Module 10

National Population Policy

Lecture 33: Family Planning Programme in India

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INTROUDUCTION

As mentioned earlier, India entered the second stage of demographic transition around 1921 after which its population started growing at rate more than 1 percent a year. Nehru wrote extensively on falling birth and death rates in the West in *Discovery of India* and was a strong supporter of family planning programme. National Planning Committee of the Indian National Congress supported promotion of family planning as a state policy strongly. This explains how after independence, the Government of India recognized the vital role of population control in the overall development of national economy and in 1952 India became the first country of the world to launch an official family planning programme. Unrestricted population growth was viewed as a serious threat to all national developmental efforts. Over the years the planners have followed different approaches towards promoting family planning among the masses. These approaches are broadly grouped into Gandhian approach, clinical approach, extension approach, cafeteria approach, coercion and rights based approach. While we started cautiously with Gandhian approach, after various experiments in this area, we have settled with a demand driven, rights based approach in which greater role is assigned to education, empowerment and meeting the unmet needs rather than attaining family planning targets This module presents the three major policy statements issued by successive governments: a statement by Dr. Karan Singh in 1976, a statement by Janata party government in 1977, and the National Population Policy 2000 statement.

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GANDHIAN APPROACH

Initially, the dominant thinking among the family planning experts in this period was Gandhian. They held the view that abstinence or "the rhythm method" was the most suitable method in Indian programme, and the artificial methods of birth control were not only unpracticable, they were likely to be misused and result in moral degradation. Rajkumari Amrit Kaur, who was the Union Minister of Health at that time was a devoted disciple of Gandhi. Thus a beginning was made with the natural methods of family planning – rhythm and withdrawal.

CLINICAL APPROACH

With the Gandhian understanding of population control, clinical approach was followed. This approach included the natural methods of family planning and clinical methods. An allocation of Rs. 65.00 lakh was made for family planning in the budget of the First Five Year Plan (1951-56) and a number of family planning clinics were established in the country to provide services to needy people. The same approach was further extended in the Second Five Year Plan period !1956-61). The budget allocation was raised to Rs. 497.00 lakh and organizational structures were developed at the national and state levels. Posts of State Family Planning Officers were created in the States, and a Director of Family Planning at the Centre was appointed.

The pilot studies carried out in the First Plan period had shown that "the rhythm method" was not effective and people were not prepared for family planning. The main causes behind the failure of the clinical approach were: female bias; jack of general motivation; cultural obstacles and ignorance. Opening of a large number of birth control clinics at that time before educating the people and raising their level of consciousness was like putting the cart before the horse. Females who constituted the target population in the programme did not enjoy the same (equal) status in the family as in the West and the Westernized Indian planners did not see that in India family planning movement could not get momentum without men's support.

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EXTENSION EDUCATION

A large number of knowledge, Attitude, and Practice (KAP) surveys were conducted in the first two Plan periods to help the planners to gather data on knowledge of family planning methods, attitude towards them and practices. The rising rather than falling growth rate of population created a panic among the planners. Thus the Third Five Year Plan stressed the role of "intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community" as a matter of the greatest significance. This paved the way for extension education approach. Under the new approach the main burden of the programme was to educate the masses by appointing an army of extension educators or change agents.

MASS VASECTOMY APPROACH AND THE USE OF COERCION

In 1965 Intra Uterine Contraceptive Device (IUCD) was introduced in the programme which produced good results initially but gradually the number of acceptors of IUCD started declining. Bleeding and rumours were the main reasons behind its failure. Then during 1972-74 mass vasectomy camps were organized in different parts of the country and the incentive schemes whereby the couples were given incentive in cash and kind for adopting sterilization was adopted. A large number of males were sterilized in them. At some places the approach appeared to be quite successful in attracting couples to family planning as it used incentives as well as group approach to family planning. However, the family planning programme failed to make headway and affect the figures of growth rate of population. There were several reasons: patriarchy because of which males were unwilling to bear the burden of family planning; rumours; failure of method in some cases; and fraudulent means to motivate people to adopt family planning.

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EMERGENCY SETBACK

Family planning programme was given utmost importance during the Emergency time when the acceptors were drawn by a technique which was quite contrary to the basic philosophy of the extension approach. Use of coercion augmented the family planning achievements in all the states in India; and some states which were always behind the target, in fact, exceeded the targets. There was a talk of making sterilization compulsory after three children and some States had even passed legislation to this effect. Population growth was viewed as a national problem of urgency and the whole bureaucratic infrastructure was used to assist in the programme. The number of sterilizations increased to 2,669,000 in 1975-76, from only 942,000 in 1973-74, and further to 8,261,000 in 1976-77. At this stage two phenomena were marked: (a) the family planning programme degenerated into sterilization programme; and (b) population control became a political problem.

