

सत्यमेव जयते

Report
of the
Family Planning
Third Five Year Plan
Committee 1960

Ministry of Health
Government of India



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No. 4-3/60-FP

DIRECTORATE GENERAL OF HEALTH SERVICES

New Delhi-2, the 5th February, 1960

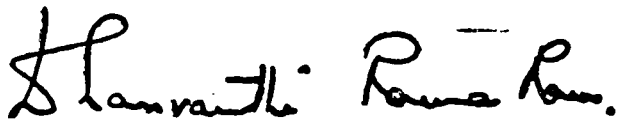
FAMILY PLANNING THIRD FIVE YEAR PLAN COMMITTEE

Dear Shri Karmarkar,

The Report of the Family Planning Third Five Year Plan Committee appointed under the Government of India, Ministry of Health letter No. F. 4-38/59-F.P., dated the 29th September, 1959, is submitted herewith.

Yours sincerely,

Shri D. P. Karmarkar,
Minister for Health,
Government of India,
New Delhi.

A handwritten signature in black ink, appearing to read 'Shri D. P. Karmarkar', written in a cursive style.

FAMILY PLANNING THIRD FIVE YEAR PLAN COMMITTEE

Chairman

Shrimati Dhanvanthi Rama Rau.

Members

Dr. Shrimati Soundaram Ramachandaran.

Shrimati Shakuntala Paranjpye.

Dr. Shrimati H. N. Unwalla.

Dr. Shrimati Kamla B. Ramier.

Member-Secretary

Lieut.-Colonel B.L. Raina.

CONTENTS

	PAGE
CHAPTER I—Introduction	1
CHAPTER II—The Population Problem	4
CHAPTER III—Review of the Family Planning Programme	17
CHAPTER IV—Recommendations by the Committee	38
CHAPTER V—Implementing Agency	66
CHAPTER VI—Financial Considerations	70
APPENDIX I—Resolution	73
APPENDIX II—Questionnaire	74
APPENDIX III—Analysis of the replies to Questionnaire	81
APPENDIX IV—Letter No. 2098-PMW/59 dated 18-10-59 from Prime Minister ..	83
APPENDIX V—Recommendations of the Committee appointed by the Panel of Health Programmes of the Planning Commission to report on Population Growth and Family Planning	84
APPENDIX VI—Planning Commission recommendations for Family Planning Programme during First Plan	86
APPENDIX VII—Constitution of Family Planning Research and Programmes Committee	89
APPENDIX VIII—Constitution of the Grants Committee	91
APPENDIX IX—Planning Commission recommendations for Family Planning Programme during Second Plan	92
APPENDIX X—Constitution of the Central Family Planning Board	94
APPENDIX XI—Constitution of the Standing Committee of the Central Family Planning Board	96
APPENDIX XII—Family Planning Staff at Central Organisation	97
APPENDIX XIII—Terms and conditions regarding financial assistance to Local Bodies and Voluntary Organisations for Family Planning Programme ..	98
APPENDIX XIV—Statement showing number of sterilization operations performed in States	117
APPENDIX XV—Statement showing number of persons trained in family planning in States	118
APPENDIX XVI—Staff and Expenditure of Family Planning Training Centres ..	119
APPENDIX XVII—Constitution of the Advisory Committee on Physiology of Human Reproduction of I.C.M.R.	122
APPENDIX XVIII—Constitution of the Demographic Advisory Committee	123
APPENDIX XIX—Constitution of Governing Body, Demographic Training and Research Centre, Bombay	125
APPENDIX XX—Constitution of Advisory Committee of Demographic Training and Research Centre, Bombay	126
APPENDIX XXI—Statement showing the educational material produced	127
APPENDIX XXII—Statement showing names, pay scales and qualifications of State Family Planning Officers.	129
APPENDIX XXIII—Progress of Family Planning Programme in States	131
APPENDIX XXIV—Proposal of the Indian Medical Association	155
APPENDIX XXV—Proposal of the Central Social Welfare Board	158
APPENDIX XXVI—Minutes of the Second Meeting of Demographic Advisory Committee	161
APPENDIX XXVII—Family Planning educational personnel, their responsibilities and training	163
APPENDIX XXVIII—Staffing Pattern of Family Planning Education at District, Tehsil and State level	167
APPENDIX XXIX—List of persons who sent replies to questionnaire	169

CHAPTER I

INTRODUCTION

1.1. *Appointment of the Committee*—The Central Family Planning Board at its meeting on the 31st August, 1959 recommended that a Family Planning Third Five Year Plan Committee should be formed with Shrimati Dhanvanthi Rama Rau as Chairman, Dr. Shrimati Soundaram Ramachandaran, Shrimati Shakuntala Paranjpye, Dr. Shrimati Kamala Ramier, and Dr. Shrimati H. N. Unwalla as members and Lieut.-Colonel B.L. Raina, as Member-Secretary. The Ministry of Health constituted the present Committee under the Government of India, Ministry of Health letter No. F. 4-38/59-F.P., dated the 29th September, 1959. (See Appendix I).

1.2. *Terms of reference*—The terms of reference to the Committee were as follows—

- (i) to review the Family Planning Programme;
- (ii) to make proposals for inclusion in the Third Five Year Plan.

The Committee was required to submit its Report by the end of October, 1959. The date of submission of the report was later extended.

1.3. The task before the Committee was difficult. The time available was short, for Questionnaires had to be issued, replies received, information analysed, and proposals formulated taking into consideration reports from expert bodies, such as the Demographic Advisory Committee, and the Committee on the Physiology of Human Reproduction.

1.4. *Programme of work*—The Committee decided to issue a Questionnaire (See Appendix II), which was sent to all Ministries of the Government of India, Chief Ministers and Health Ministers of State Governments; members of the Planning Commission and of the Health, Survey and Planning Committee, the Central Family Planning Board and the State Family Planning Boards, the Demographic Advisory Committee, the Committee on the Physiology of Human Reproduction, the Central Working Group on Health, the Ministry of Health, the Central Social Welfare Board and the State Social Welfare Boards, all officers of the Directorate General of Health Services and its subordinate offices, the Indian Council of Medical Research, the Indian Nursing Council, the Medical Council of India, the Indian Medical Association and its branches, the Family Planning Association of India and its branches, the Indian Red Cross Society, the All-India Women's Conference, the Indian Council of Child Welfare, all local bodies and voluntary organisations receiving central assistance, the Council of Scientific and Industrial Research, Principals of Medical Colleges, Heads of Departments of Economics and Social Sciences of Universities, the Director-General of the Armed Forces Medical Services, Administrative Medical Officers of States and Centrally Administered Areas, the Directors of Medical Services, Army, Navy and Air Force, the Director-General, Employees State Insurance Corporation, a number of individual experts and social workers, and the press. A large number of requests from other interested persons were

also received for copies of this Questionnaire. The response to the Questionnaire despite the short time given, was very encouraging. Altogether, about 275 replies were received within the brief period specified. A brief summary of the suggestions received is at Appendix III. The Prime Minister very kindly sent an encouraging letter (see Appendix IV) emphasising the basic approach to the problem—an approach which the Committee has constantly kept in view while preparing this Report. The Committee examined, in addition to the replies to the Questionnaire, a number of reports including the proceedings of the Central Family Planning Board, the Demographic Advisory Committee and its study group, the Committee on the Physiology of Human Reproduction of the Indian Council of Medical Research, the Central Working Group on Health of the Health Ministry and their discussions with the State Governments, the Central Health Council, the reports of the Planning Commission, the Central Statistical Organisation, the National Sample Survey, and the Ad Hoc Committee of Officers of the Ministry of Health and Ministry of Information and Broadcasting. The Committee had the advantage of receiving the views of a number of experts including those from some of the Ministries of the Central Government, Chief Ministers, Health Ministers of States and Officers concerned with various aspects of the family planning programme.

