

FAMILY PLANNING PROGRAMS IN INDIA

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B. A., Stanislaus State College, California, 1965

A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF ARTS

Department of Sociology and Anthropology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1968

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ACKNOWLEDGEMENTS

The author wants to express his sincere gratitude to Dr. Wayne C. Rohrer and to Dr. Eugene A. Friedmann for their kind help and guidance.

The author is especially grateful and thankful to Professor Joseph E. Disanto for his supervision and valuable suggestion to make this report a success.

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CHAPTER I

Introduction

The main purpose of this report is to discuss family planning programs in India. Today the government of India has taken a progressive stand on this question and is in favor of both mechanical and chemical methods of contraception in connection with family planning. As an instrument of population control family planning programs were started in India during the first five year plan (1951-1956). Population control through family planning is seen to be a means of helping to alleviate rapid population growth. Within the last two decades population growth has been recognized to be a serious obstacle in the way of improvement of social and economic conditions in India. A population increase of eleven million persons a year hinders the advance of national progress and policies for economic development. The immediate task of the family planning program is to help reduce the birth rate from forty per thousand to twenty-five per thousand by 1973.

This report is divided into four chapters. The first chapter contains an introduction to the problem, a definition of family planning, and a survey of research and

studies relevant to the subject. The second chapter describes the historical development of family planning programs and specific contraceptive methods advocated by the India government. The third chapter considers various socio-cultural factors, favorable and unfavorable which affect family planning programs. A summary and conclusions of the report are presented in the final chapter.

Definition of Family Planning¹

In general, family planning is a threefold effort: one, to space births in order to achieve an optimum interval between them; second, to limit and/or control the number of births to attain the desired size of family; and third, to treat the needs of infertile couples who want to have children.

Implementation of Family Planning

Government policy or action is a factor which can be used to support a family planning program. Governments can use various means to promote family planning programs. Official action can introduce changes into the social structure to spread the knowledge of family planning through education, mass-media, and social legislation.

¹For various definitions of family planning, see the following sources: M. C. Balfour, "Family Planning in Asia," Population Studies, XV, No. 2 (Nov., 1961), p. 102; United Nations, The Department of Economic and Social Affairs, The Mysore Population Study (New York: United Nations, 1961), p. 168; The Department of Economic and Social Affairs, Multi-lingual Demographic Dictionary (New York: United Nations, 1958), p. 38.

Survey of Research Attitudinal Relevant to Family Planning

Research studies relevant to family planning can be divided into two categories. The studies in the first category deal with attitudes of people towards family planning and also determine the knowledge and practice of family planning among the population. The second category deals with more detailed information and attempts to study the effectiveness of contraceptive methods.²

Research studies related to different aspects of family planning have been conducted in different parts of India. The main goal of these studies is to help build an effective, efficient and successful program. Research of this type has been designated as "family planning action research". Family planning action research is defined as, "A systematic and intensive effort using social science research concepts and all methods plus all other relevant knowledge and skills, to develop and maintain an effective, feasible program for helping people to accept family planning program"³ Bogue⁴ indicates that it usually involves

²For studies on effectiveness of methods. See chapter 3, p. 27.

³Moye W. Freyman and Herbert F. Lionberger, "A Model for Family Planning Action Research," in Clyde V. Kiser ed., Research in Family Planning (Princeton, N.J.: Princeton University Press, 1962), p. 444.

⁴Donald J. Bogue, "Family Planning Research: An Outline of the Field," in Bernard Berelson ed., Family Planning and Population Programs (Chicago: The University of Chicago Press, 1965), p. 721.

going into the field and collecting data in comparatively small local areas, either to test an hypothesis or to evaluate a proposed action program.

Two studies to determine the attitudes of males and females in Badlapur, a village of 3,000 population, Bombay State, India, were conducted by Morrison⁵ during 1954. Morrison selected a representative sample of 124 males within the age group 15-54 years of total universe of 573 men. Two male investigators interviewed the sample population and asked the question, "Would you like to learn a method by which you and your wife can avoid pregnancy?" Thirty-two men, representing 25.8 percent of the sample, answered in the affirmative. Five variables---a higher level of education, a larger number of living children, a larger number of living male children, a larger number of total offspring, and membership in the higher caste---were found to be significantly associated with a favorable attitude towards family planning among men. Morrison also selected a representative sample of 126 women within the age group of 15-44 years out of a total universe of 494 women. Two female investigators interviewed the sample population and to ascertain willingness to use contraceptives asked the question, "If you wish to avoid

⁵William A. Morrison, "Attitudes of Males Towards Family Planning in a Western Indian Village," The Milbank Memorial Fund Quarterly, XXXIV (July, 1956), pp. 262-286; William A. Morrison, "Attitudes of Females Towards Family Planning in a Maharashtra Village," The Milbank Memorial Fund Quarterly, XXXV (January, 1957), p. 67-80.

pregnancy or limit the size of the family, would you be willing to use contraceptives to do this?" Fifty-one women representing 40.5 percent of the sample replied in the affirmative. Four variables---a higher level of education, an older age at marriage, a greater number of years married, and a larger number of total offspring---were found to be significantly influential in creating a favorable attitude towards the use of contraceptives among females. Table 1 presents the socic-cultural and demographic variables which influenced the attitudes of men and women towards family planning in Badlapur.

TABLE 1
VARIABLES ASSOCIATED WITH WILLINGNESS TO USE
CONTRACEPTIVES IN MALE AND FEMALE SAMPLES

| Variables Considered | Significant in Association | Not Significant in Association |
|---------------------------------|----------------------------|--------------------------------|
| Education | Male and Female | ---- |
| Years married | Female | Male |
| Number of total offspring | Male and Female | ---- |
| Number of living offspring | Male | Female |
| Number of living male offspring | Male | Female |
| Age at marriage | Female | Male |
| Caste | Male | Female |
| Occupation | ---- | Male & Female |
| Age | ---- | Male & Female |

Source: William A. Morrison, "Attitudes of Females Towards Family Planning in a Maharashtra Village," The Milbank Memorial Fund Quarterly, XXXV (January, 1957), p. 67-80.

Only two variables, education and total number of children, were significantly associated with willingness to use contraceptives in both males and females, but their attitudes were also influenced by the other variables.

Morrison⁶ in another city analyzed the attitudes of industrial workers towards family planning in Ambarnath City, Bombay State, India. The sample consisted of 166 married men who were employed in industrial plants of the City. The sample males were asked the question, "Are you for or against the use of birth control?" Fifteen men or 9 percent of the sample answered in the affirmative. Morrison found that variables of a higher level of education, a larger number of living male offspring, and a greater number of years married were significantly associated with favorable attitudes towards family planning. In addition, those expressing favorable attitudes were employed in better positions.

Morrison's studies were mainly concerned with the attitudes of men and women only towards family planning in the village people and also among industrial workers. The analysis shows that demographic and socio-cultural variables

⁶William A. Morrison, "Family Planning Attitudes of Industrial Workers of Ambarnath City of Western India: A Comparative Analysis," Population Studies, XIV (March, 1961), p. 235.

are related to attitudes towards family planning.

Singh⁷ in his study also found that socio-cultural variables are significant in influencing the attitudes of the people towards family planning. He found that the number of surviving children, age of the couple, educational level and occupation of husband are factors which are related to the attitudes of the people towards the practice of family planning. These findings support those of Morrison with the exception of the variable concerning the age of the couple.

Family planning studies conducted by the Gokhale Institute of Politics and Economics⁸ reveal that people in cities as well as in villages do not know much about family planning methods and sometimes understand it as induced abortion. The studies also found a great willingness among people to learn about family planning. The studies did not show or reveal any positive social or religious opposition to family planning.

⁷ Baljit Singh, "Problem of Family Planning in the Countryside: A Sociological Analysis," Report of the Proceedings, The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (London, International Planned Parenthood Federation, 1960), pp. 94-101.

⁸ Kumidini Dandekar, "Family Planning Studies Conducted by the Gokhale Institute of Politics and Economics, Poona," in Clyde V. Kiser ed., Research in Family Planning (Princeton, N.J.: Princeton University Press, 1962), pp. 3-15.

A family planning survey was conducted by Agarwala⁹ in four villages near Delhi, India. Agarwala studied knowledge, awareness and practices of family planning among married women. The sample contained 298 married women within the age group 15-45 years. The information was obtained by interviews conducted of female research workers. The women in the sample were questioned about their awareness of family planning. Table 2 presents the results.

TABLE 2
DISTRIBUTION OF WOMEN BY AGE AND AWARENESS
AND OTHER VARIABLES

| | Age ^a | | | Total | Percent |
|--------------------------------------|------------------|-------|-------|-------|---------|
| | 15-24 | 25-34 | 35-45 | | |
| Total | 129 | 111 | 58 | 298 | 100 |
| Awareness of family planning | 49 | 61 | 39 | 149 | 50 |
| Believe in its efficacy | 40 | 54 | 35 | 129 | 43 |
| Knew a method of family planning | 13 | 24 | 18 | 55 | 18 |
| Practiced the method | 0 | 5 | 3 | 8 | 3 |
| Willingness to learn family planning | 62 | 69 | 33 | 164 | 55 |

^aAll the variables except willing to learn family planning are significantly associated with age.

Source: A. N. Agarwala, "A Family Planning Survey in Four Delhi Villages," Population Studies, XV (November, 1961), p. 113.

⁹S. N. Agarwala, "A Family Planning Survey in Four Delhi Villages," Population Studies, XV (November, 1961), pp. 110-120.

Besides revealing these findings the study also revealed that there was no widespread religious objection to family planning. The ideal size of family was considered to be five. There was general disinclination to spend money on contraceptives among the women. Age was found to be an important factor among women in influencing their attitude towards family planning. Agarwala's study also showed that there is great willingness to learn about family planning methods. But the percentage of women who practiced the method was very low.

The United Nations¹⁰ and the government of India conducted a comprehensive population study in Mysore State, India, during 1960. It included the whole Mysore State and devoted a section to the study of knowledge and the practice of family planning in the city of Bangalore and in rural areas. The respondents were classified by caste, religion and educational level in the city, but in rural areas it was not thought necessary to do so. The husband and wives were interviewed by male and female investigators and asked the question, "Has it come to your knowledge that there are methods other than abstinence by which married women can avoid or delay becoming pregnant?" The following table presents the results.

¹⁰United Nations, "The Knowledge and Practice of Methods of Family Limitations," Chapter 12, The Mysore Population Study (New York: United Nations, 1961), pp. 159-172.

