Programme: Master in Sociology **Semester II**
Postgraduate Department of Sociology,
Patna University

Course: CC-6 (Sociology of Population Studies)
Unit-V (Part A) History of Family Welfare

Learning Objectives:

- To understand the concept of family planning and family welfare.
- To explain the history of family welfare.

Introduction:

Family Planning and Welfare is one of the measures taken to control population explosion. Family planning means planning by individual or couples to have only the children they want, when they want them, this is responsible parenthood. Family welfare includes not only planning of birth, but they welfare of wholes family by means of total family health care. The family welfare programme has high priority in India because its success depends upon the quality of life of all citizens.

India was the first country to evolve a government-backed family planning programme in the 1950s when the rest of the world was not aware of the problem. Today after 70 years, India is trailing behind in population control even after declined fertility rate. During the notorious Emergency regime between 1975 and 1977, the political leaders, the government officials and policemen shouted themselves hoarse advocating sterilisation. They devised ambitious programmes and carried them out against popular wishes, and even used such harsh and coercive methods for sterilisation that today one is reluctant to talk of family planning to the populace. The concerned officials in family welfare/planning departments have been scared away from it. The experts have jettisoned hopes of reaching targets. In fact, for all practical purposes, the country is without an effective programmes or an effective target. Political parties studiously skirt the subject, and election campaigns are conducted without a word about it. What was once a highly political issue has suddenly become taboo.

In 1977, ‘family planning’ was rechristened ‘family welfare’, and tasks beyond its competence embracing all aspects of family welfare, including improvement of women’s educational level, were included in it. In its family planning awareness drive, the Government of India adopted the UNEP guideline of delaying the first child and spacing the subsequent birth (s).

Concept of Family Planning and Family Welfare

At the level of the family, family planning implies having only the desired number of children. Thus family planning implies both limitation of the family to a number considered appropriate to the resources of the family as well as proper spacing between the children. The adoption of family planning, obviously, requires conscious efforts made by the couple to control conception.

As a social movement, family planning implies an organised effort by a group of people to initiate change in the child-bearing practices of the people by creating a favourable atmosphere.

The birth control movement, as it was initially called, aimed at relieving women of excessive child-bearing, and was seen as a way of achieving the emancipation of women through the right of self-determination.

A family planning programme involves a co-ordinated group of activities, maintained over a period of time, and aimed at fostering a change in the childbearing behaviour of the females. The aim of the family planning programme may either be to improve the health status of women and their children and/or of reducing the birth rate, and thus reducing the population growth rate of the country. Most countries with a population control policy also emphasise the health aspects of family planning. The various components of the family planning programme are: (1) Information, Education and Communication Activities, (2) Contraceptives: Supplies and Services, (3) Training of Personnel, (4) Research, and (5) Administrative Infrastructure.

When the government concerns itself with promoting the total welfare of the family and the community, through family planning, the programme consists of a wide range of activities, covering education, health, maternity and child care, family planning and nutrition. Since 1977, the Indian family planning programme is known as the family welfare programme with greater emphasis on the welfare approach to the problem.

Barriers to Family Planning

Barriers to family planning include fatalism, and emphasis placed on having children in the Indian culture and religious beliefs. In addition, the use of various methods of family planning also pose certain difficulties. The methods are not always acceptable because of the possible side-effects, perceived unaesthetic attributes or the discipline their use demands. All methods are not equally effective. While sterilisation, male and female, can be considered one hundred per cent effective, a method like the IUD is considered to be 95 per cent effective, and the conventional contraceptive like the condom is considered to be only 50 per cent effective. Oral pills are almost one hundred per cent effective, but their effectiveness depends on taking them regularly and on following a certain regime. The easy availability of supplies and services is a necessary condition for the practice or adoption of family planning. When supplies and services are not easily available, it becomes difficult for people to practise or adopt family planning, even when they are inclined to do so.

History of Family Welfare

The gravity of the population problem in India was realised as far as in the year 1891 when the Census Reports involved Malthus to draw attention towards overpopulation and poverty. Subsequent Census reports more or less continued to reiterate the theme.