1.5. The Committee sat continuously from the 25th to 27th November 1959 when it examined the information and suggestions received. Before submitting this Report to the Health Minister, the Committee also personally discussed specific points regarding the programme with the Director General of Health Services and the Adviser, Health Programmes and Social Services, Planning Commission.

1.6. *Contents of the Report*—The Report has been divided into six chapters. Following the introductory first chapter, chapter II gives a brief review of some of the salient facts and figures regarding growth of population, birth rates and death rates, availability of food, employment opportunities, national and per capita income. The Committee felt that such a review was necessary in order to view the problem in its correct perspective and would assist in establishing the priority and formulating the policy for the family planning programme. Chapter III reviews the progress made so far in promoting the family planning programme. The fourth chapter outlines the Committee's recommendations for the Third Five Year Plan. The fifth deals with the implementing agency to be set up, and the sixth with financial estimates.

1.7. In view of the limited time available in making its Report, the Committee has selected certain major problems for consideration and expressed its views in broad outline. The Committee wishes to stress the fact that the rapid growth of population poses a formidable problem for the nation which must be tackled with a sense of urgency and a seriousness of purpose and in such a manner as to bring about palpable results within the next few years. The Committee hopes that although its recommendations refer to the Third Five Year Plan period, it may be possible to proceed almost immediately with the implementation of its basic recommendations.

1.8. *Acknowledgements*—The Committee desires to take this opportunity to express its gratitude to the Prime Minister for his very encouraging letter, to the Union Health Minister and other Ministers of the Government of India and of State Governments, to the Secretary, Ministry of Health, the Director General of Health Services, the Officers of various Ministries and Departments of the Union and State Governments, to local bodies and voluntary organisations and to all those others who have so enthusiastically responded to its request for information and suggestions. The Committee is also specially obliged to those whose observations, received in response to the Questionnaires, have been incorporated in the text of the Report.

1.9. The sections in this Report dealing with population projections, national income, food production, employment situation, production of contraceptives and educational programmes, are mainly based on information received from the Planning Commission and the Central Statistical Organisation, the Ministry of Food and Agriculture, the Ministry of Labour and Employment, the Ministry of Commerce and Industry, the Ministry of Information and Broadcasting, and the Ministry of Education respectively.

CHAPTER II

THE POPULATION PROBLEM

2.1. *World Population*—The study of population trends has assumed great importance in recent times practically all over the world. The United Nations, recognising this, has appointed a Population Commission, and publishes a Demographic Year Book. Demographic research centres have been established in several countries including India. The determinants of population trends are being closely studied and particularly in those countries which have adopted developmental measures they are considered from the angle of their repercussions on the pace of economic and social progress. The rapid increases in population growth are of comparatively recent origin. About three centuries ago, world population was estimated to be about 470 millions (1650). It subsequently rose to 1,091 millions (1850) then to about 2,691 millions (1955) and is now estimated to be over 2,700 millions. The startling feature of this growth is that the average annual rate of increase has twice doubled—From 1750 to 1850 it was 0.4%, from 1850 to 1950 it was 0.8% (double the previous rate) and during 1951-55 it was about 1.7%. Thus about, 45 million people are added to world population every year, or 1,23,000 per day.

2.2. This phenomenal natural increase has been due to a combination of several factors. In Europe, the discoveries of science which led to increases in food production, industrialisation and the spread of health measures also contributed to the growth of human numbers, so much so that not only did the continental populations increase but large numbers of people emigrated and colonised new territories. In the case of population increases in Latin America, Africa and Asia, however, the influencing factors have not been as balanced, the main reason for the growth having been increasing health measures (as well as measures to prevent starvation to some extent) unaccompanied by corresponding advances in the exploitation of natural resources and economic development.

2.3. The pattern of population growth has been classified in a recent report of the United Nations, as follows—

(a) Countries with high fertility and mortality with birth rates from 40-50 per 1,000 and death rates from 25-30 per 1,000 with an expectation of life of about 30-35 years, with a small number of persons over 60 years and with a high infant mortality rate. The countries of Africa and Asia and a few countries in Middle and South America show these features. The annual population increase ranges from less than 1 per cent to not more than 2 per cent.

(b) Countries with high fertility and moderate or low mortality, i.e. with death rates about 10-20 or even lower and birth rates from 40-50 in which the expectation of life is 40-50 years and the proportion of people under 20 is high; this is found in the major part of Middle and South America, in some countries of Asia and probably also in Africa, the annual increase of population being from 2-3 per cent per year or higher.

(c) Countries with low fertility and mortality rates with birth rates from 15-25, death rates about 10, low infant mortality and with persons over 60 in large proportion. Europe, the United States, Australia and New Zealand, the European population in South Africa, Japan, and Argentina are in this category. The growth of population here is at the rate of 0.5 per cent to about 1.5 per cent per annum.

While amongst the advanced nations of Europe and America the lowering death rates have been balanced by lowering birth rates, this phenomenon has not occurred and is not likely to occur in the near future in the other areas of the world except where special policies are instituted to bring about such results. The outstanding example of the institution—and success—of such a policy is Japan. At the end of the last war Japan was bereft of resources, had to receive back a large number of her emigrants and, in general, suffered from economic prostration, combined with a growing birth rate. As a result of measures adopted by that country, however, the birth rate dropped from 34.3 per 1,000 in 1947 to 17 per 1,000 in 1957, a reduction of 50%. (The Japanese population which was 78 million in 1947, however, stood at 90 million in 1957). The chief means by which Japan has nearly halved her birth rate has involved the deliberate adoption of the widespread practice of abortion. It is estimated that after the Eugenic Protection Law 1948 (revised in 1952) made abortion easier, several million abortions were carried out until in May 1959, the proportion of abortions to live births was 50 : 50. Sterilization also has spread widely in Japan. The present trend among Japanese leaders is, however, to encourage the practice of contraception (with a corresponding decrease in the practice of abortion, for the latter does produce deleterious effects on the mother's health) as a steady means of holding down the birth rate.

2.4. The U.N. Report* emphasises that a too-rapid growth of population retards development:—

“... First, it can increase the pressure of population on land that is already densely settled and so retard increase in the productivity of agricultural labour. This effect is seen not only in countries where nearly all the cultivable land is now occupied but also in many underdeveloped countries where the density of the agricultural population in the cultivated areas is high, although large areas of potentially productive land lie unused because of land ownership systems, lack of capital or techniques to exploit available land or, for other reasons.

