

Family Planning Policies

* *Mary Joseph, Lizy James*

Introduction

You have learnt About the Indian family in transition in the previous unit. A detailed discussion of family planning policies and related concepts are intended in this unit.

In India, the concept of family planning came as a control measure for population growth. When we look at world population, in just over thirty five years, 1950 to 1988 the world population doubled growing from 2.5 billion to 5.0 billion and as of 2005 has crossed six billion.

Projections based on the latest data and expected declines in fertility and mortality suggest that, India may be the largest country in the world by the year 2050 with a total population of 1.59 billion compared to China 1.55 billion . India already has more births, deaths and infant deaths than any other country.

India's family welfare programme seeks to promote on a voluntary basis, responsible and planned parenthood with the "two child norm" male, female or both through 'cafeteria approach ', that is an independent choice of family planning methods, best suited for the couples.

Population control and Family Welfare Planning are listed on the concurrent list. The Central government bears virtually the entire cost of the programme. State government and Union Territory administrations are

* *Dr. Mary Joseph, Rajagiri College of Social Sciences, Kalamassery
Dr. Lizy James, Vimla College, Trichur*

responsible for its implementation. The Central government is also responsible for programme planning, training of functionaries, research and evaluation.

Objectives and Scope of Family Planning

An Expert Committee (1971) of the WHO defined Family Planning as: a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decision by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country”.

Objectives of Family Planning

Family planning refers to practices that help individuals or couples to attain certain objectives:

- a) to avoid unwanted births
- b) to bring about wanted births
- c) to regulate the intervals between pregnancies
- d) to control the time at which births occur in relation to the ages of the parent and
- e) to determine the number of children in the family

Now you have learnt the definition and objectives of family planning. Let us see the scope of family planning services.

Scope of Family Planning Services

It is not synonymous with birth control, but is in fact more than mere birth control. A WHO Expert Committee (1970) has stated that, family planning includes in its purview.

- 1) the proper spacing and limitation of births

- 2) advice on sterility,
- 3) education for parenthood
- 4) sex education,
- 5) screening for pathological conditions related to reproductive system,
- 6) genetic counseling
- 7) premarital consultation and examination
- 8) marriage counseling,
- 9) carrying out pregnancy tests,
- 10) preparation of couples for the arrival of their first child,
- 11) Providing services for unmarried mothers.
- 12) Teaching home economics and nutrition and,
- 13) Providing adoption services.

These activities vary from country to country according to national objectives and policies with family planning. This is the modern concept of family planning.

Rapid population growth in less developed countries is a key factor in limiting the ability of these countries to raise standards of living. Important obstacles to their socio-economic development include limited resources, food distribution problems high rate of diseases and infant mortality, lack of proper sanitation, scarcity of funds and shortage of educational facilities and work opportunities.

In this context, the Planning Commission clearly, recognized the need for population control right at the beginning of the planning exercise. To quote the First Five Year Plan, (1951-56).

“The recent increase in the population of India and the pressure exercised on the limited resources of the country have brought to the forefront the urgency of the problem of family planning and population control. It is, therefore, apparent that, population control can be achieved only by the reduction of the birth-rate to the extent necessary to ‘stabilize the population’ at a level consistent with the requirements of national economy. This can be secured only by the realization of the need for family limitation on wider scale by the people”.

National Population Policy 2000

A social policy signifies consensual social purpose, and aims at progressive and structural changes. It pays appropriate attention to economic-cultural, political and social factors as also to short-term and long term perspectives. A population policy can be nothing less than a social policy. Population programme must work itself in the whole fabric of social environment and must influence and be influenced by all other measures of social changes. When a policy is translated into programmes and activities, it causes social development, with due involvement of integrated diverse range of sectoral programmes and activities.

National Population Policy 2000

National Socio-Demographic Goals for 2010

- 1) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- 2) Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.
- 3) Reduce infant mortality rate to below 30 per 1000 live births.

- 4) Reduce maternal mortality ratio to below 100 per 100,000 live births.
- 5) Achieve universal immunization of children against all vaccine preventable diseases.
- 6) Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- 7) Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- 8) Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- 9) Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- 10) Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organisation.
- 11) Prevent and control communicable diseases.
- 12) Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- 13) Promote vigorously the small family norm to achieve replacement levels of TFR.
- 14) Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred programme.

