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Family Welfare Programme and Population Stabilization Strategies in India

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The programme certainly needs to be focused at achieving various welfare-oriented targets rather than increasing the number of contraceptive acceptors

India's population in 1996 is estimated to be 952.3 million, making it the second most populous country in the world (ESCAP, 1996). The implicit annual growth rate during the 1980s was 2.1 per cent, only slightly lower than the 2.2 per cent observed during the period 1961-1981 (see table 1 for additional rates and more recent data). With the current rate of growth, India's population is expected to cross the one billion mark by the year 2000. India is likely to replace China as the world's most populous country some time before the middle of the twenty-first century.

How did it get to this point? It did not happen overnight. Soon after independence in 1947, the size and growth rate of the population were recognized as potential problems. Thus, from the early days a family planning programme was envisaged as an integral part of a comprehensive social development programme. India was the first independent country in the world to adopt a policy of reducing population growth through a government-sponsored national family planning programme, as called for in the First Five-Year Plan (1951-1956). India officially began to implement that programme in 1952. Since then the programme has undergone various changes in order to influence the reproductive behaviour of the population and increase the number of acceptors of various family planning methods. However, in spite of a long series of officially run family planning programmes during the ensuing decades, the pace of fertility decline has been relatively slow. This raises the question of whether the focus, priorities and responsibility of the family planning programme should remain the same in the future.

The reasons for the achievements and limitations of the programme are many and complex and are not without prejudice and cryptic assertions. Thus, the central issues in this discussion should be (a) a review of the basic philosophy of the family welfare programme, (b) consideration of whether the programme alone could change couples' fertility behaviour sufficiently and firmly establish a small family norm and (c) assessment of the role of development and population-influencing factors such as literacy, status of women and infant mortality, among others. Therefore, this article presents a set of observations and propositions for exploration and discussion.

Table 1: Selected demographic indicators: India, major States and capital

States/areas	Population	Growth rate	Crude birth rate	Crude Death rate	Total fertility	
	1991 census (millions)	**1981-1991 (per cent)**	**1993 * (per thousand)**	**1993 * (per thousand)**	**1970-1972**	**1990-1992**
Andhra Pradesh	66.5	23.8	24.1	8.4	4.7	3.0
Assam	22.4	23.6	29.5	10.2	5.5	3.4
Bihar	86.4	23.5	32.1	10.6	-	4.6
Delhi (Union Territory)	9.4	53.0	21.8	4.1	-	-
Gujarat	41.3	20.8	28.0	8.1	5.7	3.2
Haryana	16.5	26.3	30.6	7.8	6.4	3.9
Himachal Pradesh	5.2	19.4	26.7	8.6	4.7	3.1
Jammu and Kashmir	7.7	28.9	-	-	4.8	3.3
Karnataka	45.0	20.7	25.5	8.0	4.4	3.1
Kerala	29.1	14.0	17.3	6.0	4.1	1.8
Madhya Pradesh	66.2	26.8	33.4	12.6	5.7	4.6
Maharashtra	78.9	25.4	25.0	7.2	4.5	3.0
Orissa	31.7	19.5	27.2	12.2	5.3	3.3
Punjab	20.3	20.3	26.3	7.9	5.3	3.1
Rajasthan	44.0	28.1	33.6	9.0	6.3	4.5

Tamil Nadu	55.9	14.9	19.2	8.0	3.9	2.2
Uttar Pradesh	139.1	25.2	36.0	11.4	6.7	5.2
West Bengal	68.1	24.6	25.6	7.3	-	3.2
India (as a whole)	**846.3**	**23.5**	**28.5**	**9.2**	**5.2**	**3.7**

Sources: Office of the Registrar General, Sample Registration System Fertility and Mortality Indicators 1991 (New Delhi: Government of India, 1993). Central Statistical Organization, Selected Socio-Economic Statistics for India, Ministry of Planning and Programme Implementation (New Delhi: Government of India, 1995).

Note: * Provisional.

Population stabilization strategies

Although the First Five-Year Plan acknowledged the serious economic consequences of high fertility, the need for birth control was presented primarily in terms of concern for the health and welfare of families and their individual members. At that time planners in India had good reason to proceed cautiously in inaugurating a population policy aimed at reducing fertility, because virtually nothing was known about the attitudes of the masses or the views of religious and other leaders. Nevertheless the declared goal was a reduction in the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy.

