonexistent in remote and tribal areas (Murthy 1999). Moreover, health workers at the community level are often looked upon with distrust, and identified as interested only in recruiting “cases” for family planning.

The Reproductive and Child Health Programme recommends that women who do not deliver in institutions receive three postpartum visits, during which they are to be given an abdominal examination, and provided advice on family planning, breast-feeding and baby care. Data from NFHS-2 show not only those postpartum check-ups are almost non-existent but also that family planning is given the lowest priority among the various components of postpartum care (IIPS and ORC Macro 2000).

Nationally, less than one in five non-institutional births were followed by a postpartum check-up. Among those who received a postpartum check-up, only 27 per cent of mothers received family planning advice, compared to 43 per cent receiving

advice on breastfeeding and 46 per cent receiving advice on baby care. Adolescent mothers and women delivering for the first time were less likely than older women to receive advice on family planning. Notably, mothers received advice about family planning during postpartum check-ups for only 14 per cent of first births, although these women are more likely to need advice on birth spacing and contraception. Clearly, health workers and other providers tend to overlook adolescents and young women until they are further advanced in their reproductive careers. Stock-outs and erratic supplies of reversible contraceptives make it unrealistic to expect providers to offer clients a choice of methods.

The survey of health facilities referred to earlier reports that only 56–61 per cent of primary health centers had some stocks of condoms, IUDs and oral pills on the day of the survey. The situation was worse in states like Bihar, Orissa and Uttar Pradesh where less than one-fifth of primary health centers had some stocks of these methods (IIPS 2001b). Though the overall situation is far from satisfactory, many new initiatives and the restructuring of existing measures have been successful in improving access to and availability of contraceptive and other reproductive health services. (Santhya, McGrory and Haberland, 2001).

The social marketing and social franchising of selected reproductive health services by Janani, a registered society in Bihar combined a strong market-based approach with a community-based distribution system. Janani has been able to provide quality family planning services at an affordable price in rural areas (Gopalakrishnan et al. 2002). Janani's experiences have clearly shown that couples are willing to adopt family planning methods and pay for quality services that are easy to access (Mangal and Narayana 2001). An evaluation conducted in 2001 reports that

the system has been successful in attracting illiterate and nulliparous women (Sulzbach et al. 2002).

The Innovations in Family Planning Services project in Uttar Pradesh is yet another example of successful delivery in areas with little or no access to reproductive and child health services. The project has contributed to increased regular contact with clients, improvements in contraceptive method-mix and use of temporary methods. A survey of married women in the reproductive age group in five project districts reports that about two-fifths of women had met with a community health worker in the six months prior to the survey (Levitt-Dayal 2002). In comparison, NFHS-2 data for Uttar Pradesh show that only 3 per cent of women received at least one home visit by a health worker in the 12 months prior to the survey (IIPS and ORC Macro 2000). All the surveys and reports suggested that there is very limited access to and availability of services for adopting the family planning methods.

5.16 Poor quality of Day-to-Day Medical Consultancy

It is now widely acknowledged that the quality of family planning services is generally poor. Several studies report that little consideration is given to interpersonal interactions (Gupta 1993) Women are often treated as ignorant and incapable of intelligent action. Service providers tend to disregard women's need for privacy, and are uncaring about women's dignity. (Santhya, McGrory and Haberland. 2001).

The pre-acceptance counseling and checkup are conspicuous by their absence. Post-acceptance follow-up services are also limited, especially in the case of reversible methods. Nationally, for example, data from NFHS-2 show that three in four sterilization users and two in five users of other modern methods received follow-up services (IIPS and ORC Macro 2000).

Data from the Reproductive and Child Health Survey-1, however, indicate that a much smaller percentage of women (only one in four) received a follow-up visit from a health worker after accepting the method—27 per cent in the case of sterilization, 13 per cent for IUD and 7 per cent for pills. In many states, less than one in ten women reported receiving a follow-up visit (IIPS 2001a). It is commonly observed that auxiliary nurse-midwives do not maintain their registers adequately to follow up users, and lack a clear idea of how many have continued/discontinued the method (Foo and Koenig 2000).

According to P.S.Jhaveri the efforts of the Government of India and non-government agencies during the last ten years are commendable. In the First and Second Plans ample money was provided, and attempts were made to awaken public opinion for family planning. The motivation program was a success and it is because of the same that the word 'Family Planning' has become so popular in urban as well as in rural areas. Not only the Government agencies but social organizations also played a great role in awakening public opinion. Though people did come and are still coming for advice and assistance with regard to family planning. The objectives of the promoters could not be achieved. (<http://www.vasectomy-information.com/jhaver/index.htm>).

The Rhythm method was advocated in the First Plan, Contraceptives came in the Second Plan period and in the Third Plan period, it was oral contraceptives and sterilization en mass.

After five years of intensive propaganda and advice for contraceptives, now there is a realization that even this may not help the situation, and so the organizers of

the movement have started afresh in a new direction, viz sterilization on a mass scale.

(<http://www.vasectomy-information.com/jhaver/index.htm>).

The poor results of the methods advised, and the disappointment to those concerned and to the sponsors of the movement as well, is being now covered by excuses and suggestions. It has been said that doctors need training in family planning, and training centers have been started for the same. It has also been advocated that the family planning should be a special subject in the curriculum of studies in medical colleges in India, and of late there is a demand for a special Ministry for Family Planning. The success of the motivation, publicity and education carried out during the last ten years has given them enough courage and now they boldly come forward to seek advice and assistance for the same. Experts on family planning from abroad guided the methods to be used and they were from that growing population has been the major cause of underdevelopment in the country. It's been the main factor for the slow down of the country's economic growth.

