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History of Family Planning in India

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Abstract - India was the country in the world to launch family planning in 1952 but still striving hard to stabilize the population and also to offer healthy and productive life to its citizen. Uncontrolled population growth is impediment to national development. The core assumption behind is that decline in birth rates during the early stages of demographic transition can promote economic growth, reduce environmental pressures, reduce dependency ratio and strengthen a society's ability to invest in health and education (Code, Hoover and Press, 1958).With this aim and objectives major emphasis was laid down during the plan period to overcome the problem of population growth. Initially family planning was introduced to control the birth rate either by family limitation or spacing of the children. The period (1957-61)worked on increasing the clinics. The period (1967-74) marked the beginning of set targets for sterilization and IUD insertion. But it got setback during emergency and marked the turning point in the history of family planning. In recent years family planning has under gone a paradigm shift. It re-positioned not only to achieve population stabilization but emerged as one important intervention to reduced maternal and infant mortalities. A target free approach based on the unmet needs for contraception; equal emphasis on spacing and limiting methods and promoting "Children by choice" are the key family planning approaches.

Keywords - Replacement level, IUD, MMR, Infant mortality, Net Reproductive Rate.

Concept : Family Planning :- Family Planning at micro level would relieve women from the burden of repeated child bearing unwanted and mistimed pregnancy and free up opportunities to increase education, participate in labour force and ensure their well-being.

Family Planning is recognized as one of the cost effective solutions for achieving gender equality and equity by empowering women with knowledge and to control their physical and reproductive choices by accessing contraceptive method. Access to contraceptive helps in delaying, spacing and

limiting pregnancies; lowers healthcare costs and ensures that more girls complete their education, enter and stay in the workforce thus creating gender parity at workplace.

Family planning is defined as the desired number of children and when you want to have them by using safe and effective modern methods, by carefully spacing pregnancies of three to five years apart, a couple can build financial security allowing them to raise a family that they can properly care for. The World Health Organization, "Family Planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive method and the treatment of involuntary infertility. A women's ability to space and limit her pregnancies has a direct impact on her health and wellbeing as well as on the outcome of each pregnancy.

Family planning services are defined as "educational, comprehensive medical or social activities which enable individual, including minor to determine freely the spacing and number of children and to adopt the means by which this may be achieved. The concept and contents of family planning programme is dynamic in nature, which changes over time. In developing countries, family planning was introduced by the government to reduce population growth by reducing the fertility by the use of different reversible and non-reversible method of contraception and also find out the other main causes of rapid population growth. Few developing countries like India, Bangladesh and Sri Lanka adopted family planning programme to reduce fertility along with to protect the couples from other infections. But in most African countries where problem of HIV/AIDS is more common, the family planning programme was initiated to protect couples and children from these epidemics.

History of Family Planning in India - The growing size of the population has been always concerns of policy makers and programme managers ever since independence. Social reformers always voiced their concerns on the impact of population growth on India's economy, agriculture and good society. The planned family planning efforts in India can be traced in country's Five Year Development Plans. The First Population Survey in 1881 showed that population hardly grew between 1881 and 1921 because of epidemics, famines, war etc. India's population grew from 251 million in 1921 to 319 million in 1941. The first census of Independent India traced to 361 million in 1951. The huge hike in population and the pressure exercised on limited resources had brought to the forefront the urgency of the family planning and population control. The Government announced the National Family Programme in 1952.

Social Reformers and Activists felt that the high fertility rate among the women had a detrimental impact on their health. Large families were burden on women and nation. To liberalize women from multiple pregnancy and excessive child bearing and unwanted births, family planning clinics were set up in a few urban centers in 1920's and 1930's. R. D. Karve opened the first Family Planning Clinic in 1923 in Poona. In 1930, the native state of Mysore opened the first Government Clinic in Bangalore. In 1949, Family Planning Association of India (FPAI) was set up with Lady Dhanvanthi Rana Rau. It focused on the promotion of family planning with trained personal and financial support of government rather than voluntary welfare organizations. In 1939, National Planning Committee, a

sub-committee was appointed by Nehru under the Chairperson to examine various aspects of population problem. The committee opined that controlling the population growth necessary for the improvement of the quality of population and society.

