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DECEMBER 1970

OUR COVER

The family planning programme has to take into its fold maternity and child health services in order to make it attractive to the masses. The stress has to be not merely on a 'small family' but on a 'small and happy family'. The word 'happy' is not less important than the word 'small'. The whole programme, therefore, is envisaged as a family welfare programme.

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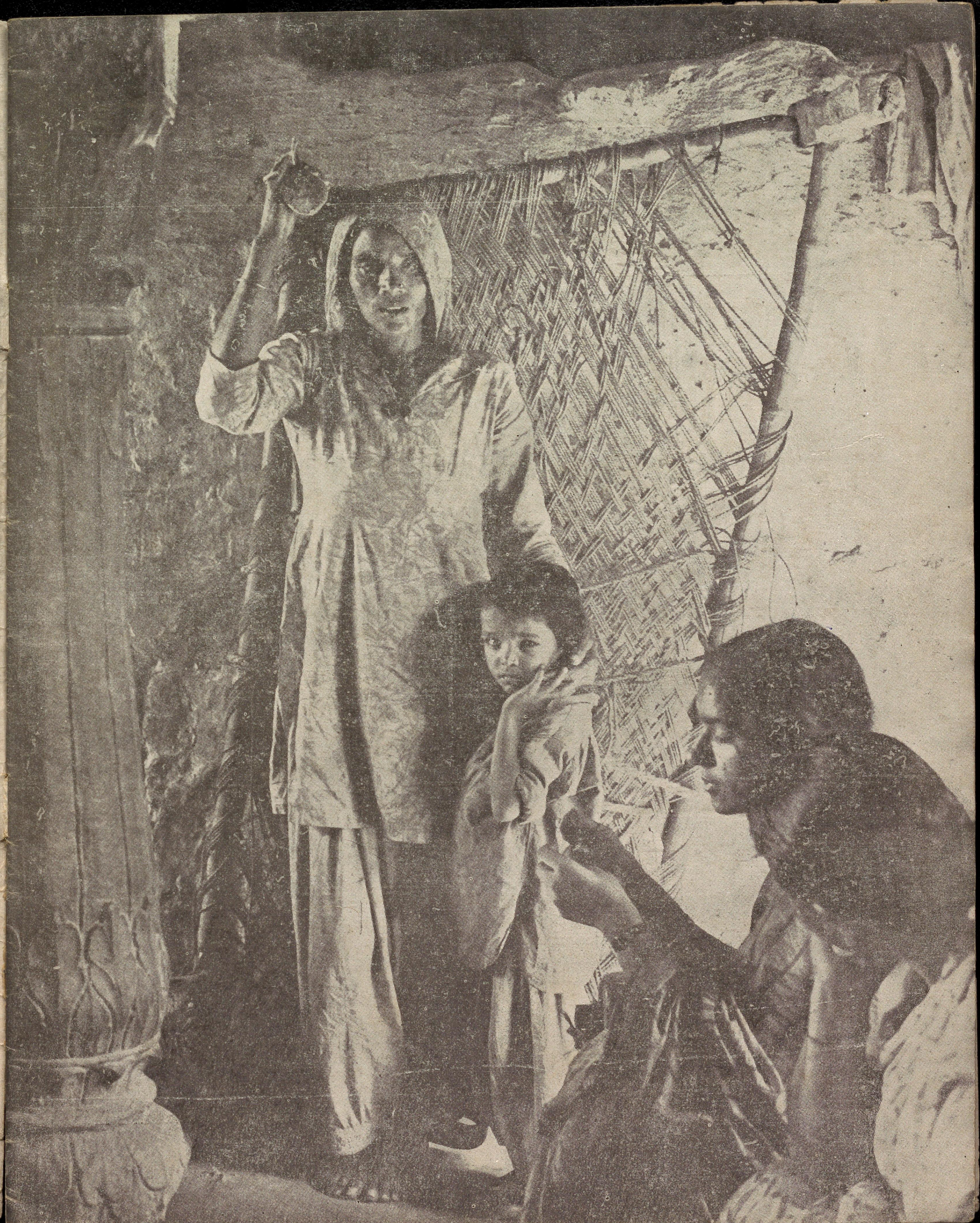


The efficiency of the Government machinery and the voluntary organizations will be the cornerstone of the achievements of family planning programmes but above all, the individual citizen by his practice of family planning will carry forward the sweep of the silent revolution and usher in an era of happiness for himself and prosperity for the country.

FAMILY PLANNING : A SILENT SOCIAL REVOLUTION

B.P. PATEL

THE United Nations Mission on Family Planning visited India last year. Naturally they were eager to find out at first hand the spread of family planning movement among the people. Passing through its streets or driving cross country they had adopted the practice of accosting an unwary pedestrian, a farmer driving a bullock or a herdsman tending the cattle. They questioned them as to what the pictures of the red triangle and four faces meant. Pat came the reply: "Reduce Children", "Plan Your Family", "Stop at two or three".

Almost cent per cent marks in the test.

High Awareness

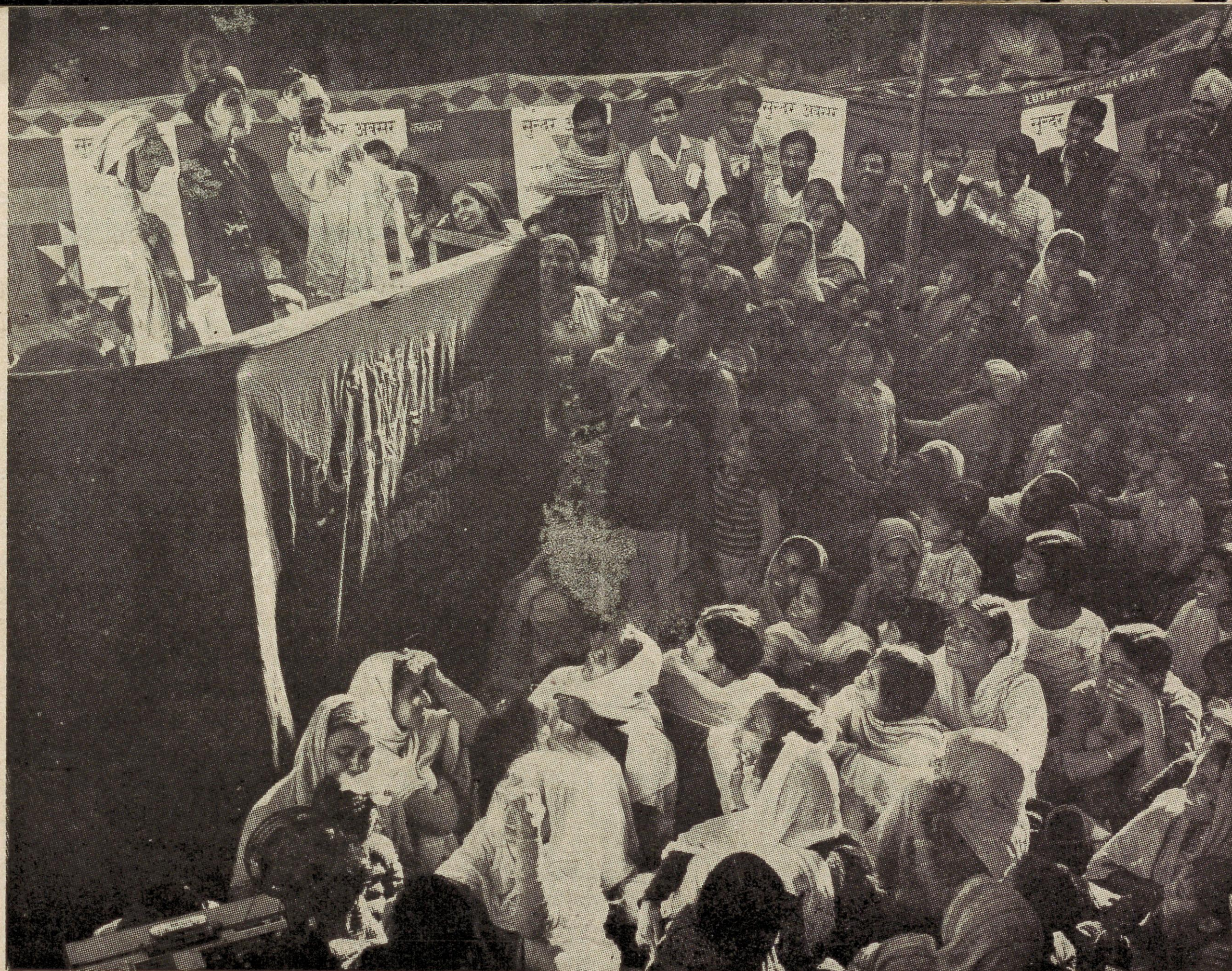
Scientific studies also indicate a high degree of awareness of family planning among the people. That in a vast country with difficult communications and 75 per cent illiteracy in rural areas inhabiting 80 per cent of the country's population, the message has already reached 90 per cent of the population is a very significant achievement.

Take another yard-stick. Of the three principal methods of contraception, namely, the sterilization, the loop and the use of conventionals, the response to sterilizations has been the most spectacular, although the Nirodh has, of late, been gaining increasing popularity

Response Akin to Social Revolution

By June, 1970, 7.5 million men and women had accepted sterilizations, 3.4 million women had accepted the loop and over 1.5 million persons were using conventional contraceptives, What is the implication of this large body of acceptors on the pattern of individual behaviour and social norms? That 7.5 million persons of whom 18.6 per cent are women have accepted the surgeon's knife as a solution to the problem of excessive child-bearing has in it all the elements of a great social revolution. For, implicit in the acceptance of sterilization is not only the consent of the couple, but a decision of the entire family and a blessing of the neighbourhood and the community of which they are members. This is a silent social revolution indeed.

A revolution by itself has, however, no meaning if it does not bring in its wave the intended benefits to the citizens and the community or usher in an era of happiness and prosperity heralded as its objective. What are the prospects of this consummation?



Puppetry is proving an effectiv e media in rural areas.

What is the strategy and constructive endeavour to achieve it? How fast (or slow) is the progress? Are our preparations commensurate with the Herculean task that is envisaged? These are the natural questions agitating the minds of many.

Three-fold Task

A noteworthy aspect of India's family planning programme is that it is an integral part of socio-economic development.

Ours was the first Government to give recognition to it as an officially sponsored programme. Nevertheless the progarmme has had to contend against the paucity of timely information on changes in the demographic pattern and the situation of rapid growth rate of population arising from the success of heal h measures for the contr l of communicable diseases. Moreover, the unexpected developments like the border wars re arded the pace of our progress. The Fourth Five Year Plan could not start as envisaged. Although the programme has gained momentum, since 1966 it had to be worked on a yearly basis, till last year. Our objective in the Fourth Plan is to bring down the existing birth rate of 39 per thousand population to 32 by the end of the current Plan, and to 25 in a decade's time.