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CONCLUSIONS AND DISCUSSION

Population growth has been a concern of the Government of India and India has a lengthy history of explicit population policy. In the 1950s, the government began, in a modest way, one of the earliest national, government-sponsored family planning efforts in the developing world.

Summary of the documents

Summary of the various documents, relating to and preceding the formulation of successive five-year plans of India extensive secondary data and lastly the data from the field has highlighted the following points.

The Indian concern with population growth and the need to influence the behaviour of the people with respect to birth control was entirely indigenous. While Indian leadership was influenced by western intellectuals, there was no extraneous pressure on the Indian authorities to adopt any particular approach in the late 1940s or early 1950s.

There were sweeping changes in some states attributed to effective population and development policies. Many factors that have contributed to lowering fertility in Kerala and increase in the marriage age and also contraception, sterilization, mother and child health programmes, better education for women, measures in favor of gender equality, and the states' political commitment to welfare action were introduced. The increase in the marriage age is estimated to account for 30% of the decline in birth rates between 1968 and 1978. Contraceptive use has also spread rapidly. The percentage of women of childbearing age using contraceptives rose from 37% in 1981 to 72% in 1992. A high rate of infant mortality was considered to hold back birth rate decline because parents have many children to ensure that some survive to adulthood.

The vaccination programme launched in 1985, which covered half of all children and reduced infant mortality, thus also contributed to the fertility decline. The rapid decline in fertility to interaction effects between the provision of family planning services and an improvement in the socioeconomic environment. But a

rapid decline in fertility may also be due to a high level of poverty. In a context of economic stagnation, as in Tamil Nadu for example, parents who want a better life for their children can only achieve their aspiration by limiting their family size, thereby lowering fertility.

The family planning programme has achieved a considerable progress in the socio-economic demographic field over the last five decades. However, the country continues to lag behind several other countries in bringing down birth rates. For example- The Tenth Plan targeted a reduction in Infant Mortality Rate (IMR) to 45 per 1,000 by 2007 and 28 per 1,000 by 2012, reduction in Maternal Mortality Rate (MMR) to 2 per 1,000 live births by 2007 and 1 per 1,000 live births by 2012 and reduction in decadal growth rate of the population between 2001-2011 to 16.2 per cent. As against an allocation of Rs.15, 120 cores for the Ninth Five Year Plan, the allocation for Family Welfare is Rs.27, 125 cores for the Tenth Plan. For the Annual Plan 2004-05, the allocation increased to Rs.5500 core from Rs.4700 core in 2003-04. Still the country continues to lag behind a number of other countries as these allocations are not sufficient.

The National Population Policy, 2000 aims at achieving net replacement levels of total fertility rate by 2010 through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve population stabilization by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environment protection. The achievement of the National Population policy, 2000 is based on the people's movement and people's participation.

To augment health care services in the rural areas of the country, a National Rural Health Mission has been conceptualized. The National Rural Health Mission (2005-09) has covered the whole country with special focus on 18 States, which have either weak socio-demographic indicators and/or primary health infrastructure. These States are (UP, MP, Rajasthan, Bihar, Jharkhand, Chhattisgarh, Orissa, Uttaranchal), the North – East States. Himachal Pradesh and Jammu and Kashmir.

Findings From the Secondary Data

In the Five Year Plans the Government of India has laid more emphasis on

the family planning programme with a larger outlay of funds. The programme included education, provision of services, training and research. Facilities for voluntary sterilization and increased availability of conventional contraceptives were provided. Research activity was extended to include study of demographic aspects, communication and attitudes in addition to the bio-medical areas.

Enough importance was given to the family planning programme and it continued with further intensification of the strategies adopted in the plans. In the Five Year Plans the Family Planning Programme continued to retain its status as one of the major national priorities.

A Reproductive and Child Health Programme encompasses the entire National Family Welfare Programme and it has a decentralized planning. The programme is funded by the Central Government with partial funding support by World Bank, DFID and UNFPA as pooled financing. The USAID and European Union are the other development partners supporting the programme from outside the pool and UNICEF and WHO provides technical assistance for the programme.

According to the information presented in chapters 2 and 3 there was no aggressive effort to encourage the use of contraceptives and limitation of family size. The policy makers believed that the high rate of population growth was the greatest obstacle to economic development. The government began a massive program to lower the birth rate from forty-one per 1,000 to a target of twenty to twenty-five per 1,000 by the mid-1970s. But it was not possible in a stipulated period.

The National Population Policy adopted in 1976 reflected the growing consensus among policy makers that family planning enjoyed only limited success. The policy makers thought that excessive family size was part and parcel of poverty and had to be dealt with as integral to a general development strategy. Education about the population problem became a part of school curriculum. Cases of government-enforced sterilization made many question the propriety of state-sponsored birth control measures.

The integration of family planning programme into the comprehensive development effort of the country has been recognized. Consequently a minimum needs programme was planned for. Such a provision is expected to help in sustained

economic development. The elements in the provision for a minimum needs programme were elementary education, rural health, nutrition, drinking water, provision of house site, slum improvement, rural roads and rural electrification.

The efforts made by the Government of India to reduce the birth rate were used to further consolidate and to intensify the structure and the components of the family planning programme. The two components, which indicated a change over the earlier periods, need to be specified. The objectives were laid down in more concrete terms, viz., the reduction of birth rate. The terms, conditions, goals and objectives for adaptation of the programme were specified in concrete terms.