TABLE 3

PERCENTAGE OF MARRIED WOMEN AND THEIR HUSBANDS WITHOUT KNOWLEDGE OF FAMILY PLANNING, AND PERCENT HAVING SOME KNOWLEDGE OF FAMILY PLANNING

| | Number Responding | Having Some Knowledge of Family Planning | Without Knowledge of Family Planning |
|--------------------------------------|-------------------|--|--------------------------------------|
| <u>Responses of wives</u> | | | |
| Banglore City (total of four strata) | 1,002 | 37.6 | 62.4 |
| Moslem stratum | 221 | 34.0 | 66.0 |
| Scheduled caste stratum ^a | 271 | 28.0 | 72.0 |
| Low literacy (Hindu) stratum | 241 | 40.2 | 59.8 |
| High literacy (Hindu) stratum | 269 | 47.2 | 52.1 |
| Rural plains | 392 | 10.7 | 89.3 |
| <u>Responses of husbands</u> | | | |
| Banglore City (total of four strata) | 791 | 37.8 | 62.2 |
| Moslem stratum | 170 | 48.3 | 51.7 |
| Scheduled caste stratum ^a | 202 | 23.3 | 76.7 |
| Low literacy (Hindu) stratum | 192 | 31.2 | 68.8 |
| High literacy (Hindu) stratum | 227 | 48.4 | 51.6 |
| Rural plains | 323 | 14.8 | 85.2 |

^aScheduled caste are those castes which have the lowest socio-economic status in present-day Indian society.

Source: United Nations, The Mysore Population Study, p. 161.

It is apparent from Table 3 that the proportion of men and women having knowledge of family planning is higher among the urban areas than in rural areas. The scheduled caste has the lowest percentage of men and women having knowledge of family planning. The educational level is directly

related to knowledge of family planning. The study also obtained information about the practice of family planning among people. The male and female investigators asked the question, "Have you at any time since your marriage made any effort to delay or to avoid pregnancy by abstaining from intercourse or by another method?" The results for Bangalore City and rural areas are shown in Table 4.

TABLE 4

PERCENTAGE OF MARRIED WOMEN AND THEIR HUSBANDS REPORTING THAT THEY HAVE PRACTICED ABSTINENCE OR OTHER METHODS OF FAMILY PLANNING FOR BANGLORE CITY AND RURAL PLAINS

| | Number Responding | Reporting Use of Any Method | Reporting Use of No Method |
|--------------------------------------|----------------------|-----------------------------------|----------------------------------|
| <u>Responses of wives</u> | | | |
| Banglore City (total of four strata) | 1,011 | 9.5 | 90.5 |
| Moslem stratum | 222 | 4.5 | 95.5 |
| Scheduled caste stratum ^a | 271 | 8.1 | 91.9 |
| Low literacy (Hindu) stratum | 245 | 5.3 | 94.7 |
| High literacy (Hindu) stratum | 273 | 18.7 | 81.4 |
| Rural plains | 392 | 2.3 | 97.7 |
| <u>Responses of husbands</u> | | | |
| Banglore City (total of four strata) | 793 | 5.8 | 93.9 |
| Moslem stratum | 170 | 3.5 | 96.5 |
| Scheduled caste stratum ^a | 204 | 1.5 | 98.5 |
| Low literacy (Hindu) stratum | 192 | 2.1 | 97.9 |
| High literacy (Hindu) stratum | 227 | 14.5 | 85.5 |
| Rural Plains | 323 | 0.6 | 99.4 |

^aScheduled caste are those castes which have the lowest socio-economic status in present-day Indian society.

Source: United Nations, The Mysore Population Study, p. 167.

It is clear from Table 4 that the percentage of people practicing family planning is higher in urban areas in comparison with rural areas. The educational level is also directly related to the practice of family planning. The study also showed significant relationship between age of couple, educational level, socioeconomic status and family planning practice. A higher percentage of women in the scheduled caste stratum practiced family planning than did men.

Another study regarding the practice of family planning methods was undertaken by Poti, Malakar and Chakaravorti¹¹ in Calcutta City. A master sample of 6,884 couples was obtained by listing in the selected areas those who satisfied these conditions: both husband and wife resident of the same household, and married only once, and wife's age to be below 40 years. The couples were classified into three social groups, and a total of 1,018 couples was selected at random from each social group or stratum. The information was obtained by questionnaire and by interviewing. That the practice of family planning is related directly to the socioeconomic level and to the duration of marriage in years is clearly shown in Table 5.

¹¹S. N. Poti, C. R. Malakar, and B. Chakarvorti, "An Enquiry Into the Prevalence of Contraceptive Practice in Calcutta City, 1956-1957," The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (London, 1960), pp. 52-67.

TABLE 5

PERCENTAGE OF COUPLES WHO EVER PRACTICED ANY METHOD OF CONTRACEPTION

| Duration of Marriage in Years | Stratum I Higher Professional ^a | | Stratum II ^b Middle Class | | Stratum III ^c Manual Labor | |
|----------------------------------|---|------------|---|------------|--|------------|
| | Couples | Percentage | Couples | Percentage | Couples | Percentage |
| 0-4 | 34 | 82 | 69 | 65 | 20 | 35 |
| 5-9 | 66 | 85 | 116 | 73 | 82 | 26 |
| 10-14 | 53 | 89 | 134 | 69 | 128 | 23 |
| 15-19 | 53 | 74 | 89 | 54 | 63 | 24 |
| 20 and over | 32 | 72 | 51 | 37 | 28 | 19 |
| All durations | 238 | 81 | 459 | 63 | 321 | 24 |

^aProfessional class includes doctors, engineers, office executives, etc.

^bMiddle class includes clerks, supervisors and retail traders.

^cManual labor class includes skilled and semiskilled workers.

Source: S. M. Poti, C. R. Malakar, and B. Chakarvorti, "An Enquiry Into the Prevalence of Contraceptive Practice in Calcutta City, 1956-1957," The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (London, 1960), p. 52.

Driver also analyzed the relationship between knowledge of family planning methods and interest in family planning by residential classification.¹² The sample contained 2,314 couples. The results are shown in Table 6. Driver's study shows that the percentage of knowledgeable couples is 46.6 in the city, 27.8 in the towns, and 25.1 in the villages. The study clearly indicates a more significant difference concerning knowledge of family planning as opposed to interest in family planning. While the level of interest is relatively stable among the groups, there is a more significant difference in the level of knowledge.

TABLE 6

PERCENTAGE OF COUPLES HAVING KNOWLEDGE OF FAMILY PLANNING METHODS AND INTEREST IN FAMILY PLANNING, BY RESIDENCE

| Residence | Number of Couples | Percentage of Couples | | | | | |
|-----------|----------------------|-----------------------|------|-------|----------|------|-------|
| | | Knowledge | | | Interest | | |
| | | Some | None | Total | Some | None | Total |
| City | 882 | 46.6 | 53.4 | 100.0 | 78.4 | 21.6 | 100.0 |
| Town | 309 | 27.8 | 72.2 | 100.0 | 72.2 | 27.8 | 100.0 |
| Village | 1,123 | 25.1 | 74.9 | 100.0 | 64.0 | 36.0 | 100.0 |
| Total | 2,314 | 33.7 | 66.3 | 100.0 | 70.3 | 29.7 | 100.0 |

Source: Edwin D. Driver, Differential Fertility in Central India (Princeton, N.J.: Princeton University Press, 1963), p. 121.

¹² Edwin D. Driver, Differential Fertility in Central India (Princeton, N.J.: Princeton University Press, 1963), p. 121.

The above studies were conducted in different parts of India under different social and cultural conditions. These studies differed considerably as to the form of questionnaire used, sample size and the manner in which inquiries were conducted. It is difficult to evaluate the efficiency and preciseness of their results because of the different socio-cultural conditions in India. These studies are not uniform in their findings and show minor variations in results. It is hard to draw generalizations applicable to the total population of India, but certain observations are obvious and can be helpful to organizers of the family planning program and to people in other areas who are concerned with research in family planning.

The studies reviewed in this section have been concerned with knowledge, attitudes and practices of family planning among the people. The analyses of these studies show that socio-cultural and demographic factors are important in the formulation of attitudes towards family planning. These factors are the following: number of living male children, number of living children, occupation, education, age, residence, caste, socioeconomic status, and years married. The studies also reveal that there is great willingness to learn about family planning methods and to practice them. The knowledge of and practice of family planning are higher among urban populations. There is no religious opposition

to family planning among the population in rural or urban areas. There is great desire to learn and to know more about family planning methods among the people.

The findings of these studies provide basic guidelines for the development of family planning programs, thereby giving the organizer some idea as to what procedures should be emphasized and how they should be accomplished. They also show that socioeconomic conditions play a significant role in the practice of family planning and that it is essential to improve the social and economic conditions to make the practice of family planning more popular.

There has been enough research done concerning the attitude, knowledge and practice of family planning in different parts of India. Some of the findings have been utilized to implement the family planning program. One area in which emphasis should be given is in motivating people to practice family planning by means of education and by improving communication methods.

Summary

The discussion in this chapter has centered about the statement of the problem, the definition of family planning and family limitation, and a review of studies relevant to knowledge, attitude and practice of family planning among people. The studies have provided useful information about family planning and social, cultural, and demographic factors

related to it. In spite of differences in methodologies, samples, questionnaires and interviewing techniques, these studies have shown many important relationships between family planning and education, residence, and socioeconomic conditions. The findings can be utilized to achieve the main objective of family planning and that is to reduce the birth rate of India from 40 per thousand to 25 per thousand by 1973. The research findings have also shown that there is a great desire to learn more about family planning methods. This attitude has encouraged the government to launch a massive family planning program.

CHAPTER II

Historical Sketch of Family Planning Programs

Before Independence (Pre-1947)

There were no official family planning programs in India before 1947. Some educated Indians and national leaders, however, were aware of family planning and tried to introduce the practice of family planning as early as 1925.

The idea of birth control in India was borrowed from England and the United States¹ where Mary Stopes and Margaret Sanger opened birth control clinics in these two countries in 1923. In 1925, Dr. R. D. Karve opened the first birth control clinic in Bombay City, India. In 1930, the government of Mysore established birth control clinics in the state hospitals to provide facilities in which people interested in limiting the size of their families could learn how to limit them.

In 1932, at Lucknow session, the All India Women's Conference supported the family planning campaign.² It also

¹D. P. Karurkar, "Inaugural Speech," The Sixth International Conference on Planned Parenthood Reports on Proceedings, New Delhi, 1959 (London, 1960), pp. 4-5.

²Savitri Thapar, "Family Planning in India," Population Studies, XVII (July, 1963), pp. 5-6.

proposed that men and women should be given instruction in methods of birth control at recognized clinics. As a result of this women's conference the Madras³ government opened birth control clinics in 1932 to provide family planning facilities for the use of people interested in limiting the sizes of their families. In the same year the Senate of Madras University accepted the proposal made by the All India Women's Conference to give instruction to medical students concerning contraceptives.

On the invitation of the All India Women's Conference, Mrs. Edith Howe Martyn and Mrs. Margaret Sanger,⁴ famous advocates of birth control, visited India in 1934. These two ladies traveled 10,000 miles in India and addressed 64 meetings in 18 cities and towns. Of the 64 meetings which they addressed, half involved medical organizations. They also met government officials and national leaders and tried to win support for a family planning movement.

