B. Ghosh

India's Population Policy—An Appraisal

INDIA has been the first country in the world to launch an official family planning programme in early 1950s. With the advent of planning aimed at social and economic transformation of the population, emphasis on population control has progressively increased. The first five year plan (1952-56) provided for an outlay of Rs. 65 lakhs of which Rs. 14 lakhs were actually spent. The plan outlay on family planning increased from Rs. 65 lakhs in the first plan to Rs. 497 lakhs in the second, Rs. 2698 lakhs in the third, Rs. 33000 lakhs in the fourth and Rs. 56000 lakhs in the fifth plan. This led to substantial expansion in the infrastructure for family planning services. During the first plan period 147 family planning clinics were established, by the end of second plan the number of clinics grew to as high a figure as 4165. As on September 1, 1974, the number of main family planning centre (rural) under Primary Health Centres (PHCs) stood at 5132 supported by 33370 subcentres of which 18255 were under family planning programme. Was this phenomenal growth the result of conscious policy planning by the authorities, or was it a process of evolution conditioned by diverse social, political and demographic forces?

Evolution of Policy (1951-75)

The belief that there was already some intrinsic demand for family planning services and that supply would induce demand, prompted the Government to open family planning clinics during the first plan. The people were expected to walk on their own into clinics to demand and receive family planning services. There was no conscious effort in this 'clinic approach* to educate the

married couples in the need for family planning or to impart knowledge in family planning method.

Whatever be the explanation for the cautiousness or conservatism of this approach, it evidently resulted in loss of time, which is a vital variable in demographic processes. Adoption of family planning methods during this period was very limited. This realisation influenced the government to turn increasingly towards an educational approach to population control. It took almost a decade of planning experience to initiate the 'extension approach' in place of *clinic approach* during the third plan period. This marked the beginning of an active information-education-communication approach to create awareness of family planning methods and motivation for contraceptive practice. The total number of family planning acceptors grew from 7153 to 104,585 in 1961 to 2,261,699 in 1966-67, which is a substantial progress indeed (see Table-l).

Even with this level of programme achievement, according to calculations of the Department of Family Planning only 4.5% of the couples in the reproductive age group were 'protected' by family planning methods in 1966-67. The programme policy makers introduced two innovations during 1966-69 to raise the level of acceptance. On the ground that acceptors of IUD and sterilisation need to be compensated for their loss of wages and out-of-pocket expenses connected with the acceptance of these methods, a system of payment of incentives to acceptors of these methods was introduced. Further, the programme administrators experienced difficulties in promoting family planning adoption per seand thought that integration of maternal and child health services with family planning would help to promote the latter. This integration idea was, however, implemented only in paper in most states. So, apparentely only the introduction of the incentive system led to an increase in the number of acceptors from 2,261,699 in 1966-67 to 3,768,487 in 1970-71- The resulting contraceptive protection amounted to 11.6% of couples. Incentives were, however, perceived by some scholars and even by some acceptors as a 'bribe' for accepting family planning (Pohlman, 1971). Incentive money was also paid to family planning workers and other officials and non-officials who procured cases for sterilisation. It is not unlikely that this had encouraged some corrupt practices among motivators, leading to deterioration of demographic quality of family planning performance. The success of two sterilisation campaigns in Kerala held in November-December 1970 and July 1971, where relatively higher incentives were paid, prompted the policy makers to try the 'mass vasectomy campaign