The task which we face now is three-fold. In the first place it consists in the follow-up of over 10 million acceptors and continuous provision of the welfare facilities to them. Secondly, the tempo of the operational programme has to be mounted so as to cover an increasing number of acceptors from year to year.

A third, and by far the most vital task is to build up the infra-structure and motivation for the long-term haul during the current Plan period itself so as to lift-up the programme readily to the heights planned for the second half of the decade.

The Strategy

Such being our task, we have evolved a definite strategy to achieve the goal. The basic component

of this strategy is that the administrative structure for family planning has been sought to be integrated with that of health, medical care and maternity-*cum*-child health. At the base, it consists of at least one primary health centre manned by two doctors (one of whom would preferably by a female doctor) together with the supporting staff for each unit of 80 to 100 thousand population and a sub-centre for every unit of 10,000 persons in charge of an auxiliary nurse midwife together with, in most cases, a male basic health worker. The philosophy behind this arrangement is that the adoption of the Small Family Norm would depend a great deal on the faith of the parents that the children that are born have a good chance of survival.

The infra-structure of the programme is being strengthened at a much greater speed than ever before. Besides providing sanitary living and working accommodation and transport facilities for doctors and para-medical staff, special allowances have been extended to doctors in distant and disadvantaged areas. Incentives would include prospects for post-graduate studies and fellowships for advance training within the country and abroad.

Yet another important element of our strategy has been the development of the Couples Survey Register not only for purposes of identifying them for provision of services and motivation but also for follow-up. These Couples Survey Registers would give us the basic data for finding where the couples are and to make services available to them.

The programme being a voluntary one without any element of coercion, it envisages provision of approved and tested contraceptive methods to the people according to their needs. There is thus a free choice or a cafeteria approach where the couples can choose the methods most suited to them. The newly married couples have at their disposal the Nirodh. And, those who have had their first child could resort to the loop or to the pill and, last of all, those who have completed the size of their family of two or three children could accept sterilization.

In the initial phases of our programme stress was undoubtedly on the coverage of the high parity couples, *viz.*, couples with a large number of children. Sterilization suited them best. The emphasis has shifted to the coverage of low parity couples for the adoption of spacing, for sufficient interval between two births, is as much in the interest of the mother's health and the growth of the child as in the interest of the curb on the population growth.

In this connection it has been observed that the age of acceptors of various family planning methods has been progressively coming down. This is indeed a very heartening feature and augurs well for the future.

There is no doubt that the quality of the services that are being provided, especially by way of thorough check-up before the insertion of the loop and periodical follow-up thereafter, has tended to raise the use-effectiveness of contraception much higher than before. Intensive approach has been adopted through special inputs in 51 populous districts or divisions which have between them one-third of the country's population, by way of post-partum facilities in about 150 hospitals which have large attendance of maternity cases and additional incentives to employees in large industrial undertakings having a labour force of about 16 million persons.

Misconceptions Clarified

The progress of this comprehensive programme of behavioural change notwithstanding, fears have been expressed that family planning has not made much impact in rural areas and that some communities are keeping away from it. This is not true. Facts do not warrant such fears. For, two-thirds of the contribution to family planning comes from rural areas where 75 per cent of the population is illiterate and static services do not exist in large tracts inhabited by one-third of the rural population. The response of our rural folk in the light of these difficulties is commendable.

As for the acceptance of the programme by different communities, it is significant to note that all of them have been participating in the family planning programme. Its appeal is universal. In fact, absence of any organized opposition from any religious or social groups is a healthy feature of the Indian programme. If the object is to locate material variations in the incidence of the programme in the country they are found to be of a geographical character and are located broadly in the region of

Gangetic plain stretching from Uttar Pradesh and Bihar to West Bengal and Assam.

There has been some decline of late in the number of sterilizations. The fall in the loop cases has been halted. This has been more than compensated by the rise in the use of condoms (Nirodh). The net result is that the number of total contraceptors has been steadily on the increase. Their number stood at 3 million in 1967-68. It rose to 3.5 million in 1969-70 comprising 1.42 million persons under sterilization, 0.45 million cases of loop and 1.58 million persons practising conventional contraceptives. We have pitched our hopes quite high for the current year—more than double of last year's performance. What actually will be our achievement who can tell? We have no doubt, however, that the total achievement of the year will be significantly higher than in previous year.

Two Great Allies

However, in a programme of social change and particularly in one like, family planning, concerned with personal and intimate life of individuals, the participation of people is of paramount importance. In this connection, two of our great allies are the

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voluntary organizations—which are but an outward expression of the community's desire to help itself —and the organized sectors of trade and industry. Their involvement and participation have to be dovetailed into the official efforts at all levels. Voluntary organizations have already to their credit pioneering work in the field of family planning the world over. The contribution of some 400 such organizations in India is quite sizeable. Nevertheless, it has to grow in size, system and closeness of tie-up with official organs of Government. It is, therefore, very significant that of late, besides the Family Planning Association of India, we have seen the emergence of the Population Council of India, under the leadership of the Deshmukhs, and, lately, of the Family Planning Foundation of which Shri J.R.D. Tata is the motivating force. The Government welcomes the association of the voluntary organizations and will want to assist them in all ways possible to develop their activities. Their association would be essentially on the basis of partnership in a common task. Now that the Fourth Plan has been finalized it would be helpful if all the voluntary organizations involved in the programme, plan more concretely the scope and size of their participation for the Plan period so that the quantum of Government assistance could be related to the quantum of work undertaken by them.

The organized sector of trade and industry has been our valued ally in providing leadership to this great task of social awakening. We have initiated an articulate project for the involvement of the 16 million labour force engaged in the trade and industry in our country. Many of these organizations provide incentives to the workers who accept family planning. An important fact which should draw more and more of the organizations in the private sector to our programme is that the family planning expenditure is exempt from income tax. Undoubtedly the acceptance of family planning by our huge labour force would have an impact on its enhanced productivity in the works and better health and happiness at home. Voluntary organizations and the organized sectors of trade and industry hold indeed the key to the rapid spread of our programme.

Impact on Social and Cultural Life

The participation of the people in family planning programme of late has manifested itself in ever-increasing and pleasing forms. It extends to the social and cultural life of our society. This is evident from the great interest evinced by creative artists in representing the theme of family planning in their work and in interpreting current happenings in terms of the family planning symbol (the inverted vermilion triangle) and the slogan (*Agla Bachcha Abhi Nahi —Do Ya Teen Ke Bad Kabhi Nahi*). Recently a young lady from Delhi, Miss Neelam Badlani, made a flower arrangement on her own representing the theme "*Hum Do Hamare Do*" and won the first prize in a flower show. One cannot fail to be impressed by the way Abu, the cartoonist, presented the case of the small car with the slogan "*Bus Do Ya Teen Bachche, Chhoti Car Main Achhe*", nor by the clever design of the artist who accommodated the four faces of family planning in the advertisement of Eagle Thermos. More and more artists and poets, dramatists and musicians are turning their attention to propagate family planning through their original creations. This is most heartening because the artists mirror the social change. In our programme we have mobilized indigenous dance and drama troupes and the puppet parties and ballad singers in the countryside because it is our conviction that the best way to reach the people is through the media they are accustomed to. To mobilize support of opinion leaders in diverse fields we have recently started a mass mailing system to provide them printed literature on various aspects of the programme and the way they could help in making it a success as a real movement of the people.

Not Our Problem Alone

The problem of population growth has been recognized the world over. But our country was the first to officially introduce a massive family planning programme. This had to be so because while the population of more developed countries increased between 1920 and 1970 by 60 per cent and of the developing regions by 111 per cent, India's population during the same period rose by 120 per cent—251 million in 1920 to 540 million in 1970. Considering the fact that our population in relation to resources is already large, incomes are low and economic development a desperate need, the growth rate of 2.5 per cent has a severely crippling effect on our development. If this growth rate popularly known as "Population explosion" were to continue any longer, there is very little hope of raising the existing low standards of living, for the surpluses of savings and

I appeal to the vast labour force—both in public and private sectors—to plan their families so that, relieved of the undue burdens at home they and their families could devote increased attention to produce more effectively more goods and services for the larger good of the largest number of the people of India. The problem of poverty and unemployment has been intensified by rapid growth in the population of the developing countries which tend to outstrip the gains that have been made on the economic front. —*V. V. GIRI*

investment will be consumed by the millions of additional mouths to feed and of bodies to nurture every year.

Reversing Trend of Growth Rate

As observed earlier, the population problem has its origin partly in the success of our programme for control and eradication of major communicable diseases which reduced the death rate while the birth rate remained constant. The birth and death rates which stood at 41.0 and 15.5 respectively in 1966 have come down to 39 and 14 at the beginning of the Fourth Plan. The annual rate of decline in mortality and fertility seem to run parallel for some time now which means that the growth rate of the population has been halted. Further massive efforts are needed to reverse the trend in the years to come. In other words, we have to mount the family planning campaign to ensure that the decline in birth rate henceforth is faster than that of mortality.

Massive Effort and Investment Needed

A programme of the magnitude like ours needs huge investment of resources. Since this is a vital programme of national development the Government has assured a free flow of funds that might be needed. The programme has drawn the attention of many friendly countries and international organizations who have come forward with offers of assistance. In the Fourth Plan a sum of Rs 315 crores has been earmarked. However, another sum of Rs 15 crores has been provided under an agreement signed with the United States Agency for International Development subsequent to the India Consortium meetings held last year under the auspices of the World Bank. This additional component will be utilized in building up the infra-structure by way of buildings and residential accommodation for centres and sub-centres in the States of Uttar Pradesh, Bihar and West Bengal in the Gangetic plain and in intensive districts of other States. Specific provision is also earmarked to accelerate development in the fields of training, research and evaluation.

On with the Silent Revolution

Our programme is indeed a people's programme and in the coming years we have to strengthen its infra-structure, map out the whole country for coverage by the governmental and voluntary agencies and to utilize the resources to yield the optimum results. We will be concerned not merely with the quantum but also the quality of the work done. High professional standards will be maintained and research findings constantly fed back into the programme through an army of trained personnel so that our people get the benefit of the latest scientific advances and in the best manner possible.

Keeping in view the progress so far made and the very comprehensive nature of the programme, we have reason to believe that the objective of a reduced birth rate of 25 over the next decade is within our reach. The cornerstone of this achievement will be the efficiency of the Government machinery and the voluntary organizations, and, above all, the individual citizen who by his practice of family planning will be carrying forward the sweep of the silent revolution that has already begun into the homes of people so as to usher in an era of happiness for himself and prosperity for the country. □

A STUDY

EDUCATIONAL SIGNIFICANCE OF SOME MCH AND FAMILY PLANNING PRACTICES

DR B.S. SEHGAL

THIS paper is a review of about 15 studies undertaken in connection with attitudes of people in the Indian cities towards Maternal and Child Health and Family Planning Practices. Though the research validity of these studies is not strictly comparable, many of them have shown certain common findings which have significance for the educational aspects of these programmes. This paper has attempted to raise certain questions pertaining to educational aspects which need consideration for making comprehensive maternal and child health and family planning programmes a success. The paper is a modified version of the paper presented in a WHO meeting in New Delhi on comprehensive Maternal and Child Health and Family Planning Services in the Urban Medical and Health Institutions in India held from June 1 to 4, 1970.