“ Second, accelerating population growth can aggravate the problem of capital shortage, which is one of the most important obstacles to economic development of nearly all under-developed countries. The faster the population grows, the larger the share of each year's income which must be invested in increasing the stock of productive equipment merely to maintain the existing level of equipment per worker. The larger the investment required for this purpose, the smaller the share of annual income that will be available either to raise the level of current consumption per capita, or to make investments which would increase productivity and permit higher levels of consumption in the future.

* Population Bulletin, Population Reference Bureau Inc. Vol. XIII No. 3 December, 1957.

“While, in a well-developed dynamic economy the demand for such capital investment may serve as a stimulus to continuing economic growth, the case of the under-developed countries with their narrow margin of income over subsistence needs is different. For most of them it is difficult to save and invest enough from their meagre annual income to permit economic development to proceed at a satisfactory pace, even without rapid population growth. It is true that if these countries can industrialize and better utilise their human as well as their natural resources, some of them, at least, will undoubtedly benefit in the long run from a substantially larger population. But even where a larger population would be advantageous in the long run, economic progress will be hindered if numbers increase so rapidly as to put an excessive strain upon the economy.

“Third, the high birth-rates of the under-developed countries create a heavy load of dependent children for the working population.....the percentages of children under 15 years of age in the less developed countries of Asia, Africa, and Latin America are generally of the order of 40 per cent or more of the total population, while the range of this ratio in the European countries is from about 20 to 30 per cent. This difference is the consequence of the higher birth-rates in the former areas. The necessity of supporting so many children puts the workers of the under-developed countries at an added disadvantage in their efforts to save and invest for economic development. It also complicates the problem of providing the children with the education that is essential for social and economic advancement in the long run”.

2.5. It is clear that world population will continue to grow rapidly for some time to come. Dr. Kingsley Davis * observes that “this explosive human multiplication, unanticipated and unexampled in history clearly cannot continue indefinitely. It would give us nearly 6,000,000,000 by the end of this century and nearly 13,000,000,000 by the end of the year 2050. How this growth is eventually stopped, and when, will play a tremendous role in human destiny. Although a climax in population growth is approaching, nothing indicates that the peak has yet been reached. The total may climb faster in the next twenty years than it did in the last twenty. Even if the rate of increase begins to decline, centuries may pass before it falls to simple replacement level ; and new billions will have been added to the human horde in the meantime. Unless a catastrophe intervenes, we and our children will share the earth with a lot more people than we do today”.

2.6. *Population growth in India, 1891-1951*—India has the second largest population in the world. In 1891 the population of India was 236 million, in 1921, 248 million and in 1951 nearly 359 million (excluding Jammu and Kashmir). The increase of population between 1891-1921 was 12 million, whereas the increase between 1921-1951, was 109 million i.e. the rate of increase was about 9 times the previous figure. The rapid growth of population in India has been brought about mainly by the decline in death rates due to improvements in public health measures. The death rate had declined from 44.4 per thousand in 1891-1900 to 27.4 per thousand in 1941-1950.

* Davis, Kingsley—*Analysis of Population Explosion*, New York Times Magazine, September 22, 1959.

Growth of Population in India (1891-1951)

Census	Birth rate per 1000 population	Death rate per 1000 population	Population in millions	Increase or decrease during the decade in millions	Percentage variation during the decade
1891	48.9	41.3	235.9	0	..
1901	45.8	44.4	235.5	-0.4	-0.17
1911	49.2	42.6	249.0	+13.5	+5.73
1921	48.1	47.2	248.1	-0.9*	-0.36
1931	46.4	36.3	275.5	+27.4	+11.04
1941	45.8	31.2	312.2	+37.3	+13.54
1951	39.9	27.4	356.9	+44.1	+14.10

* The decrease was mainly due to the influenza epidemic of 1918.

2.7. The results of a number of studies conducted during the last few years indicate that :—

- (a) The age of marriage has increased only slightly over the last 50 years.
- (b) The average number of children born per woman aged 45 and over of unbroken marriage is between 6 and 7, both in the rural and urban areas.
- (c) The age specific fertility rates show that at present the fertility is fairly low in the age group 15—19, rises sharply in 20—24, maintains that level till about the age group 35—39 and afterwards falls abruptly to a considerable extent.
- (d) The child survival ratios show an improvement in the age group 15—19.
- (e) The raising of age at marriage, unless substantial, will not bring down fertility to any great extent.
- (f) A systematic increase in the average number of children born for most recent couples was observed for various durations of marriage.
- (g) The average size of the family is about 5 both in rural and urban areas. The average number of children born is about 6.5.

2.8. *Decrease in death rates*—The last all-India survey to estimate the birth and death rates was conducted in 1951. Preliminary estimates of birth and death rates for rural India as a whole based on data for the reference period August 1957-September 1958, collected in the first two Sub-rounds of the Fourteenth Round of the National Sample Survey, were found to be 38.10 per 1000 and 19.38 per 1000 respectively. There appears to be about 5.5 per cent omission in births because of recall lapse. The estimated birth rate for rural India would be 41.3 per 1000. The birth and death rates reported from seven Rural Demonstration Health Units vary roughly between 32.7—46.9 and 7.4—22.5 respectively.

The available data indicate that the death rate in India has decreased considerably. This fall in the death rate is bound to be accelerated by the health plans of successive Five Year Plans. With the expansion of improved medical and health measures in the rural areas, increasing use of antibiotic drugs, nation-wide campaigns for the control of tuberculosis, malaria and other preventable diseases, the mortality rate of the country may fall to an unexpectedly low level. While in the West such a reduction in the death rate took many years, with modern methods of disease control the same results may be achieved in India within a much shorter period.

2.9. The increase of population was estimated to be 1.2 per cent, based on the 1951 census. The increase in population may now be in the neighbourhood of 2 per cent or even more per year.

2.10. The Expert Committee of the Working Group on Vital and Health Statistics which was appointed by the Planning Commission has prepared a series of population estimates for the country for the years 1956, 1959, 1961, 1966 and 1971, with break-up according to characteristics such as States, sex and age groups. These estimates are tentative and are based on such data as are available at present. The projections upto 1966 are based on the following assumptions :—

- (i) The 1951 Census age distribution corrected for under-enumeration in the age group 0-1 and 1-2 should be accepted as the basis for future projections.
- (ii) The general fertility rate of 0.189 consistent with a birth rate of 42 per thousand around 1951 would remain unchanged during 1951—66.
- (iii) Mortality could be taken to be improving to the extent that the expectation of life at birth steadily increases from about 32 in 1951 to 50 in 1966 (by 0.9 year, each year).
- (iv) The fall in the Indian life table death rates be assumed to be the same as that given by the appropriate U.N. Model Life Tables.
- (v) The Statewise break-down by sex and broad age groups may be worked out close by the ratio method.

