NATIONAL FAMILY WELFARE PROGRAMME IN INDIA: AN OVERVIEW

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The Family Welfare Programme occupies an important position in the socio-economic improvement. It also plays a crucial role in human resource development and in improving the quality of life of the people. In India, it forms an essential and integral part of the Twenty Point Programme of the Government of India, which stresses the need for promotion of Family Planning on a voluntary basis as a people's movement(1).

The country's population which was about 342 million at the time of independence rose to 361 million in 1951. It was 439 million in 1961. It further increased to 548 million in 1971. The 1981 census showed that India's population was 685 million, about double the figure (342 million) at the time of independence(2).

India was the first country in the world to have a Government level Programme of Family Welfare and Planning. It became an integral part of economic planning right from the First Five Year Plan(3). The beginning was modest, with a largely clinical approach. The services were being extended to those who sought the services on their own. Over the successive Plans, greater emphasis and larger outlays have been provided to strengthen the Programme. It received an extension education orientation in 1963. In 1966, the Programme was consolidated, expanded and extended, and a new Family Planning Department was created in the Ministry of Health. However, the Programme received a setback during the years 1977-1979. The effective couple protection rate, which touched a figure of 23.7% in 1976-1977, slipped down to 22.5% in 1979-80(4).

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Policy on Family Welfare Programme

A comprehensive National Population Policy was evolved in 1976(4); some of the important features of which are:

(i) Increase in the age of marriage (girls 18, boys 21 years).

(ii) Freezing of population figures at the 1971 level until 2001 for purpose of representation in National Parliament as well as for allocation of central assistance and devolution of tax revenue to the states.

(iii) Giving greater attention to girl's education and population education, in total system of education.

(iv) Involvement of all Ministries/ Departments of the Government.

(v) Increase in monetary compensation for sterilization.

(vi) Institution of group awards.

(vii) Involvement of voluntary organization.

(viii) More importance to research.

(ix) Intensive information, education and communication (IEC) activities.

National Demographic Goals

The long term demographic goals set out in the National Health Policy (1983) to be achieved by 2000 AD are shown in *Table I*(5).

Pattern of Population Growth (1951-1981)

During the thirty years since 1951, India's population has almost doubled from 361 million in 1951 to 685 million in 1981. The northern zone had the highest growth rate (112%), whereas the southern zone had the lowest growth rate of 75%(6). The growth rate was very fast in a majority of Union Territories and the smaller States of Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura, all belonging to the Eastern Zone, due to a large scale internal and international migration. Among the remaining States, Assam experienced a growth rate of 148%, Haryana 128%, Rajasthan 115%, Gujarat 110% and West Bengal 108%. In contrast, Tamil Nadu's population increased over the 30 year period by only 61%, Andhra Pradesh's by 72% and Uttar Pradesh's by 75%.

In the next decade (1990-2000 AD), the growth rate is likely to decline slowly and the pace of decline in the growth rate will depend on that of the birth rate, further improvement in mortality being dependent on accelerated improvement in the level of living of the people.

Peformance of FW Activities

(i) Sixth Plan Period

During 1979 to 1984, against a target of 24 million sterilizations, a little over 17 million sterilizations were carried out. Against the target of 7.9 million Intra Uterine Device (IUD) insertions, about 7 million IUD insertions were done. Against a target of 11 million Conventional Contraceptive (CC) users for the year 1984-1985, about 9.31 million CC users were enrolled in the programme(3,7,8).

A critical analysis of the above performance highlighted the following features:

(i) Achievements fell short of the targets, particularly in the sterilization programme. The performance in respect of IUD insertions and CC users reached a high level, around 80% and above.

(ii) The effective couple protection achieved by March 1985 was 32% but it remained below the target of 36.6%.

(iii) In the first two years (1979 and 1980), the couple protection rose roughly by 0.5 and 1%, respectively, whereas during the last three years of the programme, the couple protection steadily increased by about 2.5% each year.

The performance analysis revealed that the national averages were substantially lowered because of the relatively poor performance in the State of Uttar Pradesh, Bihar and Rajasthan. These three states which accord for a sizeable population of the country and have couple protection rate of less than 20% (Uttar Pradesh 16.7%, Bihar 16.8% and Rajasthan 19.3%) against the national average of 32. Madhya Pradesh and West Bengal had couple protection rate of 29%.

(ii) Seventh Plan Period

During 1985 to 1990, the targets and achievements made for different activities

were satisfactory (*Table II*). The performance analysis revealed that the targets were fully achieved for IUD insertions and exceeded in case of oral pill (OP) users, but performance of sterilization was short by about 24%.

Profile of FP Acceptors

It has been reported that about 70% of the couples accepting vasectomy and 82% accepting tubectomy have three or more living children. Almost 50% of the couples opting for sterilization had more than three children, while 85% IUD acceptors were having three or less living children. The mean number of living children were about 3.5 for sterilization and 2.3 for IUD acceptors. The large number of acceptors of terminal method having more than three children cannot produce significant effect on birth rate. The decline could have been expected only if couples had accepted terminal method after 2 children(9,10).