The policy focus from the beginning has been on the limitation of family size. The principal means of implementing the policy has been the propagation of the family planning programme. The programme was directed primarily at building up a large infrastructure for providing family planning advice and services and creating public opinion actively in favour of the programme. Successive five-year Plans have repeatedly stressed these objectives and approaches. The preoccupation with fertility control in every five-year Plan was translated essentially into efforts to reduce the birth rate. This objective was further highlighted from 1966-1967 onwards, when the programme to reduce the birth rate was made target oriented. This was largely the result of pressure from neo-Malthusian thinkers about the need for population control. It was argued that, without a major improvement in the adoption of family planning, national development goals would be extremely difficult to realize. A rapid decline in both the birth rate and the population growth rate was considered to be of utmost importance. Unless a sense of national urgency could be introduced in the form of compulsive persuasion in that direction, an effective decline in the birth rate would take too long to foster if it were to be solely a consequence of economic and social development. This view prompted the central Government to announce a detailed population policy introducing a number of new measures.

The introduction of a compulsory element in the family planning programme probably had a certain appeal since it would seem to offer a means for fulfiling the goal of lowering the birth rate. But was it the only way to achieve a reduction? One view preferred to emphasize general socio-economic development as the means for bringing about fertility decline, as was the experience of the now more developed countries of the world. Another view placed strong hope in the role to be played by the family planning programme. Although it is generally believed that development activities and family planning programmes are "mutually reinforcing complements" rather than "mutually exclusive", the Health Minister's policy statement of April 1976 stated, among other things, that "to wait for education and economic development to bring about a drop in fertility is not a practical solution". The rationale behind this statement could have been that India could not afford to wait for 15-20 years for general overall socio-economic development to take place in the hope that it might ultimately generate a movement towards curtailing reproduction. It is also true that, in the light of the rapid growth of population, overall socio-economic development is difficult to achieve and is not guaranteed. This does not mean that the planners and policy makers had completely ignored the permanent and lasting effects of socio-economic development on fertility attitudes. What probably had been envisaged was that limited strong measures towards curtailing fertility would be essential while general socio-economic development was taking place.

Official pronouncements and actions by the central Government indicated that it hoped to limit India's population growth through a certain degree of gentle and civilized pressure, persuasion and compulsion. It was commonly believed that, while a certain degree of control could be achieved through such measures, efforts should proceed concurrently for achieving general socio-economic development so that the two efforts could synergize each other and result in a substantial and permanent decline in fertility.

Subsequent experience has shown that this never happened -- largely because target setting and target fulfilment became entrenched within the official establishment, and maintenance of the status quo was sought on the basis that, if targets were removed, the programme would collapse (Bose, 1989:179). The 1985-1990 declared strategy emphasized, among many other things, the need to generate an environment for fertility decline through relevant socio-economic intervention. Although, at times, "attempts have been made to enlarge the definition of family planning by interpreting it as family welfare or qualitative improvement of the life of the people, the hard fact is that it has been, and still is, largely, a programme of fertility control" (Panadikar, 1981:4).

India's Eighth Plan recognizes the population challenge as one of six priority objectives for concerted and cohesive intervention; more importantly, all six of them relate to the social sector. However, in terms of implementation, the Plan still refers to demographic targets, such as reduction of the birth rate to specific levels. It does not spell out the actual

implementation of the specific activities to speed the population-influencing policies and the social change through socio-economic development. Such a situation often gives the impression that declared policies and commitments are mere rhetoric, particularly in the area of social policies in the population policy package.

Family welfare programme: achievements and limitations

In India, as in many developing countries, the family planning programme is the most direct public policy measure initiated to reduce the population growth rate. Since the formal beginning of the programme in the early 1950s, it has gone through many structural, administrative and implementation strategy changes. All those changes will not be described here; instead focus will be on only critical areas of programme activity and their impact on achievements and their limitations. There is no doubt that the facilities and services made available for family planning have increased substantially over time. In the rural areas, at the beginning of April 1991 there were 130,978 sub-centres, 22,059 primary health centres, and 1,923 community health centres (Department of Family Welfare, 1990/91:257-263). The above statistics are just one of the indicators which show that the programme has certainly succeeded in establishing a very good infrastructure through which family planning facilities and services have increased over time. However, there are some doubts about the full utilization of these services and the quality of service standards being provided by these centres (Singh, 1989:39).

The programme has contributed to large-scale awareness about family planning, contraceptives and available facilities (Mahadevan and others, 1989). There are reports of an increasing number of sterilization operations, IUD insertions and use of other contraceptive methods (Raina, 1994:172), all of which have increased the couple protection rate. According to Department of Family Planning statistics, the percentage of couples effectively protected increased from 10.4 per cent in 1971 to 44.1 per cent in 1991 (tables 2 and 3) (Department of Family Welfare, 1990-1991).