A number of societies and organizations were formed to promote the idea of family planning, and birth control clinics were set up in big cities in India. In 1934, The Journal of Marriage and Hygiene⁵ was started by Dr. A. P.

³Moye W. Freyman, "Population Control in India," Marriage and Family Living, XXV (February, 1963), p. 57.

⁴Kingsley Davis, Population of India and Pakistan (Princeton, N.J.: Princeton University Press, 1951), p. 227.

⁵S. N. Agarwala, "Population Control in India," Law and Contemporary Problems, XXV, No. 3 (Summer, 1960), p. 59.

Pillai in Bombay, and it was instrumental in diffusing information about family planning.

It was due, in part, to the impact of these developments that the National Planning Committee was set up by the Indian National Congress under the chairmanship of the late Jawahar Lal Nehru. The Committee gave support to family planning as a state policy and made several recommendations to the government. The most relevant to the subject are the following:

(1) In the interest of social economy, family happiness and national planning, family planning and limitation of children are essential; and the state should adopt a policy to encourage these. It is desirable to lay stress on self control, as well as to spread the knowledge of cheap and safe methods of birth control. Birth control clinics should be established, and other necessary measures taken in this behalf and to prevent the use of advertisement of harmful methods.

(2) We consider that the gradual raising of the marriage age and discouragement of polygamy are desirable in the interests of limitation of the size of family.

(3) The maintenance of vital statistics, and the carrying out of the periodic demographic surveys on comprehensive lines are necessary, and appropriate machinery should be devised for the purpose.⁶

This was the first committee report which specifically mentioned the implementation of family planning as a means of checking the population increase for reasons of health and family welfare.

⁶K. T. Shah (ed.), Report: National Planning Committee (Bombay, India: Vora and Co., Publisher Ltd., 1949), pp. 147-149.

In 1943, the Health Survey and Development Committee⁷ under the chairmanship of Joseph Shore was appointed by the Central Government of India. The purpose of this committee was to study the factors related to the health of the population. The committee recommended official support for birth control for the poor because of reasons of health.

The recommendations of the National Planning Committee aroused concern in government circles about the population problem and the possibility of developing the family planning program. Progress in family planning was interrupted by the outbreak of World War II in 1938 and these recommendations were not implemented.

The major achievements by way of opening birth control clinics occurred in the cities where there was enough initiative shown among the educated classes to promote family planning by use of the clinical approach. There are no records to show how much achievement was made through these clinics.

Period of Silence (1947-1951)

No substantial progress was made during the four years from 1947-1951. India gained her independence in 1947

⁷B. L. Raina, "India," in Bernard Berelson, et al (ed.) Family Planning and Population Programs, (Chicago: The University of Chicago Press, 1966), p. 112.

and the early post independence period was a period of silence on the issue of family planning. The political developments arising from the partition of the country, rehabilitation of refugees and border disputes with Pakistan kept the government busy and no attention was devoted to family planning until 1951.⁸

Only one demographic study was conducted during this time. It was under the auspices of the Indian Research Fund Association and the All India Institute of Hygiene and Public Health, and was conducted by C. Chandrasekaran and Muktha Sen. The results of the study were not published, but they were used by Kingsley Davis⁹ in his book Population of India and Pakistan.

Era of Government Involvement (1951-

In April, 1951, four years after Indian independence, the Health Panel of the Planning Commission appointed a committee to suggest a policy concerning "Population Growth and Family Planning." The committee made the following recommendations to the government:

(1) The committee recognized the need for family planning to space and to limit the number of births to protect

⁸T. J. Samuel, "The Development of India's Policy of Population Control," The Milbank Memorial Fund Quarterly, XLIV, No. 1, Part 1 (January, 1966), p. 50.

⁹C. Chandrasekaran and Muktha Sen, "Enquiry into the Reproductive Patterns of Bengalee Women," Population of India and Pakistan, Kingsley Davis (Princeton, N.J.: Princeton University Press, 1951), p. 227.

the health of mother and child. This limitation was felt to be essential to ensure an adequate share of resources for the care and upbringing of children. The Committee sought to bring the high birth rate in line with the concurrent low death rate in order to insure the success of plans and programs for national economic development.

(2) The family planning should be a social movement and should be based on individual initiative and public opinion. The state should give high priority to mass education, improvement of health and living standards, which indirectly favor family planning. The state should provide facilities through hospitals and health agencies for family planning along socioeconomic and medical grounds. The state should allocate funds for research facilities for collection of scientific information from abroad concerning all aspects of family planning. They advocated the development of safe, efficacious methods for all classes of people and the manufacture of necessary appliances and materials in India.

(3) The importance of maintenance and improvement of demographic data, and systematic study of population problems was stressed.¹⁰

Recommendations of the committee coupled with the Census Report of 1951, which showed a tremendous population

¹⁰Frank W. Notestein (ed.), "Current Items," Popula-
Index, XVII (October, 1951), pp. 256-257.

increase in India, aroused the concern of the government to do something practical towards the implementation of a family planning program. The government put the recommendations of the Planning Commission into effect through successive five year plans.

During the first five year plan (1951-1956) the government of India asked the World Health Organization for assistance in organizing studies in the rhythm method. The study was conducted in two communities, one in Ramanagram, a rural community in South India, and one in Lodi, a suburb of New Delhi. In the study in Ramanagram, 75 percent of the couples covered by the attitude survey indicated a willingness to learn this form of contraception. In Lodi community near New Delhi, 70 percent of the women--who were wives of government workers and already had some knowledge about family planning---indicated willingness to learn the method. In Ramanagram 41 out of 811, and in Lodi 27 out of 898 practiced the method.¹¹ So few people practiced the rhythm method, because of certain other factors, that was difficult to evaluate its effectiveness. That such a small proportion of the people practiced this method indicates, however, that it is not acceptable to the majority of people and that it can have little effect in reducing the birth rate of the country.

¹¹C. Chandrasekaran, "Pilot Study on the Rhythm Method of Family Planning in India," Population and Progress in the Far East, ed. Warren S. Thompson (Chicago: The University of Chicago Press, 1959), pp. 141-142.

The First Five Year Plan (1951-1956).--Family planning programs were put into effect during the First Five Year Plan. The programs were to develop an active public opinion in favor of family planning and to promote dissemination of family planning advice and service through clinics. Demographic studies¹² related to fertility patterns and mortality were taken up. Financial assistance was provided to states, local authorities, voluntary organizations and scientific institutions for research and for the opening of family clinics. In terms, the major objectives of population policy of the First Five Year Plan were:

- (1) To obtain an accurate picture of the factors which contributed to rapid increase of population.
- (2) To gain fuller understanding of human fertility and means of regulating fertility.
- (3) To devise speedy ways of educating the public.
- (4) To make family planning advice and service an integral part of the services available in hospitals and health centers.¹³

¹²Kumidini Dandekar and V. M. Dandekar, "Survey of Fertility and Mortality in Poona District" (Gokhale Institute), Publication No. 27; Kumidini Dandekar, "Demographic Survey of Six Rural Communities" (Gokhale Institute), Publication No. 37; Kumidini Dandekar and S. N. Sovani, "Fertility Survey of Nasik, Kolaba, and Satara Districts" (Gokhale Institute), Publication No. 31; in "Family Planning Studies Conducted by The Gokhale Institute of Politics and Economics in Poona," Kumidini Dandekar, Research in Family Planning, ed. Clyde V. Kiser (Princeton, N.J.: Princeton University Press, 1962), pp. 3-15.

¹³Government of India Republic Planning Commission, Second Five Year Plan, pp. 553-554.

The Second Five Year Plan (1956-1961).--During the Second Five Year Plan period the government extended the program and made the necessary modifications to improve the organization, methods and communication. The number of clinics increased from 147 in the First Five Year Plan to 1,649 in the Second Five Year Plan. In addition to use of clinics the hospitals were utilized to provide facilities for family planning. A Central Family Planning Board was set up to support the Ministry of Health. A Director of Family Planning was appointed. Training centers for training leaders in family planning. Longitudinal studies¹⁴ in family planning were taken up. Mass media including films, exhibits and slides were used to raise the national awareness of family planning. Major steps were taken towards building an organizational framework to carry on an extensive program.

Education in family planning including sex education, characteristic of a happy married life and training in child guidance were introduced into the educational system

¹⁴John B. Wyon and John E. Gordon, "A Long Term Prospective-Type Field Study of Population Dynamics in Punjab, India," Research in Family Planning, ed. Clyde V. Kiser (Princeton, N.J.: Princeton University Press, 1962), pp. 17-32; and S. M. Poti, C. R. Malakar, and B. Chakarvorti, "An Enquiry Into the Prevalence of Contraceptive Practices in Calcutta City, 1956-1957," The Sixth International Conference on Planned Parenthood, Report of the Proceedings, New Delhi, 1959 (The International Planned Parenthood Federation, London, 1960), pp. 52-60.

for girls. Training in inspection, supervision, and evaluation of these programs were also thought to be necessary kinds of training. An evaluation and assessment of the methodological approach was made. Facilities for voluntary sterilization were made available to people at hospitals and also through vasectomy camps. The states of Madras, Bombay, Maharashtra, and Kerala started intensive programs for sterilization of men.

More financial assistance was allocated for the Second Five Year Plan. The research orientation shifted from giving information and developing the right attitude toward practice of family planning to determining the efficacy and the result of methods concerning family planning on the birth rate of the communities in which they were used. A study¹⁵ to determine the relationship of socio-cultural factors in relation to family planning was undertaken in the Second Five Year Plan.¹⁶

The Third Five Year Plan (1961-1966).---In the Third Five Year planned population control became the main objective of the family planning program. Changes in the organizational structure were made. Programs were expanded on a mass scale

¹⁵United Nations, Department of Social and Economic Affairs, The Mysore Population Study (United Nations, New York, 1961).

¹⁶Government of India Republic Planning Commission, Second Five Year Plan, Government of India, pp. 553-554.

so that the knowledge of family planning could reach all the married people in the villages. Intensified educational programs to teach women about sex and the reproduction process were put into effect.

The family planning programs were integrated with those of health centers and community development projects. The manufacturing of contraceptives such as loops and condoms was started in India in order to make them inexpensive. Sterilization and intrauterine methods of contraception were encouraged and facilities were made available on a large scale. The help of doctors, mid-wives and community leaders were sought to make the program more efficient. The social aspects related to family planning such as education of women, employment of women, raising the age of marriage were also taken into consideration.¹⁷

The Fourth Five Year Plan (1966-1971).--The draft outline of the Fourth Five Year Plan states that the main purpose of family planning is to bring about a reduction in the birth rate from 40 per 1,000 persons to 25 per 1,000 persons by 1971. In this plan the major emphasis is on coordination of information concerning family planning with the information disseminated by other departments such as education, information and broadcasting, community develop-

¹⁷Government of India Republic Planning Commission, Third Five Year Plan, Government of India, pp. 675-678.

ment, and local self-government. The Ministry of Health has been redesignated as the Ministry of Health and Family Planning. More doctors and workers at various levels will be recruited to implement the program on a mass scale. The methods of sterilization and intrauterine devices for greater reliability and effectiveness are encouraged. Making abortion a legal method of family planning is also to be approved. The manufacture of contraceptives such as loops and condoms in India will be expanded to permit mass distribution. More emphasis will be given to extend knowledge of family planning to rural areas.¹⁸

Table 7 gives some idea in graphic form of the government and of the financial allocation to be provided for family planning programs in India in Five Year Plans. The funds allocated for these programs have increased from one plan period to the next.