2.11. The projected population of the whole of India by sex in different years is as shown below—

Population (in millions) as on 1st of March 1959

Year	Male	Female	Total
1951	185.9	175.9	361.8
1956	201.2	190.2	391.4
1959	213.1	201.9	415.0
1961	221.1	209.7	430.8
1966	245.6	234.0	479.6

2.12. Coale and Hoover* have also studied the growth of population in India. While estimating the growth of population they have taken into consideration the reduction in death rates that may result from extensive health measures. Based primarily upon Ceylon's experience during the malaria control period and improvements apart from malaria that had been experienced elsewhere under similar situations, it was assumed that the life expectancy at birth would increase from 31.5 years, in 1951 to 51.5 years in 1981 and 1986 for males; and from 32.8 years in 1951 to 53.1 years in 1981 and 1986 for females. Regarding fertility rates they made the following three assumptions:—

- (a) that fertility continues at the present level throughout the period 1956-86.
- (b) that fertility is reduced by 50 per cent by 1981, its decline beginning in 1966 and
- (c) that while a decline in fertility begins from 1956, the same reduction of 50 per cent is obtained by 1981.

In regard to both assumptions (b) and (c) it was further assumed that fertility would remain stationary between 1982 and 1986.

Estimated population of India (excluding Jammu and Kashmir and hill tribes of Assam) under the three assumptions, in different years

Year	Assumption (a)			Assumption (b)			Assumption (c)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1951	182.2	172.5	356.7	183.2	173.5	356.7	183.2	173.5	356.7
1956	193.0	191.0	384.0	193.0	191.0	384.0	193.0	191.0	384.0
1961	213.0	211.0	424.0	213.0	211.0	424.0	211.0	209.0	420.0
1966	238.0	235.0	473.0	238.0	235.0	473.0	231.0	228.0	458.0
1971	268.0	264.0	532.0	264.0	260.0	524.0	250.0	246.0	496.0
1976	303.0	298.0	601.0	286.0	282.5	569.0	267.5	264.0	531.0
1981	343.0	338.0	682.0	304.0	299.0	603.0	283.0	279.0	562.0
1986	391.0	384.0	775.0	319.5	314.5	634.0	297.0	290.0	589.0

The above estimates do not include the population of Jammu and Kashmir and the hill tribes of Assam.

2.13. Their estimates multiplied by 1.014 to include all areas of India may be compared with the official estimates from the following table.

*Coale Ansley, J. and Hoover, Edgar, M. : *Population Growth and Economic Development in Low Income Countries. A case study of Indian Prospects*, Princeton University Press, Princeton N.J., U.S.A. 1958.

Projected Population (in millions)

Year					Coale and Hoover		Official	
					High estimate according to assumption (a)	Medium estimate according to assumption (b)	Low estimate according to assumption (c)	Medium estimate according to assumption (d)
1961	..	..	..	..	429·9	429·9	425·9	430·8
1966	..	..	..	..	479·6	479·6	464·4	479·6
1971	..	..	..	..	539·4	531·3	502·9	527·8
1976	..	..	..	..	609·4	576·9	538·4	Not available
1981	..	..	..	..	691·5	611·4	569·9	Do.
1986	..	..	..	..	785·8	642·9	597·2	Do.

2·14. According to both estimates, official as well as those of Coale and Hoover, the population of India in 1971 would be anything between 528 million to 539 million.

2·15. A continuance of the present rate of fertility may result in a population about double its present size at the end of the 30 years' period, in which case the rise in the level of average income would be only about 13·5 per cent. The importance of a fall in fertility beginning as early as possible is brought out clearly by the figures for population and income under the two assumptions that a decline in the birth rate will start in 1956 and 1966 respectively.

2·16. Coale and Hoover have also estimated that the increase in the income per adult consumer which is computed at Rs. 341 at present would increase about 92 per cent by 1986 if the fertility were reduced by 50 per cent between 1956 and 1986; whereas it would rise only by 13·5 per cent if the present level of fertility continues. The estimates of population and income per adult consumer are given below:—

Year	Fertility		Estimated population in millions	Percentage of population increase as compared with 1956	Income per adult consumer (Rs. per annum)	Percentage increase of income compared with 1956
1956	Present level	.. ..	384	..	341	..
1986	(a) If present level continues	.. ..	775	About 102 p.c.	387	About 13·5 p.c.
	(b) If reduction by 50% between 1956 and 1981		634	.. 65 p.c.	508	.. 49 p.c.
	(c) If reduction by 50% between 1956 and 1961		589	.. 53 p.c.	654	.. 92 p.c.

2.17. The number of children (those under 15 years) per 100 persons in the age-group 15—64, and the number of non-earning dependants per 100 persons in the employable ages, will both show an increase if fertility remains unchanged. But control of fertility will help to reduce these figures, thus reducing the “dependancy load”. The relevant figures are set out in a table below. For the purpose of comparison only two of the population estimates of the authors are taken, namely, those based on the assumptions that (a) fertility remains unchanged during the period, 1956—86 and (b) that it is reduced by half between 1956 and 1981.

Year	Number of children under 15 per 100 persons in the age group 15—64		Number of non-earning dependants per earner in the age group 15—64	
	If fertility does not change during 1956—86.	If fertility is redu- ced by half bet- ween 1956—81.	If fertility does not change during 1956—86.	If fertility is redu- ced by half bet- ween 1956—81.
1956	67	67	1.51	1.51
1986	79	46	1.71	1.24

2.18. *National Income*—The national income has increased from Rs. 8,650 crores in 1948-49 to Rs. 11,570 crores (at 1948-49 prices) in 1958-59 and per capita income has increased from about Rs. 247 in 1948-49 to about Rs. 291 in 1958-59. The index numbers of national income and of per capita income, both at 1948-49 prices, are as follows :—

Year	National income crores Rs.	Index number of national income	Per capita income Rs.	Index number of per capita income
1948-49	8,650	100.0	246.9	100.0
1950-51	8,860	102.8	246.3	99.8
1952-53	9,460	109.4	256.6	103.9
1953-54	10,030	116.0	268.7	108.8
1954-55	10,280	118.8	271.9	110.1
1955-56	10,480	121.2	273.6	110.8
1956-57	11,000	127.2	283.6	114.8
1957-58	10,830	125.2	275.6	111.6
1958-59	11,570	133.8	290.7	117.7

2.19. The average annual rate of growth of national income in real terms over the decade has been 3.4 per cent, while the average rate of growth of per capita real income is only 1.8 per cent, owing to the increase in the population. The net rise in national income in real terms during the first three years of the Second Plan i.e. 1956-57 to 1958-59 was of the order of 10.4 per cent. The corresponding rise in per capita income was 6.3 per cent.

2.20. To ensure a secular trend of real per capita income three conditions are essential, namely (a) an increasing trend in output—labour ratio which implies a relative increase in the use of capital per worker where capital is derived from savings (b) ever-increasing labour skills required to utilize effectively the new capital that is created and (c) the effective use of land, labour and capital available to increase the real per capita income. The new capital formation should be such that there is a new increase in productivity, not merely a maintenance of old levels. The expected increase in population is such that increased savings become more and more difficult mainly for two reasons: (a) such unchecked increase in the population will increase in the short run, the already high rate of dependants to labour force and such an increase in dependants makes savings exceedingly difficult especially where the per capita income is low and (b) a large portion of savings should go into capital formation such as intensified farming, housing, schools, hospitals etc. for the benefit of the added population. An essential policy for success in achieving India's economic goals is therefore effective population control.