Pattern of MCH Services

The pattern of MCH services in the cities varies from State to State. In the bigger cities there are big hospitals with good obstetrics, gynaecological and paediatrics departments. These are supported by Maternity Homes with beds for normal delivery as well as ancillary maternity and child health services. In many cities domiciliary midwifery services alongwith ante-natal, post natal and infant care is provided through MCH Centres. These services are made available through Government, Corporation or Municipalities or voluntary agencies.

In a study on 'Citizens and Hospital Administration' conducted by the Institute of Public Administration, New Delhi it was found that only 15 to 30 per cent of the women consult the hospital during the ante-natal period. Nine to 24 per cent do not consult anyone during this period. Hospital was still considered by the majority a place for treatment and not for advice to the healthy. Nearly half of the 1000 women interviewed preferred home delivery. Convenience and adequate facilities at home were mentioned as the main reasons for this. Nearly 24 to 41 per cent of the women preferred to have delivery by the *Dai*—trained or untrained. In connection with the infant and the toddler about 77 to 86 per cent did not consult anyone if the child was healthy and well. These findings point to a big gap between the availability of services and its utilization in the capital town of the country.

In cities like Bombay and Bangalore most of the deliveries are conducted in institutions. It is just possible that such deliveries being conducted in these institutions may be merely per force there being no other alternative available to the people in these cities. Not many studies are available in this country which could indicate the extent of utilization of the services in the hospitals and MCH Centres ; the characteristics of the people visiting these centres and the type and nature of problems encountered in providing these facilities. Need for such studies is imperative for the further growth of these services.

Relationship of MCH and Family Planning

These two services have a common focus—the welfare of the family and more so of the mother and the child. Small family norm will only take roots in the minds of the people if the children who are born are provided with all the preventive and promotive services so that they continue to live. Again spacing of births appears to be the most important component of all post-natal and infant care. MCH services start during pregnancy and should ideally last for five years after the child is born. It is during the entire period of pregnancy, puerperium and infant care that ideal conditions exist to teach the mothers the benefits of spacing and limitation. The MCH services can provide an ideal base for an integrated services to the family. It has been observed that in cases where contraceptives are not used during post-partum period and lactation period is cut short 82.5 per cent of the women would be pregnant before 12 months, after the first post-partum monthly period. It is certain that many of these women get pregnant against their desire for another baby so soon. How such mothers can be helped is a very important question for family planning services to explore.

Most effective utilization of these services require an understanding of the people's needs, interest and expectations from such facilities. Further extension of such services will need a systematic educational effort to get people's participation based on the above findings.

Family Planning Practices

Several studies have been carried out by a number of institutes in the country to know what city dwellers believe or do in respect of family planning. A few major findings of these studies are given below:

(*a*) *Ideal Family Size* as desired by the people is as follows :

Survey Agency	*Ideal Family Size*
National Sample Survey[1] (sixteenth round urban)	3.2
Bangalore City[2] (wife response)	3.6
Fertility Control through Contraceptives[3] (Government clinics in Delhi)	3.0
Indian Institute of Public Opinion[4] (Urban attitude towards F.P. 1967)	3.1

Further, in a study by the Indian Institute of Public Opinion in 1964, it was found that about 63.4 per cent of the national population did not want any more children. However, it is seen that though a large majority of people desire a small family, they usually end up with a much larger one. According to Bogue, both in urban and rural areas the actual average family size is between six and seven children per married woman above forty-five years of age. In the 1961 Census, the percentage of births, of sixth order and above, was estimated to be about 22.8 per cent.

(*b*) *Family Size and Nutritional Status*

According to the Annual Report of the Nutritional Research Laboratory Hyderabad, 1968 family size had a significant influence on nutritional status. Nutrient intake and growth rate of infant were adversely affected by family size. The incidence of kwashiorkor was more frequent in children of later birth order. The results of a study of the possible relationship between family size and prevalence of nutritional deficiency signs amongst pre-school children and pregnant women showed the following :

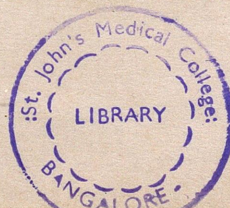
(*i*) Prevalence of deficiency signs were significantly higher in children of birth order of 4 and above as compared to children of lower birth order but was particularly marked in the case of Vitamin 'A' deficiency and protein malnutrition.

(*ii*) The average heights and weight of children belonging to lower birth orders of three and below were also significantly higher than those of higher birth orders in all age groups.

It was found that incidence as well as severity of anaemia in women whose order of pregnancy was more was much greater than in women whose order of pregnancy was three or less.

(*c*) *Knowledge and Use of Family Planning Methods*

(*i*) The Indian Institute of Public Opinion[5], New Delhi, carried out a survey in March-April 1967. The survey involved 1,021 urban and 989 rural interviews. It revealed that about 23 per cent of the respondents had not heard of family planning. Of those who had heard, 54 per cent had never practised it. About two-third of the



respondents in rural and urban areas having children did not want any more. According to its estimate 10 per cent of the people were using family planning methods.

(*ii*) In another study by the same Institute on "Urban Attitudes Towards Family Planning" in October 1967[4], carried out in eleven urban areas including Bombay, Calcutta, Delhi and Madras, it was found that almost every person interviewed (94 per cent) had not only heard about family planning but also believed such a programme was necessary for the country. Fifty-eight per cent of the people knew the location of the family planning clinics.

(*iii*) In the study on "Methods of Raising Effectiveness of Family Planning Through Hospital Care" (CFPI Monograph 5, 1969[6]), it was found that of the 200 women in-patients in the Lady Hardinge Medical College, New Delhi in the age-group 20—34 having income less than Rs 100 and on an average more than two living children, only 32.7 per cent had practised family planning at any time in their married life though all were aware of birth control.

(*iv*) In the study on "Attitudes Towards Family Planning"[7] in a Small Urban Community near Jaipur in 1964, it was observed that of the 217 persons interviewed 50.2 per cent knew of family planning and only 12 per cent practised any of the contraceptive methods.

(*v*) In the survey of knowledge of attitudes[8] towards and practice of family planning by the Indian Institute of Mass Communication in 1968, in which 169 persons were interviewed in Faridabad Town (Haryana) and 100 in a rural village Sihi, it was found that 65.08 per cent of the urban sample and 74 per cent of the rural sample had heard of family planning.

Another interesting finding was that 59 per cent of the rural sample as against 55.2 per cent of the urban sample were in favour of family planning. The practice status amongst those who had heard of family planning was about 22 per cent.

All these studies indicate a high degree of awareness and approval and a wide gap between knowledge and practice that needs to be filled up. The ideal family size of about three children is linked with the sex of the children and the general desire is to have two sons and a daughter.

Family Planning seeks to limit family's commitment : both social and economic. For each child that is born in a family there must be adequate provision for shelter, education, health and gainful employment. If this cannot be ensured immediately there is no harm in spacing births and in limiting the size of the families to such number as can be fully looked after.

—*K.K. Shah*

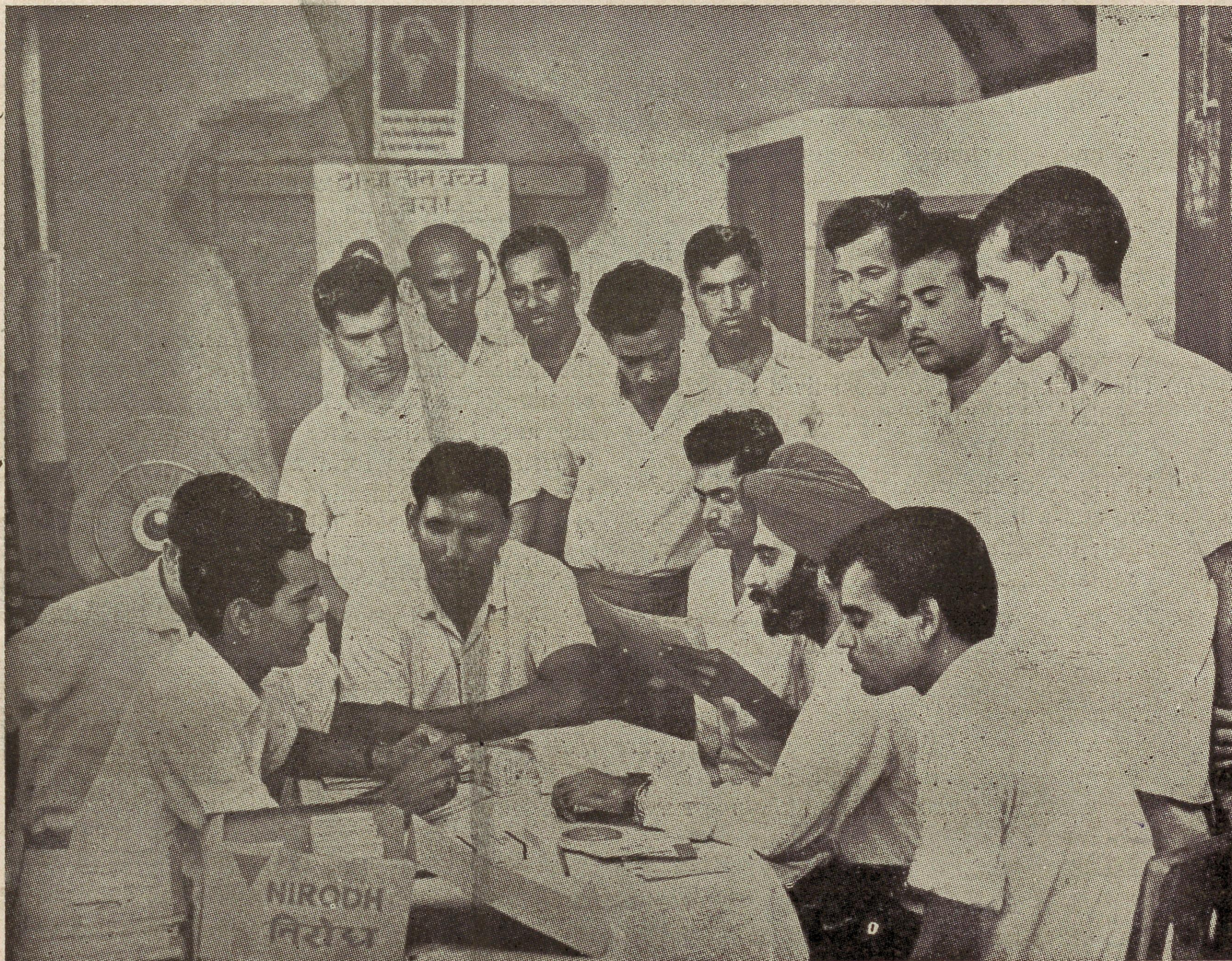
Among Government Employees

A study on Motivational Correlates of Family Planning Among Government Employees (CHEB Research Paper-7)[9] was conducted. The sample of the study consisting of 391 employees, was drawn from five Government offices in New Delhi. The sample was divided into Lower Occupation Status (Class IV category) and Higher Occupation Status (Class I, II and III). The findings showed that nearly two-third (65 per cent) of the respondents of the Upper Occupation Status used contraceptives and nearly two-third (62 per cent) of the respondents of the Lower Occupation Status did not do so. The latter category also started practising family planning relatively later. The desired family size between the users and non-users was the same, indicating the gap between desire and practice. Spacing and the threat to the mother's health were mentioned as the main reasons for those accepting family planning. Of the non-acceptors, only one-fifth were not interested in the programme; the rest indicated their willingness to try the methods later.