Table 2: Couples effectively protected in major India States by various methods of family planning, 1991

States/areas	Percentage of couples effectively protected due to:			All methods	Percentage accounted for by sterilization
	Sterilization	**IUD**	**Other**		
Andhra Pradesh	33.6	3.6	5.0	44.3	75.8
Assam	25.8	1.6	0.9	28.2	91.5
Bihar	22.3	2.9	0.8	26.0	85.8
Delhi (Union Territory)	21.1	9.1	10.2	40.4	52.2
Gujarat	39.3	11.0	7.5	57.8	68.0
Haryana	32.8	12.7	11.1	56.6	58.0
Himachal Pradesh	37.5	8.7	5.8	52.1	72.0
Jammu and Kashmir	17.8	2.5	0.8	21.1	84.4
Karnataka	38.8	5.4	2.6	46.9	82.7
Kerala	45.8	5.2	4.6	55.6	80.9
Madhya Pradesh	27.1	5.3	78	40.3	67.2
Maharashtra	42.1	6.7	7.4	56.2	74.9
Orissa	31.3	5.6	4.1	41.0	76.0
Punjab	41.1	24.3	10.4	75.8	54.2
Rajasthan	21.9	4.4	2.7	29.0	75.5
Tamil Nadu	45.0	8.8	3.5	57.3	78.5
Uttar Pradesh	19.9	11.4	4.2	35.5	56.1
West Bengal	29.1	2.2	2.4	33.7	86.3
India (as a whole)	**30.3**	**6.7**	**7.2**	**44.1**	**68.7**

Source: Department of Family Welfare, "Family welfare programme", In: India Year Book (New Delhi, 1990-1991).

Table 3: Number of couples effectively protected by various family planning methods, selected years from 1970 to 1991

	Eligible		

Period	couples (thousands)	Couples effectively protected due to:			All methods
		Sterilization	IUD	Other	
1970-71	94,489	7,584	1,288	1,963	9,853
		(8.0)	(1.4)	(2.1)	(10.4)
1975-76	105,239	14,692	1,101	3,528	17,843
		(14.2)	(1.0)	(3.4)	(17.0)
1980-81	116,033	23,321	1,173	3,809	26,444
		(20.1)	(1.1)	(3.3)	(22.8)
1985-86	129,432	34,312	4,800	10,744	45,163
		(26.5)	(3.7)	(8.3)	(34.9)
1990-91	145,140	43,497	9,664	17,814	64,071
		(30.3)	(6.7)	(12.3)	(44.1)

Source: Department of Family Welfare, "Family welfare programme", In: India Year Book (New Delhi, 1990-1991).

Note: Figures in parentheses are percentages.

Since the goal of the family planning programme has always been established in terms of demographic targets, it is logical that its performance would have to be evaluated in terms of its impact on the reduction of the birth rate. The various fertility indicators certainly do show some trends towards declining fertility in India. The crude birth rate seems to have declined from about 45 per thousand in the 1950s to 28.5 per thousand in 1993. The total fertility rate has also declined from about 5.2 children per woman (1970-72) to 3.7 (1990-92). This amounts to a nearly 28 per cent decline in fertility during the period 1970-1990. A number of other demographers (Jain and Adlakha, 1982; Rele, 1987; Visaria and Visaria, 1994) also reported a reduction in fertility during the last few decades.

Questions have been raised whether the decline has been sufficiently large to merit applause for the efforts of the family planning programme. It is our view that birth rates and total fertility rates are still too high. Also, the pace of the fertility decline is slowing; it almost came to halt in the 1980s (Jain, 1989:2729; Raina, 1994:197).

Another aspect of the programme which needs to be evaluated concerns the number of acceptors of family planning and their demographic characteristics. Even though the couple protection rate has increased from 10.4 per cent in 1971 to 44.1 per cent in 1991, most of this increase has been achieved through sterilization alone. In 1991 nearly 69 per cent of the total couple protection rate was accounted for by sterilization (table 2). Also, there has been some inconsistency between the couple protection rates and total fertility rates observed among various States. This raises a question concerning the accuracy of reporting the non-reversible methods used and the efficiency with which they have been used. The demographic characteristics of the the couples concerned also are not very conducive to a steep decline in fertility. The mean age of acceptors is above 31 years. These couples on average have at least 3.3 living children (table 4). This profile has hardly changed over the years. This means that the programme has not been very successful in recruiting younger couples with lower parity. It also has not been able to popularize the use of reversible methods.

Table 4: Demographic characteristics of acceptors of vasectomy, tubectomy and IUD, selected years from 1977 to 1988

	1977-1978	1982-1983	1987-1988
Vasectomy			
Mean age of wife (years)	31.5	31.1	32.4
Average number of living children	3.1	3.4	3.6
Tubectomy			
Mean age (years)	30.1	30.5	30.2
Average number of living children	3.5	3.7	3.3
IUD			
Mean age (years)	28.1	27.7	27.4
Average number of living children	2.6	2.5	2.3

Source: Department of Family Welfare, Demographic Profile of Family Planning Acceptors (1987-88), Ministry of Health and Family Welfare (Government of India, 1990).