TABLE 1—FAMILY PLANNING ACCEPTANCE IN INDIA SINCE 1956

Year	*Sterilisations*	*IUD Insertions*	*c.c. Users*	*Total acceptors*	*Percent of Tubectomies to total sterilisations*
1956	7,153	—	—	7,153	66.5
1957	13,736	—	—	13,736	69.8
1958	25,148	—	—	25,148	53.5
1959	42,302	—	—	42,302	58.3
1960	64,338	—	—	64,338	41.6
1961	104,585	—	—	104,585	38.9
1962	157,947	—	—	157,247	28.9
1963	170,246	—	297,613	467,859	32.7
1964	269,565	—	438,903	708,468	25.4
1965 Jan. to 1966 March	670,823	812,713	582,141	2,065,677	14.0
1966-67	887,368	909,726	464,605	2,261,699	11.5
1967-68	1,839,811	668,979	475,236	2,984,026	10.4
1968-69	1,664,817	478,731	960,896	3,104,444	16.9
1969-70	1,422,118	458,726	1,509,378	3,390,222	25.8
1970-71	1,329,914	475,848	1,962,725	3,768,487	33.9
1971-72	2,187,336	488,368	2,354,191	5,029,895	25.9
1972-73	3,121,856	354,624	2,397,904	5,874,384	16.3
1973-74	942,402	371,594	3,009,995	4,323,991	57.2
1974-75	1,349,045	430,269	2,516,870	4,296,184	54.8

SOURCE : Family Welfare Planning in India : Year Book 1974-75.

approach' at a wide scale. Apart from higher-than-usual incentive rates, this approach had the following special features : (i) location of camps in state, district/taluks headquarter or at a hospital or village level; (ii) payment of

reward to motivators, in addition to incentive payments and issue of special certificates etc. to officials; and (Hi) an intensive mass communication programme.

Most successful mass campaigns benefitted from dedicated leadership at state, district and lower levels. The adoption of 'mass vasectomy campaign approach' helped to raise the total number of acceptors from 3,768,487 in 1970-71 to 5,874,384 in 1972-73. The percentage of couples with contraceptive protection rose during the period from 11.6% to 15.8%. Although the campaign approach proved highly successful in the states like Kerala and Gujarat, the poorly administered campaigns in some other Indian states created doubts in the minds of academicians and administrators about the merit of this new approach (Ghosh, 1976). Some academicians went all out to recommend that "the mass vasectomy camp approach should be immediately stopped" (Banerji, 1974). The glaring failures of the approach were much talked about, and its two salient merits were totally lost sight of : (i) the campaign approach could yield performance levels considerably higher than what could be achieved in a normal programme; and (ii) it could succeed in generating massive acceptance in areas inhabited predominantly by socio-economically weaker sections who were not adequately accepting contraception in a normal programme (Ghosh, 1976).

There were also financial cuts in the budget resulting in suspension of camps. The new approach was, thus, abandoned without any serious effort to improve its performance through better styles and techniques of management. This led to a fall in sterilisations from 3,121,856 in 1972-73 to 942,402 in 1973-74. Though the performance of the programme in 1974-75 was better, the tempo of the programmes remained at a low ebb till the announcement of a 'National Population Policy' in April 1976 by the Central Government.

The Cafetaria Approach

In the early stage (1956-62) of the programme 'sterilisation* was the principal method available to couples interested in family planning. Female sterilisations (tubectomies) dominated the scene in the early years (66.5% tubectomies), but their proportion declined consistently till it reached as low a level as 28.9% in 1962. In 1963 the distribution of conventional contraceptives such as foam tablets, jelly/cream, diaphragm and condoms became a regular function of the PHCs. The IUD (loop) was introduced in the programme in 1965. At about this time, the talk about 'cafetaria approach' started. Under this approach the

people were to be given all the information regarding all the available methods of contraception from which individually they could freely choose a suitable method,