Condom was the most popular method used regardless of occupational status, though knowledge about the sources of its supply was poor. IUCD and vasectomy ranked nearly twice among the users of the Lower Occupational Status as compared to other category. Tubectomy was least frequently practised among all users.

Studies on Medical Practitioners

'A socio-medical survey on practice of birth control among medical men'[10] was done as early as



Nirodh is being extensively popularized through subsidized sales and free supplies.

1951. Out of 189 physicians interviewed, 82 per cent reported use of some family planning methods. Average number of children in the sample was 3.6. Coitus Interruptus was the method preferred by most. A study on the Conviction of Private Medical Practitioners[11] about family planning and their performance in the promotion of family planning practices (CHEB March 1970) was conducted. Fifty practitioners in the age group 41—60 were studied. A large number of them (56 per cent) desired a maximum of two children and the rest three. Actually, however 60 per cent of them had three or more children. Nearly all (96 per cent) had used family planning methods at one time or the other. Amongst the methods used by them, condom (48 per cent), pill (8 per cent) and tubectomy (10 per cent) were mentioned. Forty-three practitioners, however, advocated vasectomy to their clients, though none had got it himself. Thirty-two practitioners advocated pills to their clients though only four preferred it for their own families. Condom was, however, used and advocated by an equal number of practitioners.

These studies indicate that even medical men who are best acquainted with the methods are not able to keep their family size to the desired level.

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The faith in the methods preferred by them has implications for the general public.

Studies of Industrial Workers

The Family Planning Association of India[12], Delhi Branch, conducted a study in September 1967 which revealed the following :

(*i*) Seventy per cent of these workers were in need of family planning services.

(*ii*) A majority of these workers were immigrants from as many as ten States of India.

(*iii*) Ninety-six per cent of them lived in nuclear families and the size of their families ranged from two to 12.

(*iv*) Nearly 90 of the workers desired spacing of two and a half to three years between each birth; the actual average spacing, however, was only 1.5 years.

(*v*) 76.38 per cent of the couples expressed one to three children as an ideal size of the family whereas in actual practice the number of couples with this size came to 44.55 per cent.

(*vi*) Vasectomy, condom and IUCD were the popular methods accepted by workers.

Family Planning Association of India at its Headquarters at Bombay undertook comprehensive work in 56 industrial units in Bombay between July 1967 and September 1968 covering a population of 111,700. An impressive case load of 8,436 including 1,504 (18 per cent) sterilizations was achieved in about 15 months. The interest of the Indian Chamber of Commerce; Voluntary participation of workers and their leaders and additional monetary incentives have been responsible for this. Industrial workers form a sizeable group in many towns. Special educational-*cum*-service programmes are needed to tackle this group effectively.

Motivation and Communication Aspects

Not many people have studied these factors in depth.

The maternal and child health services (MCH) constitute an important part of family planning programme. The MCH Services aim to ensure that every child receives adequate nourishment, health supervision, efficient medical attention and that every expectant and nursing mother maintains good health, knows the art of child care and bears healthy children.

The question of family planning is one of very great importance. It is necessary as a social obligation in the present circumstances of India and for the health and happiness of the family. The growth of the population is intimately connected with our strategy for development in India.

—JAWAHARLAL NEHRU

In a CFPI study[13] about Adoption of New Contraceptive in Urban India, 3 colonies in New Delhi were surveyed for IUCD Programme. This study deals with the diffusion of the process of IUCD acceptance of 182 users. Most of the families belonged to the educated modern group of the working and middle classes.

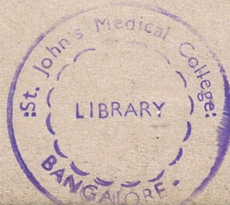
The main findings show that as compared to husbands, more wives first become aware of the innovation. They also took more initiative in collecting additional information on the device. Considering both the stages of 'awareness' and 'interest' together in relation to the use of different communication media, it was found that personal sources were most intensively used by wives and mass media were the least important to them. In case of husbands, mass media were important at the awareness stage and personal sources were more relied upon at the interest stage. The data also indicated that both the wife and husband were involved in the decision making. Only in the case of 7 per cent of the cases, the wife made the decision, took the advice and informed the husband later. In about 50 per cent of the cases, where both were involved the wife made the final decision and in about 45 per cent cases the husband played this role. In about 66 per cent of the cases, users were consulted either by the wife or the husband; in two-third of such cases this was done by wife. About 80 per cent of the respondents were using or had used some other method before accepting IUCD. Another interesting finding was that the majority of respondents had high aspiration for their children's education (96.5 per cent); were reading printed mass media (74.4 per cent); had modern ideological orientation to life (61.6 per cent) and were having a non-ritual religious orientation (46.8 per cent).

In the study of Motivational Correlates of Family Planning[9] by CHEB, it was found that while both users and non-users were concerned about their children, the users of family planning methods were more pre-occupied with better upbringing of children and achievement of long-term and short-term material goals. The non-users, on the other hand, were more concerned with maintenance of their present economic status. Amongst the major concerns for the future, both the users and the non-users were worried about ill health. It was significant to know that while people think about their happiness and aspiration, health is not mentioned as a priority goal, but when people were asked about their major worries and fears, health became important. It was also found that users of family planning were relatively more concerned about family relationship, improvement of standard of living and opportunities for achieving significant material goals. On the other hand, non-users were relatively more concerned about the unemployment, debt and poverty. The study also collected level of striving which suggested that users were relatively high strivers than non-users. Economic concern has been found to be a major factor in family planning acceptance in many other studies as well.

Leadership Involvement

Not much information is available about leadership participation in the urban family planning programme. Some of the experiences of CHEB in its urban field areas are as follows:

1. Leadership in the area was found to be individualistic, everyone being a leader for himself.
2. In a population of 10,000 only 53 leaders could be identified. Of these only 15 were found to be interested in the programme. Ten of these 15 were women.
3. Formal leadership was based on political affiliations. They had neither time nor interest in the programme. Only activities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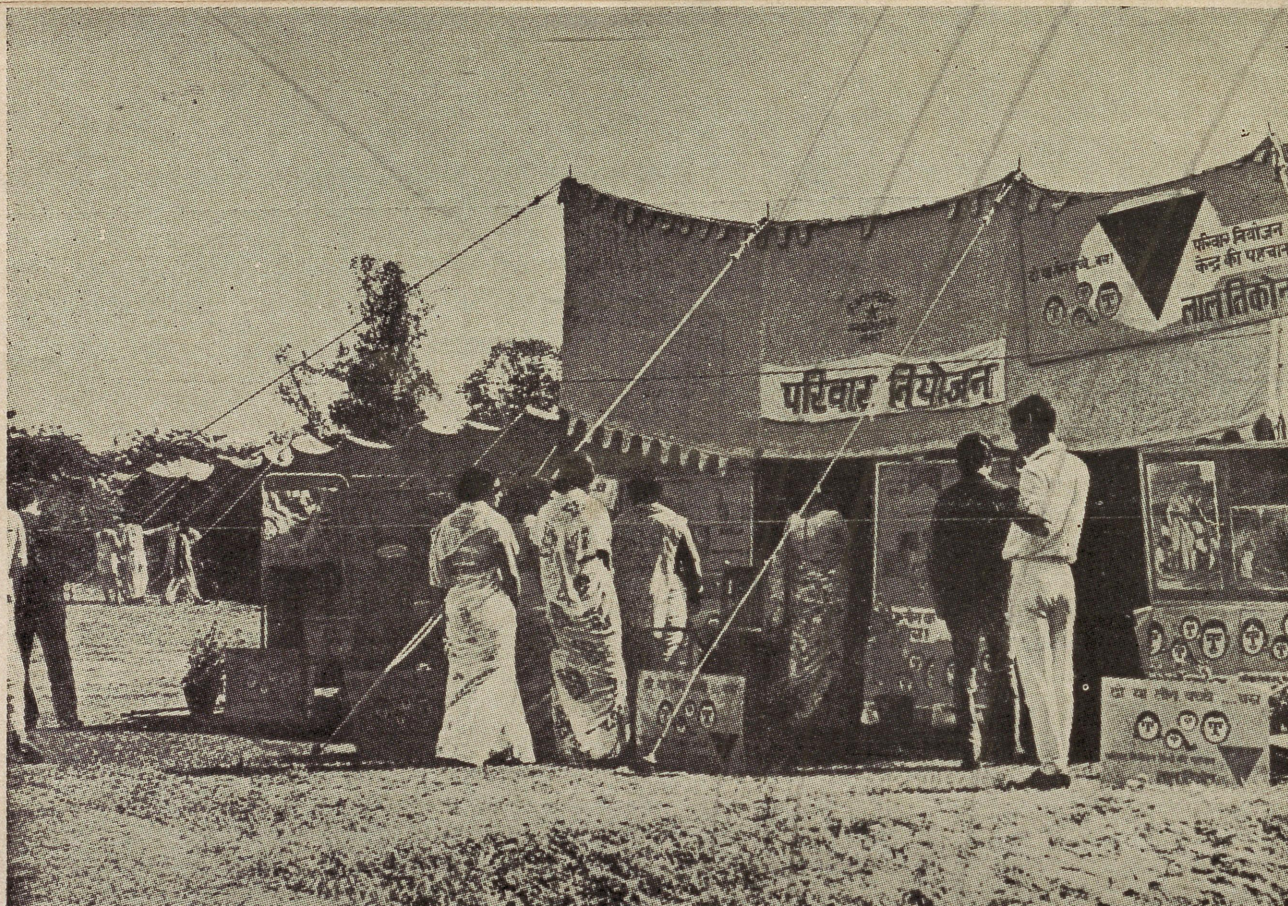

The camp approach is being used increasingly. Besides providing services at a central place, this approach creates a climate for wider social approval.

which gave economic gains or prestige were undertaken by them.