2.21. *Employment*—According to recent estimates, the total population of India was of the order of 415 millions at the beginning of March, 1959. It was observed in the 1951 census that about 40 per cent of the population constituted the working force. Assuming that this proportion remains the same, the present size of the working force is estimated at 165 millions.

2.22. The bulk of the working population is engaged in agriculture while the numbers employed in industry and services are not relatively large. It is estimated that about 122 million are employed in agriculture, 17 million in industry and 26 million in the services. Experience indicates that out of an increase of 20 million persons in the working force during 1941-51 as many as 14 million had to be absorbed in agriculture. This is contrary to the experience of industrialised countries like the U.S.A. where the number employed in agriculture actually declined during 1940-50 while, at the same time, all the increase in the working population was absorbed in industry and services. In Japan too, during the same period a larger proportion of the increase in the working population was absorbed in industry and services compared to agriculture. It is, therefore, evident that a large part of the future rise in population and hence the working force has to be absorbed in agriculture till such time as there is a change in the industrial pattern of the country.

2.23. The employment situation by the end of the Third Plan or the future plans cannot be accurately visualised at present till the plan frames are ready. It is, however, anticipated that the population will increase from 430.8 million in 1961 to 479.6 million in 1966 resulting in a rise of 48.8 million. It is estimated that this will involve an increase in the working population by 15 million during the Third Plan period. The increase in the working

force together with the backlog of the unemployed remaining at the end of the Second Plan will determine the magnitude of the employment problem and set a limit to the number of jobs to be created during the Plan period in order that the unemployment situation will not at least deteriorate. The extent to which employment targets can be achieved will, however, depend on the resources available under the Plan.

2.24. Another aspect of the employment problem is that of diverting the surplus manpower from agriculture to non-agricultural occupations. According to one view, the working population in agriculture should be gradually reduced to 55 per cent of the total by the end of the Fifth Plan. This objective implies creation of more employment opportunities in non-agricultural occupations which, in turn, are linked up with the size of investment that is possible during the successive Five Year Plans.

2.25. The employment aspect of a plan is, to a large extent, connected with the population growth. It can be anticipated that as a result of the progress made so far by the development plans and consequent improvement in health and sanitation, the death rate will go down. The declining rate of mortality, unless accompanied by a fall in the birth rate will, naturally, lead to a rapid increase in population which, in turn, will contribute large additions to the future working force.

2.26. The present indications are that the death rate will go down from 21.6 per thousand per annum during the Second Plan period to 18.2 during the Third Plan period, while there will be only a small change in the birth rate from 40.7 to 39.6 during the period. Consequently, the population is estimated to go up at an annual rate of 2.1 per cent when there will be an increase of 48.8 million in the total population and a corresponding rise of 15.0 million in the working force.

2.27. In order to tackle the employment problem in the future plans, it is imperative that from now onwards the population growth is interpreted in terms of additional jobs that are likely to be required to meet the growth in the working force. The decline of birth rate may not be very significant with reference to the additions to the working force in the immediate future as those who constitute the potential working force are already born. But it is essential that a beginning should be made in cutting down the birth rate to curb the future increases in the working population which will otherwise assume large dimensions. There is already a surplus of manpower for whom adequate employment opportunities have to be created during the current plan and, unless the rate of population growth is now brought down, the pressure on the employment market will continue to rise during the future plans.

2.28. *Food situation in India*—The food situation in India has undergone a significant change during the last decade or so. While during the forties and early fifties, the food problem caused concern due to stagnant agriculture combined with an increasing population, during the late fifties there has been increased production. Nevertheless the food problem continues to cause grave concern owing to growing numbers and increasing demand mainly caused by heavy developmental expenditure, deficit financing, increased money supply and increased purchasing power with the public.

2.29. After a serious set-back to the production of foodgrains during 1957-58 a record crop of 73.5 million tons of foodgrains has been harvested in 1958-59. It is expected that although at the end of the Plan period, the revised target of 80.5 million tons for food grains may not be reached, the original target of 75 million tons will be achieved and may well be exceeded to some extent. The index number of production of foodgrains and population in India during the last ten years are shown in the following table:—

Year	Production (million tons)	Population (million persons)	Index number of food grains pro- duction	Index of population	Index of production per head of popu- lation
1949-50	54.0	356.84	100	100	100
1950-51	50.0	361.29	90.5	101.2	89.4
1951-52	51.2	367.10	91.1	102.9	83.5
1952-53	58.3	373.00	101.1	104.5	96.7
1953-54	68.7	379.00	119.1	106.2	112.1
1954-55	67.0	385.10	115.0	107.9	106.4
1955-56	65.8	391.40	115.3	109.7	105.1
1956-57	68.7	399.10	120.5	111.8	107.8
1957-58	62.5	407.00	108.0	114.0	94.7
1958-59	75.5	415.00	128.2	116.3	110.2

2.30. From the figures of production given above, it will be observed that despite annual variations, on the whole there has been a rising trend in the production of foodgrains. The index number of production has risen from 100 in 1949-50 to 115.3 at the end of the First Five Year Plan (1955-56) and further to 128.2 in 1958-59, thus showing an increase of 15.3 per cent during the First Plan period and another 11 per cent during the first three years of the Second Plan period. As against this, the population rose by 9.7 per cent during the same period and by another 6 per cent during the first three years of the period of the Second Plan.

2.31. In spite of improvement in the total as well as per capita production, the supply of foodgrains is still lagging behind the actual needs of the people and the problems of shortages and high prices continue.

2.32. With the increase in purchasing power and progressive urbanisation, the people are changing over in increasing measure from coarser foodgrains such as jowar, bajra, barley, ragi, etc. to superior grains like wheat and rice. This has the effect of an increase in the demand specially for wheat and rice. An examination of the position in the last few years will illustrate how the demand on foodgrains is increasing in the country. In 1953, the total gross production of cereals was 49.2 million tons. It was then found possible to meet

the requirements of the country by importing only 2.0 million tons of food grains (cereals), the total gross availability for the year being 51.2 million tons. In 1957, the production of cereals had gone up to 57.25 million tons and although this figure exceeded the total availability of 1953 by about 6 million tons, there was heavy pressure on the supply of foodgrains and the prices were steadily rising. It was, therefore found necessary to import as much as 3.58 million tons of foodgrains (cereals) in 1957, and as against the total gross availability of 51.2 million tons in 1953 that in 1957 was 60.83 million tons.