The question is whether the continued emphasis on terminal methods (particularly sterilization), users of which are mostly at older ages and higher parity, will be able to bring about replacement-level fertility in the near or even distant future. The total fertility rate for 1990-1991 has been estimated to be on the order of 4.3. The age pattern of fertility in rural India at this level of total fertility implies that women, on average, have three children by the time they are 30 years of age. The age pattern of sterilized women suggests that the family planning programme by now has captured most of the demand for sterilization. Unless a demand is created for terminating childbearing at younger ages and lower parity, a further decline in fertility is unlikely to take place. Jain (1989) has clearly demonstrated through the application of a simulation model that, if the current pattern of contraceptive mix were to continue, a very high percentage of couples under age 30 using sterilization would be needed in order for the country to reach replacement-level fertility. This is unlikely to happen under the conditions of relatively high infant and child mortality currently prevalent in India. Couples under the age of 30 years are most likely to use temporary methods of contraception for birth-spacing rather than to stop childbearing permanently. It is essential to net "high-risk" couples in order to ensure the future success of the programme. Such couples naturally will be young and of lower parity. Because they would not be suitable candidates to recruit for sterilization, attention certainly must be given to the need for expanding the use of reversible methods.

One can safely say that, although some progress has been made, it has not been enough. This raises the question of whether family planning has affected human reproductive behaviour to the extent of being able to promote the ideal of a small family size. In light of this we need to look at certain aspects of the programme, both in terms of its philosophy and implementation strategies of the past.

It is also appropriate to look at the recent proposed changes to India's population policy. The proposed population policy (draft document, as it is called) emphasizes that the policy needs to be tailored to suit the particular socio-cultural and socio-economic factors prevailing in each area of the country. Such a shift in approach is fundamental to achieving a population policy driven by people's perceived needs. It proposes that the current target-oriented approach of a centrally sponsored/vertical programme be replaced by a people-oriented, decentralized approach. The principle of integration and decentralization in this proposed policy document also calls for a restructuring of the Ministry of Health and Family Welfare (Expert Group on Population Policy, 1994:27). The proposed policy argues that there is a need for a structure which has the requisite authority, autonomy and accountability to make this happen. Under the new structure, the establishment of a Population and Social Development Commission is proposed. The commission's responsibilities would include formulation and implementation of population policies and strategies. It is argued in the proposed policy document that the setting up of such a commission supported by a "population and development fund" would enable the governmental and non-governmental organizations concerned to have the means, flexibility, will and enthusiasm to achieve national goals. Based on this, it is necessary to address those issues which will increase the effectiveness of the programme in the future.

Role of the target approach

Target setting became the main feature of the Indian family planning programme from the mid-1960s (see Raina, 1988). Bose (1987) has also provided a good discussion on the implications of family planning targets. He came to the conclusion that target setting was merely a routine approach to streamline the programme. Unfortunately, over the years, the target has become an end in itself and not the means to bring about a decline in the birth rate (Bose, 1989:186). In order to fulfil targets, it was inevitable that a great deal of drafting and mobilization of personnel from other "nation-building" activities would be required for the sake of the family planning programme. However, these personnel were not equipped to deal with such sensitive areas as those related to individual family life. So the kind of persuasion and pressure applied by these people was very crude, lacking the human touch.

The problem was further compounded by the incentives and sanctions offered by State Governments to their staff for fulfiling quotas. This resulted in over-reporting performance and a tendency to pressurize the people, which at times resulted in unethical practices. Total preoccupation of field staff with target fulfilment also resulted in the neglect of motivational and other necessary functions. Thus, the negative family planning programme image created through the target approach needs to be changed.

Does this mean that targets should be totally abolished and, along with them, the role of terminal methods de-emphasized? The answer is no. Rather than phobia, a redefinition is needed in terms of what is realistic and feasible. Terminal methods (sterilization) need to be continued as part of the family planning programme. This is largely because a significant proportion of the rural and some urban sections of the population are illiterate and have inadequate means for practising other conventional methods of contraception. It seems that terminal methods will remain best suited for this section of the population for some time to come. Advocacy for and popularization of sterilization should remain as one of the targets of the programme. However, this aspect of the programme should not be converted into a "numbers game". Any incentive in the form of compensation money (for the loss of wages etc.) should be retained but it should not be promoted in such a way that it appears to be a bribe. Moreover, motivators and workers should not be given incentives. The role of incentives and disincentives should be addressed in a more rational manner with respect to their effectiveness for promoting the acceptance of the small family norm. Couples with two or fewer children should be given higher incentives.

There is a need to introduce other forms of target-oriented goals for programme workers. For example, each worker should be encouraged to maintain a register of eligible couples and their children, keeping it complete and up to date so as to assist them to set their own programme norms. Thus, they would be able to adopt a needs-based approach to motivate

couples to accept family planning welfare services rather than strain themselves to attain unachievable targets (Sawhney and others, 1989:2). In other words, the programme needs to be focused at achieving some welfare-oriented targets rather than a certain number of contraceptive acceptors (particularly those of sterilization).