4. Women leaders took more interest and devoted time and effort for activities organized in their areas. Linking family planning with such programmes like nutrition education, child care, maternal health and observance of certain festivals sustained interest of women leaders. A few of them worked as depot holders.
5. Contacting male leaders—who remain very busy—by workers was extremely difficult.
6. Influence of social pressure for motivation was rather limited.
7. Class distinction was found more predominant than caste distinction. Persons with high income did not like to move amongst poorer sections.
8. A great reluctance was observed in disclosing information to friends and neighbours about income and use of family planning methods.
9. Persons from higher and middle income groups were hesitant to accept permanent methods; perhaps because of availability of abortion services and their capacity to afford and avail these services.
10. The process of decision making was confined to the husband and the wife and even other family members were rarely consulted. At times satisfied acceptors played a significant role at the time of decision making.
11. Permanent methods were adopted in several cases whenever there was an unwanted pregnancy.

Awareness not leading to motivation is a waste of communication effort. Though studies have indicated a general superiority of personal communication for motivation over mass media, some of the studies have shown the effectiveness of such mass media as radio, film, literature, etc., at intermediate stages of decision making.

There are some general conclusions which can be drawn from all these studies. They are:

1. There is very limited use of MCH facilities in the cities and the factors responsible for this are not known.
2. Though there is a large-scale awareness about family planning the knowledge about methods is limited.

3. A wide gap exists between desired family size and actual practice of contraceptives.
4. Extent of practice and preference of such methods as condom, jelly and pill in the higher status and vasectomy and IUCD in the lower occupational groups in the urban areas was seen.
5. Doubts, fears and hesitancy prevail on the part of a large number of people to try the methods advocated.
6. Differences exist in the future hopes and aspirations of the users and non-users.
7. Ill-health leading to serious economic consequences is a major concern and worry of the urban middle class.
8. It is the couple who makes the decision in most of the cases and the wife has a major say in it.
9. There are limitations of leadership participation and use of social pressure for motivation.
10. No use is being made of knowledge in the general health and nutrition field for educating people to have small families.

Some Educational Problems

1. Need for depth studies to find out reasons which prevent people from accepting MCH and contraceptive services in the cities. To highly motivated group simple information may suffice; but for non-acceptance due to deep-rooted hesitation and fears, it is necessary to know the cause of such fears for proper educational and counselling efforts. It is essential to know the positive and negative motives of the majority of couples who are hesitant though desirous of using MCH and family planning services.

2. Studies of communication methods and techniques for effective educational planning to suit the diverse socio-cultural groups; their needs, interest, aspirations and expectations.

3. Studies of problems related to leadership role and participation in the urban programme to draw out an educational methodology.

The above group of studies will be needed for planning "What & How" of Education.

4. Need for effective training of family planning and MCH workers in :

(*a*) Conviction and faith in contraceptive methods and with possibility of achieving programme goals through education and motivation.

(*b*) Thorough knowledge and understanding of the health and nutritional needs of a family and its relationship to family income, family size, child and family welfare, etc.

(*c*) Ways and means of getting community involvement in MCH services which is utterly neglected at present.

(*d*) Knowledge of health education concepts and principles and skills to diagnose and tackle common barriers of acceptance through systematic educational efforts.

5. Dichotomy of family planning and MCH functions in the minds of the workers and the clients and in the actual implementation of these programmes.

6. Negative factors for non-acceptance like dissatisfied use; service quality and staff behaviour need to be identified and properly met.

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"Attention has to be devoted to the extension approach. It is the extension approach that will take the family planning programme to the grass-roots in the far-flung areas of a State like Rajasthan which is still backward in many respects", said **Shrimati Sumitra Singh,** *Rajasthan's Minister of State for Family Planning in an interview with* **Swasth Hind.**

FAMILY PLANNING CATCHING UP IN RAJASTHAN

MANY families with large number of children are unhappy and some families without any child are unlucky. "To make all families happy, healthy and economically viable or better, family planning is a "*must*", says Shrimati Sumitra Singh, Rajasthan's Minister of State for Family Planning.

In an interview with *Swasth Hind*, Smt. Singh affirmed that family planning does not mean restricting "the number of babies alone; rather its purpose is to ensure the total welfare of the individual members constituting the family".

Extension Approach

Shrimati Singh is convinced of the extension approach of educating the people and winning them over to the philosophy and goals of the family planning programme. Health, sanitation and other aspects of medical services should be taken up as a whole and linked up with family planning.

"Our approach to the population programme should be an integrated one.... Nobody is prepared to listen if an exclusive idea of family planning is intended to be conveyed to the people. It is the extension approach that matters most", she says.

"If family planning has to take grass-roots in the far-flung areas of a State like Rajasthan" she says emphatically, "extension of medical services has to be strengthened. Family planning programme cannot be isolated from the health and medical programmes."

Shrimati Singh feels that the acceptability and adoption of family planning do not depend on official trumpet alone. "Harnessing non-official agencies and voluntary organizations is very important. To ensure better results we must coordinate and integrate our activities with other welfare programmes".

Changing Human Behaviour

Ready acceptability of any idea or programme in a country bound by tradition and conservatism according to her, is not possible. This is especially so in Rajasthan which has been subject to feudal rule. Even in programmes where the results are spectacular within a short period or are demonstrable, people

do not easily accept them. Citing Community Development Programme, as an instance, she says that though the programme was launched to revolutionize the rural areas, it took time to have its impact on the masses. Of all the changes, change in human behaviour is the most difficult.

"Naturally in a programme like family planning", she says "men and women have to be tactfully persuaded on the question of its adoption. Ultimately, it is the individual men and women who have to accept the programme and it is they who are to be convinced. Temperament, psychology, individual outlook, local environments, habits, customs and a host of other factors exercise a great influence in the acceptance of any new idea or the programme.

Indigenous Media

"It is in this context", she says, "mass communication plays a vital role in changing peoples' attitudes and behaviour". While the mass media programmes have made good impact in Rajasthan, the extension approach under the family planning programmes needs to be fully vitalized. The traditional media like folklore, folksongs, *Hari Kathas*, *Bhajan Mandalis*, puppet shows, songs and dramas with a discriminate dosage of family planning should be utilized in the rural areas.

She said that in spite of certain bottlenecks Rajasthan has made good progress in family planning. The Programme is gradually catching up. She said since the inception of the family planning programme in 1965-66, nearly one lakh IUCD insertions had been carried out. While this is particularly noted in rural areas, people in more advanced areas of the State have already shown considerable interest in the programme.

The special drives and campaigns have recorded impressive results as could be seen from the ever increasing achievements. During the Family Planning Fortnight in September last year, 7,833 sterilizations were performed and 2,791 women accepted IUCD. A unique feature of the programme, according to Smt. Singh was the competitions organized for the *Panchayat Samitis* in showing results. This had its desired effect.

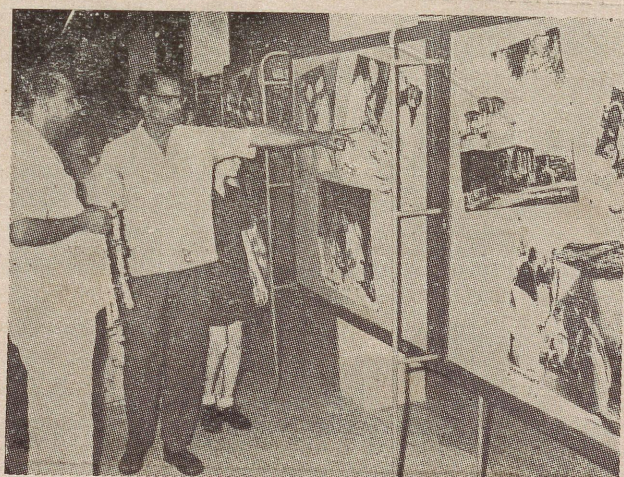
"The use of conventional contraceptives is also gaining momentum. The number of users has gone up to 600 per cent by the end of 1969-70 as against the base year 1966-67. Over 5,130 sterilization operations were performed during the first quarter (April to June 1970) of the current year. The number of insertions (IUCD) during the same period was 3,260."

Depot Holders' Scheme

Nirodh as a convenient and easy method is being popularized in the rural areas, she says. So far 624 Post Offices have been registered in various areas of the State under the Depot Holders' Scheme, she added.

"While, the Intensive District Programme introduced in Udaipur in 1969-70 has started yielding good

Some panels in the Family Planning Exhibition organized by the Rajasthan Family Planning Bureau at Jaipur.



Demonstrations with the aids of models help women understand the contraceptive techniques.

results, plans are being finalized to cover Jaipur District this year."

"Incentives to the workers are being given by way of commendation certificates, prizes, etc., to whip up their enthusiasm. Awards to best family planning workers and institutions create and sustain competitive spirit among them."

Smt. Singh says that the "nation-wide family planning programme has picked up good momentum in our country in the last few years. Rajasthan is no exception to this. And we will certainly make every effort to make the family planning a social movement. A vast section of the people have started realizing an imperative necessity of restricting birth rate for individual and collective betterment". "It is the family welfare programme, the total welfare of all the members of the family, that needs to be stressed."

In a mood reminiscent of the crusader in her, Smt. Singh says: "We have undertaken a gigantic task towards the vital interest of the human beings at large. We should not rest on our oars till we accomplish our goal. Otherwise, this huge tidal wave of increasing population will totally sweep us away."

Group discussion on family planning in a far-flung village in Rajasthan (top). A Qawali function as part of family planning campaign (below).

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FAMILY PLANNING IS PLANNING FOR FAMILY HEALTH

A WHO Scientific Group on the Health Aspects of Family Planning which met in Geneva in June 1969 agreed that the health impact of family planning occurs primarily through the following effects on human reproduction:

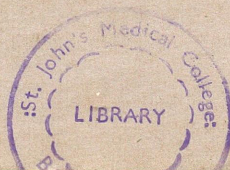
- the avoidance of unwanted pregnancies and births, and the occurrence of wanted births that might otherwise not have taken place;
- a change in the total number of children born to a mother;
- variation in the intervals between pregnancies; and
- changes in the time at which births occur, particularly the first and the last, in relation to the age of the parents, especially the mother.

How Unwanted Pregnancies Affect Health ?

From the viewpoint of health, abortion outside the medical setting is one of the most dangerous consequences of unwanted pregnancies; mortality and immediate morbidity risks are high; much less is known about the long-term effects for the woman and for other members of the family. However, where pregnancy can be terminated legally for social or personal reasons, as well as on medical grounds, mortality rates directly related to termination are in general very low, short-term morbidity varies, and long-term morbidity from induced abortion has so far not been assessed. The unmarried mother and her child, face significantly higher heal h risk than the married mother and her child—even when allowance is made for socio-economic factors. In New York City, from 1955 to 1959, maternal mortality and morbidity rates for out-of-wedlock births were as much as nine times higher than the rates for legitimate births. There is evidence of a higher incidence of mental disturbance among mothers who have had unwanted pregnancies. This may, however, be due to the occurrence of a higher rate of unplanned pregnancies in women already disturbed.