2.33. The following table shows the quantity of foodgrains imported from foreign countries since the year 1948 and the value thereof. It will be seen that the imports have been fluctuating according to the needs of the country, depending on production of foodgrains from time to time. In 1953-54, when the production of foodgrains reached the peak, the imports were curtailed to the minimum. In 1954, the imports were only 8.1 lakh tons and in 1955, 7 lakh tons, as against the peak figure of 47.25 lakh tons in 1951:—

Year							Quantity (in 000 tons)	Value (lakhs of Rupees)
1948	..	..	..	..	..	..	2,841	12,972
1949	..	..	..	..	..	..	3,706	14,460
1950	..	..	..	..	..	..	2,125	8,060
1951	..	..	..	..	..	..	4,725	21,679
1952	..	..	..	..	..	..	3,864	20,907
1953	..	..	..	..	..	..	2,003	8,595
1954	..	..	..	..	..	..	808	4,702
1955	..	..	..	..	..	..	707	3,311
1956	..	..	..	..	..	..	1,420	5,634
1957	..	..	..	..	..	..	3,582	16,218
1958	..	..	..	..	..	..	3,175	12,052

2.34. The demand for foodgrains during the Third Five Year Plan period will be influenced by (a) the increase in population; (b) urbanisation and (c) the increase in purchasing power of the people as a result of increase in national income and heavy development expenditure. It is difficult to give a firm estimate of the likely imports but it seems that it will be necessary to continue to import 3 to 4 million tons annually for some years to come. The Foodgrains Enquiry Committee recommended* that "for an effective solution of the food problem, not only determined all-out efforts to step up production have to be made but the high rate of increase of population has to be checked. We, therefore, urge that a nationwide campaign for family planning, enlisting the efforts and energies of social workers particularly women, medical men, scientists, sociologists, economists, administrators and political leaders be launched".

* Report of the Food-grains Enquiry Committee 1957, page 133.

2·35. Food requirements not only include foodgrains but protective foods like vegetables, fruits, milk, poultry, fish, meat etc. The supply of these is far from adequate. Similarly human requirements include not only food but housing, educational and medical facilities and other measures for the improvement of the general socio-economic standards of the people.

2·36. *Optimum population*—The Committee appreciates that no definite view can be expressed regarding the optimum population for India, as it depends upon the consideration of innumerable variables whose precise magnitude cannot be predicted with any accuracy. Shri Ashoka Mitra, the Registrar General, considers that “at the present rate of employment and residual employment even a population of 400 million in 1960 will be much above the optimum”.

2·37. The above brief examination of the position concerning the rise in the growth of population, the levels of income, both national and per capita, the growth of employment opportunities, the increase in food production and consumption, combined with the increasing requirements for housing, education, health and other facilities for improved living standards, leads to the irresistible conclusion that unless population growth can be substantially curtailed, the people will not enjoy the full benefits of their intensive efforts to increase productivity and accelerate development under the Plans.

CHAPTER III

REVIEW OF THE FAMILY PLANNING PROGRAMME

3.1. *Health, Survey and Development Committee*—In 1943, the Government of India appointed the Health, Survey and Development Committee under the Chairmanship of Sir Joseph Bore with Dr. K.C. K. E. Raja as Secretary. In the report issued by this Committee, birth control services were recommended primarily for health reasons.

3.2. In March 1950, the Government of India appointed the Planning Commission, and in the following year the Commission began to explore the problem of population growth in connection with the recommendations that had to be made for the first Five Year Plan. This subject came up for discussion both in the Advisory Health Panel and the Advisory Social Welfare Panel appointed by the Planning Commission. On the 11th April, 1951, the Advisory Panel on Health Programmes appointed a sub-committee on family planning. This sub-committee strongly recommended that family planning should be recognised officially in order to safeguard the health and well-being of mothers and children and to aid the national economy by reducing the birth rate concurrently with the death rate, thereby helping to stabilise population growth. It was recommended that a financial allocation be made for services and scientific research in family planning. (See Appendix V).

3.3. In the meantime, during 1951, the Ministry of Health invited, through the W.H.O., Dr. Abraham Stone to carry out a survey in India from the point of view of introducing pilot studies in the rhythm (safe period) method of family planning in the country.

In the same year, the Indian Council of Medical Research held a symposium (19th November 1951) and recommended the establishment of a broad-based research committee on the medical and biological aspects of human reproduction, to work in close co-operation with the Central Government and the Planning Commission. Also, the Adviser, Health Programmes, Planning Commission, carried out a survey of existing conditions and formulated proposals. On the 10th April 1952, the report of the Sub-Committee on Population Growth and Family Planning was discussed and the establishment of two Committees was suggested, namely, the Population Policy Committee and the Population Research and Programmes Committee.

3.4. *First Five Year Plan*—On the 7th December, 1953, the Planning Commission recommended that a programme for family limitation and population control should (a) obtain an accurate picture of factors contributing to the rapid population increase in India (b) discover suitable techniques of family planning and devise methods by which knowledge of these techniques can be widely disseminated and (c) make advice on family planning an integral part of the service of Government Hospitals and Public Health Agencies. The programme was to include the provision, in Government Hospitals and Health

Centres, of advice on methods of family planning for married persons who required such advice for health reasons, field experiments on different methods of family planning for the purpose of determining the suitability, acceptability and effectiveness in different sections of the population; development of suitable procedures to educate the people on the family planning methods, collection from representative sections of the population of information on reproductive patterns and attitudes and motivations affecting the size of the family, studies on the inter-relationship between economic, social and population changes, collection and studying of information about different methods of family planning and making such information about different methods of family planning available to professional workers, and research into the physiological and medical aspects of human fertility and its control. (See Appendix VI).

3.5. *Research & Programmes Committee*—The Population Policy Committee came into being on the 7th April 1952, and on the 6th May, 1953, the Family Planning Research & Programmes Committee was appointed to recommend programmes and research schemes and the amount of assistance to be given to existing voluntary organisations after a review of their work. (See Appendix VII.)

3.6. The Family Planning Research & Programmes Committee recommended the allocation of Rs. 65 lakhs under various main heads appropriated for family planning under the Five Year Plan, as follows:—

Heads	Allocation for five years (Rs. in lakhs).
Subsidy to State Governments and voluntary organisations	30.00
Training programme (model training centre)	7.50
Training programme for the interim period	1.00
Education for family planning	5.00
Establishment of units for the evaluation of contraceptives—	
(a) Laboratory studies .. 0.60	
(b) Studies in selected clinics .. 2.20	2.80
Research on the biology of human reproduction	3.00
Research on attitudes and motivations affecting fertility and economic and social determinants of population trends	9.00
Existing research centres, Lodi Colony and Ramanagaram	3.50
Headquarters staff including expenditure on meetings etc.	3.20
Total	65.00

3.7. Two sub-committees of this Committee were also set up (a) on social economic and cultural studies and (b) on the biological or qualitative aspects of population. A Standing Committee was also formed for regulating the testing and evaluation of contraceptives.

3·8. *Family Planning Section*—A Family Planning Section was created in April 1952 in the Planning and Development section of the Director General of Health Services. The Staff of this Section included : one Section Officer, one Assistant, Two U.D.Cs. and two L.D. Clerks. The Adviser, Health Programmes, Planning Commission, was placed in overall charge of this Section. An Officer on Special Duty for Training was appointed.