The targets were assigned to the district and the primary health centers through the States. Efforts were made to achieve results through appropriate education and motivation together with the full involvement of general health services in the programme. This led to a greater integration of health, family planning and maternity and child health activities.

The strategies in the five-year Plans were a continuation as well as a change over the earlier phases. The Plans' approaches are to increasingly integrate family planning services with those of health, maternity and child health and nutrition. The efforts made to convert more and more vertical programme workers into multipurpose workers. The continuity is in setting specific targets. The change is in reorganization of the personnel at the primary health centers to be involved in the total health programmes. This change in approach was clearly reflected in the policy statement of the government. But the achievement of the goal has become complicated. India has a comprehensive population policy, which includes four major aspects: birth rate, death rate, migration and distribution of the population. It is essentially concerned with a control of birth rate.

The department of family planning is clear as to its charter, viz., to reduce birth rate to a given level. There is an improvement in the quality of the life of the people as reduced birth rate and enhanced the living conditions of the people. The Overall performance of family planning was some better. During the 1980s, an increased number of family planning programs were implemented through the state governments with financial assistance from the central government. In rural areas, the

programs were further extended through a network of primary health centers and sub centers. By 1991, India had more than 150,000 public health facilities through which family planning programs were offered. Four special family planning projects were implemented under the Seventh Five-Year Plan. One was the All-India Hospitals Post-partum Programme at district- and sub district-level hospitals. Another program involved the reorganization of primary health care facilities in urban slum areas, while another project reserved a specified number of hospital beds for tubal ligation operations. The final program called for the renovation or remodeling of intrauterine device (IUD) rooms in rural family welfare centers attached to primary health care facilities.

The Indian programme has been in operation for about five decades although an all out effort was made only about 30 years ago. The programme seems to be more successful in states that are relatively at a high level of economic development. The birth rate has not come down.

There is a positive relationship between adherence to traditional social cultural norms and birth rates in India. There is a positive relationship between economic development and acceptance of family planning in India. The family planning is more accepted in states where high level of economic development is there. There is a negative relationship between economic development and birth rates in India. That is, states in India, which are at a high level of economic development, will have low birth rates.

Economic development was measured by examining key indicators such as per capita income, literacy rate, percent of urban population to total population, and percent of population in labor force other than agriculture. The influence of traditional social cultural norms was examined through a descriptive analysis of religion, early age at marriage, university of marriage, preference for sons, joint family system, and the caste system. The most of the Indians are below poverty line.

It is recognized that there is a very close relationship between total development of the country and population growth. There is evidence that the States, which are more developed, have a higher rate of performance. Some items (urbanization, rate of literacy, income per capita, etc.) were examined. Besides these,

the government has sought the support of women's organizations, trained social workers and industrial Christian Missionary. The level of development could be one factor. Implicit in this argument is the view that if there is development, the problem of population will take care of itself. This could even be an escapist approach. The need to work for total development cannot be overstated but this should not prevent continued frontal attacks on population control.

The political support in India for the family planning programme has been examined from the inception of the programme. None of the political party manifestos made a reference to the population problem since the inception of the family planning programme.

Many have emphasized the need for a forthright political commitment. Some political parties are opposed to the programme, which makes it difficult for other parties to come out openly for the programme. It is a sensitive area as there are religious and political overtones.

The unambiguous support of the political leaders could make a change in the attitudes of the people. One State pointed out that it had two seats less in the Parliament because of reduction in the population. There are some factors of caste and religion were also became the integral parts of the family planning. However, there are some unfavorable factors with which India has to contend. Perhaps the most distressing of these is injecting of communal and religious bias into the programme while the government has made every effort to keep it truly national, above and beyond party and religious and caste politics certain parties with religious and caste affiliations and overtimes have attacked the programme on the ground that its actual implementation is changing the ratio among the existing religious groups.

Social and cultural attitudes were not favorable to family planning. Muslims, Christians and other ministry religious community's composition of the Indian population show no signs of changing. The status of women in rural areas is dependent on the number of children, particularly sons. The desire for old age security makes them have more children so that there is an assurance of the survival of at least some of them.

The control of birth of children is a personal matter. The relationship between

personal welfare and national welfare is not easily conceived. The programmes tend to make personal welfare an end in itself. The message of personal good being a part of social good has yet to get across. The strategy in a programme is dependent on the technology available. A search is on for a cheap, dependable, easily administered and reversible method of birth control.

It is a national programme with a vast infrastructure for the implementation of the programme. There are a large number of training institutions established to train the personnel. The role of research-bio-medical, demographic and socio-economic is recognized and funds are made available for conducting studies. There is a wide network for mass education. Supplies of contraceptive have been inadequate.

The organized sector and voluntary organizations have been involved in the family planning programme. Provision has been made for feedback through the evaluation and intelligence cell. However the financial resources are not substantial. The objectives have been stated in specific and measurable terms. Although the programme operates by itself, its relation to other aspects is recognized. On the whole, accomplishments are commendable. However, on many grounds it appears likely that mortality rates and population growth rates have begun to drop.

The major problem has been of getting qualified personnel. Only a little more than half the required staff is in position at the rural level. Apart from this there is mobility. The involvement of the States is minimal. States do not seem to have any programmes and the programmes are centrally sponsored and funded. The targets are set in a rather mechanical manner.

The mass media have not got across the full message of the programme to the public. The programme continues to operate in isolation and has not involved the general administration very much. Sufficient use of research institutions is not being made to get a comprehensive feedback. There is no clear political commitment to the programme.

The role of the extension educator has come in for many discussions. The need for motivating the people is accepted. Both in Tamil Nadu and U.P. the feeling is that they have not been able to build rapport with the community. Most of the extension workers are trained social scientists. Unfortunately, at times, the

appointments have been political.