Effects of Pregnancies and Births

While maternal and mortality risk is slightly less with the second and third pregnancies than with the first, it rises with each pregnancy beyond the third and increases significantly with each pregnancy beyond the fifth. A study in India, in an area with a maternal mortality rate of 10 per 1,000 live births and where the average number of pregnancies was more than eight shows that the mother has about one chance in ten of dying in childbirth eventually. Clinical impressions and some studies suggest that nutritional deficiency in the mother, resulting in anaemia, calcium deficiency, and difficulties in breast-feeding the child, is associated with high parity that is, a greater number of children born to her. Several studies have also documented the highly significant correlation between increasing foetal death rates and the number of pregnancies. Several other studies have shown a higher risk of death from infectious disease for infants born into families that are already large; this may be accounted for, at least partially, by the increased risk of cross-infection. Attention has also been drawn to the relationship between high parity and problem families; a particular problem is deprivation of maternal care.



Beneficial Effects of Spacing

Spacing is considered to refer to the interval between conceptions and births. Late foetal and neonatal mortality rates have been reported to be lowest when the interval from the termination of one pregnancy to the beginning of the next is between two and three years. A progressive rise in infant mortality as births intervals decrease has been demonstrated. Epidemiological studies in India showed the highest infant mortality rates where the birth interval was less than 24 months. This trend was particularly noticeable during the neonatal period. The incidence of diarrhoeal disease, the principal cause of death in developing countries during the first two years of life, is clearly associated with poor weaning practices, and early weaning often follows a short pregnancy interval. The ensuing malnutrition, which reaches its peak during the second year of life, is also related to the high incidence of other infectious disease during this period.

Timing Involves Risks

Timing refers to the time at which births occur, particularly the first and the last, in relation to the mother's age. Generally, the risk of the mother dying increases below the age of 20 and above the age of 30—35 years. In many countries complications of pregnancy and delivery show the same pattern of risk, with the highest rates below 20 and over 35 years of age. A study in India has shown the risk of foetal loss to be of the order of 105—125 per 1,000 pregnancies in the 30—34 age-group, but rising rapidly to more than 200 per 1,000 pregnancies for women in their early forties. A number of congenital anomalies are associated with advancing maternal age. For instance, Down's syndrome, often referred to as Mongoloid idiocy, has an incidence of about one in 2,000—2,500 live births; this rises to one in 300 for mothers aged 35—39, and becomes progressively more frequent, the incidence being at least one in 50 and possibly as high as one in 35 in the children of the very oldest mothers.

Genetic Effects of Family Planning

In the presence of certain serious hereditary disorders, the successful use of birth control methods may prevent illness and suffering. Genetic counselling may be offered as part of family planning advice. Genetic counselling should not be equated with advising people not to have children. However, a possible long-term effect of counselling is a decrease in the frequency of certain genetic conditions in a population. Family planning practices may also have other long-term genetic consequences, although these are still largely a matter for speculation.

Birth Control Methods and Health

In addition to their action in the regulation of pregnancies, that is, timing, spacing, and number, birth control methods and procedures may also produce side-effects that have a direct impact on the health of the individual. Methods of births control involving surgical procedure may carry a risk to life. However, reported mortality rates for tubectomy or interruption of pregnancy performed in an adequate medical setting under general anaesthesia are very low. Where maternal mortality rates are relatively high, as in many of the developing countries the risk from birth control is less significant in comparison with the risks associated with pregnancy. Mortality from illegally induced abortions far exceeds mortality from the use of contraceptive methods. Although there is at present no evidence that harmonal steroids or intra-uterine devices (IUDs) have a carcinogenic effect, or that any method has harmful effects on future fertility, these questions are under study and require continued surveillance.

Certain common side-effects are associated with many methods of birth control. Their incidence may be influenced by the women's general level of health and nutritional state and by the co-existence of certain disease conditions. In many instances, the severity and range of side-effects are greatest in the period immediately after the introduction of a method

We shall always bear in mind, in extending our activities, the fact that WHO's responsibilities in regard to human reproduction and family planning are concerned, above all, with promoting family well-being. As we see it, family planning is valid only if its essential objective remains that of ensuring the survival of the mother and the child and their happiness within the family. *—Dr M.G. Candau*

and tend to diminish subsequently. The continuation of any of the common side-effects may make it necessary to abandon the method for health reasons. In general, as with mortality, the morbidity associated with the use of methods of birth control should be compared with the morbidity—and mortality—from unwanted pregnancies and their possible consequences.

Impact of Family Planning on Family Health

Many of the intricate questions involved in assessing how and to what extent the changes in reproductive performance brought about by family planning will affect the health status of families can be definitely answered only in epidemiological studies that seek to determine casual chains and interactions. The relevant studies may require laboratory work, clinical studies, epidemiological investigations, administrative research, action research, and operations or systems analysis. Much of the work will be of an inter-disciplinary nature.

Needs for innovative approaches to family planning in health services prompted the World Health Organization to stimulate and support field research projects during the past years. Studies under way are aimed at evaluating the relative merits of different approaches to the provision of family planning care in the context of comprehensive health services for mothers and children in rural areas, and the tasks and training of various categories of health auxiliaries for integrated family planning. Another field project tries to assess the impact of intensive child care on acceptance of family planning. It examines the hypothesis that parents will be more willing to space and limit family size with an assurance of child survival. Operations-research methodology constitutes an important part of these studies; such scientific evaluation should help to translate research findings in to practical improvement of field service and training programmes. *—WHO*

MANDATE OF W.H.O.

The resolutions of the World Health Assemblies of the past few years have defined WHO's role in the area of family planning. They enable WHO to advise governments, upon request, in the development of health programmes concerned with family planning services. The resolutions emphasize that activities in the health aspects of family planning should be included as part of the health services and that family services, where introduced, should not impair the normal preventive and curative functions of health services. WHO does not endorse or promote any particular population policy, recognizes that the problems of human reproduction involve the family unit as well as society, and that the size of the family is the free choice of each individual family.

WHO has received many requests for assistance in the health aspects of human reproduction and family planning. Almost all of these requests are concerned with the introduction, the integration and the development, of family planning health services in general health services, and the Organization is actively fulfilling its responsibilities in this regard.

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The training programme for the MEIOs is based on the principle of 'learning by doing'. The entire programme has laid emphasis on specific job needs of the MEIOs and on the maximum involvement of the trainees.

Preparing For Communication Task

D. LAKSHMINARAYAN

IT was well over 9.00 p.m. on July 17, 1970. There was light in a lone building in the locality which was gulfed in darkness. Inside this building Central Health Education Bureau, New Delhi—four groups of nine officers each were engrossed in work, unmindful of the hours passing by and unconcerned about their dinner getting cold. Indeed, their task was not an easy one. They were working on a report of their field work, to be presented the following morning before an audience comprising specialists in health education, mass communication and extension education. This was, however, not an isolated evening of hard work for these officers. For the past thirteen days, they had virtually been racing against time in completing their jobs. Yet, their keenness to learn and demonstrate this learning through a practical assignment in the field, in a way, revealed the priority programme—family planning—for which they were working.

Who were these officers ? And what were they upto ? All these officers except three are working for the family planning programme as Mass Education and Information Officers (MEIOs) in different districts of Madhya Pradesh. The other three were : one officer from the Railway Board, New Delhi, and one each from Afghanistan and Nepal. These officers were participants to the Third Training Course for Mass Education and Information Officers, organized from July 1 to 18, 1970, by the Central Health Education Bureau (CHEB), and the work they were engaged in formed part of this training programme.

Conscious of Their Goals

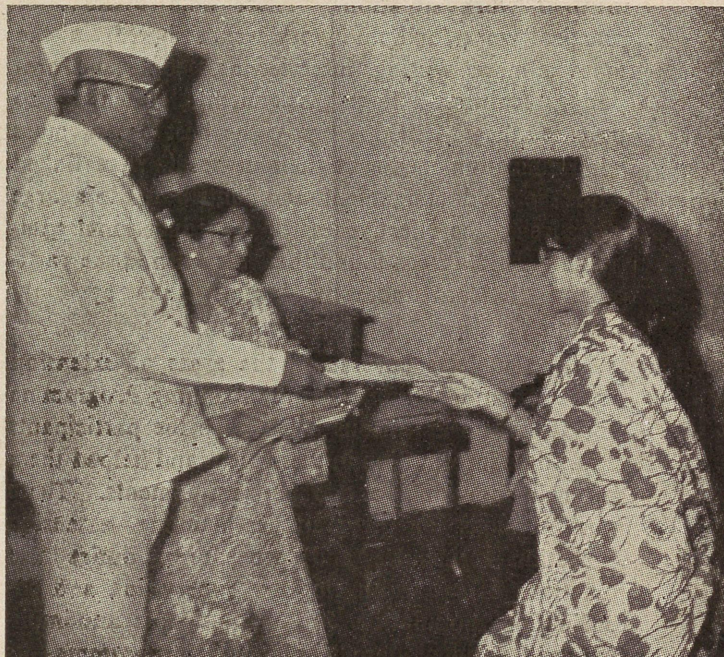
"Family planning is more easily talked about than practised. The urgency of making the people accept the programme pre-supposes availability of a band of dedicated and well-trained workers. And, among the workers to be trained, the communicators should obviously come first", one of the participants remarked. And all others shared this feeling and made efforts to benefit the maximum from the training.

This training programme, as the two previous ones organized by the CHEB for the MEIOs, had its basis on the principle of "learning by doing". The training was aimed to let the participants, after being exposed to the theory, by themselves demonstrate the extent to which the theory could be put into practice.

"The entire training has been designed", said Dr (Mrs) P. Anand, Deputy Assistant Director General (Training), CHEB, and coordinator of this course, "with emphasis on specific job needs of the MEIOs, and it seeks to achieve maximum involvement of the trainees. The training is job oriented and skill-focused".

The training programme for MEIOs, as evolved by the Bureau, is built on the duties and responsibilities of these officers. The training schedule is worked out after analysing the different job responsibilities of these officers which can be grouped under three major areas : mass communication for family planning, National Family Planning Programme and Extension Education. During the third course, as many as 35 one-hour sessions were arranged to cover the various aspects of these subjects, in a matter of fifteen working days.

The participants welcomed this comprehensive learning opportunity, but expressed concern over the short duration. Shri D.C. Dashottar from Ratlam District, was echoing this feeling of the participants when he said that 15 working days "are rather too few" to enable the participants, coming as they did from different backgrounds, "to digest the fund of knowledge provided by a host of experts". And yet, once the course was on, the officers enthusiastically utilized the many learning opportunities provided in class sessions and in the field.



Shri B. S. Murthy awarding certificate to a trainee.

Teams Go To Field

A noteworthy feature of this course was a practical assignment in the rural field and demonstration area developed by the Bureau in Pataudi Block of Gurgaon District, Haryana. Indeed, this was yet another step taken by the CHEB to make its training programmes meaningful and practical. In the first training course for the MEIOs, emphasis had been laid on defining the activities of this category of officers and selecting the training content and methodology of delivering them. The second course gave the trainees an exposure to a field situation other than their own and see for themselves the family planning programme in operation. The MEIOs visited the intensive family planning district of Gurgaon in Haryana and spent a day there. They also visited the Pataudi Primary Health Centre and one of the sub-centres of this block and held discussions on the programme operation with the district, block and other staff. This time, the participants to the Third Training Course spent six of the 15 working days in the Pataudi Block. They planned, implemented and later evaluated an educational campaign, which was given as a major assignment to them.