3·9. *Grants Committee*—On the 28th May, 1954 the Government of India appointed a Grants Committee to scrutinise and recommend for sanction, applications for assistance for family planning work as well as research (see Appendix VIII).

The pattern of financial assistance approved by the Government of India was as follows :—

<i>Non-recurring</i>	100%
<i>Recurring expenditure—</i>	
First six months	100%
Next twelve months	66·3%
Next twelve months	50%
Next six months	33½%

3·10. *Progress—First Five Year Plan Period*—During the period of the first Five Year Plan, grants-in-aid were given to 15 State Governments, 8 Local Bodies and 35 Voluntary organisations. The number of clinics opened was 147 (21 rural and 126 urban). These included 86 by State Governments, 27 by Local Bodies and 34 by the voluntary organisations. Ad hoc training courses were conducted under government auspices and 67 persons were trained including 30 doctors, 32 health visitors and 5 social workers. (This was in addition to about 300 persons trained by the Family Planning Association of India). 70,000 posters and 20,000 folders were printed and distributed. Two films were produced and nine films were obtained from other sources and made available to different organisations. Medical, biological and demographic research schemes were undertaken. Two medical officers were sent on deputation in August 1955 on fellowships granted by the T.C.M. for higher training at North Carolina University, U.S.A., for a period of about 12 months. During their stay abroad they studied the working of family planning clinics at various places. Both of them qualified as M.P.H. The rural centre at Ramanagaram where the pilot studies on the rhythm method had been conducted was upgraded in April 1955 as the Rural Family Planning Training, Demonstration and Experimental Centre after the conclusion of the pilot studies. Provision was also made in the Drugs and Magic Remedies (Objectionable Advertisement) Act 1954, for controlling objectionable advertisements. During this period the total expenditure incurred by the Central Government was Rs. 15·82 lakhs. Thus, there was an unexpended sum of Rs. 49·18 lakhs from the allocation made available of Rs. 65 lakhs. This was due to the slow pace at which the various component parts of the programme got under way. To some extent this was inevitable, since the ground work for the programme had to be laid from scratch.

3.11. *Second Five Year Plan*—The Planning Commission in their Second Five Year Plan observed that the programme had progressed sufficiently to call for its further development on systematic lines, for continuous study of population problems and for a suitable Central Board (more or less autonomous in working) for family planning and population problems. The recommendations made by the Planning Commission included extension of family planning advice and service; establishment and maintenance of a sufficient number of centres for the training of personnel; development of a broad-based programme of education in family living which would include within its scope sex education, marriage counselling and child guidance; research into biological and medical aspects of reproduction and of population problems; demographic research, including investigation of motivation in regard to family limitation as well as studies of methods of communication; inspection and supervision of the work done by different agencies, governmental and non-governmental, to which grants would be made by the Central Board; evaluation and reporting of progress; and establishment of a well-equipped central organisation. (Appendix IX).

3.12. *Central Family Planning Board*—The Central Family Planning Board was formed on the 1st September, 1956 with the Health Minister as Chairman (See Appendix X), for the expeditious implementation of the programme. On the 26th September, 1956, the Officer on Special Duty (later designated as Director, Family Planning) was appointed. At its first meeting on the 27th October, 1956 the Board recommended that a Standing Committee be appointed and that the States should appoint States Family Planning Officers to supervise family planning work in the States, the Government of India agreeing to pay the entire expenditure for three years for such Officers. At the suggestion of the Prime Minister made while inaugurating the second meeting of the Board, the family planning programme was discussed in a meeting of the National Development Council attended by the State Chief Ministers. The periodic Conferences of Health Ministers and Administrative Officers of the States, and of Community Development Commissioners have also considered this subject. The Standing Committee was constituted on the 2nd January, 1957 under the Chairmanship of the Secretary, Health Ministry. (Appendix XI).

During the years 1956-1959, the Central Family Planning Board held 7 meetings and its Standing Committee held 4 meetings. The official members of the Standing Committee were, however, virtually in continuous session.

3.13. Among the important steps taken to promote the family planning programme were : the development of administrative machinery at the Centre and the States for this purpose, simplified procedures for giving grants, liberalised and flexible assistance to voluntary organisations and local bodies, the issue of contraceptives at free and subsidised rates, extension of training programmes including courses at medical teaching institutions, starting of a broad-based education programme, encouraging people's participation in the programme through voluntary work, the extension and intensification of research, both demographic and medical, especially as applicable to immediate problems, an acceleration of measures to produce contraceptives in India, the extension of the requisite facilities for sterilization. The programme was

developed as a four-fold action-cum-research programme comprising Service, Training, Education and Research, with the close co-operation of governmental and non-governmental agencies.

3.14. The Family Planning Section in the Directorate General of Health Services is still being built up, the present staff consisting of 8 technical personnel and 13 administrative staff. (See Appendix XII).

3.15. *Pattern of Assistance, Second Five Year Plan*—The grants to family planning clinics are given generally on the following pattern :—

	Rural	Urban
<i>Non-recurring—</i>		
	Rs.	Rs.
Equipment, furniture and publicity material etc.	500	2,000
Stocking of contraceptives	500	500
	1,000	2,500
<i>Recurring—</i>		
One lady doctor & One part-time male doctor		5,000
Social worker or health visitor or field worker (family welfare worker)	3,000	3,000
One (Peon) clinic attendant		1,000
Contingencies	500	500
Conveyance allowance	500	..
Distribution of contraceptives	1,500	1,500
	5,500	11,000

3.16. The pattern of financial assistance offered for the family planning programme for M.C.H. Clinics run by the Indian Red Cross Society is as follows :—

Category I	Population below 2,000	Grant given for distribution of contraceptives.
Category II	Population between 2,000 and 5,000	Grant given for contraceptives, health visitors, and contingencies.
Category III	Population between 5,000 and 10,000	Grant given for part-time medical officer, wholetime health visitor, contingencies and distribution of contraceptives.
Category IV	Population above 10,000	Grant given for full-fledged clinic on approved pattern.

3.17. All contraceptives in rural and urban centres are authorised for free issue to persons with incomes below Rs. 100 per month; at half rates to those with incomes between Rs. 100 and Rs. 200 per month, and at full rates to those with income above Rs. 200 per month. Foam tablets and sheaths are issued free in rural clinics irrespective of income.

3.18. *Commercial Organisations*—Commercial organisations, manufacturers, mills, factories etc. if recommended by the Administrative Medical Officers of the State, who may be interested in establishing, with their own funds, family planning clinics in their concerns for the benefit of their workers will each be sanctioned a token grant of Rs. 1,000 per annum for distribution of contraceptives. Free educational material and facilities for training will also be provided.

3.19. *Medical and Health Centres*—All the primary health centres, hospitals, dispensaries and maternity homes having no family planning clinics and which are run or recommended by the State Governments are sanctioned each a grant of Rs. 1,500 per annum for the distribution of approved contraceptives.

The provision of Rs. 80,000 for building purposes for a Primary Health Centre includes provision for accommodation for the family planning clinic.