The family welfare programme has affirmed and in places suffered setback on account of centralized planning and forgot setting from the tap.

To assess the generalizability of the demographic transition theory, variable death rate was introduced in the regression model used to analyze the data. To measure the effect of family planning program, the variable percent of couples protected against risk of pregnancy was used. Unlike most of the other studies which compare developed and developing countries to study the phenomena of fertility, mortality, and economic development, this study has used a state in India as the unit of analysis.

There is a positive relationship between death rates and birth rates in India. There is a positive relationship between economic development and acceptance of family planning in India remains inconclusive. However, the affect of family planning in India cannot be completely ruled out.

The programmes seem to be more successful in states, which are relatively at a high level of economic development. This implies that it may not be prudent to invest large sums of money in family planning programs in states, which are at a low level of economic development. Instead more efforts should be made to improve the economic situation such as improved literacy, increasing urbanization and industrialization etc.

Education proved to be an effective instrument of population control. Compulsory education is an important element in the development strategy. At present, especially in the rural areas, conditions are not conducive enough to motivate parents so send their children to school. Female literacy is extremely low.

Large amounts of money need to be invested in the educational system, including free education up to high school level, free school lunch programs, and a good transportation system. Special emphasis must be placed in educating women, especially in rural areas. This development must go hand in hand with creating job opportunities for women outside of their homes and training women for urban occupations. Purposeful education and consequent economic freedom will enable women to decide when and whom they will marry or whether they will be

homemakers or career women or both, how many children they will choose to bear and whom they will have. This will be both the cause and consequence of the biological emancipation of the woman of India.

Mortality, fertility and fertility control are closely interwoven in an intricate web of relationship. To treat family planning as a categorical isolated service instead of treating it in the context of an effective and personalized means to keep children alive and well is a big error. The need for the study of small communities regarding frequencies and causes of preventable deaths has been voiced time and again.

Current population policy does not address itself to the important question of old age security. At present, only a small number of government employees and employees in some private industries are covered by pension and retirement plans. The approach of the government is to make family planning programme as one of people's operation with government cooperation. The predominant rural population still depends on sons to care for the aged.

Findings from the field

The percentage of acceptors of family planning is not same in the both villages. Family planning is an intimate aspect of individual's personal life. It can be presumed that younger people show greater interest in family planning than their older counterparts and it is a good sign for the programme. The elements of coercion should not be in the family planning programme. People are not happy with the role of the Government. People's perception about the programme is not positive. The progress of the programme is invisible. Social and economic factors made people to have additional children. Respondents wanted to have permanent incentives. They did not have substantial awareness about the programme.

The major responsibility for the programme, planning and policy formulation rest with the central government and execution of the plan is the responsibility of the state government. This situation has reduced the state governments to mere agencies of the central government. The state governments playing only a passive role and majority of them seem to be happy with the situation. So there should be equal distribution of the powers between the Central and state Governments.

One more could be derived from the available literature and from the field that

if funds are withdrawn from the central government one day the state governments will become tools in the hands of the central government and Constitutional structure will be break down. This is not a good sign for the programmatic and it is very clear to note that active involvement of the state governments and central governments is necessary for the success of the programme. The organizational strategies should not be based upon inadequate or non-existing empirical foundations. Administrative perspective and skills are often missing from family planning programme. It should not be.

The nature of the programme made by the government to control the growth of population is temporary which does not make the people, the staff and the states enthusiastic about taking initiative in the field. The nature of the programme should be permanent. The rigidity of the center affects the programme as local conditions differ from state to state. The attitude of the Central Government should be so flexible. The strategies for the realization of the set goals need to be suitably modified and made relevant to each state. The states need to be given administrative and financial flexibility to adapt the programme according to their requirements, keeping in view of the local conditions.

The data collected from the field was used to find out the impact of the family planning programmes. The data showed the people's perception on the family planning methods in both the villages. It differs from one village to another village. The most of the respondents were positive towards the family planning methods. But they were not satisfied with the running system because they do not have adequate incentives to allure the respondents from the field. The most of the respondents have expressed that if incentives are more acceptances of family planning also will be more. They did not have an idea about the problem concerning growth and considered controlling the population as a good measure. This shows that people's cooperation should not be default. The population policy must, therefore, give direction for seeking people's cooperation.

The field data shows that there is a need to provide greater facilities and to provide ample incentives to the people to motivate them to adopt the family planning as a small family norm. It is interesting to note that the majority of respondents have expressed that they have knowledge about family planning and they are to pro-small

family set-up. They have to be persuaded by education to come forward and accept the idea of small family norm. Majority of the respondents did not favor it and it should be allowed only for health reasons.

So far many measures have been taken up by the Government of India to control the growth of population. Plans and policy statements are indications of concern of the government. The impact of the policies assessed through effective evolution of the programme following its implementation. Techniques and new methods are needed and welcomed for controlling the growth of population control.

The same structure and components of policies must be relevant to be skills and attitudes of people. Population must be combined with population education so that social responsibility could be inculcated in the public. Whatever it may be for lowering the birth control the programmes, inputs, socio-economic development and legal provisions are some of the important roles have is played. The administrative structure needs to be efficient and effective and geared to get the help of the people for whom the programme has been developed.

The temporary status of the staff of the programme needs to be reviewed. Population trends and population policies are to be interlinked in numerous ways. It has been observed that high fertility rate is one-way response to the social ties and economic shortcomings of the system. It is difficult for family planning to succeed without parallel changes in the social situations, the living conditions of the masses.