Methods of Family Planning

Appliance and non-appliance methods of family planning were prescribed for couples to use in limiting the number of children. Information about these methods was provided through the clinics. As the program of family planning developed, these methods were evaluated in relation to their

¹⁸Government of India Republic Planning Commission, Fourth Five Year Plan, A Draft Outline, pp. 346-349.

TABLE 7

INDIA'S FAMILY PLANNING EXPENDITURES 1951-1971
(One dollar = 7.5 rupees.)

| Five Year Plan | Expenditure (Millions of rupees) |
|----------------|-------------------------------------|
| First | 1.5 |
| Second | 21.6 |
| Third | 261.0 |
| Fourth | 950.0 |

Source: Dudley Kirk, "Prospects for Reducing Natality in the Underdeveloped Areas," The Annals of the American Academy of Political and Social Sciences, CCCLXIX (January, 1967), p. 51.

effectiveness. The clinics were opened throughout the country during the periods of First and Second Five Year Plans (1951-1961). The clinics were integrated with hospitals and with health centers in urban areas as well as in rural areas.

These clinics were supposed to provide advice and services free of cost to people interested in family planning. The social workers assigned to these clinics were required to make house calls in the locality and to invite married women and their husbands to visit the clinic for family planning service. If the couple paid a visit they were given advice on planning their families. The wife was examined and a family planning method was prescribed for them to use.

The clinics kept all the records and all the visits made by the wife and the social worker were recorded in their case files. The methods prescribed by these clinics were:

| For women | For men |
|-----------------------------|-------------------------|
| Jellies and creams | Condom |
| Diaphragm | Vasectomy ²⁰ |
| Foam tablets | Abstinence |
| Salpingectomy ¹⁹ | Coitus interruptus |
| | Rhythm |

These methods are usually prescribed separately and sometimes a combination of two methods is prescribed. The acceptability of the method is dependent upon the simplicity of the method and its effectiveness. Agarwala²¹ conducted a study on the effectiveness of contraceptive methods prescribed by clinics in Metropolitan Delhi. The method of inquiry was based on a study of case cards and follow up visit cards of the person who visited the family planning clinics of Delhi. Data was collected for 8,825 persons from twenty-two clinics in Delhi. In those clinics in which the number of patients was below 300, the follow up cards were not studied. In some cases the follow up case cards were not available. For these two reasons the records of 2,913 persons were excluded from the

¹⁹Salpingectomy, a sterilization operation for women, is a major operation and requires a long period of hospitalization, but if done after delivery it does not require any special hospitalization.

²⁰Vasectomy, a sterilization operation for men, is a simple operation and can be easily performed under local anesthesia.

²¹S. N. Agarwala, Fertility Control Through Contraception, A Study of Family Planning Clinics of Metropolitan Delhi (New Delhi: Directorate General of Health Services, Ministry of Health, Government of India), pp. 8, 11.

total of 5,912 patients who were retained for sample study. For 5,912 patients studied, only 3,522 were given a prescribed method for family planning and the remaining 2,390 were lost. The term "lost" refers to those couples who never returned to the clinic after their first visit or moved away from the locality. Thus, the study is limited to 3,522 persons who cooperated with the clinic. The literacy rate of the sample population was high and the group can be categorized as "white collar" because most of the husbands were clerks or officials in the government offices. The methods prescribed by the clinics and their distribution is shown in Table 8.

It is apparent from the table that diaphragm and jelly was the most widely prescribed method used by the couples. The findings of this study show that through regular practice of these methods, couples were in a position to reduce by nearly 78 percent their risk of pregnancies, which would have occurred if they had not taken clinical advice. This study was the first one to evaluate the effectiveness of contraceptive methods by use of Pearl's formula.²² The preg-

²²The effectiveness of contraceptive methods is studied in terms of period of exposure to the risk of pregnancy and is measured by the failure rate or pregnancy rate, per 100 years of use, computed by the following formula:

$$R = \frac{\text{Number of accidental pregnancies} \times 1,200}{\text{Total months of use}}$$

A high failure rate indicates a low level of contraceptive effectiveness, a low rate a high level of effectiveness.

nancy rate for diaphragm and jelly was ten and condom and jelly was fifteen. The pregnancy rates also differed according to the socioeconomic level. The study sample represented a highly educated, urban, motivated and cooperative group of people. As Agarwala himself noted, the information in the case cards is not reliable and it is incomplete and inadequate in providing accurate results. The study showed optimistic results because of the special socioeconomic characteristics of the group.

TABLE 8
CONTRACEPTIVES PRESCRIBED BY THE CLINIC

| Prescribed Contraceptive | Number of Patients | Percent |
|--------------------------------|--------------------|---------|
| Diaphragm and jelly | 2,750 | 78.1 |
| Condom and jelly | 451 | 12.8 |
| Vasectomy | 75 | 2.1 |
| Condom or diaphragm with jelly | 51 | 1.4 |
| Condom | 50 | 1.4 |
| Foam tablets | 47 | 1.3 |
| Condom and foam tablets | 38 | 1.1 |
| Jelly | 27 | 0.8 |
| Other contraceptives | 13 | 0.4 |
| Salpingectomy | 11 | 0.3 |
| No information | 9 | 0.3 |
| Total | 3,522 | 100.0 |

Source: S. N. Agarwala, *Fertility Control Through Contraception*, op. cit., p. 38.

Another study to evaluate the effectiveness of clinical contraceptive methods was conducted by Israel and

Kamat.²³ Data was collected for 8,319 persons from sixteen clinics. With the exception of three clinics the remaining thirteen were situated in urban areas in Bombay, Bangalore, Bengal, Ajmer and Imphal. The sample was selected from case study cards. The method prescribed by clinics and their distribution is shown in Table 9.

TABLE 9
DISTRIBUTION OF METHODS OF CONTRACEPTION

| Method | Cases | Percentage |
|---------------------|-------|------------|
| Diaphragm and jelly | 4,821 | 57.95 |
| Jelly alone | 1,023 | 12.29 |
| Foam tablets | 2,119 | 25.47 |
| Condom | 115 | 1.38 |
| Other methods | 212 | 2.54 |
| No contraception | 329 | 3.95 |
| Total | 8,319 | 99.98 |

Source: Sarah Israel and Melba Kamat, "A Study of the Effectiveness of Contraceptive Methods in Family Planning Clinics in India," The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (London, 1960), p. 264-268.

It is apparent from the table that diaphragm and jelly, jelly, and foam tablets were the most widely distri-

²³Sarah Israel and Melba Kamat, "A Study of the Effectiveness of Contraceptive Methods in Family Planning Clinics in India," The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (The International Planned Parenthood Federation, London, 1960), pp. 264-268.

buted methods. The pregnancy rate per 100 years of exposure for all users of diaphragm and jelly was 6.1, while for jelly alone it was 11.0, for foam tablets 14.7, condoms 2.6 and for other methods 10.9. The combined pregnancy rate for all methods of contraception was 8. The pregnancy rate show that condom was the most effective method followed by diaphragm and jelly, jelly alone and foam tablets. The study also revealed that couples can reduce their pregnancies by practicing clinical contraceptive methods. This study, like Agarwala's study, had a highly educated, urban, motivated and high socioeconomic status group. This study compared the socioeconomic levels of couples in two clinics and found that motivation and practice of contraceptives were directly related to the socioeconomic status of the person participating. No follow up study was made and no interviewing was done of the patients who used contraceptive methods. Comparing Agarwala and Israel and Kamat's studies, similar results were found because of similar conditions such as urbanization, education and higher socioeconomic level. The studies found that in urban areas clinical methods are effective and couples can reduce their birth rate by practicing these methods. The practice of the clinical method is correlated to the socioeconomic status of the person. Diaphragm and jelly, jelly, condom and foam tablets are the most popular methods prescribed by the clinics.

These studies did not make use of representative samples of the population of India and hence results of these studies cannot be applied to the total population of India.

Singh²⁴ and Chandrasekhar's studies which have been conducted in rural areas found different results concerning the use of clinical contraceptive methods. Singh did a study on the acceptability of contraceptive methods such as rhythm, oil plug, sponge and foam tablets. The study revealed that use of foam tablets was the most popular method practiced among women to avoid pregnancy in rural areas. The clinics did not prescribe methods such as diaphragm, condom or jelly because of the complications arising out of their use.

The study also showed that establishment of clinics is a prerequisite if family planning is to be practiced by any appreciable proportion of married couples in the area. Singh also found there was a lack of motivation to practice family planning in the population of a village. This lack of motivation is due to poor socioeconomic conditions, high illiteracy and rigid traditional value structure. Singh also discovered that the acceptability of a method of family planning is dependent on the motivation to practice family planning.

²⁴Baljit Singh, "Problem of Family Planning in the Countryside: A Sociological Analysis," The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (The International Planned Parenthood Federation, London, 1960), pp. 94-101.

Chandrasekhar²⁵ conducted a study on "Motivations and Methods" in the village of Mangdu, in Madras State, India. Six hundred seventy-three women between the ages of 15 and 45 years were contacted and of this group 632 received the contraceptive and appliance for use. These women were convinced of the need of family planning and were taught the use of the method. Of the 632 women, 192 conceived and confessed to the interviewer that they did not use the contraceptives. The contraceptive method prescribed by the clinic in the village were foam powder and sponge. The study revealed the fact that if rural people have the motivation and were taught the use of contraceptives, about two thirds of them are willing to use family planning methods. The success of this study is due to several factors which were present in the village of Mangdu. One was the presence of the clinic in the village. Another was the strenuous efforts made by the research team which made house to house visits in the village and contacted all the married couples in order to convince them of the advantages of family planning. The study points out that acceptability of contraceptives is one thing but the actual practice in using them is another matter. Acceptance does not indicate

²⁵S. Chandrasekhar, "Family Planning in Indian Village: Motivation and Methods," The Sixth International Conference on Planned Parenthood, New Delhi, 1959 (The International Planned Parenthood Federation, London, 1960), pp. 101-108.

use. It is very hard to find out the real reasons for acceptability and also the reasons for rejection.

Singh's and Chandrasekhar's studies show that people in the rural areas do not have strong motivations to practice family planning. Foam tablets and sponges were the most popular and acceptable methods. The studies do not provide statistical data to support the relationship.