Decentralization

The family planning programme has been accepted since its beginning as an integral part of the planning process in India. The pattern of funding and the working strategy adopted under the programme has resulted in centralized planning and centralized decision-making. The family planning programme had traditionally delivered the "same packages" to all areas of the country. A major shortcoming of this approach was its failure to recognize that, in a diverse and pluralistic society such as India, it is seldom possible to build consensus quickly and to organize effective support for implementing nationwide programmes. Among the developing countries, India presents a unique case in terms of the sheer number of people involved and the extreme heterogeneity of its cultures, languages and socio-economic conditions. An important lesson to be learned from past failures is that the family planning programme in India must be planned in the context of the country's diversity. Hence, there is a need to achieve greater decentralization, both in planning and implementation. To improve the effectiveness of the family planning programme, it must be decentralized to reach the grass-roots level (Gandhi, 1989).

The Eighth Plan envisages the need for people's participation and a community-based system. The Expert Group on National Population Policy in its draft policy states:

"Policies and programmes will have to be tailored to suit the particular socio-cultural and socio-economic factors prevailing in each area. The year 1994 provides an excellent opportunity for promoting the concept of unity in national population goal but diversity in implementation strategies. With the Panchayat Raj Act coming into force in all States and Union Territories, there is a real opportunity for planning at grassroots level". (1994:3)

Based on the national population policy framework, each panchayat (village council, or local administrative unit) or similar local government body can be encouraged to prepare a socio-demographic profile and develop a plan of action for achieving population stabilization. The benefit of such an approach is that programme decision-making would be brought into direct contact with those whose needs are ultimately to be served or whose preferences in matters of reproduction it is hoped to influence. This should help the family planning programme to become "internalized". In the past, the family planning programme failed to pay adequate attention to the users' perspectives. This resulted too often in a failure to achieve high rates of contraceptive acceptance and prevalence (Zeidenstein, 1989). Recently, the central Government came to the realization that the success of the programme demands as much in terms of the initiative and cooperation of the people as it does with regard to its status as an official programme. Hopefully this realization will soon be translated into action through the process of decentralization.

Quality of information and services

It has been argued that public services in India lack sufficient outreach, are of poor quality, and have staff who are inadequately trained. Also, family planning education suffers from funding gaps and lack of communication expertise (Coley and Camp, 1992). Past experience has shown that this situation has resulted in a poor quality of information and services. Most people in India know about sterilization and many of them know about IUDs, but knowledge about other methods is low. It is essential therefore that knowledge about other methods be improved along with improvements being made in the availability of such methods. Owing to the lack of knowledge about these methods and their often less-than-desirable effectiveness, there is little sustained motivation to use such methods. In order to popularize the use of these methods, it is essential that India's family welfare programme incorporate certain strategies to develop and improve interpersonal communication.

The programme also has suffered from bad publicity and rumours. This is the direct result of a lack of proper after-service care and concern, a low level of general awareness, apathy, coercion and people having misconceptions about certain family planning methods. It is essential, therefore, that in the future bad publicity should be avoided, but this cannot be done unless proper after-service care, follow-up services and the like are consistantly provided. Thus, it is encouraging to observe that the aformentioned national population policy draft document states:

"The provision of quality health services and, in particular, screening and aftercare services for contraceptive acceptors are high priority issues. The credibility of the programme can improve only through improving the quality of services, efficient logistical support and better management at the grassroots level". (1994:28)

Role of information, education and communication

Information, education and communication (IEC) efforts are vital for the successful implementation of population policy. Since the inception of the family planning programme, Indian planners have attached great importance to IEC. However, the infrastructure for implementing IEC measures, both at the central Government level and in the States, remains inadequate (Expert Group on Population Policy, 1994:30). The objective of the IEC component of the family welfare programme should be to increase the general awareness of population, health and family welfare issues, particularly with the intention of creating greater demand for family planning and health services. IEC should form the backbone of motivational efforts in disseminating

messages on family planning and contraception.

In order to achieve the above-mentioned goals, it is essential that the family welfare programme utilize mass media and person-to-person communication channels. The mass media can play an important role in promoting awareness, whereas interpersonal communication can play a very important role in changing behaviour and promoting the acceptance of family planning among a variety of people.