The earliest reference to population control is found in the report of the All India Women's Conference held in 1932. However, Dr. R.D. Karve, in 1925, opened a family clinic in Bombay in the face of all opposition. Thereafter at official level, in 1930, Mysore Government opened a family planning clinic in the state. On December 1935, Society for the Study and Promotions of Family Hygiene was founded with Lady Cowasji Jehangir as its first president. The National Planning Committee of the Indian National Congress, set up in 1935 strongly supported family planning as a state policy and in 1936 first women family planning centre was opened. In the same year, Dr. A.P. Pillai conducted a family planning course. In 1937, family planning clinics were opened both in Uttar Pradesh as well as in Madhya Pradesh. In 1940, Sir P.N. Sapru successfully moved a resolution in the Council of States for the establishment of birth control

clinic in the country. In 1946, Bhore Committee in its report made very strong recommendations in favour of opening birth control clinics. In 1949, Family Planning Institute was set up in Bombay which is still working for population planning programme in India. In the same year, Jawaharlal Nehru made the nation realise the need and necessity of family planning programme through planning commission.

After Independence, although the enormity of the population problem was generally realized there was little consensus on how to grapple with the problem. In this direction a first step came with the creation of a Family Planning Cell in the Directorate General of Health Services (DGHS) in the year 1952. The programme which was termed as 'Birth Control Movement' in the pre-Independence period was renamed as the National Family Planning Programme (NFFP). Thus, officially mobilised in 1951, about 150 family planning clinics were established during the First Five Year Plan period (1951-56). Since then, a network of Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub-Centres (SCs) have been created for implementing family planning programme through state governments with a hundred percent assistance. A large number of centres and sub-centres are created in rural areas in each Five Year Plan.

Of various method of family planning, the government till recently depended more on the 'camp approach' which relied implicitly on the district authorities applying pressure on their officials to intensify the sterilization campaign (mostly male sterilization). The government set targets for different states and districts and adopted persuasive, monetary, as well as coercive measures to achieve targets. The highest rate of target achievement (200%) was in 1976-77, while the achievement of sterilization targets in different years has normally varied between 40 percent and 65 percent. The highest rate of achievement in 1976-77 has been described as 'Sanjay effect' which was the result of coercion, cruelty, corruption, and inflated achievement figures. The worst victims of cruelty and brutality were the Harijans, peons, clerical staff, school teachers, innocent rural people, hospital patients, jail inmates and pavement dwellers. This brutality through family planning (sterilisation) method ultimately led to the fall of the government in 1977.

The PHCs in villages, engaged in family planning programs, perform two soecific functions: providing services to people and disseminating information about these services in an effective manner in order to motivate people to accept family planning. Nearly half a million medical and paramedical persons are engaged in the programmes, besides half a million part-time village health guides.

Family Welfare through Five Year Plans

The policy context of planned family planning efforts in India can be traced in country's Five-year Development Plans which constituted the development agenda of the country. India's First Five-year Development Plan (1952-57) recognised that the increase in population and the pressure exercised on India's limited resources had brought to the forefront the urgency of the problem of family planning and population control. The Plan argued that application of medical knowledge and social care had lowered the death-rate, while the birth-rate remained fairly constant which had led to rapid increase in the growth of population. The Plan acknowledge that a lowering of the birth-rate might occur as a result of improvements in the standards of living but such improvements were not likely to materialise if there was a concurrent increase of population. The Plan, therefore, emphasised that population control could be achieved only

by the reduction in the birth-rate to the extent necessary to stabilise population at a level consistent with the requirements of the national economy. The Plan advocated that this could be secured only by the realisation of the need for family limitation on a wide scale by the people. The Plan however insisted that the main appeal for family planning was based on considerations of the health and welfare of the family. Family limitation or spacing of the children was necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form part of the public health programme.