In 1965-66, the first year of its introduction, the number of IUD insertions reached a figure of 812,713, which marginally improved to 909,726 in 1966-67. Subsequently it declined. This shows that the 'cafetaria approach' was not consciously followed even in the early years of its introduction. The programme had always been seen to push one method or the other to the forefront. Condom was put on the commercial channel in 1968-69 and the distribution of conventional contraceptives immediately doubled to record 960,896 C.C. users. The stagnation in the use of IUD was accompanied by a consistent rise in the use of conventional contraceptives. In 1971-73, the years of mass vasectomy camps, the number of sterilisations doubled or tripled over the 1970-71 level, while the number of IUD and C.C. users stagnated at the previous level, or even declined. The downward trend in proportion of tubectomies among sterilisations was reversed after the mass vasectomy camps. Extra emphasis was placed on tubectomy camps and the percentage of tubectomies rose from 16.3% in 1972-73 to 57.2% in 1973-74 and 54.8% in 1974-75. The oral pill offered so far under pilot projects was introduced for more extensive distribution in 1974. The enactment of medical termination bill made available legal abortions from 1974 onwards. Even among the conventional contraceptives, whereas distribution of condom increased by more than 20 times between 1963-64 to 1974-75, the distribution of diaphragms during that period came down to one-tenth and that of jelly/cream tubes declined to one-third of its former level. Similarly the distribution of foam tablets also fell in 1974-75 to about one-tenth of its level in 1963-64. It is true that the performance of different methods of family planning depended heavily on the relative popularity enjoyed by each method; however the relative popularity itself was constrained by the vigour with which individual methods were pushed by the programme and the field workers on account of the target orientation of the programme. 'Cafetaria approach* proved therefore to be only a theoretical concept. The people did not really get an opportunity to know the merits and demerits of different methods so that they could exercise a free choice in the matter.

Population Policy Statement (1976)

A historic population policy statement was announced in April 1976 by the Central Ministry of Health and Family Planning. This was the first time that

the policy and approach to the population problem was clearly and specifically enunciated for the benefit of the citizens, putting an end to many controversies and uncertainties regarding the family planning programme. It reasserted that the population problem would be treated as a top national priority and with commitment. An integrated package of health, family planning and nutrition would aim at through reorienting medical education, restructuring the health care delivery system, and elimination of ignorance, illiteracy and superstitions. Stress was laid on population control without waiting for education and economic development to cause fertility decline. It set the goal of reducing the birth rate from 35 to 25 per thousand population between the beginning of the fifth plan and the end of the sixth plan. It specified that legal minimum age of marriage would be raised to 18 for girls and 21 for boys. Further, it pronounced that allocation of central resources to states and representation in parliament/legislatures would be decided according to 1971 population sizes until the year 2001; that special measures for raising levels of female education will be adopted; that population values will be introduced in the educational system; and that intensive monitoring of family planning performance and review by the Union Cabinet at least once a year would now be a regular feature. It provided also for a differential incentive scheme based on number of living children, introduction of group incentives, and extension of facilities for sterilisation and MTP to rural areas.

It envisages increasing use of voluntary organisations for promotion of family planning and continuing research in reproductive biology and family planning. As regards the highly controversial measure of compulsory sterilisation, it was left to individual state governments to decide the issue keeping in view the available infrastructural facilities. The states willing to pass legislation on compulsory sterilisation were advised to bring in the limitation after three children. It was left to the states to introduce measures such as preference of allotment of houses, loans etc. directed towards employees and citizens. The Union Government also proposed to amend service/conduct rules to ensure acceptance of small family norm by its employees. A multi-media motivational strategy was to be evolved and used to spread the message of family planning throughout the country.

Evaluation of the 1976 Population Policy and Programme

The policy in effect outlined two approaches towards solution of the population problem; *(a)* beyond family planning measures, and *(b)* measures to

encourage family planning practice. Measures following under the first category like raising age at marriage and female education, were readily appreciated by many academicians; however, it has also been contended that, a minimum age at marriage of 18 for girls will not quite achieve a demonstrable demographic impact; it is not likely to further promote responsible parenthood; and that it would not make a decisive difference in the matter of safeguarding the health of the mother and the child (Mitra, 1976*a*). Further, its implementation has been widely held in doubt; would it not be only on paper like the 'Sarda Act'? Raising female educational level was certainly welcome, but this required some basic changes in social values of the people. The need to involve voluntary organisations, to conduct research in reproductive biology and family planning and to integrate health services through a multi-purpose worker approach were also generally appreciated.