In the past few years, India has experienced a considerable technological revolution in terms of information. A high level of communications technology is available in India, unlike in many other developing countries. These changes have also had some impact on the remotest parts of the country, but not fully. This is largely due to a lack of local interest in the contents of the networked information. Information suited to the needs and interests of the rural population needs further development. Centrally designed, stereotyped programmes for rural areas are not uncommon. The development of a regional programme, utilizing local personnel and personalities with whom people can associate, is essential if family welfare messages and related information are to be communicated more effectively. In the past, the mass media achieved limited success in making people aware of the concept of family planning, but this awareness has not resulted in the motivation of couples in terms of self-referral and the increased practice of contraception. Such advances can take place only if a mass media campaign is followed by interpersonal communication. This point has been among the weakest aspects of the Indian family welfare programme, but it could be improved by training some of the existing personnel of primary health centres and sub-centres. These comprise the workers who come into direct contact with prospective contraceptive users. Thus, it is essential that these workers be skilled in interpersonal communication techniques. It is surprising that the latest draft document of the national population policy does not clearly emphasize the role of interpersonal communication as an effective means for motivating people towards the adoption of contraception.

Development from the point of view of quality of life

There are many macro-economic models which have been developed to study the impact of rapid population growth on economic development (Leibenstein, 1954 and 1985; Nelson, 1956; Coale and Hoover, 1958). There are some other macro studies which further examined the consequences of rapid population growth on issues such as education and health costs (Jones, 1975a and 1975b). Such studies provided strong hints about the costs likely to be involved in the development process as a consequence of population growth. As a result, most developing countries have accepted family planning programmes, indicating that they accept the general argument that a growing population hinders development and such growth should be checked in order to accelerate the process of socio-economic development.

Recently, many have come to believe that family planning programmes alone cannot bring down population growth to a level that would make development sustainable. Thus, the positive role of socio-economic development is beginning to be recognized in policy circles. It is being argued that macro development, which had been emphasized in the early debate on population and development, is not directly relevant unless it is beneficial for improving the individual's quality of life. Vijayanunni (1994:193) concludes that what is important is not overall development through large-scale projects and programmes, the benefits of which reach the common man/woman only indirectly and after a long gestation period, but welfare-loaded policies and programmes which impart direct and immediate benefits to the people. It has been asserted that India's model for development has been a major cause of its current economic conditions: i.e. it seeks increased productivity, rather than an equitable distribution of resources, and subsidies in public health and education for the poor (Ravindra, 1993:27). In the light of these arguments it is appropriate that India's population programme should be integrated with socio-economic development factors which concentrate on improving the undesirable conditions in which many people live. The most important question that needs to be asked is: "Which socio-economic aspects of the development programme are most likely to improve the individual's quality of life and influence his or her fertility behaviour"?

A number of international and national studies have shown that the level of literacy, status of women, infant and child mortality, mortality in general and level of poverty all play a major role in influencing a society's population growth rate. The experience of many Asian countries in the ESCAP region has shown that fertility decline can be achieved by a mix of these factors without large-scale industrialization and attainment of high levels of economic growth. Unless there is an improvement in these basic areas of Indian society, the country is unlikely to achieve further gains in its effort to influence the fertility behaviour of its citizens and firmly establish the small family norm.

The following section reviews the role of these development variables in the Indian context.

Table 5: Selected population related indicators: India, major States and capital

States/areas	Infant mortality rate	Literacy rate 1991		Percentage poverty level	Percentage urban	Percentage of women in employment[b]
	1993[a]	Males	Females	1987-1989	1991	
Andhra Pradesh	64	56.2	33.7	31.7	26.8	12.3
Assam	81	62.3	43.7	22.8	11.1	29.4

Bihar	70	52.6	23.1	40.8	13.2	6.8
Delhi (Union Territory)	-	82.6	68.0	-	89.9	12.3
Gujarat	58	72.5	48.5	18.4	34.4	12.3
Haryana	65	67.9	40.9	11.6	24.8	11.7
Himachal Pradesh	63	74.6	52.5	9.2	8.7	11.0
Jammu and Kashmir	-	-	-	13.9	23.8	10.0
Karnataka	67	67.3	44.3	32.1	30.9	16.1
Kerala	13	94.5	86.9	17.0	26.4	35.1
Madhya Pradesh	106	57.4	28.4	36.7	23.2	9.7
Maharashtra	50	74.8	50.5	29.2	38.7 1	2.8
Orissa	110	62.4	34.4	44.7	13.4	7.9
Punjab	55	63.7	49.7	7.2	29.7	13.4
Rajasthan	82	55.1	20.8	24.4	22.9	12.2
Tamil Nadu	56	74.9	52.7	32.8	34.2	20.6
Uttar Pradesh	93	55.4	26.0	35.1	19.9	7.6
West Bengal	58	67.2	47.2	27.6	27.4	10.0
India (as a whole)	**74[c]**	**63.8**	**39.4**	**29.9**	**25.7**	**13.6**

Sources: Bose, A. Population of India: 1991 Census Results and Methodology (New Delhi: D.K. Publishers (P) Ltd., 1991). Central Statistical Organiation, Selected Socio-Economic Statistics for India, Ministry of Planning and Programme Implementation, (New Delhi: Government of India, 1995).