To work on this educational campaign, the participants were divided into four groups. Five villages were selected for implementing this campaign. Each group had one woman MEIO (there were four in the batch), to make it easier to reach the women in the rural community. The field assignment gave the MEIOs a "real feel" of the field work. "Such an experience has been extremely useful to us. This exercise has revealed that if the educational efforts are related to specific needs of the community, the impact is surely greater", many of the participants stated.

The importance attached to such a field assignment for the MEIOs was emphasized by Dr B.S. Sehgal, Director, Central Health Education Bureau, during his address to the trainees. Dr Sehgal said that this project work was designed to help the participants concentrate their efforts on the specific tasks before them, and use in the field situation the theory learnt in class sessions.

Individual Assignments

The trainees were given a number of individual assignments too, in the area of mass communication. This is sure to be of significant use to the participants

in their work situations. There were sessions of practical work (or home work was assigned) in the areas of news writing, interviewing people and preparing features. These assignments, intended to prepare the MEIOs to make the best use of mass communication media at their disposal, were linked with the field assignment and contributed in a large measure to the effectiveness of the educational campaign. And, it was found that this spurred the participants to learn more by 'doing' than by only 'listening'.

The subjects covered in the areas of extension education and National Family Planning Programme and its set-up at various levels gave the participants up-to-date information in these areas and helped them in their individual and group assignments. There were sessions on programme planning, extension education—principles and procedures, duties and functions of extension workers, supervision and co-ordination, population problems—trends and implications, national family planning programme—its components, history and set-up and methods of conception control. These gave the trainees a fund of knowledge in each area and helped them project a correct image of the family planning programme during the campaign. Since the sessions in these subjects had been logically arranged, the evenings of each day saw the MEIOs attempting to co-relate the class sessions to their field projects. Needless to say, they met with quite a success in this exercise. In fact, the field assignment helped the participants in making their perception clear about an important area of their work—supervision of staff and coordination of their work with other agencies. It enlightened them more about their own roles and those of their supervisors and subordinates. It also offered an opportunity for them to plan their programme within resources available in the respective villages.

Plan of Operation

The four groups implemented the educational campaign in the villages of Kaprivas and Malpura (two villages were allotted to one group because of smaller population), Dharuhera, Nandrampurbas and Kharakhara. In two separate visits, first for two days in the beginning of the course and the second for four days towards the end of the course, the participants planned and implemented, as also assessed the impact of the educational campaign on the community.

Though much of the group work for the assignment was done in the CHEB itself, the help provided by the staff of the District Health and Family Planning Bureau of Gurgaon, right from the Chief Medical Officer down to the village worker or the *dai* (in the respective villages), contributed in no small measure to the successful completion of the campaign.

The campaign assignment was also designed to develop in the participants a favourable attitude towards self-appraisal and self-criticism. It gave an opportunity to them to evaluate the usefulness or otherwise of the various steps they had taken at different stages of the programme implementation. Indeed, one of the specific strengths of the CHEB's training is the constant evaluation and feedback about the training programme with a view to improve the teaching in successive courses.

A word more about the plan of operation of the campaign : In the first visit, the trainees identified the educational needs of their respective villages. For this purpose, they collected the necessary data both from records available at the District Family Planning Bureau at Gurgaon, the Pataudi Primary Health Centre and by interviewing officials and people. During the second visit, the participants implemented the programme. They utilized the educational material developed by them and those procured from various sources. They arranged filmshows, group meetings, and made individual contacts. The women members in each group held discussions with women in the five villages and tried to remove doubts about the family planning programme and the different contraceptive methods. Each group then evaluated its own performance and prepared a report of the work done. This report was presented on the concluding day to the faculty, programme chiefs and mass communication specialists.

Late Dr S.S. Bharara, Asstt. Commissioner, Family Planning, addressing the trainees after the presentation, said that the campaign exercise had required hard work and that too within a limited time. As could be expected in any short duration exercise, shortcomings could not be avoided. But the process of this exercise was itself an achievement, for which both the trainees and trainers deserved credit.

(*Contd. on page 378*)

ON FAMILY PLANNING

STUDY ON PILL USE

WOMEN using the pill are younger, better educated and come from higher income group as compared to users of other methods of contraception. This is revealed in a study of about 9,000 women throughout the country under the 'Pill Pilot Project' by two family planning experts according to a press release.

The study also showed that the pill users had greater previous experience of contraceptives.

About 75 per cent of the women studied came from urban areas.

The study was conducted by Dr (Mrs) Leila Mehra, Deputy Assistant Commissioner of Family Planning Department and Dr P.S. Mohapatra, Assistant Director, Demography and Statistical Division of the Central Family Planning Institute, New Delhi.

WIDER DISTRIBUTION OF NIRODH

FIFTY per cent of couples in the reproductive age group must practise contraception regularly at any given time if the national objective of reducing the birth rate from 2.5 per cent to about 1.5 per cent is to be achieved in next few years. This was stated by Shri B.S. Murthy, Minister of State for Health and Family Planning at the first meeting of the Nirodh Advisory Committee held at New Delhi on 9 September, 1970.

The Minister also added that various studies had revealed that among the conventional contraceptives Nirodh was the most popular and acceptable device because it was a reliable, simple and non-clinical method.

Stressing that Nirodh was the best method for spacing and ideal for younger couples, Shri Murthy called upon the experts to create the necessary atmosphere for adoption of small family norm.

The Nirodh Advisory Committee which met under the Chairmanship of Shri B.S. Murthy was convened to suggest measures for boosting up the distribution and sale of Nirodh under the Commercial Distribution Scheme, Free Supply Scheme and Depot Holder Scheme.

CHECKING POPULATION GROWTH

THE Uttar Pradesh Governor, Dr B. Gopala Reddi, inaugurated the National Family Planning Drive on 14 September, 1970.

Dr Reddi, at a function organized by the Red Cross Society, said that people were now responding to the family planning programme after some initial resistance. This was a happy sign and officials and non-official agencies should make a coordinated effort to propagate the idea of family planning among the people.

The Governor said that involvement in the programme of non-official agencies like Red Cross was welcome. He further said that researches on other methods of contraception were being carried on. But we should take full advantage of methods available at present. He said family planning and population control had become a basic programme. All our other programmes relating to the future well-being of individuals and the nation would depend on the success of this programme.

F.P. NECESSARY FOR SURVIVAL

THE former U.P. Chief Minister, Shri Charan Singh called for a massive campaign to educate the masses and induce them to adopt family planning. He said that much would depend on the educational and motivational efforts to bring home to the people the need for smaller families.

Shri Charan Singh was inaugurating a State level seminar on social welfare and family planning at Lucknow on 6 September, 1970.

He said that the population had negatived the gains in developmental fields. He added that there were other compelling reasons like proper up-bringing of children, health of parents especially of mothers,

adequate nutrition and economic well-being which were in favour of family planning. The programme could succeed only with the cooperation of the people.

Shri Charan Singh said that raising the age of marriage of both boys and girls might help reduce the birth rate. He also suggested that the question of imposing a tax on families having more than specified number of children should be examined as a means of controlling population explosion. He said that cheap, reliable and completely satisfactory methods of birth control should be evolved which would be readily acceptable by the people concerned.

Earlier, Shri S.P. Pande, Secretary, Medical Health said that family planning programme was no longer confined to limiting births. It had been expanded to include welfare of families. He said there was need for an intellectual and sociological upheaval in the thinking of the people. If the implications of the family planning programme could take root in the minds of the people the problem of population growth would be solved successfully.

CO-ORDINATING F.P. PROGRAMME

A SEVEN-NATION Working Group of family planning officials and specialists has urged the establishment of national bodies to co-ordinate the training of personnel in family planning programmes and has sought assistance from United Nations bodies to help up-grade existing training institutes.

The Working Group, organized by the United Nations Economic Commission for Asia and the Far East, met in Bangkok from 27 July to 7 August 1970. The meeting was attended by 21 senior officials in family planning from the following ECAFE nations which are now developing their own programmes: Ceylon, Indonesia, Iran, Malaysia, Nepal, the Philippines and Thailand. Discussions were led by the specialists in family planning training and programme from India, Japan, Switzerland and the United States, while consultant experts attended from India, Malaysia, Republic of China, Republic of Korea and the United Nations.

Planning of Training

The Working Group in its report urged the establishment, in each country, of a national co-ordinating body on training of personnel in family planning programmes to assess the training needs of the country in family planning, to help maintain adequate standards of education and equitable distribution of training loads among the various institutions, and to co-ordinate training activities and the various forms of assistance to the training programme to ensure the maximum utilization of facilities and resources.

It further recommended periodic working sessions between training centres and training programmes, administrators and the creation of a standing committee in each country to set standards for training and qualifications.

Welcoming ECAFE's proposal to help countries conduct national seminars on family planning, particularly in the field of training personnel, the Working Group requested ECAFE and other United Nations bodies for assistance in facilitating the exchange of audio-visual training aids. The Working Group further requested ECAFE, the United Nations and its specialized agencies to help up-grade existing family planning training institutes through fellowships and study grants for national institute faculties; travel study tours for trainees to observe training programmes in other countries; provision of funds for additional faculty and staff for the institutes for an initial period, such faculty and staff to be absorbed later under the regular budget of the institutes; provision of funds for improving facilities, augmenting equipment and purchasing books, journals and other literature; and provision of consultants on request.

Other recommendations of the Working Group sought improvement of information clearing house facilities, called for special attention to evaluation of training programmes by visiting United Nations missions,, and that ECAFE "should provide a forum for the exchange of ideas and experience on evaluation of training programmes in family planning among countries of the region".

—*U.N. Weekly Newsletter, 21 August 1970*

PROBLEMS OF POPULATION GROWTH

PRESIDENT RICHARD NIXON of the United States of America on 18 July, 1969 in his message to the U.S. Congress on the problem of population growth proposed the creation of Commission on Population Growth and the American future to look into three specific areas. First, the probable course of population growth, internal

(*Contd. on page 378*)

Around the states

MAHARASHTRA

Twelfth Convocation of the DTRC

SHRI K.K. SHAH Union Minister of Health, Family Planning, Works, Housing and Urban Development in his convocation address of the Demographic Training and Research Centre (DTRC) on 31 May, 1970 in Bombay advised the demographers to leave the "comforting illusions" of statistics and to provide realistic estimate of the progress made.

Dr Rafiq Zakaria, Minister for Health and Family Planning presided over the function and distributed the Certificates and Diplomas to the trainees. Besides the India nationals, the Centre had students from Afghanistan, Indonesia, Hong Kong, Republic of Korea, Western Samoa, Taiwan and South Vietnam.