Strategic themes

- i) Decentralised Planning and Programme Implementation

- ii) Convergence of Service Delivery at Village Levels
- iii) Empowering Women for Improved Health and Nutrition
- iv) Child Health and Survival
- vi) Special efforts for Under-Served Population Groups who are people living in Urban Slums, Tribal Communities, Hill Area Populations, Displaced and Migrant Populations, Adolescents. Efforts to increase participation of men in Planned Parenthood
- vii) Diverse Health Care Providers including private practitioners, private hospitals, NGOs, etc.
- viii) Collaboration With and Commitments from Non-Government Organisations and the Private Sector
- ix) Mainstreaming Indian Systems of Medicine and Homeopathy
- x) Contraceptive Technology and Research on Reproductive and Child Health (xi) Providing for the Older Population
- xii) Information, Education, and Communication

Legislation

It is recommended that the 42nd Constitutional Amendment that freezes till 2001, the number of seats to the Lok Sabha and the Rajya Sabha-based on the 1971 Census be extended up to 2026.

Public support

38. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout

society. The government will actively enlist their support in concrete ways.

New structures

i) National Commission on Population

A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all states and UTs, and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministries and Departments, for example Department of Woman and Child Development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, and reputed demographers, public health professionals, and NGOs as members. This Commission will oversee and review implementation of policy. The Commission Secretariat will be provided by the Department of Family Welfare.

ii) State / UT Commissions on Population

iii) Coordination Cell in the Planning Commission

iv) Technology Mission in the Department of Family Welfare

Funding

Funding to be obtained from a variety of sources including international sources, national governments, state governments, NGOs etc.

Promotional and motivational measures for adoption of the small family norm. The following promotional and motivational measures will be undertaken:

- i) Panchayats and Zila Parishads will be rewarded and honoured for exemplary performance in

universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.

- ii) The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs. 500 is awarded at the birth of the girl child of birth order 1 or 2.
- iii) Maternity Benefit Scheme run by the Department of Rural Development will continue. A cash incentive of Rs. 500 is awarded to mothers who have their first child after 19 years of age, for birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth and BCG immunisation.
- iv) A Family Welfare-linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible (along with children) for health insurance (for hospitalisation) not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilisation.
- v) Couples below the poverty line, who marry after the legal age of 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, will be rewarded.
- vi) A revolving fund will be set up for income-generating activities by village-level self help groups, who provide community-level health care services.

- vii) Creches and child care centres will be opened in rural areas and urban slums. This will facilitate and promote participation of women in paid employment.
- viii) A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent.
- ix) Facilities for safe abortion will be strengthened and expanded.
- x) Products and services will be made affordable through innovative social marketing schemes.
- xi) Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.
- xii) Increased vocational training schemes for girls, leading to self-employment will be encouraged.
- xiii) Strict enforcement of Child Marriage Restraint Act, 1976.
- xiv) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994. (xv) Soft loans to ensure mobility of the ANMs will be increased.
- xvi) The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation. This freeze needs to be extended until 2026.

Socio-Demographic goals in 2010

- 1) Implementation in totality of the Minimum Needs Programme in particular, universalisation of primary education and reduction in the drop-out rates of primary and secondary school students, both boys and girls, abolition of child labour and priority to primary health.
- 2) Reduction in the incidence of marriage of girls below the age of 18 years to zero.
- 3) Increase in the percentage of deliveries conducted by trained personnel to 100 percent.
- 4) Reduction in maternal mortality rate to less than 100 per 100,000 live births.

Family Welfare Programmes Through Five Year Plans

You have read about Family Planning Policies developed by the Government of India throughout the Plan periods. Now let us look at the Family Welfare Programme developed through the Five Year Plans.

The country is committed to attaining the goals of "Health for All" and a "Net Reproduction Rate of Unity" by the year 2000 A.D. through the universal provision of comprehensive primary health care services to all and an easy access to family welfare planning and maternal and child health facilities.

The National Family Planning Programme (1951) is the expression of the collective concern for the population problem. After 10 years of its introduction, the Department of Family Planning was organized at the Centre. Now it is called the Department of Family Welfare. At the State or Union Territory level, there are directorates of Family Welfare Planning. Over the years, the programme has evolved a nationwide physical infrastructure and huge reservoir of skills.