The Second Five-year Development Plan (1957-61) proposed a programme for family limitation and population control. The Plan suggested that this programme should, among others, make advice on family planning an integral part of government hospitals and public health agencies and called for establishing clinics, one for 50,000 population, in all big cities and major towns. For small towns and rural areas, the Plan proposed to establish clinics in association with primary health units. The Plan also proposed training in family planning to all medical and nursing students and availability of family planning services in all hospitals and an increasing number of dispensaries in due course.

The Third Five-year Development Plan (1961-66) emphasised that the greatest stress should be placed on the programme of family planning and that the objective of stabilising the growth of population over a reasonable period must be at the very centre of planned development. The emphasis during the Plan was on expanding the availability of family planning services, especially sterilisation services within the public health care delivery system.

The Fourth Five-year Development Plan (1969-74) signalled the domination of the demographic rationale of family planning over its health rationale. The Plan, for the first time, set up targets in terms of sterilisation and IUCD insertions and to widen the acceptance of oral and injectable contraceptives in order to achieve theaim of reducing the birth rate to about 32 per thousand population by 1973-74 from the birth rate of 39 per thousand population that prevailed at that time. The Plan also targeted to increase the number of users of conventional contraceptives 3.24 million persons in 1969-70 and 10 million persons by 1973-74 with the ultimate aim of protecting 28 million couples and averting 18 million births through family planning by the year 1973-74. In order to give a push to planned family planning efforts, the Department of Family Planning was created within the Ministry of Health and Family Welfare at the national level. This was the beginning of the target approach that dominated the planning and implementation of planned family planning efforts in India for the next 35 years.

The Fifth Five-year Plan (1974-79) also gave topmost priority to family planning. The period 1974-79 was also a period of political turbulence in India. Emergency was clamped in 1975 and a major push was given to family planning, especially sterilisation, during 1975-77. This push brought in elements of coercion and force in planned family planning efforts. The defeat of the party in power in the 1977 general elections put planned family efforts on a back-burner. The new government that came into power even changed the name of the Department of Family Planning to the Department of Family Welfare and the name of the National Family Planning Programme to National Family Welfare Programme.

The Sixth Five-year Development Plan (1980-85) attempted to bring the planned family efforts at the centre stage of the development agenda of the country and aimed at the long-term demographic goal of reducing the net reproduction rate (NRR) to one by 1996 for the country

as a whole and by 2001 in all the States from the NRR of 1.67 that prevailed at that time. As a result, the focus of the Department of Family Welfare was no longer confined to family planning alone. Health related issues such as reduction in infant, child and maternal mortality started getting a priority over family planning within the Department. Planned family planning. Planned efforts however continued to be based on the target driven approach.

The Seventh Five-year Plan (1985-90) targeted a couple protection rate of 42 per cent to bring down the birth rate to 29.1 per thousand population along with targets in terms of reduction in the death rate, infant mortality rate and improvements in the coverage of child immunisation and ante-natal care. The Plan stipulated 31 million sterilisations, 21.25 million IUD insertions and 14.5 million conventional contraceptive users. There was however a definite shift in the focus of Department with the launch of Universal Immunisation Programme 1985.

Containing population growth was one of the six most important objectives of the Eighth Five-year Plan (1992-97) which aimed at reducing the birth rate from 29.9 per thousand in 1990 to 26 per thousand by 1997. The Plan stressed the need of a National Population Policy and suggested an inter-sectoral approach supported by political commitment and popular mass movement. During this Plan period, the target based approach of planned family planning efforts was replaced by the community needs assessment approach. Moreover, increasing attention was accorded to child survival and safe motherhood with the launch of Child Survival and Safe Motherhood Programme. Family planning was just one of the many components of this programme.

During the Ninth Five-year Development Plan (1997-2002), the rationale for planned family planning efforts was confined to meeting the felt-needs of family planning of eligible couples. Planned family planning efforts were completely subsumed in the reproductive and child health efforts resulting in a substantial dilution of family planning efforts.