Notes: a Provisional.

b Percentage of women employed in organized sector.

c Excludes Jammu and Kashmir.

Infant mortality and expectation of life

If fertility reduction is to be achieved, infant mortality deserves the highest priority among all the social development factors mentioned. This is because society in general and specific households in particular, which are exposed to high infant mortality, tend to want high fertility in order to ensure that enough children will survive so that the family will contain the desired number of living children. Although there is evidence to suggest that the infant mortality rate has been declining steadily over the last few decades, it is still relatively high. Infant mortality was estimated to be around 74 per thousand during 1993 (table 5), which means that nearly one out of thirteen children dies before reaching his or her first birthday. The situation is even worse in some other States. In Uttar Pradesh, Madhya Pradesh and Orissa, the infant mortality rate is in the range of 93-110 per thousand, with some rural areas experiencing even higher rates. This means that one out of nine children dies before reaching his or her first birthday.

In comparison with many other countries in the Asian region, Indian infant mortality rates are still very high. Even the world's most populous country, China, has been able to reduce its infant mortality rate to less than 30 per thousand. Jain and Visaria (1988), in their review of research done in India, indicate that a significant decline in infant mortality can be achieved primarily through the prevention of neo-natal tetanus, immunization of children and use of home-made treatments for diarrhoea. The policies and programmes of the health sector also need to concentrate on improving the occurrence of births in institutions, or at least where a trained birth attendant provides assistance. Research has shown that such improvements tend to lower infant mortality. Kerala State, where over 95 per cent of births occur either in institutions or are assisted by a trained birth attendant, has been able to reduce its infant mortality rate to 22 per thousand.

With the new emphasis on decentralization contained in the national population and family welfare policy, it will be possible to identify specific local areas where the risk of infant mortality is high and incidence of birth attendance by trained personnel is low. This will mean that programme emphasis could be directed towards achieving a lower level of infant mortality by making efficient use of the resources allocated, even without a significant improvement in the level of economic development. Universal immunization and ante-natal care programmes could be intensified in such targeted areas, thus reducing the cost of these services and making them accessible to low-income families through family welfare and health programmes. Such steps are likely to bring the population closer to the health system and thus indirectly increase the utilization of health system facilities for delivering babies, for family planning and for treating the ill. In this way, family planning could be seen as a part of the country's general welfare programme. As implied in the Bali Declaration on Population and Sustainable Development, the attainment of lower levels of infant mortality should be the prime objective of any population and

welfare policy that is concerned about the quality of life of the people and the reduction of fertility. This is particularly so in Indian society, where children, especially sons, are considered as social security assets for their parents' old age. In such a setting, parents can hardly be expected to reduce their fertility if infant and child mortality rates are high.

There has also been some modest improvement in lowering overall mortality in India during the past few decades. The expectation of life at birth has risen from 50 years in the early 1970s to 58 years during the period 1986-1990, and 62 years in 1996 according the most recent estimate (ESCAP, 1996), a level that is very low compared with those of various other countries at the same level of socio-economic development, e.g. China (about 69 years), the Philippines (about 68 years) and Sri Lanka (about 73 years) (ESCAP, 1996). These countries have been able to achieve a higher life expectancy through their public health and welfare programmes. The improvement in infant mortality and mortality rates in general contributes substantially to the overall improvement of the individual's and family's welfare and results in a better quality of life for the people. Benefits experienced at the individual and family level due to a lowering of infant and general mortality rates help to create a positive environment which favours a downward trend also in fertility.

Status of women

It is being increasingly recognized that there is a close association between various aspects of women's status or position in society and demographic patterns of fertility, mortality and migration. This association has been shown to be more pronounced in respect of fertility and the social processes associated with it. General improvement in the status of women, accompanying their growing economic, social and political participation outside the home, has resulted in the need for families to shift some household functions that have traditionally been performed by women to other family members. A review of demographic research around the world clearly indicates that fertility decreases as the status of women improves. While it is difficult to assess accurately the status of women within society and individual households, it is generally agreed that indices relating to educational, health status and labour force participation are particularly important for studying the association between population and the status of women.

It is widely recognized that the status of Indian women is low; for the majority, equality of women with men is more an exception than the rule. It has been argued that this situation is largely due to India's high level of poverty, but this view does not hold up when the status of women is compared with the situation in some equally poor societies. The causes are complex and go beyond the intention of this article. However, it is a fact that women in India have limited access and opportunities in such areas as education, health and employment. As India's 1991 census data show, only 39 per cent of females aged seven years and older are literate, whereas male literacy for the same age group is nearly 25 percentage points higher. Further, female literacy varies widely according to State, ranging from as high as 87 per cent in Kerala to as low as 21 per cent in Rajasthan (table 5). Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan, which together account for nearly 40 per cent of India's total population, have a female literacy rate of approximately 25 per cent. Thus, if the situation of women in India as a whole is to improve, obstacles to women's advancement in the field of education must be removed in order to increase their literacy and ability to participate fully in society. Women must be able to enjoy a considerable measure of autonomy if the country is to attain its socio-economic development goals. The examples of Sri Lanka and Kerala State (India) clearly demonstrate that, when such obstacles to women's advancement are eliminated and a high level of literacy is achieved, there is a distinct improvement in the content and pace of development as well as in the quality of life of the entire community (Salas, 1984:24).