1) **Family Planning Programmes under the First Five Year Plan (1951-56).**

While formulating the First Plan, it was assumed that the population would continue to grow at the rate of 1.25 percent per annum. Therefore, under the Medical and Public Health Plan, a component entitled Family Planning and Population Control was included for the first time with an allocation of Rs. 6.5 million for this activity.

The main appeal for family planning was based on considerations of health and welfare of family. It was understood that family limitation or spacing of children was necessary and desirable in order to secure better care and upbringing of the children. It was then firmly believed that all progress in this field depended on creating a sufficiently strong motivation in favor of family planning in the minds of people. After that it would only remain to provide the necessary advice and service, based on acceptable, efficient, harmless and economic methods. For carrying out the programme of family planning two committees were constituted one to deal with population policy and the second for research and for framing programmes relating to family limitation.

Thus, India was the first country in the world to have an official policy on population and to launch a National Programme of Family Planning in 1952. The Family Planning programmes in this plan were expected to obtain. 1) an accurate picture of the factors contributing to the rapid population increase, 2) to discover suitable techniques of family planning, 3) to devise methods by which knowledge of these techniques could be widely disseminated, 4) to make advice on family planning an integral part of the services of government hospitals and public health agencies.

2) **Family Planning Programmes under the Second Five Year Plan (1956-61)**

During the Second Plan the strategy was the same as in the First Five Year Plan, that is expansion of

family planning services facilities through clinics. The budgetary provision for family planning increased from Rs.6.5 million in the First Plan to Rs. 50 million in second Plan. The distribution of contraceptives was extended through Primary Health Centers, Government Hospitals and Dispensaries, and Maternity Homes run by the State Governments. In both the rural and urban areas, contraceptives were issued free to those with a monthly income below Rs. 100, and at half price to those in the Rupees 100-200 income group. The Central Family Planning Board recommended the inclusion of sterilization operations in the family planning programme in hospitals and institutions where facilities existed. An incentive scheme paying Rs.10/- to a sterilization acceptor as compensation for the loss of wages was first introduced in Tamil Nadu followed by other States.

Research and Training Activities

Research activities were extended to the fields of reproductive physiology, demography and communication action. Considerable progress was achieved at the contraceptive testing units in Bombay under the guidance of the Indian Council of Medical Research and the All India Institute of Hygiene and Public Health in Calcutta. Demographic research centers were set up in Bombay, Calcutta, Delhi and Trivandrum. The United Nations Regional Demographic Training and Research Centre at Bombay, established in 1956, became a reputed centre for training students in Demography and population studies from different countries of Asia and the Pacific region. Several valuable field investigations were carried out during 1951-61 such as the India-Harvard Ludhiana Population Study, the Mysore Population study, and the Lodhi Colony Study in Delhi and the Singur Study in Calcutta. A broad-based training programme was developed which included establishment of centers for family planning. Family Planning was incorporated in the normal training

programme of a number of training institutions for doctors and medical auxiliaries.

In this plan, a Central Board for Family Planning and Population Problems was set up at the national level. Its responsibilities were to take care of extension of programme, training of personnel, and organizing bio-medical and demographic researches. It was also responsible for carrying out inspection/supervision of governmental and non-governmental agencies receiving grants, monitoring and evaluation etc.

3) Family Planning Programmes under the Third Five Year Plan Period (1961-66)

The Third Five Year Plan document sounded a note of concern that the Family Planning programme was a most difficult one to carry out and it raised problems of great complexity. It was realized that, sustained and intensive efforts were called for over a fairly long period before family planning could become a popular movement and part of the accepted attitudes of the people generally.

During the Third Plan period, the programme was strengthened further and an expenditure of about Rs.250 million was incurred. The basically clinic oriented approach during the first two plans was replaced by an extension education through the network of primary health centers and sub centers in the urban areas. The change in strategy involved utilization of interest and influential local leader in villages for promoting a small-family norm and carrying the message of family planning to the couples.

The objectives of this extension approach, which continues to be a pervasive methodology in the Indian Family planning programme to date are:

- 1) creation of a group norm of a small family size in every community by educating and involving opinion-leaders,

- 2) providing information to every eligible couple on available contraceptive methods, and
- 3) making provision for contraceptive service facilities in a socially and psychologically acceptable manner.