In 1943, the Government appointed a Health Survey and Development Committee under the chairmanship of Sir Joseh Bhore. In 1946, Bhore Committee gave the report highlighting that with improvement in health, control of disease and famine population size will in runaway process so it is advisable for the nation to take deliberate action to limit the size of *family and that could not be achieved through self-control to any material extent (India* Health Survey and Development Committee, 1946).

The Post-Independence Family Planning :It is in this scenario that in 1952, India became the first country in the developing world to launch family planning programme. The programme advocated that population control can be achieved by reducing the birth rate. Family limitation or spacing of the children was necessary and desirable for the better health of mother and better upbringing of children.

The period (1957-61) worked on increasing the clinics, one for every 50,000 population in all big and major towns. In rural areas, the plan proposed to establish clinic in association with Primary Health Centre. As a consequence huge hike in the clinics were realized. It increased from 147 to 1649 clinics at the end of Second Plan. The training to all medical and nursing students was proposed to increase so that family planning services are available in hospitals and dispensaries.

The period (1961-66) attained the population growth at an average annual rate of 2 percent. The Planning Commission expressed the concern that sustained and intensive efforts are required to face the population problem. In 1965, Lippe's Lop (in IUD) as a birth spacing method was introduced and sterilization services within the public health care delivery system was strengthened. The time period between (1969-74) demonstrated the domination of the demographic rationale of family planning over its health rationale. The plan marked the beginning of set targets for sterilization and IUD insertions and to widen the acceptance of Oral and Injectable Contraceptives to achieve the aim of reducing the birth rate from 39 per thousand to 32 per thousand by 1973-74. The plan targeted to increase the number of users of conventional contraceptives. 3.24 million persons in 1969-70 to 10 million person by 1973-74 with a aim to protect 28 million couples and averting 18 million births through family planning by 1973-74. To boost planned family planning efforts, the Department of Family Planning was created within the Ministry of Health and Family Welfare at the national level. In 1970, the Government introduced vasectomy in camp mode in Kerala, Bihar, Gujarat, Haryana, Tamil Nadu, Maharahstra and Uttar Pradesh and as a result 3million sterilization was organized between 1972-74.

Family Planning During Emergency : In Bucharest World Population Conference was held in September 1974, where Mr. Karan Singh, Health and Family Planning Minister coined the famous slogan that "Development is the best contraceptive", but barely in the next year in 1975, the same minister alluded that legal limitation on the family size is needed, in terms of compulsion in the

national interest to achieve the target of 25 birth rate by 1983-84, if population continued to grow it will nullified all the progress. Realizing this fact National Emergency was announced on 25th June 1975 and the target was fixed at 4.3 million sterilization for 1976-77. Many states and North Indian States raised the sterilization target to 8.6 million and actually there were 8.3 million sterilizations which were more than three times the number of sterilization, male and female together performed in the previous year. In fact, 6.5 million sterilizations were performed in just six months.

During the Emergency period in April 1976, National Population Policy was announced. Various population related measures were announced such as raising the minimum legal age of marriage of girls to 18 years and 21 for boys and giving priority to female literacy. There was an increase in payments for sterilization acceptors and grading the payment on the basis of the number of children that the couples have before accepting the method was introduced.

This period also marked the period of political turbulence in India. This period brought in the element of coercion and force in planned family planning efforts. The incidents of harassment and rumors of coercion did brought a backlash in the achievements of all family planning methods. The number of sterilization declined from 8.3 million in 1976-77 to less than 1 million in 1977-78. The new Janta Government changed the Department of Family Welfare and the name of the National Family Planning Programme to National Family Welfare Programme.