The policy statement did not consider some of the other aspects important in influencing fertility. The impact of mortality on fertility for instance was not taken into account. Similarly, impact of increased female labour force participation as well as of economic and social considerations on fertility decisions etc. have not been explicitly considered in shaping the 'beyond family planning' measures incorporated in the population policy. It was also unclear as to how the government was going to operationalise some of the 'beyond family planning' measures.

The policy statement's explicit reference to compulsory sterilisation implied indirect support of the central government on this issue. This intensified the debate on this controversial subject leading to increase in the apprehensions on the part of academicians, administrators as well as the citizens. The state governments of Maharashtra, Punjab, Haryana etc. took steps to enact a law for this purpose. The social environment was not conducive to such a law and hence it could not finally be enacted. The problem of implementing a social legislation like this was perhaps being underplayed. "It is difficult to believe that a society that cannot ensure complete registration of births and deaths or compulsory primary education for all children is either ready for compulsory sterilisation and family limitation or has an adequate base for implementing such a policy without the possibility of gross abuse" (Visaria and Jain, 1976).

The policy statement implied that there was going to be special emphasis on terminal methods. In any case, the policy did not highlight the importance of promoting non-terminal methods. The statement was in effect indifferent to

the findings of a national level study undertaken in 1970 that 'vigorous promotion of non-terminal methods could lead to substantial increase in the practice of family planning' (ORG, 1973).

About its immediate impact on the society, the editorial in Centre Calling (December 1976) claimed, "Never before in the history of family planning programme in the country the popular response to the concept of small families has been so overwhelming. It seems as if a tidal wave of enthusiasm has suddenly swept over all inhibitions, hesitations and perhaps indecisions. Large crowds of acceptors are queuing up for sterilisation in cities and villages alike." As seen from Table 2, not only a high annual performance figure was achieved by 17 states and 3 union territories which exceeded their sterilisation targets in the first eight months, some of these reached their targets within the first quarter itself! The level of acceptance was so high that it was even beyond the expectations of the Department of Family Planning. In the seven months period April 1976-October 1976 alone nearly 5 million sterilisations were performed against nearly 22 million in the previous 20 years. The three states Madhya Pradesh, Uttar Pradesh and West Bengal performed in April-October 1976, 17-18 times the number of sterilisations it performed in April-October 1975. Bihar and Rajasthan improved their sterilisation performance by nearly ten times in the same period. Other states also achieved a much improved performance.

The reasons for this spectacular success as viewed by then Government can be summarised as follows :

(i) Commitment of state leadership increased after the policy announcement ;
(ii) Policy announcement and subsequent actions were made at a time when awareness of importance of family planning was high, but acceptance rate was low;
(iii) Extension of responsibility for motivation to all other departments in addition to the medical departments ;
(iv) Special directives from the state government to eligible employees ;
(v) Announcement of national emergency and the national policy ;
(vi) Effective monitoring of programme performance ;
(vii) Incentive at individual/community level and dis-incentives ; and
(viii) Integration of family planning with MCH etc."

(See Centre Calling, Vol. XI, No. 12, December 1976 for detailed discussions on the subject).