In the clinic approach, the family planning personnel wait for eligible couples to come to their seeking advice and supplies. In the extension approach the crucial task of identifying, informing and motivating the eligible couples for family planning was given to the peripheral health workers, particularly to the auxiliary nurse-midwives (ANMs) and family planning health assistants (FPHAS). In respect of advocates on methods of family planning, the 'cafeteria approach' was adopted, leaving the choice of the method to an acceptor. The responsibility of distribution of simple contraceptives and giving general advice on family planning was given on a much larger scale to voluntary organizations, paramedical personnel and to extension educators, trained in family planning.

The family planning programme was viewed mainly as a positive policy instrument for achieving the demographic goal. It was not considered as a social welfare measure for improving the status of women in the country or helping couples to space and limit the number of children according to their desire.

The programme gained momentum in 1966 when a Department of Family Planning was constituted in the Ministry of Health and Family Planning at the Centre. It was to give technical and administrative direction and guidance to the programme and to bring about effective co-ordination of its various facets. The emphasis was placed on time-bound and target oriented programmes. The Third Five Year Plan stated that "the objective of stabilizing the growth of population over a reasonable period must be at the very centre of planned development".

4) Plan-Holiday (1966-69)

The period 1966-69 was termed as a “plan-holiday” when the earlier programmes were continued with annual budgeting and target setting. The programme was integrated with the health programme in the country such as integrated with public health programme as maternal and child health (MCH) services operated through the primary health centers (PHCs) in rural areas and urban family welfare planning centers (UFWPCs) in town and cities.

The expenditure during this period increased to Rs. 704.6 million. Two aspects that characterized the programme at this stage were:

- a) The pattern of personnel to be deployed in the programme was decided at the national level, purely on the basis of the population size of a PHC, district or state
- b) the choice of the methods available to couples was limited with emphasis on IUD and sterilization, although as a matter of policy, all methods were to be made available to the couples leaving the choice entirely to them.

5) Family Planning Programmes in the Fourth Five Year Plan (1969-74)

In the fourth five year plan, family planning was included among the programmes of the highest priority. A numerical target was set for reducing the crude birth rate from 39 by the end of the Plan period and to 25 by 1979. These demographic goals were translated into targets of family planning acceptors to be recruited under the programme. To achieve these targets, a concrete programme was drawn up for expanding the facilities. It was by providing services and expansion of motivational and educational aspects through the mass media. An outlay of Rs.3,300 million was made in this

Plan for the programme and the actual expenditure was Rs. 2884.3 million. It is estimated that as a result of the programme 28 million couples were protected by 1973-74 and the births turned away during this plan period were estimated at 12 million.

During this plan period, the programme for popularization of oral pills was also expanded. Surgical equipments were provided in rural and urban family welfare centers for vasectomy operations and a system for free distribution of condoms was introduced. By the beginning of this Plan(1969), sterilization became the major task in the government strategy to be met. Increased emphasis was placed on the adoption of the 'camp approach'. In this approach sterilization operations were carried out in villages at suitable locations for conducting surgery and the infrastructure facilities were strengthened in the rural areas. The incentive money was also raised. At the end of this Plan period the mass-camp approach was replaced by the "mini-lap approach" under which in any one camp not more than 25 persons could be operated. This change over was felt necessary since a large number of complaints were received from persons operated upon in large camps. As a consequence, the programme suffered a set back in 1973-74, when the number of sterilization done declined to 0.9 million from 3.1 million in the previous year. In 1971, Parliament passed a law liberalizing induced abortions under an Act entitled "Medical Termination of Pregnancies Act" which became effective from 1st April 1972, making it possible for pregnant women to have legal abortion under certain specified conditions .

6) Family Planning Programme under Fifth Five Year Plan (1974-79)

This plan witnessed a dramatic rise and fall in family planning acceptance in the country. The Fifth Plan document refixed the demographic goals so as to achieve

a birth rate of 30 by 1979 and 25 by 1984. During 1974-78 a sum of Rs.4,089.8 million was spent on the programme and it received an enormous boost from the government in 1976 with the announcement of the National Population Policy, a comprehensive policy formulated for the first time.

The performance in the family planning programme during the year 1976-77 was the best to be realized ever, with a total of 8.26 million sterilizations, and all-time record.

The programme suffered a serious set back after 1976-77 and a revised policy on family welfare was announced in April 1977 (1.4.2). The term family planning was changed to "family welfare" to include maternal and child health programmes as an integral part of the programme.