Family Planning in 1980 Decade : The demographic goal of lowering fertility in terms of birth rate, it was now expressed in terms of Net Reproduction Rate (NRR) of Unity or 1 by 1996 for the country as a whole and by 2001 in all the states from the NRR of 1.67 which prevailed at that time. The focus was now shifted to other health issues of reducing infant, child and maternal mortality.

Three important developments of decade 1980's were (i) promotion of spacing methods with targets; (ii) uniform payment f incentives to acceptors and motivators of contraceptive; (iii) continuation of targets given to the functionaries of department of government other than health and family welfare. IUD and pills were introduced and in spite of official procurement or pursuing "Certificate Approach' sterilization was the backbone of contraceptive use in India. In fact, the findings also pointed out that for the majority of the couples sterilization was the final method of contraception.

National Family Planning Programme During the Five Year Plans of India : India is the second most populous country in the world sustaining 16.7 percent as the world population on 2.4 percent of the world's surface area. Realizing that high population growth is inevitable during the initial phases as demographic transition and there is urgent need to accurate the pace of the transition. India became the first country to formulate a National Family Planning Programme in 1952. The objective of the policy was 'reducing birth rate to the extent necessary to stabilize the population at a level consistent with requirement of national economy'. The First Five Year Plan stated that 'the main appeal for family planning is based on considerations of health and welfare of the family. Family limitation or spacing of children is 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 First Five Year Plan (1951-1956) : The rapid increase in population attained the attention of the Planning Commission. The Draft Outline of the First Plan published in July 1951 contained a section on "Population Pressure: Its Bearing on Development" which recognized that India had a population problem. "The increasing pressure of population on natural resources retards economic progress and limits seriously the rate of extension of social services, so essential to civilized existence. A population policy is, therefore, essential to planning. The final version of the First Plan reiterated: "The Pressure of population in India is already so high that a reduction in the rate of growth must be regarded as a major desideratum.

The Second Five Year Plan (1956-1961) : Pointed out that the rate of population increase was one of the key factors in development and underscored the fact that "a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and of capital equipment relatively to population as in India, the conclusion is inescapable that an effective curb on population growth is an important condition for rapid improvements in income and in levels of living." It is important to note that the Planning Commission has never considered a population control programme as an alternative to socio-economic development. The population pressure was likely to increase; it accepted the need for curbing the birth rates. "This highlights the need for a large and active programme aimed at restraining population growth even as it reinforces the case for a massive developmental effort."

The Third Five Year Plan (1961-1966) : While considering population control in the context of long term development stated : "The objective of stabilizing the growth of population over a reasonable period must therefore be at the very center of planned development.

The Fourth Five Year Plan (1969-1974) : Viewed population not only from the point of view of economic development, but also from that of social change. "Under Indian conditions, the quest for equality and dignity of man requires as its basis both a high rate of economic growth and a low rate of population increase. Even far reaching changes in social and economic fields will not lead to a better life unless population growth is controlled. The limitation of family is an essential and inescapable ingredient of development".

The Draft Fifth Five Year Plan (1974-1979) : It concluded: "If family planning is less of a success than assumed above, the total increase in population would be even larger. It is of the utmost importance that family planning must achieve at least that much success as has been assumed for the above projections. Given the needed effort, it is as attainable target".

The time and target oriented approach of family planning had been introduced in the Fourth Plan had been continued in the Fifth Plan. The Fifth Plan had also laid down targets "a target for a birth rate of 25 per thousand and a population growth rate of 1.4 percent by the end of the Sixth Plan period was expected and those targets were expected to be reached". The Ministry of Health and Family Planning has introduced a national population policy in April 1976 and stated that "The policy envisages a series of fundamental measures including raising the age as marriage, female education, spread of population values and the small family norm, strengthening of research in

reproductive biology and contraception, incentives for individuals, groups and communities and permitting state legislatures to enact legislation for compulsory sterilization".