Some Tentative Suggestions and Recommendations

Despite five decades of effort by the Government of India to promote the adaptation of family planning methods, a large percentage of couples report unmet for contraception. If this unmet need could be met, population stabilization goal would be achieved. Although these suggestions have not come out my study the same may be considered for further study.

India's Family Welfare Programme placed heavy emphasize on sterilization as the major method of family planning. For providing sterilization services requires well-trained medical personnel and well-equipped facilities. A permanent and rigid method may not be preferred when levels of infant and child mortality are high, or because of religious beliefs. So there is a need to expand the range of choices of

contraceptives as well as to improve the quality of services provided to couples, both in rural and urban areas. There is an urgent need to restructure the existing family planning programme.

The research and studies should be focused on poorly performing states based on the available data and Surveys. There is a wide gap between the health infrastructure and manpower in those states. To bridge the gap between these two, the Government of India should have to make a more flexible approach. Care should be taken to ensure the uninterrupted supply of essential drugs, vaccines and contraceptives of required quality and quantity to all the people.

The State Governments and Panchayati Raj Institutions should have to play a bigger role in the supervision and monitoring of PHCs. In most states the PRI involvement is not very effective mainly because the population programmes are not functioning or not representing effectively poor people. Even when the family planning workers are active they have no authority to change the existing system. They have to be given authority. In many cases, there is a need to develop better co-ordination mechanism between local self-governments and health care institutions. It is necessary to orient the PRI members about their roles and responsibilities in providing better public health services as well as the need for assigning top priority to health issues among the activities of the PRIs.

There should be concerted efforts necessary to improve the coverage and quality of registration of births, deaths, marriages and pregnancies. A motivated ANM, Anganwadi Worker should play an important role in this regard. The complete registration of births can be entrusted to the local bodies with clear-cut guidelines. There should be strict enforcement of the Child Marriage Restraint Act, 1976, implying prevention of marriages of girls and boys below the legally permissible ages of 18 and 21, respectively, would facilitate not only reduction of high risk teenage pregnancies but also help in human resource development amongst these younger girls and boys during their formative years towards improvement in the quality of life in the long run. .

The structure of the antenatal and institutional delivery care is doing well in some parts of the country. It should help towards reduction in neo-natal component of

infant mortality as well as maternal mortality, which in turn has externalities towards better acceptance of the family welfare program interventions and thus accelerate the process of fertility transition and population stabilization.

To improve the operational efficiency of the programmes, the Health Management Information System (HMIS) needs to be strengthened. The timely and accurate information gives the health managers the ability to monitor inputs and outputs of the system and help them to assess the costs and returns from various procedures. In many cases, measuring performance and distributing that information will automatically provide certain incentives for the service providers to perform.

The success of the Family Welfare Programme depends to a great extent on the personnel who are working in various institutions meant for the adoption of the family planning methods. Regular in-service training to enhance their knowledge and skills and to familiarize them with the new programmes should become a part of regular activity of the health department. They should also be in a position to develop local level health plans taking into account the health conditions of the people and their requirements.

Incentives for family planning acceptors and disincentives to those opposed it have resulted in an explosion of controversies, some arguing in defense of them and others against. But these controversies are based largely on personal perceptions of individual analysts rather than on people's perception. The policy framers should give importance to people's will before they frame policies.

The structure of incentives and disincentives were not so encouraging to the people to accept family planning. The measures adopted under the new policy were not appreciated. The element of compulsion was removed. It is clear that, better result can be obtained by educating the people about it unless they are willingly co-operating it is difficult to keep their interest sustained in the programme. The analysis of data shows that total tubectomies figures did not show the same trend. It seems the coercive methods were not in practice. The government of India has failed in caring out set targets. And also disincentives also were not forced. Moreover the element of coercion was not appreciated. It is the duty of the government that of the country need to be educated about family planning so that its acceptance becomes voluntary.

The vast numbers of the people of India should be treated by the policy makers as a greatest asset. In order to stabilization the growth of population there should be an effective dialogue and co-ordination between the Government and the subjects. The following activities should be taken up. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a steady, equitable improvement in family incomes, will facilitate early achievement of the socio-demographic goals.

There has been some attempt to get the cooperation of the private practitioners, to spread the message of family planning in the rural areas. Over two-thirds of the rural people go to the indigenous medical practitioners. Their help could be sought to motivate the people to limit the size of the family. The traditional village midwife should help though she has been rather reluctant—efforts must continue to get her cooperation. The Government should recognize the services of village midwives. The Government should give a pious place to these people in their policies.

About 60% of population is below 25 years of age. The age groups concentrated on, so far are higher. The younger age group needs to be educated as early as possible. The educational institutions should be brought into the programme more prominently. In the rural areas, through the workers in the community development programme (both male and female) and the panchayat leaders, the lower age groups should be contacted. The government should make policies to educate the rural youth about the programme.

A pre-counseling programme should be introduced. The training programme for the personnel should include sessions on pre-counseling. They should be told what action to take for specific reactions. This could help in creating greater confidence and for a better follow up.

Studies in depth must be conducted which would throw light on the causes for differential performance. Research studies on motivation among workers, the administrative system, the impact of training, are necessary. Providing tenure to the workers would mean better motivation. The programme could be specified as an indeterminate period rather than ten years duration. The training of the workers

should be broad-based so that they could be absorbed in other health programmes with some orientation if need be. The multi-purpose approach might provide a solution.

The programme for controlling the population is a long-standing one. Substantial progress has been made—the most important of which is the creation of an infrastructure reaching the remote areas of the country. The progress has not been as rapid as planned. There should be a real concern regarding this.