7) Family Welfare Programmes under the Sixth Five Year Plan (1980-85)

The sixth Five Year Plan in its objectives, stated that one of the major areas of effort which was included pertains to promoting policies for controlling the growth of population through voluntary acceptance of small family norm. The Plan envisaged the long term goal of reducing the Net Reproduction Rate to unity by 1995. for the country as a whole and by 2001 in all the states, This was expected to be made possible by reducing the birth rate to 21 and death rate to 9 and increasing the proportion of couples protected by family planning to about 60 percent. It is understood that the programme was required to be reactivated by education and persuasion of people, avoiding any form of coercion. The small family norm was to be built into the social and cultural ethos of the people. A multi-pronged but integrated approach was advocated. It comprised of:

- 1) education and employment, particularly of women,
- 2) eradication of poverty, 3) provision of maternal and

child care services including immunization, prophylaxis against anemia and nutrition, 4) building up of health care facilities in rural areas with due attention to control of communicable diseases, 5) promotion of preventive health, 6) water supply and sanitation.

Family Welfare services and supplies were sought to be made available on an extended scale through the health infrastructure in the country. All existing channels of communication including governmental extension machinery, voluntary organizations, youth organizations, women's organizations, village opinion leaders etc; were to be fully mobilized for promoting the widespread acceptance of family planning methods.

While formulating the targets for family planning methods, adequate attention was given to raising the level of acceptance of non-terminal/spacing methods in the contraceptive mix. During the sixth plan, an allocation of Rs. 101.00 million was made for family welfare sector. At the end of the Plan, it was envisaged that the couple protection rate due to contraception would go up to 36.6 percent.

During 1983, the government of India adopted a National Health Policy under which it was sought to be achieved through universalisation of primary health care and reaching Net Reproduction Rate of Unity by 2000 A.D.

8) Family Welfare Programme under the Seventh Five Year Plan (1985-90)

The Seventh Five-Year Plan document has declared the approval of the long-term demographic policy of reaching a net reproduction rate of 1 by the year 2000.A.D.

In terms of specific family planning goals for the Plan period, the following targets have been stipulated.

- 1) Effective couple protection rate (CPR) of 42 percent to be realized by 1990.

- 2) Crude Birth Rate (CPR) 29.01 to be realized by 1990.
- 3) Crude Death Rate (CDR) 10.4 to be realized by 1990.
- 4) Infant Mortality Rate (IMR) 90 per 100 live births by 1990
- 5) Immunization of children-universal coverage; and
- 6) Ante-natal care -75 percent of all pregnant women.

In order to reach the above targets, particularly 42 percent couple protection, the Seventh Plan stipulated 31 million sterilizations, 21.25 million IUD (Intra Uterine Devices) insertions and 14.5 million users of conventional contraceptive by the end of the Plan year 1989-90.

Inter-sect oral co-ordination and cooperation and involvement of voluntary agencies in the programme are contemplated to be implemented in a bigger measure in the field of health and family welfare. Community participation is being achieved through the utilization of non-government organizations, informal leaders in the community, political leaders and other social workers.

Special programmes to reduce the infant mortality rate to the level of 90 per thousand per year by 1990 have been implemented. Special schemes for the reduction of diseases among children, such as diarrhea, dysentery and respiratory diseases are being implemented. A Universal Immunization Programme (UIP) providing immunization for children and oral dehydration therapy for treatment of diarrhea diseases was implemented. The UIP covered all districts of the country by 1990. The Seventh Plan has provided an outlay of Rs.32560 million for the family welfare sector.

During the Seventh Plan, the oral pill distribution programme had been intensified. Besides, a subsidized marketing programme for promoting the oral pill with

brand name MALA-D has been launched utilizing the distribution network and services of selected pharmaceutical companies.

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

The basic premises of the Family Welfare Programme till now have been-

- i) Acceptance of the family welfare is voluntary.
- ii) The Government's role is to create an environment for the people to adopt small family norm. This is done by spreading awareness, information and education by ensuring easy and convenient availability of family planning aids and services and by giving incentives for adopting family planning.
- iii) The programme, which is a 100% Centrally Sponsored Scheme has integrated family planning and Mother and Child Health (MCH) services and is being implemented through countrywide network of primary health centres and supporting institutions.

In spite of these efforts the results have been far from encouraging.