The Sixth Five Year Plan (1980-1985) : The Sixth Five Year Plan laid down 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 states. The implications of these long-term demographic goals are as follows:

A. Birth rate per thousand population would be reduced from the level of 33 in 1978 to 21.
B. The death rate per thousand populations would be reduced from about 14 in 1978 to 09 and infant mortality rate would be reduced from 129 to 60 or less.
C. The average size of the family would be reduced from 4.2 children to 2.3 children.
D. As against 22 percent as eligible couples protected in 1979-80, 60 percent would be protected by the year 1984-85.

The Seventh Five Year Plan (1985-1990) : The daft of the Seventh Five Year Plan states that "the family welfare programme occupied an important position in the socio-economic development plans. It planned a crucial role in human resources development and in improving the quality of our people. It has formed an essential and integral part of 20 point programme which stressed the need for promotion of family programme on a voluntary basis as a people's movement. The health policy had targeted a long-term demographic goal of reaching a net reproduction rate of 1 by the year 2000 A.D. but a review as achievements of the Sixth Plan indicated that this goal could be reached only by the period 2005-2011. A total outlay of Rs.3256 Crores was allocated for the family welfare programme during the Seventh Plan.

The Eighth Five Year Plan (1992-1997) : It was towards human development that health and population control are listed as two of the six priority objectives of the Eighth Plan. It was towards this end that population control, Literacy, Primary Health Care, provision of adequate food and safe drinking water, employment generation and basic infrastructure were listed as priorities". To reinforce the sense of urgency and priority, along with the directional paper of Eighth Plan population control was also included as an agenda in the meeting of National Development Council held on December 23, 1991 and a separate paper prepared by the Planning Commission". The Eighth Plan clearly recognized if the present trend of population growth did not halt, it would never be possible to render social and economic justice to millions of our masses. The Eighth Plan has targeted to achieve the following demographic goals by 1997

A. Crude Birth Rate – 26.1
B. Effective Couples Protection Rate – 56.1.
C. Infant Mortality Rate – 70.1
D. Literacy Rate – 75.1.
E. Net Reproduction Rate equal to unity by the period 2011-2016 A.D.

In order to achieve the targets, the Government had prepared an "Action Plan" which had the following features:

- Improving the quality of family welfare services;
- Introducing a new package as compensation and incentives with the co-operation of State Government;
- Initiative innovative programmes in urban slums for propagating family welfare
- Increasing the involvement of voluntary agencies and privae organizations in family welfare programmes;
- Linking grants that are provided to State Governments for rural development and poverty alleviation to districts on the basis of their performance in the birth rate;
- Reducing a strong preference for a son on the part of a family having one or two daughters by providing social security measures.

During the Eighth Plan, a sum of Rs.6500 crores had been spent on the implementation of the programme, the eighth Plan envisages a series of incentives and disincentives in order to promote and popularize the family planning programmes. The incentives had been given to the employees of the Central Government, State Government and Public Sector Undertakings who had accepted two child family norms. These incentives included special increments such as cash award, priority in house building schemes and grant of leave travel concession benefits and the disincentives included as restriction on free medical benefits, no maternity leave and no preference in Government services.

The Government of India in the previous had appointed an expert group on National Population Policy under the Chairmanship of Dr. M.S.Swaminathan which submitted its reports on 22nd May, 1994. The report had suggested a number of socio-demographic goals

A. Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 and attaining two-child norm;
B. Full coverage of registration of births, deaths, marriage and pregnancy;
C. Universal access to information/counseling and services for fertility regulation and conception with a wide basket of choices;
D. Infant Mortality Rate to reduce below 30 per thousand live births and sharp reduction in the incidence as low births weight (below 2.5 kg.) babies;
E. Universal immunization of children against vaccine preventable disease. elimination of tetanus and measles.
F. Promote delayed marriage for girls, not earlier than the age of 18 and preferable after 20 years of age;
G. Achieve 80 percent institutional deliveries and increase in the percentage of deliveries conducted by trained persons to 100 percent;
H. Containing of sexually transmitted diseases;