Mathen, in the Rural Population Control Study of Singur also found that foam tablets was the most widely accepted method among the females. The other methods besides foam tablets were coitus interruptus, and the rhythm method. As Mathen explains it, "The Singur population was not a highly motivated group and therefore, the chief consideration in the choice of method, was ease in application."²⁶ It is evident the motivation is very important in the acceptance of method and in practicing it regularly. The continued practice of the methods will be dependent on the degree of effectiveness of the method as well.

Gordon and Wyon²⁷ in their study also found that foam tablets were the most widely accepted method among

²⁶K. K. Mathen, "Preliminary Lessons Learned from the Rural Population Control Study of Singur," Research in Family Planning, ed. Clyde V. Kiser (Princeton, N.J.: Princeton University Press, 1962), pp. 33-49.

²⁷Gordon and Wyon, op. cit., p. 28.

couples. There were four other methods besides foam tablets; they were spermicidal jelly and pad, concentrated salt solution and pad, rhythm method, and coitus interruptus. These studies clearly point out that motivation is a very important factor in making the choice of method. The social and cultural values such as religious, moral, and ethical are also important influences in the acceptance of family planning methods in villages. The knowledge concerning family planning methods is different in urban than in rural areas. The United Nations study shows the results in Table 10.

Sterilization.--The clinical methods also included sterilization of wife and sterilization of husband as family planning methods and the surgical sterilization of husband and wife as family planning methods is quite popular among rural as well as among urban populations in comparison with other methods. Sterilization was prescribed in some cases by taking into consideration the efficiency, reliability and permanent results. The government and organizers of family planning programs encouraged its use in hospitals and in special camps.

Surgical sterilization was originally used to save the life or health of a mother threatened by pregnancy. In later years sterilization was used for eugenic purposes, that is to prevent persons suffering from hereditary disabilities from having children.

TABLE 10

PERCENTAGE OF MARRIED WOMEN AND THEIR HUSBANDS REPORTING KNOWLEDGE OF SPECIFIED METHODS OF FAMILY PLANNING, IN BANGLORE CITY AND RURAL ZONE III

| Area | Number Responding | Safe Period | Withdrawal | Condom | Douche | Pessary Dia- phragm or Cervical Cap | Rampon or Sponge | Steriliza- tion of Husband | Steriliza- tion of Wife |
|------------------------------|-------------------|-------------|------------|--------|--------|---|---------------------|----------------------------------|-------------------------------|
| <u>Responses of Wives</u> | | | | | | | | | |
| Banglore City Total | 1,002 | 9.2 | 6.1 | 9.0 | 3.8 | 5.8 | 2.3 | 8.6 | 26.2 |
| Rural Plains | 392 | 2.6 | 1.3 | 0.5 | 1.0 | 0.0 | 0.0 | 1.0 | 5.9 |
| <u>Responses of Husbands</u> | | | | | | | | | |
| Banglore City Total | 791 | 11.4 | 9.5 | 10.5 | 5.9 | 9.1 | 3.9 | 16.9 | 25.2 |
| Rural Plains | 323 | 5.3 | 1.5 | 2.2 | 0.3 | 0.9 | 0.0 | 5.3 | 5.3 |

Source: United Nations, The Mysore Population Study, op. cit., p. 162.

Voluntary sterilization as a method of family planning is a one way street, for this method is irreversible and permanent. It cannot be employed to space births but only to control or stop the occurrence of further pregnancies. It can be used only by persons who have the number of children they desire.

State government of Bombay, Madras, Maharashtra and Kerala provided facilities for sterilization operations in hospitals for men and made these operations desirable. Salpingectomy, the sterilization operation for women, is a major operation and requires a long period of hospitalization, but if done after delivery it does not require any special hospitalization. Vasectomy, the sterilization operation for men, is a simple operation and can be easily performed under local anesthesia. The sterilization operation has proved effective, efficient, permanent and inexpensive.

The government has also started a program of payment of small financial subsidies to compensate for the loss of wages and to cover travel expenses for those who volunteer for vasectomy. The amount of these subsidies differs from state to state depending upon the motivation of the people. The vasectomy has been popularized by vasectomy camps in villages.

Dr. Phadke conducted a follow up study on 655 vasectomized persons and found that vasectomy does not affect

the health of husband or wife and does not have any influence on the sex life of the couple. One should be very careful in drawing any generalizations for the country as a whole. But the study does indicate that vasectomy has good chances for success if there are no ill effects on the health of the person.²⁸

Another study by Dandekar²⁹ on the effectiveness of vasectomy camps reveals some additional facts about vasectomy. The data for this study were obtained from the District Health Officer from those who volunteered for the operation. The data included the names and addresses of men, their places of residence, their ages, number of male and female children, and their occupation. The data covered 45 camps in the district of Ahmed Nagar in the period of July, 1959 to January, 1962. A total of 3,465 men had undergone vasectomy. The camps were located in 25 villages or towns. A man over thirty years of age was accepted for vasectomy if he had three children, one of whom was a male at least eight years old. Time was given for emotional preparation to enable him to realize the seriousness of his decision. A certificate provided for this purpose was to be signed by

²⁸C. P. Blacker, "Voluntary Sterilization: Transitions Throughout the World," The Eugenic Review, LIV, No. 3 (October, 1962), p. 152.

²⁹Dandekar, Population Studies, XVII, No. 2, (November, 1963) op. cit., p. 154.

husband and wife. Relationship between age, occupation, income, and number of children of persons who were vasectomized was studied.

The findings showed that the majority of men who volunteered for vasectomy were agriculturists, who were in the 30-52 years of age group, who had had four to six children, were in the lowest income group and who were from small villages or towns.

Dandekar concludes with these remarks,

It should be remembered, however, that even if the effect of the camps has been small, they have no doubt helped to create a climate favorable for popularizing family planning and family limitation. In the initial stages this is a very important result.

That the number of sterilizations is increasing in India can be seen from Table 11 below.

TABLE 11
STERILIZATIONS PERFORMED IN INDIA AFTER 1955

| Year | Males | Females | Totals |
|--------|--------|---------|---------|
| 1956 | 2,333 | 5,490 | 7,833 |
| 1957 | 9,072 | 9,850 | 13,530 |
| 1958 | 9,072 | 16,801 | 25,873 |
| 1959 | 13,925 | 21,797 | 35,722 |
| 1960 | 31,067 | 15,198 | 46,265 |
| 1961 | 33,792 | 12,821 | 46,613 |
| Totals | 93,860 | 81,966 | 175,827 |

Source: Blacker, The Eugenic Review, LIV, No. 3, p. 150.

The table shows that before 1960 the sterilization of women was the leading one, but from 1960 on vasectomy has taken a lead. Vasectomy is encouraged because it is cheap and an easier operation in comparison with salpingectomy. While vasectomy has become more widespread, the number of females undergoing sterilization has decreased. Tietze³⁰ lists the advantages of sterilization as being: essentially irreversible, cheap, efficient, and reliable.

IUCD.--The intrauterine contraceptive device, commonly known as the loop, has also been introduced into the family planning program. This method is particularly useful to avoid pregnancy and to space births. The ease with which it can be inserted and removed and its indefinite period of use has made it quite popular among the younger age groups. The popularity and acceptance of IUCD has been indicated by Agarwala,

Intrauterine contraceptive device is a major family planning method in India. It has proved extremely popular. While by March 1965, about 0.72 million females availed themselves of this facility, the number of users by the end of September, 1966, was around 1.2 million compares favorably with the aggregate of 1.8 million sterilization operations performed till September, 1966, even though sterilization had a start of about eight years.³¹

³⁰Christopher Tietze, "Induced Abortion and Sterilization as Methods of Fertility Control," Public Health and Population Change, ed. M. C. Sheps and J. C. Ridley (University of Pittsburg Press, 1965), pp. 411-416.

³¹S. N. Agarwala, "The Progress of IUCD," The Participant Journal, Indian American Technical Cooperation Program (February, 1967), pp. 24-25.

Agarwala's views give an encouraging picture of IUCD but a follow up study done by him does not wholly support him.

Agarwala did a follow up study on 867 cases enrolled over a period of 15 months in clinics. Expulsion, removal, pregnancy and drop out rates on the basis of clinic data and survey data obtained by following up each case through home visits were calculated and compared. The removal and pregnancy rates were low for clinic data as compared with field data. This situation may be due to failure to report the removal or pregnancy to the clinic. The drop out rate is high in this sample because of the high discomfort rate. Discomfort includes prolonged bleeding and physical pain. Agarwala also compared expulsion and removal rates in India with other Asian countries like Taiwan, Korea and Pakistan. He found them in line with other countries. For some reasons discomfort rate declines sharply in the first month of insertion in other countries while it remains high for a long period in India. As Agarwala points out, "The results cannot be utilized for use in drawing valid conclusions regarding the efficacy of IUCD. The results also cannot be taken to indicate the percentage of IUCD's which will be after a given period of time."³²

³²Ibid., p. 24.

The studies conducted concerning the effectiveness and acceptability methods have served a useful purpose by providing some indication of the lack of effectiveness and acceptability of the methods to the program planners.

Besides these methods which have been discussed, the people are given a free selection of methods. As Bhatia points out,

The free selection of methods in the program emphasizes a 'cafeteria approach', permitting each couple to select its own appropriate contraceptive, whether the loop, vasectomy or salpingectomy, the condom, diaphragm, foam tablets, jellies or rhythm method.³³

Summary

The historical development of family planning has been discussed in pre and post independence periods. Most of the work was accomplished by implementing the programs through Five Year Plans. The programs have been extended on large scale and large financial allocations have been made. The appliance and non appliance methods have been used. Methods such as diaphragm and jelly, condom, foam tablets have proved successful in cities while foam tablets has been the favorite method in villages. Sterilization and IUCD won the most popular methods which are encouraged by the government.

³³Deepak Bhatia, "Family Planning: The Battle Joined," Participant Journal, Indian American Technical Cooperation Program (February, 1957), p. 20.

CHAPTER III

Social Factors Affecting Family Planning Programs

Favorable Social Factors

Social and cultural factors which are favorable to family planning are those which accelerate the knowledge and practice of contraceptive methods among the people. These factors also bring a social change in society and cause a change in the value structure. In terms of family planning changes must take place in the family attitude because the family is the social unit which translates into behavior the cultural values and norms pertaining to reproduction. Social changes also affect the economic institutions of the society which in turn require further changes in the family functions which it performs for the society. The social factors which are favorable to family planning are urbanization, industrialization, education and the changing role of women.

Urbanization.--Urban social conditions in India create a favorable climate for family planning in an indirect way the urban social milieu discourages large families¹ because of high economic cost, and because of limited space;

¹William F. Kenkel, The Family in Perspective (New York: Appleton Century Crofts, Inc., 1960), p. 213.

urban environments are not considered an appropriate place for rearing children. In order to limit the size of family the couples turn to family planning devices. Urban social conditions create a feeling of independence and individuality² among people. This situation encourages them to make their own decisions to break away from the traditional value structures. The social ties between the old and the new generations are weakened. Social control of the elders is rejected and the couple thinks in terms of the family procreation. They conform to the pattern of a small sized family. In order to attain this goal to control the size of the family they seek the help of the family planning programs and utilize these facilities.