The following strategies will be adopted for achieving the goals of family welfare during the Eighth Plan.

- i) Convergence of services provided by various social services sectors.
- ii) Decentralised planning and implementation will be another strategy.
- iii) Panchayati Raj institutions like Gram Panchayat and Zila Parishads, etc., will have to play significant role in planning, implementing and administering the programme. The role of the Centre will be

limited to general policy planning and coordination, providing technological inputs of local self-government.

- iv) The younger couples, who are reproductively most active will be the focus of attention, with necessarily a greater emphasis on spacing methods, although the terminal methods would continue to remain the important means of birth control.
- vi) The targeted reduction in the birth rate will be the basis of designing, implementing and monitoring the programme against the current method of couple protection rate.
- vii) The outreach and quality of family welfare services will be improved by ensuring adequate drugs and other essential supplies at the Sub-centre and PHC by suitably increasing the funds for this purpose.
- viii) The entire chain of CHC, PHC and Sub-centres will be equipped to deliver general health and MCH services in an integrated manner with a strong referral support and linkage at the District level.
- ix) Child survival and safe motherhood initiatives will be vigorously pursued. These initiatives will include (a) strengthening of Universal Immunisation Programme, (b) greater emphasis on Diarrhoea Control Programme and effective implementation of art programme, (c) Acute Respiratory Infections Control Programme, (d) Anaemia Management Programme and not just Anaemia prophylaxis, (e) Safe Motherhood Programme with high risk pregnancy approach and (f) intensified effort for training of birth attendants.
- x) Training will not only aim at providing requisite knowledge and skill, but also ensure development of such behavioural attributes that will be conducive to a closer interaction with the community. The

methodology, the logistics and the content of training programme will be continuously reviewed. Special programmes would be chalked out for imparting pro-service and in-service training in programme management and IEC activities. To meet the training needs, various training institutions will be strengthened or new ones established, by providing adequate funds, staff, equipments and mobility.

- xi) The entire package of incentives and awards will be restructured to make it more purposeful.
- xii) There is an urgent need to secure involvement and commitment of practitioners of all systems of medicine in the Population Control Programme.
- xiii) The role of voluntary organisation in a mass movement such as population control is critical for generation of momentum and accelerating the pace of progress.
- xiv) As an extrapolation of the concept of voluntary organisations, is the role and place of organised corporate sector which covers approximately 20 million workers and their families. Effective methods will be evolved to get the organised sector involved in the implementation of family welfare programme.
- xv) Special efforts will be made to involve the community in the Family Planning Programme. The strategy will be to prepare the community to accept the responsibility, the ownership and the control of
- xvi) The village/neighbourhood tea shops, pan shops, public distribution system shops, pharmacies, cooperatives, etc., will be utilised for community based contraceptive sale and distribution.
- xvii) The social marketing of oral pills as well as for market research and educational activities will be

done with help for the Corporate Sector possesses special skill and sensitivity.

xviii) Information, Education and Communication, which are critical inputs will be further strengthened and expanded.

xix) A new thrust in the research and development of methods aimed at regulation of fertility in the male, and of vaccines for fertility regulation, both in the male and female, will be given. Fertility regulation practices such as the use of special herbs by the community particularly in the tribal areas, will also be subjected to research. While intensification of bio-medical research is necessary, research in social and behavioural sciences to explore the human dimensions is vital. Health systems research to optimise operational framework, to improve the efficiency and effectiveness of the service provided and to evolve cost-effective interventions in various areas of family planning operation, will be given high priority.

xx) A continuous monitoring, review and evaluation is an essential component for the successful implementation of the programme.

xxi) The family planning programme has a multi-sectoral dimension.

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

The reduction in the population growth rate has been recognised as one of the priority objectives during the Ninth Plan period. The current high population growth rate is due to: (1) the large size of the population in the reproductive age-group (estimated contribution 60%); (2) higher fertility due to unmet need for contraception (estimated contribution 20%); and (3) high wanted fertility due to prevailing high IMR (estimated contribution about 20%). 3.5.6 The enabling objectives

during the Ninth Plan period, therefore, will be to reduce the population growth rate by

The objectives during the Ninth Plan will be:

- To meet all the felt-needs for contraception
- To reduce the infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility

The strategies during the Ninth Plan will be:

- to assess the needs for reproductive and child health at PHC level and undertake area- specific micro planning
- to provide need-based, demand-driven high quality, integrated reproductive and child health care.
 - a) meeting all the felt-needs for contraception; and
 - b) reducing the infant and maternal morbidity and mortality so that there is a reduction in the desired level of fertility

The strategies during the Ninth Plan will be:

- a) To assess the needs for reproductive and child health at PHC level and undertake area- specific micro planning; and
- b) To provide need-based, demand-driven high quality, integrated reproductive and child health care.