Ninth Five Year Plan (1998-2002) : Reduction in population growth is one of the major objectives of the Ninth Plan during the Ninth Plan period. The Department of Family Welfare implemented the recommendations of the N.D.C. Sub-committee and centrally defined method of specific targets for

family planning was abolished. The emphasis shifted to decentralized planning at the district level based on assessment of community needs and implementation of programmes aimed at fulfillment of these needs and State specific goals for process and impact parameters for maternal and child health and contraceptive care were worked out and used for monitoring progress efforts were made to improve the quality and content of services through training to upgrade skills for all personal and building up of a referral network. A massive pulse polio campaign was taken up to eliminate polio. The Department of Family Welfare set up a consultative committee to suggest appropriate restructuring of the structure funded by the States and the central and revised norms for re-imbursement by the Center and has started implementing the recommendations of the Committee monitoring and evaluation had become a part of the programmes e.g. (i) Reduction in maternal mortality rate to less than 100 per one lakh live births; and (ii) Universalization of primary education and reduction in the drop-out rates at primary and secondary levels to below 20 percent both for boys and girls.

The Tenth Five Year Plan (2002-2007) : During the Tenth Plan, the paradigm shift, which began in Ninth Plan will be fully operationalized. The shift was from:

A. Demographic targets to focus on enabling couples to achieve their reproductive goals;
B. Method specific contraceptive targets for meeting all the unmet needs for contraception for reduction in unwanted pregnancies;
C. Numerous vertical programmes for family planning and maternal and child to be integrated health care for women and children;
D. Centrally defined targets for community need assessment and decentralized area specific micro planning and implementation of the programme for health care for women and children, to reduce infant mortality and reduce high desired fertility;
E. Quantitative coverage to emphasis on quality and content of care;
F. Predominantly women centered programmes for meeting the health care needs as the family with emphasis on involvement as men in Planned Parenthood;

The Tenth Plan had fully operationalized efforts to:

1. Assess and meet the unmet needs for contraceptives;
2. Achieve reduction in the high desired level of fertility through programmes for reduction in IMR and MMR; and
3. Enable families to achieve their reproductive goals.

If the reproductive goals of families are fully met the country would be able to achieve the national population policy replacement level of fertility by 2010. The medium and long-term goals will be of continuing this process to accelerate the pace of demographic transition by 2045. Early population stabilization will enable the country to achieve its developmental goal of improving the economic status and quality of life of the citizens.

The Eleventh Five Year Plan (2007-2011) : The Eleventh Five Year Plan will continue to advocate fertility regulation through voluntary and informed consent. It will also address the special health care needs of the elderly, especially those who are economically and socially vulnerable:

1. Reduce infant mortality rate to 28 per live births. Reduce total fertility rate to 2.1
2. Reduce malnutrition among children of the age group of 0-3 to half at its present level .Reduce anemia among women and girls by fifty percent by the end of the plan.

Reproductive and Child Health Programme (RCH) : In 1997, Reproductive and Child Health Programme was launched which adopted in principle of client satisfaction and high quality and integrated health services. It seeks to integrate services for the prevention and management of unwanted pregnancy, the promotion of safe motherhood and child survival, reproductive tract infections and sexually transmitted infections. The programme extended its services for neglected population groups, including adolescents economically and socially disadvantaged groups such as urban slum and tribal populations. It focused on utilizing and upgrading the existing health infrastructure rather than creating any new structures. It emphasized the programme to people's programme by decentralized, participatory and monitoring seek to involve several stakeholders including (NGOs), the private sector, Panchayati Raj Institutions and Civil Society in more meaningful way to move forward (MOHFW, 1997). RCH seeks to address gender issues by addressing the quality of care, increasing the availability of female health care provides at the Primary Health Center, improving the adolescent girls care, organizing gender sensitization training for stakeholders, encouraging male involvement in productive health. (World Bank, 1997).

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