The demographers, Shri Shah said, have a vital role in assisting policy-makers and planners. He said that the methods of evaluation had not been up to the mark. He called upon them to provide estimates of the population growth which are required for family planning, health, education manpower, food and urban development. He advised the demographers to get themselves involved in metropolitan planning and also in studies of the inter-relationship between various socio-economic and cultural factors and population growth.

Dr S.N. Agarwala, Director of the Centre welcomed the guests and presented the Centre's report for the year 1969-70. He said that the name of the Centre would soon be changed to "International Institute for Population Studies" in keeping view with the new responsibilities to be undertaken by the Centre.

All-India Seminar on Family Planning Evaluation

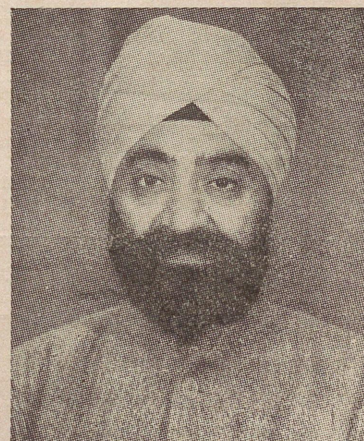
SHRI B.P. PATEL, Secretary, Ministry of Health, Family Planning, Works, Housing and Urban Development inaugurated an all-India Seminar on "Evaluation of Family Planning Programme in India". The Seminar was organized by the International Institute for Population Studies (IIPS) Bombay, from July 13 to 15, 1970. Officials of the Central and State Governments and of Union

DR S.S. BHARARA

We regret to report the death of Dr S.S. Bharara, Assistant Commissioner in the Department of Family Planning on 8 October, 1970 in New Delhi. Dr Bharara was 48.

Dr Sardool Singh Bharara started his career as Medical Officer of Health in Uttar Pradesh in 1948 and later became the Health Education Officer of Directorate of Medical and Health Services, U.P. In 1964, Dr Bharara joined the Central Health Education Bureau as Deputy Assistant Director General, in-charge of Training. Later, he was Assistant Director in-charge of Training at the Central Family Planning Institute before he took over as Assistant Commissioner in the Department of Family Planning.

The staff of the Central Health Education Bureau at a meeting on 12 October adopted a condolence resolution. The resolution described Dr Bharara as "a great votary of Health Education to which he dedicated himself with heart and soul". In his death the discipline of Health Education "has lost a great Health Educator".



DR S. S. BHARARA

Territories working in the field of family planning; demographic and family planning research centres; expert bodies like the Planning Commission, Central Statistical Organization, etc., and foreign foundations working in India, like the USAID and the Ford Foundation, were invited to attend. The United Nations (Population Division) and the ECAFE (Population Division) were special invitees. The Seminar was attended by nearly 100 delegates.

Shri B.P. Patel, in his inaugural speech, brought out that heavy responsibility lay on the shoulders of those who were involved in the tasks of evaluation, target-setting and cost-benefit analysis. All of these are important problems in which the Government of India is considerably interested. But in view of the non-availability of some important data, the assumptions involved in various calculations and the complex inter-relationship among various factors, he said the research workers should exercise due caution in interpreting results.

In his welcome speech, Dr S.N. Agarwala, Director, IIPS, pointed out that the main objective of the Seminar was to bring together the administrators, family planning workers and researchers on a common platform for a free exchange of ideas among them. He said that if all those who were involved in the great task worked together and appreciated each other's specific roles, the family planning programme would make more rapid progress.

UTTAR PRADESH

World Bank Appraisal Mission visits Uttar Pradesh

THE World Bank Appraisal Mission during its visit to Uttar Pradesh, met Governor, Dr B. Gopala Reddi, on 12 August, 1970. During its 10-day visit to the State, the Mission met Chief Minister, Health Minister, officials of the State Government and representatives of voluntary organizations. The Mission visited the districts of Faizabad, Sultanpur, Rae Bareli, Barabanki, Muzaffarnagar and Mathura and held discussions with the officials and family planning workers.

DELHI

WHO Delegates Visit CHEB

DR CHITT HEMACHUDHA, Deputy Under Secretary of State for Public Health, Ministry of Public Health, Bangkok; Dr Kong Suvarnarat, Director, Division of Provincial Hospitals, Department of Medical Services, Ministry of Public Health, Bangkok; and Dr D.A. Jayasinghe, Deputy Director, (Public Health Services), Directorate of Health Services, Colombo, visited the Central Health Education Bureau on 28 September, 1970. They were representing their respective countries at the 23rd Session on the South-East Asia Regional Committee of the World Health Organization which concluded in New Delhi on 28 September, 1970.

Dr B.S. Sehgal, Director of the Central Health Education Bureau, received the visitors and explained to them the set-up of the Bureau, its objectives and activities. The visitors evinced keen interest on the training activities and research studies being conducted by the Bureau. A number of questions relating to the minimum requirements for setting up Research Cell in a Health Education Bureau, the type of activities that could be organized in schools for the health education of students and production and evaluation of different types of media came up for discussion. The Chiefs of different Divisions of the Bureau were present during this meeting.

Dr Dradjat D. Prawiranegara visited the Bureau on 29 September and held discussions with the Chiefs of different Divisions.

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NEWS

HEART ATTACKS IN YOUNG ADULTS

As a result of information collected over a wide area in the world the thinking now is that heart attacks in young adults and in early middle age are due to causes different from heart attacks in elderly persons.

In the former case it is considered that it tends to run in families and the salient factors are metabolic disorders, often of an overt inherited nature, and excessive cigarette smoking. While in the older age groups, the main influences are hypertension and degenerative arterial changes.

The Scientific Council on Arteriosclerosis and Ischaemic Heart Disease of the International Society of Cardiology has examined what should be done on an international basis to elaborate this hypothesis in the hope of deriving, at a later date, some form of intervention in adolescence. A cooperative study has, therefore, been sponsored and launched to collect data from young adults with proven myocardial infarction and their first degree relatives.

This co-operative study extends throughout the world. The centres have been chosen because there is evidence, which was reviewed at a meeting of the Council's Research Sub-committee in Chicago, in November 1969, to suggest that certain risk factors may be acting discretely in these parts of the world.

The research programme is currently at the stage of accumulating evidence about the prevalence and characteristics of coronary heart disease in these various centres. Once this has been completed, it is planned that specific laboratory research projects should be developed to examine in depth the nature of the influences which are operating internationally to cause the premature onset of ischaemic heart disease, and certain laboratories will be invited to collaborate.

It is only in this way that accurate information will be accumulated concerning coronary heart attacks in young adults and the influences which favour its development in certain families. No national study can be expected to yield enough information.

—*Heart News, July* 1970.

EUROPEAN HEART WEEK

The International and European Societies of Cardiology are sponsoring a European Heart Week to take place from 21 to 28 February 1971. It would basically consist of educational and fund-raising activities and include a European television and radio programme both at the national and international levels.

The idea of such a programme was launched by Mr P.J.H. Kierkels, Director of the Netherlands Heart Foundation, and a number of European associations, societies and foundations of cardiology have expressed their interest in taking part in it. The programme sponsored by the Swiss Heart Foundation and television network and the National Committee consists of Dr P.W. Duchosal of Geneva, Mrs G. Salmanowitz of Versoix and Dr W. Schweizer of Basel.

A technical coordinating meeting of interested organizations was convened at the LSC premises in Geneva on 17 March, 1970.

The World Health Organization and its Regional Office for Europe have promised their cooperation. Negotiations are proceeding with Eurovision and Intervision. Several newspapers and broadcasting stations have already given advance publicity to this project.

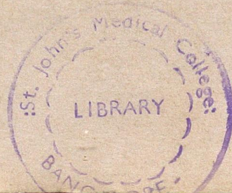
—*Heart News, July* 1970.

ENZYMES IN TREATMENT OF DISEASES

Enzymes, the biochemicals currently used to prolong the life of beer and to improve detergents, may in future play an important part in diagnosis and treatment of diseases.

This glimpse of the research now going on into enzymes was given recently when a £ 500,000 production plant was opened at Maidstone (South-East England) by Whatman Biochemicals Ltd.

Mr Colin Knight, Managing Director of Whatman Biochemicals, said there were numerous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potential uses for enzymes which have yet to be fully developed. Their use as therapeutic drugs, for instance, was not yet established.

"But current research indicates that in the future enzymes will provide a means of treating a number of diseases", he said. "We expect advances in medical and scientific research to result from the opening of this new plant."

The new Whatman complex will work with British University laboratories to bring research to a commercial level. The plant is said to be the most modern of its type and will supply biochemicals to other countries as well.—(*Courtesy: BIS*)

Preparing for Communication Task—(*Contd. from page 372*)

Depth Exercise

It was in between the two visits to the field area that the MEIOs, apart from sitting through three to four sessions each day, had a depth exercise in studying the needs of the community and relating their educational programmes to these needs. This called for sustained and prolonged work. Group guides and consultants from the CHEB faculty were with them to provide the necessary guidance but the trainees were to come out by themselves with the findings and relate these to the campaign plan. The work required combined efforts and was an occasion to demonstrate the team spirit and healthy competition among the four groups. It further helped the participants to understand the process of give and take and coordinating efforts.

The advice of Shri B.S. Murthy, Union Minister of State for Health, Family Planning, Works, Housing & Urban Development that success for an MEIO "does not depend only on acquiring knowledge, but on efforts—honest, organized and dedicated—to show results through the knowledge gained", was most timely. Shri Murthy, who distributed certificates to the trainees at the valedictory session on July 18, 1970, said that while the training should make the MEIOs more adaptable and agile, the real substance should come from themselves.

Shri Murthy's another advice was equally significant. The MEIOs, he said, worked in particular communities. They must first grasp the background of that community and then take up educational efforts. "You must speak their language, with their thoughts and feelings, intentions and aspirations. Your material should not be 'bookish' or borrowed, but should depend for contents on the community's folklore, cultural heritage and incidents."

The Challenge Will Be Met

These were admittedly the most appropriate words to mark the end of this training course. The training "though strenuous" was rewarding, as unanimously voiced by the participants. Shri S.V. Trivedi, a participant had this to say: "We feel more confident now to meet the challenge of population explosion and are surer to bring about a social change for a better life to our people."

Problems of Population Growth—(*Contd. from page 374*)

migration and related demographic developments between now and the year 2000. Second, the resources in the public sector of the economy that will be required to deal with the anticipated growth in population. Third, ways in which population growth may affect the activities of the Federal, State and local governments.

The membership of the Commission, the President said, should include two members from each house of the Congress together with knowledgeable men and women who are broadly representatives of American Society. The Commission should be empowered to create advisory panels to consider sub-divisions of its broad subject area and to invite experts and leaders from all parts of the world to form these panels in their deliberations.

The President said that the Commission should be established for a period of two years and that the interim report be submitted to him and the Congress at the end of the first year.

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