An all India survey conducted by Khan and Prasad showed that contraceptive prevalence rate was quite low below 25 years of age(11). The distribution of contraceptive methods by age groups indicated that only 28% couples adopt terminal methods below 25 years whereas this percentage was 57.5 in age-groups 25-29 and above. This highlights that in order to achieve couple protection of 60% by 2000 AD, special attention should be given to couples below 25 years of age. It was also found that the contraceptive prevalence rate in the age-groups 15-19 years and 20-24 years was only 5.7 and 16.0%, respec-

TABLE I--*National Demographic Goals*

Parameter	2000 AD	1990
Birth Rate (BR)	21 per 1000 population	29.1
Death Rate (DR)	9 per 1000 population	10.4
Infant Mortality Rate (IMR)	Below 60 per 1000 live births	87.0
Couple Protection Rate (CPR)	60%	42%
Net Reproduction Rate (NRR)	1	--

TABLE II--*Performance of Family Welfare During VII Plan*

	Target (in millions)	Achievement in (millions)	% achievement	Remarks
Sterilization	31.00	23.70	76.50	There was a shortfall of 7.3 million sterilizations
IUD	21.25	21.28	100.14	Target fully achieved
CC & OP Users*	14.50	15.94	109.93	Achievement exceeded the targets

*Indicates targets and achievements of year 1989-90.

tively, whereas it was 32.0% in the age-groups 25-29. These findings indicate that there is a substantial scope for increasing contraceptive prevalence rate in the age-group 15-25 years and marginal scope in case of other age groups. In younger age-group, it is difficult to increase contraceptive prevalence rate substantially through sterilization because of a majority of couples have one or two children and are newly married. These findings suggest that there is urgent need to promote spacing methods among younger couples which could have a significant effect on fertility rate.

Recommended Strategies for the Eighth Plan

The following strategies may prove useful for the Eighth Plan:

(i) The basic approach for the future should be to consolidate and strengthen the infrastructure already created under the Family Welfare Programme. The objective should be to make the infrastructure fully operational by removing various bottlenecks in funding, shortage of trained man-power, *etc.* Steps should be taken to improve the quality of services.

(ii) The spacing methods like IUD, CC and OP should be accorded the highest priority as means of protection. Nonetheless, sterilization should continue to be an important part of contraception.

(iii) Maternal and Child Health (MCH) Programme should be given a high priority. The MCH sector should be given priority and emphasis should be placed on its integration into the Primary Health System.

(iv) Tracing and motivation of programme personnel should be given high priority.

(v) Disaggregated area specific planning should be the cornerstone of planning strategy. Greater decentralization both in planning and implementation is envisaged involving State Governments and Local Bodies like Panchayats, Municipal Corporations, Voluntary Organizations, *etc.* effectively in the Programme. Special efforts should be made to strengthen infrastructure in the weak performing States. Some of the schemes under the Programme should be transferred to local self Governments keeping in line with the process of decentralized democracy.
An area specific approach should be evolved, especially for the four backward States of UP, MP, Rajasthan and Bihar. Integration of various sectors of family planning, MCH, IEC, Community participation, *etc.* should be done at the central point while preparing area specific plans.

(vi) States should be given adequate flexibility in setting their own targets in accordance with the goals and guidelines decided at national level.

(vii) The entire package of incentives and awards should be restructured to make it more purposeful by doing away with cash incentives to promoters and acceptors of Family Planning and the State Governments. These could be replaced by community

based incentives. MCH and Nutrition parameters can also be included for determining awards for communities. The possibility of introducing certain disincentives to the non-adopters of family planning can be considered. However, such measures should not contravene fundamental rights of the people.

(viii) Effective intrasectoral coordination should form an important part of the strategy. At the top policy making level, there is need to have a Cabinet Level Committee to ensure effective intrasectoral co-ordination. At the operational level, co-ordinated action by related sectors effecting skill building among women, female employment, female education, delaying age of marriage, their overall development, *etc.* should be ensured.

(ix) Innovative steps should be taken to involve voluntary agencies to make it a people's programme.

(x) To increase community participation, greater efforts should be made to create awareness among the communities of the services available so that they start demanding these services as a matter of right. The strategy should be to prepare the community to accept responsibility, ownership and control of the programme fully in the long run.

(xi) The IEC Programme started in the earlier Plans should be further expanded and strengthened especially, the intra-personal communication channels. Integration between health and family welfare sectors of IEC should be the first step in this regard. More innovative use of mass media channels especially TV and Radio should be ensured. The Ministry of Information and Broadcasting may be given the responsibility of putting across the message of various parameters to effect population control, general and social awareness of the people at large.

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NOTES AND NEWS

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Guest Editor – Dr. Vimlesh Seth

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