The Tenth Five-year Plan(2002-07) called for the integration of numerous vertical programmes for family planning and maternal and child health into integrated programme of health care for women and children; a shift from demographic targets to enabling couples to achieve their reproductive goals; and meeting all unmet needs of contraception to reduce unwanted pregnancies. The target regime of planned family planning efforts also staged a comeback in terms of centrally defined targets to community needs assessment. The National Rural Health Mission was launched during the Plan and the Department of Family Welfare was merged with the Department of Health.

The Eleventh Five-year Plan (2007-12) reiterated the goals and objectives of the National Rural Health Mission which also included reduction in total fertility rate to the replacement level. However, at the policy level, the focus explicitly shifted towards universal access to health care rather than universal access to family planning. Planned family planning efforts were conceptualised within the framework of health care and were limited to voluntary fertility regulation only.

The approach paper for the Twelfth Five-year Plan (2012-17) has recognised that the total fertility rate continues to be above the replacement level that was supposed to be achieved by the end of the Eleventh Five-year Plan and that the couple protection rate has stagnated. The papers stresses that the need for population stabilisation is urgent as widely differing rates of population growth in a democratic set-up could potentially generate regional conflicts. The

approach paper recommends dedicated funding for family planning services in high fertility states, bundled with reproductive and child health care services under the National Rural Health Mission. It is also recommended that convergence should also be established with programmes that address the underlying factors of high fertility like child mortality, women's empowerment, early age of marriage etc. The approach paper however lacks a comprehensive approach towards population stabilisation. For example, the approach paper is silent about the challenge of population momentum in those State and Union Territories of the country which have either achieved or close to achieve the replacement fertility.

Attitude towards family planning

The idea of family planning has been successfully brought to the notice of an average Indian women. The attitude of a woman towards family planning is influenced by her education, age, income background, husband's occupation, and her (working) status among other factors. In terms of age, it has been found that the percentage of women approving family planning decreases as the age group increases. But the acceptance is about two-third even among the older age groups. This clearly shows that the great majority of Indian women approve of family planning, irrespective of age.

In a survey conducted in Rajasthan in 1988 by Kothari and Gulati, it was found that out of total persons studied, 88.1 percent were in favour of family planning and 11.9 percent were against it. Kothari, in another study published in 1994 and conducted in Rajasthan in 1993, also noted that according to the findings of the National Family Welfare Survey of the women married in the 13-49 years age-group, 90 percent knew some method of family planning, and 76.2 percent were aware of some sources of getting the required contraceptives, though only 31.8 percent were actually using the contraceptives.

A survey was conducted on the attitude towards family planning in Velore city of Tamil Nadu and its surrounding villages by Rao and Inbaraj. In all, 2,426 persons were interviewed with the intention of finding out whether they considered it within the power of the couple to control the number of children. Around 37 percent replied in the affirmative and 41 percent replied in the negative. Of those 899 persons who considered it possible, 46.6 percent considered it possible through family planning measures, 37.5 percent through control on self, while 15.9 percent did not point to any specific method. When they were asked whether they themselves were in favour of family planning, 64.6 percent said 'Yes' and 25.4 percent said 'No'. The reasons given for hostility to family planning measures were: it was harmful to women, it went against family economy, it was against God's will, and it constituted unnatural behaviour. However, since seven out of every ten persons were in favour of family planning, it points to the fact that people today have ceased to be very traditional in their beliefs and values.

A study made by the National Institute of Community Development covering 265 villages in 16 states and 43 districts and 7,224 respondents also revealed that 51.6 percent were in favour of family planning and 23.7 percent were against it.

Since illiteracy is found more among the poorer section of our society, it is seen that women with low education in the lower strata are more reluctant to accept family planning methods. Their contention is that since they have no money to fall back upon, their only hope of survival is their children's income. An average poor Indian couple is not satisfied with fewer than two or three children. Time and again, studies in various parts of the country have revealed this

fact. About a decade ago, a large scale survey covering some 32,000 respondents sponsored by the Ministry of Health and Family Welfare came to the conclusion that most couples wanted not only three or more children but they also wanted that two of them should be sons.

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