Another factor which favors family planning in urban areas is the availability of family planning facilities in cities. The presence of family planning facilities on large scale in urban areas helps to increase the spread of knowledge and practice of family planning methods in Indian cities.³ The studies conducted by Driver,⁴ and United Nations (The Mysore Population Study)⁵ support this proposition. (See Table 4 and Table 6).

²Louis Wirth, "Urbanism As a Way of Life," American Journal of Sociology, XLIV (July, 1938), pp. 10-11.

³N. V. Sovani, "Internal Migration and Future Trend of Population in India," World Population Conference (New York: United Nations, 1967), II, p. 41.

⁴Driver, op. cit., p. 121.

⁵United Nations, The Mysore Population Study, op. cit., p. 161.

Industrialization.--Bottomore also states, "The development of industry and urban way of life is likely, in the long run, to engender the same desires to limit family size as were produced in Western societies under similar conditions."⁶ Bottomore in the above quotation notes another factor which contributes to limit the family size and encourages the practice of family planning methods, namely industrialization. As Raina puts it,

In the Western countries industrialization was the main force which led to voluntary large-scale adoption of contraception for restricting family size. It may have been partly due to environmental factors in the industrialized areas, such as overcrowding, lack of proper housing and other civic amenities. These factors are present in the industrialized areas in India, but it is not certain how far they are operating towards a reduction in fertility.

Raina and Bottomore are doubtful about the same impact of industrialization of family planning programs in India that it has had in Western countries.

Industrialization stresses a small size family pattern, because large families become a block to the rising aspirations of couples who want to achieve a high social mobility and material goods. Industrialization causes internal migration from rural to urban areas and provides oppor-

⁶T. B. Bottomore, Sociology: A Guide to Problems and Literature (London: George Allen and Unwin, Ruskin House, 1962), p. 88.

⁷B. L. Raina, World Population Conference (New York: United Nations, 1967), II, p. 103.

tunities to seek employment outside of agriculture. In other words, it causes a change in the occupational structure of society. Large numbers of children are not required for manual labor as they are in an agrarian economy. This situation is also explained by Breznik⁸ who is of the opinion that transfer of certain economic functions of the family to other institutions and decline of infant mortality indirectly encourages people to use family planning methods to control the size of their family. Thus, industrialization by stressing small family size pattern and by causing change in occupational structure of society encourages the utilization of family planning facilities.

Education.--The better educational facilities in urban areas are also responsible for strong motivation towards family planning among urban people. Education is a significant factor which is favorable to family planning program. Education brings a change from traditional value orientation to non-traditional value orientation. As the educational level not necessarily for individuals goes up the fertility rate goes down. The National Sample Survey⁹

⁸Dusan Breznik, "Female Fertility in Industrialized Countries: Present Situation and Future Outlook," World Population Conference (New York: United Nations, 1967), p. 197.

⁹Raina, World Population Conference, II, p. 103.

has shown that there is an inverse relationship between number of children born and the educational level. The educational level of women particularly plays a very significant role in giving them an awareness of social responsibility and knowledge of family life. Special educational programs have provided them with the knowledge of sex and reproduction. Morrison,¹⁰ Driver,¹¹ and the United Nations (The Mysore Population Study)¹² studies indicate that there is high correlation between educational attainment and practice of family planning. Table 12 shows the results from the Mysore Population Study. The data shows that the practice of family planning is directly related to the educational level of husband and wife. As Srinivas describes, "education also provides women with employment opportunities outside the home and their jobs conflict with pregnancy."¹³ They think of avoiding pregnancy and seek the help of family planning programs.

¹⁰Morrison, The Milbank Memorial Fund Quarterly, XXIV, op. cit., p. 286.

¹¹Driver, op. cit., p. 126.

¹²United Nations, The Mysore Population Study, op. cit., p. 163.

¹³S. M. Srinivas, Social Change in Modern India (Berkeley: University of California Press, 1966), p. 128.

TABLE 12

PERCENTAGES OF COUPLES PRACTICING ABSTINENCE AND
OTHER METHODS OF FAMILY PLANNING BY
EDUCATIONAL LEVEL FOR BANGLORE CITY

| | Number Interviewed | Reporting Use of Any Method | Reporting No Use of Any Method |
|---|-----------------------|-----------------------------------|--------------------------------------|
| <u>Educational Level of Wife</u> | | | |
| None or Primary School | | | |
| Illiterate | 419 | 4.5 | 95.5 |
| Literate | 158 | 11.4 | 88.6 |
| Middle School | 161 | 20.5 | 79.6 |
| High School or University | 55 | 50.9 | 49.0 |
| <u>Educational Level of Husband</u> | | | |
| None or Primary School | | | |
| Illiterate | 205 | 5.4 | 94.6 |
| Literate | 184 | 6.0 | 94.0 |
| Middle School | 178 | 7.3 | 92.7 |
| High School | 143 | 16.8 | 83.2 |
| University | 83 | 47.0 | 53.0 |

Source: United Nations, The Mysore Population Study, op. cit., p. 168.

The changing role of women.--As Kapadia writes,

"Education has brought women out of the confines of the house and put them into contact with the philosophy of liberalism and the democratic traditions of the West."¹⁴ Education has provided women with employment opportunities and has

¹⁴K. M. Kapadia, Marriage and Family in India (Oxford University Press, 1965), p. 268.

created an alternative role for them other than marriage and familial life. Women are breaking traditional restrictions and entering the political and social life of the nation.¹⁵ There is great awakening among the women concerning their individual rights. Education of women makes them conscious of the conflict between the achievement of high living standards and large families.¹⁶ They think in terms of controlling the size of their families and seek the help of the family planning programs.

The above discussed social factors stress the need of a small family pattern and hence discourage high fertility. In order to attain this goal to control the size of family and to avoid pregnancy, people seek the help of the family planning program. All these social factors are interrelated to produce the net result to increase the adoption of family planning programs to reduce the birth rate. In this way these social factors have motivated certain aggregates of people to practice family planning methods and created a favorable situation for family planning programs.

¹⁵Ibid., p. 266.

¹⁶Ibid., p. 269.

Unfavorable Social Factors

The following social factors have encouraged high fertility in the past in order to compensate for the high mortality. These factors have stressed large families to provide manual labor necessary for an agrarian economy. These social factors have undergone considerable change but they still have great impact on the life of society.

Joint families.--The institution of the joint family is considered to be one of the main cultural factors favoring high fertility in India. The development of the joint family in India is related to an agricultural economy, which is still predominant in India. Taylor et al. define the joint family as follows:

The principal features of joint family of tradition are: that it is three generational in depth, that its members live under the same roof, and that property of whatever kind is shared by all. It is self-sufficient unit socially and economically, the center of the universe for the whole family, the arbiter of life's important decisions, the supplier of daily and lifetime needs, the reservoir of deep loyalties and bonds of affection. It is a kinship group that serves at once, a place of abode and center for social, recreational, and religious activities. It is within this family circle that all momentous decisions are made of education, career and marriage and all developments, events that take place, worships, weddings and other celebrations, births and deaths and appropriate ceremonies.¹⁷

¹⁷Carl Taylor et al. India's Roots of Democracy: A Sociological Analysis of Rural India's Experience in Planned Development Since Independence (New York: Frederic A. Praeger, 1965), p. 58.

This definition describes the special characteristics of the joint family. Some sociologists including Davis,¹⁸ Lorimer,¹⁹ and Bottomore²⁰ agree that the joint family is conducive to high fertility in India. This hypothesis was tested and empirical evidence was presented from a study where Driver²¹ selected a sample of 2,314 couples, 1,619 living in nuclear families and 695 in joint families. The sample was selected from cities, towns and villages in Nagpur district in central India which had a population of 1,234,556 by the 1951 census. The result of his study showed no significant difference between the fertility level of the two groups. Data collected from a village called Singer²² in West Bengal shows no significant difference between fertility levels of couples living in nuclear families compared with those living in joint families. Nag²³ also found that

¹⁸Kingsley Davis, "Institutional Patterns Favoring High Fertility in Underdeveloped Areas," The Eugenic Quarterly, II (March, 1955), pp. 33-39.

¹⁹Frank Lorimer et al., Culture and Human Fertility (Paris: UNESCO, 1954), p. 201.

²⁰Bottomore, op. cit., p. 178.

²¹Driver, op. cit., p. 83.

²²Nathen, op. cit., p. 43.

²³Honi Nag, "Family Type and Fertility," World Population Conference (New York: United Nations, 1965), II, p. 160.

the number of children per couple in the joint family is lower than in the nuclear family. Thus the hypothesis that the joint family favors high fertility may be rejected. Nag²⁴ notes lack of adequate privacy because of overcrowded housing and relatively more adherence to the traditional taboos on sexual intercourse on particular days and the presence of in-laws and other relatives as discouraging factors to high fertility in joint families.

The joint family is in a period of transition in India. There is need for more studies to explore further the relationships between joint family and fertility. Family planning is practiced less among couples living in joint families than among those living under other family arrangements. The United Nations study shows the following results. (See Table 13).

It is clear from the figures in Table 13 that the practice of family planning methods is lower among couples living in joint family than among those living in nuclear family or living independently with children. Thus the institution of joint family is not favorable to family planning programs.

²⁴Ibid., p. 161.

TABLE 13

PERCENTAGES OF COUPLES PRACTICING ABSTINENCE AND OTHER METHODS OF FAMILY PLANNING BY FAMILY COMPOSITION FOR BANGLORE CITY

| Family Composition | Number Interviewed | Reporting Use of Any Method | Reporting No Use of Any Method |
|--|--------------------|-----------------------------|--------------------------------|
| Living with husband's parents or grandparents. | 308 | 13.0 | 87.0 |
| Living with husband's sibling/or their spouses. [Joint family] | 63 | 5.4 | 93.6 |
| Living with other relatives. | 184 | 9.8 | 90.2 |
| Living with no relatives except children [Nuclear family] | 231 | 15.6 | 84.4 |

Source: United Nations, The Mysore Population Study, op. cit., p. 168.

Factors related to marriage.--Factors related to marriage are important factors which contribute towards high fertility in India. Marriage is considered a religious duty in Indian society. The kinship structure of society encourages marriage to strengthen kinship solidarity by making alliances with other families. These alliances increase economic and political potential. Marriage is also considered a social necessity to fulfill the group needs of

replacement of labor supply by bearing a large number of children. Also, marriages are arranged by the families and consanguineous ties are preferred over conjugal ties. The kinship structure and an agrarian economy encourages high fertility.

Another significant factor noted by demographers and sociologists which gives rise to the high fertility in India is the age at marriage. As Bose²⁵ puts it, "In India, women are married at an early age. Indian women therefore, start their reproductive life early." Agarwala provides data on the change in the average at marriage for boys and girls from 1901-1951.