Improvement in the status of women achieved through education increases their access to other value systems and also improves women's knowledge, attitudes and practice of family planning (Mason, 1984:45). Such improvements would also increase the effectiveness of the family welfare programme in India. Caldwell and others (1988) report from their intensive investigation of demographic change in rural Karnataka that husbands treated wives who had been to school differently and listened to them more closely than husbands whose wives had not been to school. Education thus increases women's participation in the decision-making process with regard to family size. Improved status of women in India through increased education and higher literacy should result in a sustained decline in fertility. It would also improve the overall quality of family life. For example, an educated mother is better able to understand the need for and practice of hygienic forms of child care and thus can positively influence the rate of infant and child survival.

The four aforementioned States with high female illiteracy also have fertility levels that are higher than those for India as a whole. Further, in those States, the percentage of women employed in the organized sector is very low. According to the 1991 census, only 13.6 per cent of the female labour force is employed in the organized sector (table 5), which indicates a lower status of women and increasing economic dependency, and in turn reduces their power in family decision-making. Put simply: unless significant progress is achieved in improving the status of women in India, a further reduction in fertility is highly unlikely.

Level of poverty

Population and poverty are both linked with the welfare of the individual, the overall quality of life in a society, and, by the same token, national development. The interrelationships between population and poverty can be examined at two levels: the macro, or aggregate level, and the micro, or household level. It is the micro level, where decisions are usually made with regard to family size, that serves as the starting point for most of the interactions between poverty and fertility. Nearly 30 per cent of India's population live below the poverty level (table 5); in some States the percentage of people living in poverty is as high as 40-44 per cent. Such a large proportion of the population living in poverty has an overall negative effect on the quality of

life of the people. This is manifested in many ways. For example, high infant and child mortality rates are common among the poor. Since poor parents desire to have some of their children survive to provide support for them in their old age, they maintain high fertility rates in order to offset high infant and child mortality rates; in other words, they have more children than they actually need for "insurance" purposes (ESCAP, 1985). Another factor contributing to high fertility among the poor is their lack of knowledge of and access to family planning methods and services, as well as the lack of the means to practise the methods. It is essential therefore that poverty be alleviated and unemployment and underemployment be reduced. In addition there must be social "safety-nets" in the face of insecurity, child morbidity and mortality if the small family norm is to be accepted in India. Thus, the minimum needs programme needs to be pursued much more rigorously by the Government in order to improve the basic quality of life for the majority of India's population.

Discussion and concluding remarks

In order to achieve a greater demographic impact, the image of the family welfare programme has to be changed, that is from being solely a birth control programme to a programme for improving the people's quality of life. Today the Indian programme stands at the crossroads of the future: joint efforts through the improvement of the quality of family welfare services and a basic improvement in the quality of life (achieved through improvements in literacy, status of women and infant mortality, and a reduction in the level of poverty) are prerequisites for India to achieve its stated objectives of reaching replacement-level fertility -- a TFR of 2.1 -- by the year 2010.

If the current programme emphasis and format continues, then even a family's own practice of birth control may come to be seen as not a personal but a governmental responsibility. Unfortunately there are many who are beginning to assume that fertility control cannot be practised without a government family planning programme. This kind of thinking needs to be changed. Otherwise the Indian Government will find itself committed to a major long-term programme which it may find increasingly difficult to sustain.

The sooner this responsibility is transferred to individual families the better. This cannot be done without paving the way for the acceptance of the small family norm by society. In this regard, it is essential to increase the contraceptive prevalence rate from the current 44 per cent to at least 70 per cent in order to achieve the aforementioned goal of replacement-level fertility and maintain it at that level. This cannot be done without some improvement in socio-economic conditions; family planning alone cannot provide the solution. There exists a threshold above which socio-economic development has to rise in order for the small family norm to prevail in a society. The programme certainly needs to be focused at achieving various welfare-oriented targets rather than increasing the number of contraceptive acceptors (particularly acceptors of sterilization). Also, to improve the effectiveness of the family planning programme, it needs to become decentralized to reach people at the grassroots level, mainly in the villages. Such a strategy might in the immediate future slow down the current decline in fertility while the necessary changes are being implemented, but this would be for the long-term good of the people and the country. The one thing that cannot be allowed to happen is for the authorities to panic once again and resort to drastic action if they observe what would be only a temporary stalling of the fertility decline.

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