The programmes will be directed towards:

- a) Bridging the gaps in essential infrastructure and manpower through a flexible approach and improving operational efficiency through investment in social, behavioural and operational research
- b) Providing additional assistance to poorly performing districts identified on the basis of the 1991 census to fill existing gaps in infrastructure and manpower.

- c) Ensuring uninterrupted supply of essential drugs, vaccines and contraceptives, adequate in quantity and appropriate in quality.
- d) Promoting male participation in the Planned Parenthood movement and increasing the level of acceptance of vasectomy.

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

- a) Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM&H;
- b) Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management;
- c) Involvement of the industries, organised and unorganised sectors, agriculture workers and labour representatives.

The NDC Committee on Population has recommended that there should be:

- Decentralised area specific planning based on the need assessment
- Emphasis on improved access and quality of services to women and children
- Providing special assistance to poorly performing states/districts to minimise the inter and intra-state differences in performance

Creation of district level databases on quality and coverage and impact indicators for monitoring the programme

IICPD has advocated similar approach.

Concordance between National (NDC Committee) and International (ICPD) efforts has improved funding and accelerated the pace of implementation of the family welfare programme.

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- 2) Emphasis on improved access and quality of services to women and children
- 3) Providing special assistance to poorly performing states/districts to minimise the inter and intra-state differences in performance
- 4) Creation of district level databases on quality and coverage and impact indicators for monitoring the programme.

11) **Tenth Five Year Plan (2002-2007)**

The NDC Sub-Committee on Population recommended that there should be a paradigm shift in the Family Welfare Programme and the focus should be on:

- Decentralised area-specific planning based on need assessment.
- Emphasis on improved access and quality of services to women and children.
- Providing special assistance to poorly performing states/districts to minimise the differences in performance.
- Creation of district-level databases on quality, coverage and impact indicators for monitoring the programme.

Department has drawn up the National Population Policy 2000 (NPP 2000), which aims at achieving replacement level of fertility by 2010. A National Commission on

Population was constituted in May 2000, in line with the recommendations of the NPP 2000.

Currently some of the major areas of concern include:

- the massive inter-state differences in fertility and mortality; fertility and mortality rates are high in the most populous states, where nearly half the country's population lives;
- gaps in infrastructure, manpower and equipment and mismatch between infrastructure and manpower in primary health centres (PHCs)/ community health centres (CHCs); lack of referral services;
- slow decline in mortality during the 1990s; the goals set for mortality and fertility in the Ninth Plan will not be achieved;
- there has been no decline in the maternal mortality ratios over the last three decades, while neonatal and infant mortality rates have plateaued during the 1990s;
- the routine service coverage has declined, perhaps because of the emphasis on campaign mode operations for individual components of the programme;
- in spite of the emphasis on training to improve skills for the delivery of integrated reproductive and child health (RCH) services, the progress in in-service training has been very slow and the anticipated improvement in the content and quality of care has not taken place;
- evaluation studies have shown that the coverage under immunisation is not universal even in the best performing states while coverage rates are very low in states like Bihar; elimination of polio is yet to be achieved;

- the logistics of drug supply has improved in some states but remains poor in populous states;
- decentralised district-based planning, monitoring and mid-course correction utilising the locally generated service data and Civil Registration has not yet been operationalised.

Approach during the Tenth Plan

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

The shift was from:

- demographic targets to *focussing on enabling couples to achieve their reproductive goals,*
- method specific contraceptive targets to *meeting all the unmet needs for contraception to reduce unwanted pregnancies;*
- numerous vertical programmes for family planning and maternal and child health to *integrated health care for women and children;*
- centrally defined targets to *community need assessment and decentralised area specific micro planning* and implementation of program for health care for women and children, to reduce infant mortality and reduce high desired fertility;
- quantitative coverage to *emphasis on quality and content of care;*
- predominantly women centred programmes to *meeting the health care needs of the family with emphasis on involvement of men in planned parenthood;*
- supply driven service delivery to *need and demand driven service; improved logistics for ensuring adequate and timely supplies to meet the needs;*

- service provision based on providers' perception to *addressing choices and conveniences of the couples.*

Three of the 11 monitorable targets for the Tenth Plan and beyond are:

- reduction in IMR to 45 per 1,000 live births by 2007 and 28 per 1,000 live births by 2012;
- reduction in maternal mortality ratio 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.