There should be sense of helplessness in the Department family planning. Some States have even suggested compulsory sterilization after specific number of children. The Union Health Minister in a recent speech said that at present it was not necessary to consider such a proposal. There should be dynamism in the programme as various schemes are being tried. So it is not beyond the scope of the organization to achieve the targets set.

The major objective of the population policy must be to make people accept the small family norm as the top most point to control to achieve this, mere technocratic approach can not be the solution to the growth of population. It is also important to know that people are made to aware the life of high quality possible with a small family because of more leisure, more resources and more happiness. There was a change from traditional attitudes to modern attitude i.e. small family norm. The efforts of the voluntary organizations have been so limited and diffuse, their workers so few, their funds so small as to make appear too restricted to doing local good deeds rather than bring capable of national political influence.

The Family planning programme should become a national movement with commitment to curb the population growth. Important elements of such movement are active participation of all sections of people particularly women so that it had become a people' movement which at present is viewed by the public as a routine governmental activity, propagation of a happy family concept rather than a small family concept as has been the case so far.

There should be different policies and measures to suit different regions and the rural population. It is so because there are differences in respect of population growth in different regions in terms of rural and urban areas. Social conditions and

growth rates differ from one state to another state. Among states there are many differences. Significant differences among states also exist in respect of age at marriage.

One more important key remedy lies in empowering the women by involving them in decision-making in respect of the family size and spacing of children. Women should be empowered. This is achieved by improving the conditions of women by providing education, health care, and economic opportunities. Infact measures for population control should be such as place women at the heart of the development agenda.

It should be recognized that there is an urgent need for improving the existing set of methods to control population growth in this respite. Infrastructure for family planning needs to be vastly expanded and its fuller utilization is ensured. New incentives to be introduced to encourage women to pursue education and to delay marriage. Research should be made fruitful, both by making use of the existing results, as also by looking into new areas such literacy and marriage age, literacy and birth –control devices etc. Voluntary agencies are sought on a much larger scale than at present for the conduct of the family planning programmes.

On the one hand, efforts are to be made to improve the quality of life of the people through accelerated economic development and on the other constant measures are taken to the population control. It has been a continuous fight for matching the developmental effort with the ever-raising population. In India people are bound by tradition, ignorance, poverty and unemployment. The social and religious customs are such that a couple wants to have at least one or two sons. It is, therefore, very difficult for any government to bring change in the attitude and practices of people concerning family norms in a short time. The policy makers should not violate social and religious customs of the people.

The heavy centralization of India's family planning programs often prevents due consideration from being given to regional differences. Centralization is encouraged to a large extent by reliance on central government funding. As a result, many of the goals and assumptions of national population control programs do not correspond exactly with local attitudes toward birth control. There should be mutual

understanding between the states and union Governments.

The family planning programme cannot succeed only as an official programme. Its success depends much on the initiative and people' cooperation. It has to be achieved with the help of people. Diagnostic approach is also required to review the policies time to time. It helps in developing and introducing corrective policies by the governments in India so that the programme moves in right direction.

It is very clear that the family planning programme, like other programmes has different levels of objectives. There are a lot of differences between the immediate objective and the ultimate objective. The immediate objective is the extent to which the population makes use of services offered by the programme. The ultimate objective of the programme is to reduce the fertility rate so that its impact can be felt in terms of birth rates. The services are delivered to the public depends on a variety of variables such as demographic, socio-economic and programme inputs. The family planning programme should become a subject, which concerns people's personnel life. Communication among the family members should also be an important factor in the decision making process about the number of children a couple would like to have.

However, the total number of acceptors of the family planning from the inception to the present day has increased. Most of them have accepted sterilization method. During the time of emergency period efforts were more in direction of sterilization. Large number of family planning camps was organized for the public. Sharp increase in the number of sterilizations and leading to corresponding decrees in the acceptance of conventional contraceptives presents an interesting picture.

Family planning is focal point of planned development. It should become a people' movement. Population and development are congruent concerns and, therefore, must be pursued simultaneously. It must be recognized as essential instruments of social change. The relating to this must be carried out within the overall framework of social and economic development in the spirit of humanity.

India's Family Welfare programme placed heavy emphasize on sterilization as the major method of family planning. Many other Asian countries started their

family planning programmes with spacing methods and then gradually introduced sterilization. Providing sterilization services requires well-trained medical personnel and well-equipped facilities. A permanent method may not be preferred when levels of infant and child mortality are high, or because of religious beliefs. Therefore, sterilization should be the last resort than the first one in the contraceptive choices given to the public. So there is a need to expand the range of choices of contraceptives as well as to improve the quality of services provided to couples, both in rural and urban areas.

Concerted efforts are necessary to improve the coverage and quality of registration of births, deaths, marriages and pregnancies. A motivated ANM, Anganwadi Worker or ASHA can play an important role in this regard. The responsibility of ensuring the complete registration can be entrusted to the local bodies with clear-cut guidelines.

Stricter enforcement of the Child Marriage Restraint Act, 1976, implying prevention of marriages of girls and boys below the legally permissible ages of 18 and 21, respectively, would facilitate not only reduction of high risk teenage pregnancies but also help in human resource development amongst these younger girls and boys during their formative years towards improvement in the quality of life in the long run.

Focused attention on antenatal and institutional delivery care would help towards reduction in neo-natal component of infant mortality as well as maternal mortality, which in turn has externalities towards better acceptance of the family welfare program interventions and thus accelerate the process of fertility transition and population stabilization.