TABLE 2—FAMILY PLANNING PERFORMANCE DURING APRIL-OCTOBER 1976 AND PERCENTAGE INCREASE OVER APRIL-OCTOBER 1975

Name of State/ Territory	Performance during April-October 1976			Performance during April-Oct. 1976 as % of performance during April-Oct. '75		
	IUD insertions	Sterilisations	Eq. Conventional contraception	IUD	Sterilisation	C.C.
Andhra Pradesh	7,837	287,278	31,451	132	395	109
Assam	6,663	153,889	17,231	72	155	111
Bihar	9,795	204,260	18 859	156	1,196	78
Gujarat	14,042	188,730	168,598	131	291	166
Haryana	26,574	79,024	183,815	183	508	153
Himachal Pradesh	1,349	50,095	7,234	124	322	225
Jammu and Kashmir	2,834	4,398	3,509	306	336	204
Karnataka	18,784	283,220	48,849	158	618	68
Kerala	10,201	123,157	25,360	68	208	103
Madhya Pradesh	13,423	743,096	59,787	72	1,866	88
Maharashtra	8,903	500,164	150,622	112	362	85
Manipur	759	2,963	2,700	107	788	310
Meghalaya	515	6,613	1,358	126	637	111
Nagaland	—	—	—	—	—	—
Orissa	11,029	195,358	10,576	105	276	57
Punjab	18,703	66,338	135,506	103	305	97
Rajasthan	7,441	292,155	54,054	69	920	117
Tamil Nadu	21,553	311,736	161,774	178	192	184
Tripura	211	10,684	3,817	173	602	232
Uttar Pradesh	75,190	555,372	157,538	102	1,773	73
West Bengal	20,040	731,195	249,998	244	1,741	406
Rest of India	14,363	188,887	440,440	102	272	106
All India	290,209	4978,612	2977,781	116	536	119

SOURCE : Centre Calling Vol. XI Nos. 1 and 12.

Without discounting the role of any of these factors, it is notable that many citizens and administrators complained of coercion in family planning. Some of these factors (viz. iii, iv, v and vi) might have indeed vitiated the philosophy of voluntary acceptance of family planning on which the policy had rested. The Government of Madhya Pradesh issued directives that all eligible employees of the State Government should undergo sterilisation operation by the 6th December which had a salutary effect on the role of acceptance (sec Centre Calling Vol. XI : No. 12, Dec. 1976), even the union government amended the Central Civil Services (Conduct) Rules 1964 to ensure that the number of children of a government servant does not exceed the limit of three; these measures could certainly be construed as mild-to-severe coercion.

Government of Punjab declared a number of disincentives for employees 'who flout family planning advice'. These disincentives included non-availability of loans for housing, withdrawal of accommodation, and even denial of job opportunity. Almost all the states adopted similar measures after the adoption of the population policy statement. These steps helped to generate a high acceptance rate but they also created good deal of resentment among the citizens. In some states, like Uttar Pradesh, the District Magistrates and Divisional Commissioners were charged with the implementation of the programme. This fact would seem to facilitate coercive tendencies because of the great power vested in these officials. The differential incentive scheme would seem to encourage corrupt practice among both couples and motivators of claiming higher incentive payment by false declaration of lower family size. The close monitoring of the programme by state and central ministers and high level officials would seem to have promoted an atmosphere of fear and vindictiveness among the officials to adopt corrupt practices to get the pat for creditable work. The Prime Minister and Health Minister decried all rumours of coercion, but even their support of a 'harsh attitude' and 'gentle and civilised pressure' were not appreciated by the people. The mass media have, since the lifting of emergency and fall of the Congress government, been replete with stories of coercion in family planning. Careful revision of the 1976 population policy statement thus became inevitable in less than a year's time.

New Population Policy (1977)

A new statement of policy on the 'family welfare programme* was issued by the Janata Government on April 28, 1977. The new government expresses its total commitment to the population programme, as a means of individual and

national development and well being. The programme is renamed as 'family welfare Programme'—and it is proposed to integrate it with health as well as other welfare programmes such as nutrition.., food, clothing, shelter, drinking water, education, employment and women's welfare. It proclaims that 'there is no room for compulsion, coercion or pressures of any sort.' It is assumed that given the necessary information, the couples will accept the small family norm provided adequate services are made available. This assumption is similar to the tenets of the clinic-cum-extension approach. The programme proposes to promote all the methods (with equal emphasis). As regards payment of incentives (monetary compensation) for sterilisation and IUD, it is proposed to retain this practice as the acceptance of these methods involves to and fro journey to clinic, stay in hospital and possible loss of wages. Under the proposed integrated rural health scheme comprehensive training of 'dais* is proposed with a view to making adequate MCH care available to mothers. The proposal to raise legal minimum age of marriage to 18 for girls and 21 for boys, is retained. It also proposes to promote women's educational level through formal and non-formal educational channels. The principle of linking a portion of central assistance to state plans with performance in family welfare programme is continued. Prompt steps to incorporate population education in school curricula are envisaged. Coordinated work of all media agencies under state and central governments using all media channels, including extension education, is expected to promote family planning effectively. The new policy statement also emphasises the change agency role of voluntary institutions/ associations including panchayats. The research work in the field of reproductive biology and contraception will continue. The welfare orientation has led to emphasis on coordinated work by all ministries and departments. The family welfare performance of the states is to be monitored and reviewed by the Union Cabinet. It is suggested that suitable machinery for ensuring coordination with other welfare programmes be set up in each state.