TABLE 14
CHANGE IN AVERAGE AGE AT MARRIAGE FOR GIRLS AND BOYS
FROM 1901-1951

| | 1901-1911 | 1911-1921 | 1921-1931 | 1931-1941 | 1941-1951 | 1951-1961 |
|--------|-----------|-----------|-----------|-----------|-----------|-----------|
| Female | 13.07 | 13.53 | 12.52 | 14.94 | 15.38 | 16.60 |
| Male | 20.41 | 20.74 | 18.44 | 20.30 | 19.93 | N.A. |

Source: S. N. Agarwala, "The Age at Marriage in India," Population Index (April, 1957), pp. 96-97.

The age at marriage for males is variable and for females it is rising. The legislature attempts to raise the age at marriage for girls by the Sarda Act of 1930 and Hindu

²⁵Nitai Chandra Bose, "A Note on the Effect of Postponement of Marriage on Fertility," World Population Conference (New York: United Nations, 1967), II, p. 128.

Code Bill have had some influence on this situation.

The average age for the wife for different marriage cohorts and the percentage of births by age of the mother are shown in Table 15 and Table 16. The average age at marriage for the wife has gone up in India. The data in Table 16 show that almost 10 percent of the children are born to women between 20-24 years of age.

TABLE 15

AVERAGE AGE AT MARRIAGE FOR THE WIFE FOR DIFFERENT MARRIAGE COHORTS: NATIONAL SAMPLE SURVEY SECOND AND FOURTH ROUNDS, RURAL, 1951-1952

| Before | | | | | |
|--------|-----------|-----------|-----------|-----------|-----------|
| 1910 | 1910-1919 | 1920-1929 | 1930-1939 | 1940-1945 | 1946-1951 |
| (1) | (2) | (3) | (4) | (5) | (6) |
| 12.3 | 13.3 | 13.6 | 14.2 | 14.4 | 14.6 |

Source: Ajit Das Gupta *et al.*, "Couple Fertility," National Sample Survey No. 7 (Government of India, New Delhi, 1955); in, Nival Chandrasekar, "A Note on the Postponement of Marriage on Fertility," World Population Conference 1965 (New York: United Nations, 1967), II, p. 129.

Chandrasekar²⁶ and Mukerjee²⁷ strongly recommend

²⁶ Chandrasekar, "Too Many People: Is India Facing Disaster," U. S. News and World Report (April 3, 1967), p. 92.

²⁷ Radha Kama Mukerjee, "Motivation and Values," in Clyde V. Kiser (ed) Research in Family Planning, (Princeton, New Jersey: Princeton University Press, 1960), p. 539.

raising the age at marriage further as a step in reducing the birth rate. Raina²⁸ is also of the opinion that raising the age of marriage and postponement of marriage will delay the onset of childbearing and hence will reduce the actual reproductive period. Driver²⁹ and United Nations studies³⁰ reveal an inverse relationship between age at marriage and number of children born to females. The kinship structure of society in India encourages large families for economic and political alliances and contributes towards high incidence of marriage at young age and does not favor family planning programs. The young age at marriage for girls does not provide them with time for education and mature understanding of the family planning and hence, is not favorable to family planning programs.

Desire for children.--As stated earlier agrarian economy encourages large families for manual labor. Because of this reason, women are motivated to have children as soon as possible after their marriage. These motivations are

²⁸Raina, op. cit., p. 102.

²⁹Driver, op. cit., p. 83.

³⁰United Nations, The Mysore Population Study, Chapter 12, op. cit., p. 116.

TABLE 16

PERCENTAGE DISTRIBUTION OF BIRTHS BY AGE OF MOTHER:
 NATIONAL SAMPLE SURVEY, SEVENTH ROUND, RURAL,
 1953-1954

| Age of mother | | | | | | |
|--------------------|--------------|--------------|--------------|--------------|------------------------|--------------------|
| Below 20 (1) | 20-24 (2) | 25-29 (3) | 30-34 (4) | 35-39 (5) | 40 and above (6) | All Ages (7) |
| 18.1 | 30.7 | 22.0 | 15.0 | 8.5 | 5.7 | 100 |

Source: Vital rates, National Sample Survey No. 54 (Government of India, New Delhi, 1962); in, Nitai Chandres Das, "A Note on the Postponement of Marriage on Fertility," World Population Conference 1965 (New York: United Nations, 1967), II, p. 129.

mainly concerned with the economic reasons. Chandrasekaran³¹ analyzed the motivations of women desiring more children in urban and rural areas in Mysore State, India. The main motivations for desiring to have more children are insuring family survival, helping to increase family income and old age security. Table 17 shows that there is a greater desire for sons than for daughters. The desire for sons is related to inheritance, perpetuity of family lineage, performance of religious rites for the dead and old age security. The desire to have a male heir is a very strong one and sometimes more births take place just to have a son.

³¹C. Chandrasekaran, "Fertility Survey in Mysore State India," Current Research in Human Fertility (New York: Milbank Memorial Fund, 1955), p. 18.

TABLE 17

MOST IMPORTANT MOTIVATIONS FOR WOMEN WISHING TO HAVE MORE CHILDREN

| Motivation | Bangalore City | | Rural Area | |
|---|----------------|------------|------------|------------|
| | Number | Percentage | Number | Percentage |
| To Be Taken Care of in Old Age | 77 | 21.2 | 45 | 27.4 |
| To Insure Family Survival | 49 | 13.6 | 25 | 14.8 |
| To Avoid Community Criticism | 3 | 0.8 | 5 | 2.8 |
| To Follow Community Pattern | 0 | 0.0 | 0 | 0.0 |
| To Follow Friend's Pattern | 1 | 0.3 | 0 | 0.0 |
| To Help Increase Family Income | 22 | 6.0 | 19 | 9.9 |
| To Insure Proper Share of Family Property | 3 | 0.8 | 3 | 1.6 |
| To Make Home Happier | 86 | 23.7 | 24 | 12.2 |
| Desire for Boys | 56 | 15.4 | 20 | 11.6 |
| Desire for Girls | 30 | 8.2 | 12 | 6.8 |
| Companionship to Children | 14 | 3.8 | 6 | 3.1 |
| For Household Help | 7 | 1.9 | 4 | 2.1 |
| As Girls are More Attached | 7 | 1.9 | 5 | 2.6 |
| Other Reasons | 3 | 0.8 | 0 | 0.0 |
| No Reason Given | 6 | 1.6 | 10 | 5.2 |
| Total | 364 | 100.0 | 192 | 100.0 |

Source: C. Chandrasekaran, "Fertility Survey in Mysore State, India," Current Research in Human Fertility (New York: Milbank Memorial Fund, 1955), p. 18.

Morrison³² studied the relationship between willingness to use family planning and the number of living male children and total number of living children and found a significant association. The desire for children and particularly for sons is related to high fertility and couples do not think of family planning unless they have the children which they want to have.

Religion.--The teachings of Hindu religion advocate large families.

The traditional stress on the high procreation and survival of at least one scion [descendent] has understandably made for high fertility, in the face of high mortality....The custom of early marriage and high incidence on marriage no doubt received support from this procreational concern. And the consequences, when large families ensued were eased by support given by the joint family and caste solidarity.³³

The above quotation explains that in order to compensate for high mortality and through emphasis on marriage, religion encouraged high fertility in India. Raman also comments upon the role of religion in India.

In India religion is still an important factor to be reckoned with and not a spent force as some believe it to be. It is often said that the Hindu religion is not antagonistic to the practice of birth control. This is however, a moot point. In fact, it is rarely that we come across active, explicit and clear support to the idea of family size regulation in the tenets of Hindu religion.³⁴

³²Morrison, The Milbank Memorial Fund Quarterly, op. cit., p. 286.

³³Richard M. Fagley, "Doctrines and Attitudes of Major Religions in Regard to Fertility," World Population Conference 1965 (New York: United Nations, 1967), II, p. 78.

³⁴M. V. Raman, "Attitudes Towards Family Size and Fertility Control in India: An Assessment," World Population Conference, 1965 (New York: United Nations, 1967), II, pp. 164-165.

The low status of Women.--The social status of women in Indian society is an important factor which has great bearing on the family planning programs. The women are subordinate to men in Indian society. They have been confined to the home and have been segregated from the mainstream of life.

Davis points to the practice of Purdah³⁵ among Muslims and to some extent among Hindus, to the confinement of women to their home, and to their role which identifies them with reproduction and makes them subordinate to men. Women's education was discouraged because they did not need it to follow a career or profession. Because of this factor women are barred from participating in the labor force of the nation. As Nevette puts it,

Although there is a centuries old tradition of respect for women, this respect is based largely upon wives having many children, particularly sons. The desire for male children, coupled with the fear that an unmarried girl will get spoiled, led to the widespread custom of early, even pre-puberty marriages, which has been prevalent for about two thousand years. A tradition of female subjugation was established and strengthened by such factors as the subordinate position of the young wife in a joint household, and the practice of sati [practice among wives to burn themselves alive with the dead body of their husband].³⁶

³⁵Purdah is a social practice among Muslim women to cover their faces from outsiders and it has also been adopted among Hindus to some extent.

³⁶Nevette, "Age At Marriage, Parental Responsibility and the Size of Family," World Population Conference 1964 (New York: United Nations, 1967), II, p. 176.

The lack of education and prevalence of the practices mentioned by Navette have kept the average woman in ignorance.

Summary

The favorable social factors involved in family planning are those factors which stress the small family pattern by bringing change in the social and economic functions of the family. Thus they motivate people to seek the help of family planning programs and adopt family planning practices.

The unfavorable social factors are factors which have encouraged large families in the past and are still prevalent in India. These factors stressed high fertility which was a necessity for an agrarian economy which lacked an advanced technology. The factors are undergoing change but still have great impact on the Indian social scene.

Singh explains the relationship between social factors and family planning programs.

Success of any programs of family planning under existing conditions found in villages in India depends as much if not more, on the strengthening of motivations towards planning parenthood and removal of institutional and social impediments inherent in large scale ignorance, illiteracy and mass poverty.³⁷

³⁷Singh, op. cit., p. 94.

CHAPTER IV

Summary

This report has discussed the family planning programs as an instrument of population control in India. Family planning has been defined as an effort to space and to control the number of births in order to attain the desired size of family. The development of a national program, began to emerge with the First Five Year Plan (1951-1956). High level family planning boards were set up at the center and in the different states of India. A director of family planning was appointed and family planning officers were appointed at the state level. The director was later promoted to the status of Director-General of the family planning programs in India. The office of the director-general was coordinated with that of the Ministry of Health. The Director-General was the head of this national family planning program. He was assisted by the state family planning officers. The programs started in different states in India are directed towards the development of national family planning. In March 1967, a minister was appointed to the Parliament as Minister of Health and Family Planning and family planning has been given a priority to reduce the national birth rate.