Population stabilization is a multicultural Endeavour requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a

steady, equitable improvement in family incomes, will facilitate early achievement of the socio-demographic goals.

Family planning should not erode into public health programmes. Integrating them with primary health care has slowed down the health care services especially maternal and childcare services and is beginning to harm both. While in some states like Kerala, they can deal primarily with problems of sterility and in others they can deal with facilitating women to space and limit their family size.

Demographically, the impact of a programme on fertility so far has been seen by the reduction in the fertility rates among women above the age of 30, because of the emphasis on sterilization as the major method of family planning. This trend has to be changed. There can be no uniform population policy at the national level. The center should encourage states to develop and implement their own state level population policies and serve as friend, philosopher and guide to the states.

There is no need to have uniform demographic goals as achieving replacement level of fertility by the year 2010 as mentioned in NPP 2000. Each state should be encouraged to have its own goal in terms of meeting the unmet need of contraception through the family planning clinics.

The rate of population growth was a major concern for Indians since the beginning of the twentieth century. The intellectuals had voiced concern about the impact of population on the resource base and the future development of the nation. The political leadership of the country readily recognized the problem of population growth.

It would be wrong to claim that India's population policy has failed completely because population growth has accelerated in spite of the positive impact of family planning programmes. Demographic inertia must be taken into account. The birth rate did fall sharply, but since the death rate also fell, the growth rate did not come down. It appears India's young population hampers the target of rapid population stabilization. Even though fertility is falling, the number of people of childbearing age is increasing, so the number of births remains high.

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International Women's Health Coalition - www.iwhc.org

ISIS Women's International Cross Cultural Exchange – www.isis.org.ug

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APPENDICES
APPENDIX--A

MILESTONES IN THE EVOLUTION OF THE POPULATION POLICY OF INDIA

1940 The subcommittee on Population, appointed by the National Planning Committee set up by the President of the Indian National Congress (Pandit Jawaharlal Nehru), considered 'family planning and a limitation of children' essential for the interests of social economy, family happiness and national planning. The committee recommended the establishment of birth control clinics and other necessary measures such as raising the age at marriage and a eugenic sterilization programme.

1946 The Health Survey and Development Committee (Bhore Committee) reported that the control of disease and famine and improvement of health would cause a serious problem of population growth. It considered deliberate limitation

1946 Bhore Committee Report of births desirable.

1951 The draft outline of the First Five Year Plan recognized 'population policy' as 'essential to planning' and 'family planning' as a 'step towards improvement in health of mothers and children'

1952 The final First Five Year Plan document noted the 'urgency of the problems of family planning and population control' and advocated a reduction

in the birth rate to stabilize population at a level consistent with the needs of the economy.

1952 Launching of Family Planning Programme

1956 The Second Five-Year Plan proposed expansion of family planning clinics in both rural and urban areas and recommended a more or less autonomous Central Family Planning Board, with similar state level boards.

1959 The Government of Madras (now Tamil Nadu) began to pay small cash grants to poor persons undergoing sterilization as compensation for lost earnings and transport costs and also to canvassers and tutors in family planning.

1961 The Third Five Year Plan envisaged the provision of sterilization facilities in district hospitals, sub-divisional hospitals and primary health centres as a part of the family planning programme. Maharashtra state organized 'sterilization camps' in rural areas.

1963 The Director of Family Planning proposed a shift from the clinic approach to a community extension approach to be implemented by auxiliary nurse midwives (one per 10,000 population) located in PHCs. Other proposals included: (a) a goal of lowering the birth rate from an estimated 40 to 25 by 1973; and (b) a cafeteria approach to the provision of contraceptive methods, with an emphasis on free choice.

1965 The intrauterine device was introduced in the Indian family planning programme.

1966 A full-fledged Department of Family Planning was set up in the Ministry of Health. Condoms began to be distributed through the established channels of leading distributors of consumer goods.

1972 A liberal law permitting abortions on grounds of health and humanitarian and eugenic considerations came into force.

1976 The statement on National Population Policy, made in the Parliament by the Minister for Health and Family Planning, assigned 'top national priority and commitment' to the population problem to bring about a sharp drop in fertility. The Constitution was amended to freeze the representation of different states in the lower house of Parliament according to the size of population in the 1971 Census. The states were permitted to enact legislation providing for compulsory sterilization.

1976 Statement of National Population Policy

1977 A revised population policy statement was tabled in Parliament by a government formed by the former opposition parties. It emphasized the voluntary nature of the family planning programme. The term 'family welfare' replaced 'family planning'

1977 Policy Statement on Family Welfare Programme Both statements were laid on the Table of the House in Parliament, but never discussed or adopted.

1982 The draft Sixth Five Year Plan adopted a long-term goal of attaining a net reproduction rate of 1.0 on the average by 1996 and in all states by 2001. It adopted the targets for crude birth and death rates, infant mortality rate and life expectancy at birth and the couple protection rate, to be achieved by 2001. (The numbers were based on the illustrative exercises of a Working Group on Population Policy set up by the Planning Commission during 1978.)

1983 The National Health Policy incorporated the targets included in the Sixth Five-Year Plan document. While adopting the Health Policy, the Parliament emphasized the need for a separate National Population Policy.

1983The National Health Policy of 1983 emphasized the need for "securing the small family norm, through voluntary efforts and moving towards the goal of population stabilisation". While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy.