A Critique **of the** New Policy—Concluding **Remarks**

It is, perhaps, too early to pass a judgement on the new policy. Announcement of the policy has restored the trust of the people in the Government's desire to promote their welfare. What worries one is how exactly this 'welfare* is going to be brought about. The policy does not clearly outline how the programme will be integrated with other welfare measures. Earlier attempts to integrate family planning with MCH services, the interrelation between which

is so natural, met with very limited success. This suggests that integration of family planning with other welfare programmes is laudable, but difficult indeed (Ghosh 1976fl). The new policy should have clearly laid down the steps through which integration would be achieved, and shown integration itself and the consequential benefits would be evaluated. The programme seems to rely on the clinic-cum-extension approach supplemented by a compensation payment scheme. It is unclear how the government will actually promote all the methods 'with equal emphasis'. Should the choice of methods be left to the people, what the programme personnel need to do is only to provide information on all the methods to a couple interested in contraception. Methods like rhythm or withdrawal are known to be ineffective and it is not worthwhile to promote such methods equally with other much more reliable methods.

The Conference of Health Ministers, which considered the policy proposal, decided that there should be a uniform rate of compensation. This is a welcome change in the programme. It is also necessary to ensure that the programme officials and field workers fully explain to the people the idea behind payment of compensation money ; no worker should use the 'compensation money* as an 'incentive' or 'lure' to attract a person without the necessary motivation to accept family planning.

The problems of implementing the envisaged social legislation on age of marriage have not received adequate attention of the policy makers, and thus its feasibility is still in doubt. The proposal to include population education in school curricula can be appreciated but it is uncertain how far this measure is likely to induce acceptance of family planning. Studies have shown that even in case of couples in lower income brackets ever-use of contraception is positively correlated with the educational level of the wife. This justifies the importance attached to women's education. However, if contraception can be encouraged even through raising general educational level, what additional benefits do we expect to generate through inclusion of population education in the school curricula ? In view of the fact that in the rural areas where the real problem is, the education system is in the doldrums, it calls for vigorous effort of promoting and upgrading general education alongwith population education.

The policy makers appreciated the role of mass media in promoting family planning and urged a coordinated effort of all media agencies for this job.

These media agencies put up a very poor show so far as work in the rural areas is concerned (Ghosh 1977). It would be necessary to correct the deficiences in these organisations before expecting them to play any meaningful role in family planning motivation work.

As in the 1976 Policy, the new policy also proposes a close monitoring of programme performance. In line with this the Health Minister's Conference decided that 'targets under family welfare should be treated as milestones and yardsticks in the programme. The targets should not be fixed with a view to counting the number of heads but to achieving the objective of reducing the birth rate to 30 per thousand by March 1979 and 25 per thousand by March 1984 (Centre Calling, April-May 1977). The adherence to target system and close monitoring of performance when the programme is supposed to be completely voluntary is indicative of an ambivalence present in the policy statement. Though the experience of the earlier government will certainly act as a deterrent to any over-ambitious attempt at programme implementation, it is necessary that the policy is completely unequivocal about the voluntary nature of the programme. This presents difficult problems of evaluating the programme and giving it a sense of direction. One hopes that the determination of the present government and the dedication of the programme officials will be instrumental in giving a proper shape to the policy in the form of a well-managed family welfare programme in India,

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