The objective of the early exploratory studies dur-

ing the First Five Year Plan was to assess the attitudes of the people towards family planning and to obtain data concerning the extent of knowledge and practice of contraceptive methods. The studies also tried to determine whether there would be any resistance to family planning program or not. These studies were conducted in different parts of India. The studies conducted by Agarwala, Dandekar and Chandrasekhar revealed that there was a great desire to learn about family planning and hence encouraged the government to extend the family planning program. Some well directed and specific studies were conducted to evaluate the effectiveness of contraceptive methods or of combining a teaching program with family planning methods. These studies are the Singur study, and Ramangram and Lodi study.

The programs have been expanded in terms of their achievements through Five Year Plan periods. The changes have also taken place in the distribution of methods. The clinical methods were emphasized in the early period of the development of the program. Agarwala and Israel and Kamat studies showed that clinical methods are successful in urban areas while Chandrasekhar, Singh, and Mathen's studies show that use of foam tablets was the most widely accepted method in rural areas. These studies in rural areas also show that people in rural areas lack a motivation to practice family planning. Sterilization has been emphasized as a family

planning method and facilities have been provided for people interested in family planning. Vasectomy is encouraged because it is a simple and inexpensive operation as compared with salpingectomy. The intrauterine contraceptive device is the most recent method used in family planning by people in India. It is very hard to predict the success of any of these methods. All methods are available to people. They have freedom and choose the method they want.

The government is also considering seriously of making abortion a legal method of family planning. More emphasis is given to motivating people through education and through community programs in villages. The programs have been coordinated with those of the Departments of Education, Broadcasting and Information, and Community Development Projects. Family planning programs have been recognized as the only means of putting a check on population growth and have been given priority in relation to all plans and policies concerning economic development. There is no evidence to indicate whether the programs have made any impact on the national birth rate since their beginning in 1951. It is very difficult to predict the future outcome and achievements of the family planning program. Progress has been very slow in the past, but government and people are now concerned about the problem. It will not be an exaggeration to say that with the body of knowledge, experience and technology gained, the future holds a better prospect than did the past.

Family planning is a sensitive and complex issue and has many social, psychological, ethical and moral implications. Changes in social and economic institutions of society will also be essential to make the family planning programs a success.

Conclusions

The population growth in India is a result of two main variables, fertility and mortality. Table 18 shows that in the past high birth rates were compensated by for high death rates. However, in the last two decades the death rate has declined considerably while the birth rate has remained high. The result has been a tremendous population growth.

(1) As compared with some other underdeveloped countries the rate of population growth in India is not high as is clear from Table 19. The large size of population contributed towards a large growth of population. Some authors¹ agree that large size of population, high dependency ratio and large proportion of agricultural population hinder the economic development of India. The per capita income of India as compared with that of underdeveloped and developed countries is the smallest. Table 19 presents the results.

¹Davis, *op. cit.*, p. 85; Ansley J. Coale and E. N. Hoover, Population Growth and Economic Development in Low Income Countries (Princeton, N.J.: Princeton University Press, 1956), p. 25; Joseph J. Spengler and Otis Dudley Duncan, Population Theory and Policy (Glencoe, Ill.: The Free Press, 1956), pp. 311-312; Taylor, *op. cit.*, p. 106; and, Harvey Liebenstein, Economic Backwardness and Economic Growth (New York: John Wiley and Sons, Inc., 1957), p. 56.

TABLE 18

ESTIMATE OF AVERAGE DEATH RATES, BIRTH RATES AND
NATURAL INCREASE OF POPULATION IN INDIA
DURING DECADES 1881-1961

| Decade | Births per 1,000 Population per Year | Deaths per 1,000 Population per Year | Natural Increase |
|------------------------|---|---|---------------------|
| 1881-1891 ^a | 48.9 | 41.3 | 7.6 |
| 1891-1901 | 45.8 | 44.4 | 1.4 |
| 1901-1911 | 49.2 | 42.6 | 6.6 |
| 1911-1921 | 48.1 | 47.2 | 0.9 |
| 1921-1931 | 46.4 | 36.3 | 10.1 |
| 1931-1941 ^b | 45.2 | 31.2 | 14.0 |
| 1941-1951 ^b | 43.1 | 30.9 | 12.2 |
| 1951-1961 ^c | 40.0 | 21.7 | 18.3 |

^aThe rates for the decades 1881-1891 to 1931-1941 are taken from Kingsley Davis, The Population of India and Pakistan (Princeton, N.J.: Princeton University Press, 1951), p. 85.

^bThe rates for 1941-1951 are provided by the Office of Population Research, Princeton, N. J., and presented in C. Chandrasekaran, "India's Population Problem" unpublished paper at the inaugural conference of the Demographic Teaching and Research Center on November 5, 1957, p. 3.

^cThe rates for the decade 1951-1961 are presented in United Nations, Demographic Yearbook (New York, 1960), pp. 483-505.

(2) Family planning programs were considered the best means to reduce the birth rate from 40 per thousand to 25 per thousand by 1973 and to insure the success of programs and policies of economic development in India.

(3) The research studies reveal that people in urban areas have strong motivation to practice family planning

TABLE 19--DEMOGRAPHIC AND ECONOMIC INDICATORS OF UNDERDEVELOPED AND DEVELOPED COUNTRIES OF THE WORLD

| | Total Population In Millions 1960 | Rate of | | Rate of Population Growth Per Cent Per Year | Agricultural Working Population Per Cent of Total Working Population (1960 Census) | | Per Capita Income In Dollars Per Year | | 5-14 Age Group As Per Cent of Total Population 1960 | |
|-------------|-----------------------------------|---------------------------------------|-------------------------------------|---|--|---------------------------------------|---|--|---|--|
| | | Economic Growth Per Cent (in Fifties) | Population Growth Per Cent Per Year | | Working Population Per Cent of Total Working Population (1960 Census) | Per Capita Income In Dollars Per Year | 5-14 Age Group As Per Cent of Total Population 1960 | | | |
| India | 432.6 | 3.4 | 2.0 | 70 | 73 | 24 | | | | |
| Pakistan | 92.7 | 2.3 | 2.1 | 75 | 74 | 27 | | | | |
| Ceylon | 9.9 | 4.4 | 2.8 | 53 | 129 | 25 | | | | |
| Thailand | 26.3 | 3.2 | 2.6 | 82 | 93 | 29 | | | | |
| Malaya | 3.2 | 4.1 | 3.1 | 58 | 241 | 26 | | | | |
| Tai Wan | 10.6 | 7.1 | 3.1 | 50 | 115 | 27 | | | | |
| Philippines | 27.8 | 5.2 | 2.1 | 58 | 191 | 28 | | | | |
| Hong Kong | N.A. | --- | 2.7 | 7 | 258 | -- | | | | |
| Singapore | N.A. | --- | 2.9 | 8 | 361 | -- | | | | |
| Japan | 93.0 | 7.5 | 0.9 | 30 | 504 | 22 | | | | |
| Comparison | | | | | | | | | | |
| U.K. | 52.7 | 2.7 | 0.8 | 5 | 1,288 | 15 | | | | |
| U.S.A. | 180.7 | 9.0 | 1.6 | 7 | 2,691 | 20 | | | | |
| U.S.S.R. | 214.4 | 2.8 | 1.7 | 39 | --- | -- | | | | |

^aS. Chandrasekhar, "Asia's Population Problem," Asia: A Handbook, ed. Guy Wint (Anthony Blond, Ltd., 1965), pp. 561-562.

^bAlfred Lui, "Population Growth and Educational Development," Annals of the American Academy of Political and Social Sciences, CCCLXIX (January, 196), pp. 109-120.

^cA. J. Jaffe, "Population Trends and Controls in Underdeveloped Countries," Law and Contemporary Problems, XXV (Summer, 1960), p. 518.

methods because of higher educational and socioeconomic levels, while people in rural areas have weak motivation because of high illiteracy level and rigid social attitudes and values.

(4) The socio-cultural and demographic variables such as education, occupation, caste, number of living children, number of living male children and age of husband and wife and the joint family system are very important in the formulation of attitudes towards family planning and practices.

(5) The clinical methods such as diaphragm, jelly, and condom have been widely accepted in cities while foam tablets and sponges have been widely accepted in rural areas. Voluntary sterilization of men and IUCD is also becoming popular among the people in India.

(6) There is no evidence available to indicate whether or not family planning programs have made any impact on the national birth rate in India.

Suggestions

(1) There is need for an intensive effort to motivate people to practice family planning in rural areas. Such programs should explain and stress the welfare of children as the benefit resulting from family planning.

(2) Sterilization of men and IUCD should be emphasized as the family planning methods in preference to other methods.

(3) Special emphasis should be given to social changes such as education of women to give greater freedom and rights to women, to encourage women's participation in the labor force. These changes can be introduced through political and through educational systems for the future and present generations.

(4) Political legislation should be used to make necessary social reforms such as raising the age of marriage for females and legalization of abortion as a family planning method.

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FAMILY PLANNING PROGRAMS IN INDIA

by

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B. A., Stanislaus State College, California, 1965

AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF ARTS

Department of Sociology and Anthropology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1968

ABSTRACT

This report has discussed family planning programs in India as an instrument for population control. The alarming rate of population increase has been recognized as a hindering factor in social and economic development in India. The aim of the program is to help reduce to present birth rate of 40 per thousand to 25 per thousand.

The family planning programs were initiated in India with First Five Year Plan period (1951-1956) as part of the official policy of population control.

Research studies to assess the attitudes towards family planning have been conducted in different parts of India. The analyses of these studies show that socio-cultural and demographic factors such as number of living male children, number of living children, occupation, education, age, residence, and socioeconomic status are important in the development of attitudes towards family planning. The studies also reveal that knowledge of and practice in family planning are higher in the urban population than in the rural population. There is no organized religious or social opposition to family planning programs. Finally studies indicate that there is great desire to learn more about family planning in India.

Mechanical, surgical, and chemical methods of contraception have been used by the government in family planning programs. The mechanical methods include rhythm method, abstinence and coitus interruptus. Chemical contraceptive methods include diaphragm and jelly, condom, foam tablets or combination of these methods. Voluntary sterilization and intrauterine contraception devices have also been used and encouraged on a large scale. The studies conducted to determine acceptability and effectiveness of these methods show that chemical contraceptive methods such as diaphragm and jelly, condom and foam tablets are widely accepted in cities but that use of foam tablets is the most favored method in villages. Finally the studies bring out the fact that motivation in practicing family planning is related to education, occupation and socioeconomic status of the users.

The socio-cultural factors such as urbanization, industrialization, education coupled with the changing role of women contribute towards a favorable acceptance of family planning programs. These factors bring changes in the social and economic functions of the family and thereby motivate people to seek the help of family planning programs and to adopt family planning practices. Factors such as joint family system, desire for large number of children, and low status of women encourage having large families, because these factors are suited to agrarian economy. Therefore, they tend

to hamper the success of family planning programs.

There are no evidences to indicate whether the programs have made any impact on the present birth rate in India, but with better informations, experience and available help from other countries, some success, even though not as great as desired one is likely to be achieved in the near future.