1991The National Development Council appointed a Committee on Population with Shri Karunakaran as Chairman. The Karunakaran Report (Report of the National Development Council (NDC) Committee on Population) endorsed by NDC in 1993 proposed the formulation of a National Population Policy to take a " a long term holistic view of development, population growth and environmental protection" and to "suggest policies and guidelines (for) formulation of programs"and "a monitoring mechanism with short, medium and long term perspectives and goals" (Planning Commission, 1992). It was argued that the earlier policy statements of 1976 and 1977 were placed on the table, however, Parliament never really discussed or adopted

them. Specifically, it was recommended, "a National Policy of Population should be formulated by the Government and adopted by Parliament.

1993 A Committee on Population, set up by the National Development Council in 1991, in the wake of the census results, proposed the formulation of a National Population Policy.

1993 An Expert Group headed by Dr. M.S. Swaminathan was asked to prepare a draft of a national population policy that would be discussed by the Cabinet and then by Parliament.

1994 The Expert Group set up by the Ministry of Health and Family Welfare in 1993, to draft the National Population Policy recommended the goal of a replacement level of fertility (a total fertility rate of 2.1) by 2010. Other proposals of the expert group included (i) removal of method-specific targets down to the grassroots level; (ii) an emphasis on improving the quality of services; (iii) a removal of all incentives in cash or kind; (iv) a National Commission on Population and Social Development under the chairmanship of the prime minister. The draft statement was circulated among the members of Parliament and various ministries at the centre and among the states for comments.

1994 Report on a National Population Policy by the Expert Group headed by Dr. Swaminathan. This report was circulated among Members of Parliament, and comments requested from central and state agencies. It was anticipated

that a national population policy approved by the National Development Council and the Parliament would help produce a broad political consensus.

1997 The cabinet headed by Prime Minister I. K. Gujral approved a draft National Population Policy, to be placed before the Parliament. With the dissolution of the lower house of Parliament, the action was postponed.

1997 On the 50th anniversary of India's Independence, Prime Minister Gujral promised to announce a National Population Policy in the near future. During 11/ 97 Cabinet approved the draft National Population Policy with the direction that this be placed before Parliament. However, this document could not be placed in either House of Parliament, as the respective Houses stood adjourned followed by dissolution of the Lok Sabha.

1999 Another draft of National Population Policy, placed before the cabinet, was remitted to a Group of Ministers (GOM) headed by the Deputy Chairman of the Planning Commission, to examine the scope for the inclusion of incentives and disincentives for its implementation. The GOM consulted various academic experts and women's representatives and finalised a draft, which was discussed by the cabinet on 19 November 1999, and which was revised further for re-submission.

1999 Another round of consultations was held during 1998, and another draft National Population Policy was finalised and placed before the Cabinet in March 1999. Cabinet appointed a Group of Ministers (headed by Dy Chairman, Planning Commission) to examine the draft Policy. The GOM met

several times and deliberated over the nuances of the Population Policy. In order to finalise a view about the inclusion/exclusion of incentives and disincentives, the Group of Ministers invited a cross-section of experts from among academia, public health professionals, demographers, social scientists, and women's representatives. The GOM finalised a draft population policy, and placed the same before Cabinet. This was discussed in Cabinet on 19 November, 1999. Several suggestions were made during the deliberations. On that basis, a fresh draft was submitted to Cabinet.

2000 National Population Policy was adopted by the cabinet and announced on February 2000.

National Rural Health Mission The National Rural Health Mission 2005 (NRHM) recently launched by the Hon'ble Prime Minister is a departure from the earlier policy and plan documents in two aspects. First, it takes the programme in a "Mission Mode" probably encouraged by the success of the earlier missions such as the Technology Mission. Secondly, more importantly, it is not obsessed by the desired goals of impact but rather it focuses on inputs, strategies and programmes to be done, and leaves the ultimate impact as an outcome of what is done.

APPENDIX--B**Questionnaire for collection of data For
People's Perception on Family Planning Programmes**

1. What is the most serious problem in India?
2. Do you know about family planning programme run by the Government of India?
3. Did you adopt any family planning methods?
4. How do you think about family planning methods?
5. How do you think of incentives and disincentives of family planning programme?
6. What would you prefer-cash incentives or Kind incentives?
What are the advantages by adopting Family planning?
7. What are the functions of the Government of India in controlling the birth rate?
8. How do think of the role of the Government of India in this programme?
9. What is your perception about the family planning run by the Government of India?
10. Did any family personnel visit your house to inform about the programme?

11. What policy exists today? Is it contraceptive, birth control, family planning, fertility control, population and population policy?
12. For whose benefit the family planning method made for?
13. What are the measures required to be taken up for adopting family planning?
14. Should there be an element of compulsion for family planning?
15. To extent have the family planning programme been accepted and to what extent have you been opposed within the inter-intergovernmental and non-government sectors?
16. What level of priority could be placed in the policy for creating awareness and acceptance of the programme in the younger generation?
17. What could be the extent of involvement of non-governmental agencies in the programme?
18. Should the states also adopt the policy resolution in their respective legislatures?
19. Should exclusively the Government of India conduct the family planning programme?
20. Should the administrative system be flexible or rigid?
21. Should monetary incentives be given?

22. What should be done by the Government of India to promote the programme?
23. What are main factors to adopt the programme?
24. What are the reasons for not accepting the programme?
25. What is your personal opinion about the family planning programme?
26. Who actually shows interest in adopting the programme?
27. What are advantages and disadvantages of the family planning programme?
28. What would motivate you to adopt the family planning method?
29. Is there any relationship between economic development and birth rates?
30. What would you think about population policies of the Government of India? Is good? Or bad?
31. Do you think the population policies of the Government away to the people or not?

PERSONAL PROFILE

Name

Age

Sex

Education

Occupation

Marital Status

Residence