Path Ahead and Goals Set

Reduction in fertility, mortality and population growth rate are major objectives of the Tenth Plan. These will be achieved through meeting all the felt needs for health care of women and children. The focus will be on improving access to services to meet the health care needs of women and children by:

- a decentralised area-specific approach to planning, implementation and monitoring of the performance and effective mid-course corrections;
- differential strategy to achieve incremental improvement in performance in all states/districts;
- special efforts to improve access to and utilisation of the services in states/districts with high mortality and/or fertility rates;
- filling the critical gaps, especially in CHCs, in existing infrastructure through appropriate reorganisation and restructuring of the primary health care infrastructure;
- ensuring, that post of specialists in CHCs do not remain vacant; upgrading skills and redeploying existing manpower to fill other critical gaps;

- streamlining the functioning of the primary health care system in urban and rural areas; providing good quality integrated RCH services at the primary, secondary and tertiary care levels and improving referral services;
- providing adequate supply of essential drugs, diagnostics and vaccines; improving the logistics of supply;
- well coordinated activities for delivery of services by public, private and voluntary sectors to improve coverage;
- involvement of PRIs in planning, monitoring and mid-course correction of the programme at the local level;
- involvement of industry in the organised and unorganised sectors, agriculture workers and labour representatives in improving access to RCH services;
- effective use of social marketing to improve access to simple over the counter (OTC) products such as ORT and condoms;
- effective IEC and motivation programmes; and effective inter-sectoral coordination.

Evaluation of Family Welfare Programmes

The National Family Planning Programmes (1951) is the expression of the collective concern for the population problem. After a decade, the Department of Family Planning was organized at the Centre. Now there is a near universal awareness of family welfare planning, its concepts and techniques. Over the years, the programme has evolved a nationwide physical infrastructure and a huge reservoir of skills. At the centre, there is a Department of Family Welfare and

at the State and Union Territory level, there are Directorate of Family Welfare Planning.

Although the National Family Planning Programme started in 1951, it has not made a significant impact on reduction of fertility. Reduction in birth rate over the years has fallen much short of the planned targets over the successive Five Year Plans. During 1970, the birth rate did not come down from about 39 to 34, but from 1977 onwards it has been stagnating around 33 with a slight fall witnessed after 1984. It has been estimated that, the programme has been able to avert over 106 million births, in the country at a total investment of Rs. 4683 crores (approximately) upto the end of 1988-89. Thus Rs. 442 has been spent per birth averted in the programme including the cost of infrastructure.

During the last 40 years Indian Health and Family Welfare Programme has grown manifold. At present about 16,000 Primary Health Centers (PHCs) and 113,000 sub-centers are functioning in rural areas for providing Health and Family Welfare Services. Through various studies conducted on the Health and Family Welfare Programme, it is found that although it has attained remarkable organizational accomplishment, the programme as a whole has yet to succeed in either curbing population growth or reducing infant mortality to the desired levels.

Available statistics also show that, performance of the programme is not uniformly poor all over the country. For example while States like Kerala, Maharashtra, and Tamil Nadu have performed quite well in terms of both health and FP programme, the States in the Hindi-belt, particularly UP, Bihar, Rajasthan and Madhya Pradesh have failed in their attempt to implement the programme effectively and increase contraception to the desired level. If India has to achieve its target of "Health for All by 2000 A.D" and Net Reproduction Rate

(NRR) equal to one by 2006, by lowering the infant mortality to less than 60 and birth rate to 21, a serious attempt should be made to understand the reasons for the ineffective implementation of the programme, so that corrective measures could be taken.

Conclusion

In this chapter, you have learnt about the Definition, Objectives, Scope and need for Family Planning. This chapter also dealt with Family Planning Policies, and Family Welfare Programmes developed by the Government of India, through the Five Year Plans. The unit concluded with an evaluation of Family Welfare Programme.

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