CAFETERIA APPROACH

In the Third Plan period itself (1961-66) family planning was made a target oriented programme. It was proposed to reduce the birth rate in India to 25 births per 1000 population by 1973. The target was later modified to reduce birth rate to 25 as early as possible. A cafeteria approach was then adopted to provide a range of effective and approved family planning methods according to needs and preferences of the individuals, e.g., condoms, diaphragms, jelly, cream, foam tablets for newly married couples, IUCD for couples with one or two children, and sterilization for couples who have completed their desired family size.

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By 1980 the term **“cafeteria approach”** became a buzzword in family planning programme and the influence of this approach continued. It may also be said that while we have more catchphrases in family planning today, the idea that the needy couples must be informed about all the methods of family planning and all methods of family planning must be accessible to them, so that they can practice one according to their own considerations continues. Broadly speaking, the different family planning methods are divided into two categories: terminal methods; and spacing methods. The former methods refer to methods which are used when couples have completed their desired family size and do not want to produce more children; they may go for male or female sterilization. The latter methods refer to those methods which are used to create gap between successive childbirths. For example, a young couple may produce a baby quickly after marriage but may like to have another child after four-five years. Then they may use condoms or IUCD. When they want a child they may discontinue the method and plan a baby. Under cafeteria approach it was thought that we should motivate younger couples to go for delayed childbirth and use spacing methods rather than focus on aged couples and motivate them to go for sterilization. In the context of high and natural fertility, the fertility impact of terminal methods may be much more than that of terminal methods.

The basic idea behind cafeteria approaches still continues. It recognizes that different people have different needs, based on their religion, age, family size preferences, economic conditions and many other factors. The state policy should be to provide a method of their choice and not insist on any one method. Ironically, most users of family planning have gone for female sterilization. This is a situation that has not changed till now. This works against the policy of cafeteria approach and depicts male domination in society.

In India fertility has declined, partly due to family planning programme and partly due to development, but not to the desired level. The issue is: has family planning programme in India failed? One can argue both ways. In this context the views expressed by Dyson are worth consideration (Box 10.1).

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Table 1: The Time Line of Family Planning Policy in India

Before independence	**Factors behind general support for population control among the elite** • Lack of awareness among common people • Arguments in favour of population policy among the political and intellectual elites • Isolated efforts to establish clinics and inform people • Strong support for population control by Gandhi and Nehru despite difference in understanding of population dynamics and approaches to means of birth control
1952	**Family planning starts with Gandhian approach** • State sponsored family planning programme started • Gandhian approach with abstinence and rhythm as the main methods
1950-60	**Clinical approach** • Economic models suggesting a negative relationship between population growth and development • Estimation of demographic rates and ratios • Knowledge, attitude and practice (KAP) studies • Research in reproduction • Clinical approach
1960-70	**Extension approach and experimentations** • Extension programme • IUCD programme • Target orientation (Third Five Year Plan) • Organizational changes
1970-80	**Camp approach** • The concept of sustainable development • Mass vasectomy camps • National level studies in family planning • First population policy statement announced • Policy under Janata Govt. asserting voluntarism
1980-90	**Cafeteria approach** • Cafeteria approach and emphasis on limitation of family size rather than on contraception • Planning in terms of NRR (with the goal of achieving NRR of unity by 1996)
1990-2000	**Target free approach** • Collection of detailed national and regional level data on population, development and well-being • Abolition of targets • Shift from national to area specific approach
2000-	**National Population Policy 2000** • National Population Policy • Unmet needs concept • A rights based approach • HIV/AIDS • Participatory approach

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BOX 10.1: FAMILY PLANNING PROGRAMME IN INDIA

The Indian family planning programme is often dismissed as a 'failure'. But in my view this is an unjust and rather too simple characterisation. Among other things, the programme's *proper* evaluation would need to take account of:

(i) the sheer size and complexity of the task which it has had to tackle, namely reducing the birth rate in a huge, poor, poorly educated, and largely rural population
(ii) the aforementioned fact that in many respects India has been a *pioneer*; this is most commonly illustrated by the statement that it was the first country in the world to announce an official family planning programme (in 1952). But actually India has led the world in many other ways too (e.g. in the development of several methods of sterilisation). The main point I am making, however, is that it is particularly difficult to be a pioneer, and that pioneers inevitably tend to make more mistakes than those who follow and,
(iii) the fact that in the past some politicians have shied away from their duty of ensuring that Indian women, and men, have a real 'right to choose'. By this I mean their responsibility of making sure that everyone has access to safe, effective and affordable methods of contraception. Indeed there are still significant parts of the country where this 'right to choose' needs to be expanded. But this requires political backing and greater resources.
Of course, India's family planning programme has had its failings. For example, it has been much too 'target-bound', and for much too long it has badly neglected the promotion of *reversible* forms of contraception (today about eighty percent of all married women who are currently using a modern method of contraception are relying upon sterilisation (i.e. tubectomy)).
Nevertheless, despite its problems, there can be little doubt that the Indian birth rate would be somewhat higher today, and the country's population would be larger still, if the family planning programme had not existed.

- From Dyson (2003)