3.20. The pattern of Central assistance to State Governments, local bodies, and voluntary organisations is as under—

						State Govts. & Local Bodies	Voluntary Organisations	
							Rural	Urban
<i>Non-recurring</i>	..	..	..	..	..	100%	100%	100%
<i>Recurring—</i>								
First Year	..	..	..	..	..	80%	100%	100%
Second Year	..	..	..	..	..	70%	100%	80%
Third Year	..	..	..	..	..	50%	100%	80%
Fourth Year	..	..	..	..	..	30%	100%	80%
Fifth Year	..	..	..	..	..	20%	100%	80%

The expenditure for contraceptives in all rural and urban clinics and for clinics in medical teaching institutions is borne entirely by the Central Government.

3.21. The procedure laid down for financial assistance to local bodies and voluntary organisations is given in Appendix XIII.

3.22. *Budget Provision & Expenditure—Second Five Year Plan*—A total provision of Rs. 497 lakhs (including Rs. 400 lakhs at the Centre and Rs. 97 lakhs in the States) was made for the Second Five Year Plan period. The tentative allocations were: Service—Rs. 373.25 lakhs; Training—Rs. 15.75 lakhs; Education—Rs. 50.00 lakhs and Research—Rs. 50.00 lakhs. The budget provision approved for 1956-57, 1957-58, 1958-59 and 1959-60 was Rs. 30 lakhs, Rs. 25 lakhs, Rs. 46 lakhs and Rs. 80 lakhs respectively.

Budget Provision and Estimated Expenditure

(Rs. lakhs)

	1956-57		1957-58		1958-59		1959-60	
	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure	Budget	Anticipated exp.
1. Clinics ..	12.00	3.05	15.07	16.34	26.15	19.98	46.03	45.39
2. Training and Education ..	9.00	0.67	5.23	2.22	8.50	5.04	24.61	1.76
3. Research ..	6.00	3.99	3.56	6.70	8.65	5.76	5.21	3.14
4. Organisation	3.00	0.93	1.14	0.75	2.70	0.72	4.15	0.74
Total ..	30.00	8.64	25.00	26.01	46.00	31.50	80.00	51.03

3.23. *Service Provision—Second Five Year Plan*—The Plan provided for the opening of 500 clinics in urban and 2,000 clinics in the rural areas. Normally each clinic was required to cover a population of 50,000 in the urban and 66,000 in the rural areas. The grant for rural clinics provides one worker only to strengthen the staff of the unit to which it is attached. In the absence of information regarding the work load, and difficulties in finding doctors for rural areas, provision for a doctor in rural clinics was not made. Two pilot clinics in each State were, however, authorised to have a woman medical officer.

The phasing of clinics was as follows :—

	1956-57	1957-58	1958-59	1959-60	1960-61	Total
Rural	100	200	300	600	800	2,000
Urban	30	40	80	150	200	500

3.24. Against the target for 1956-60 of 1200 rural and 300 urban clinics 691 rural and 309 urban clinics have been opened so far.

Number of clinics opened during 1956—60 (upto 30-10-1959).

Sponsor	Rural	Urban	Total
State Governments	654	209	863
Local Bodies .. ..	..	27	27
Voluntary Organisations	37	73	110
Total	691	309	1000

Out of 310 districts of India, 262 now have family planning clinics. The urban clinics include 21 in medical colleges, 63 in teaching institutions for medical auxiliaries. Apart from the regular clinics, out of 4,163 M.C.H. Centres, 1,318 have family planning clinics.

3-25. It is estimated that 46.65 lakhs couples have been contacted by the clinics and 11.5 lakhs couples were given contraceptives. The sale of contraceptives has been increasing since 1956. The sales in 1957 were twice the sales during 1956 and the sales during each of the years 1958 and 1959 were about six times the sales during 1957.

3-26. *Sterilization*—The Central Family Planning Board recommended the inclusion of the sterilization operation in the family planning programme, the cases to be selected after a careful examination by a qualified doctor of the patient's family history and condition. The operation needs the prior consent of both husband and wife, and must be performed in hospitals or medical institutions where the requisite facilities for performing such operations exist. The Central Council of Health at their meeting held in Shillong in January 1959, recommended that the State Governments should intensify the family planning programme, including surgical facilities, at their hospitals and medical institutions and the Central Government could give financial assistance to State Governments for establishing such surgical facilities. The Ministry of Health has also sanctioned extra personnel to strengthen the staff of the Safdarjang Hospital, New Delhi, for performing sterilization operations and similar facilities are being extended to other hospitals. The Ministry of Home Affairs has decided to grant special casual leave not exceeding six working days to Government servants who undergo vasectomy or salpingectomy operation under the family planning scheme. The Executive Committee of the Medical Council of India, at their meeting held on the 26th September, 1957 on the subject of sterilization operations for medical, eugenic and socio-economic reasons, decided that males and females may be allowed to be operated upon for sterilization in hospitals and private nursing homes, provided it is voluntary and with the consent of both husband and wife. The Indian Medical Association has also supported sterilization.

3-27. Sterilization facilities are being extended in the States, especially in Madras. The number of sterilization cases reported in India during 1956 was 7,823, and during 1958 this number increased to 25,873 (Appendix XIV). These are considered to be underestimates.

3-28. *Manufacture of Contraceptives*—There are at present two units in the country engaged in the manufacture of rubber contraceptives. The combined installed capacity of these two units for male contraceptives is about 16 lakhs numbers per year. Against this the production during the past few years is as follows—1954: 345, 252; 1955: 111, 552; 1956: 78, 612; 1957: 108, 456; 1958: 155, 760; and 1959 (January August): 124, 956. The current demand for male contraceptives has been estimated at 8 million per year which is likely to go up to 10 million per year by the end of 1961. It would thus be seen that the current production of male contraceptives in the country is not adequate to meet the demand. Even if the existing capacity is fully utilised, it would meet the estimated demand only to the extent of about 20 per cent.

3-29. With regard to female contraceptives there is no indigenous production for the diaphragm type of contraceptives. The requirements for the diaphragm contraceptives which would be 3,000,000 during 1959-60 would rise upto 5,000,000 by 1960-61. The cervical cap female contraceptive is also being manufactured in India though the production capacity is very limited.

3-30. In view of the meagre production of these items in the country the Government have been following a liberal import policy. Till June, 1957, these items were on O.G.L. after which they were placed on quota licensing. Contraceptives falling under this item were exempted from payment of customs duty leviable thereon. The particulars with regard to the imports of rubber contraceptives from 1957 onwards are as follows:—

Rubber Contraceptives	(Quantity in '000' doz.) (Value in '000' Rs.)					
	1957		1958		1959 (January—July)	
	Quantity	Value	Quantity	Value	Quantity	Value
U. K.	49	71	86	109	89	96
Czechoslovakia	32	23	..	..	2	1
Japan	168	95	111	67	63	38
U.S.A.	276	458	162	230	145	192
Others	59	29	3	3	3	4
	584	676	362	409	302	331

3-31. Manufacture of rubber contraceptives involves a considerable amount of technical skill. It is perhaps for this reason that the existing capacity is not being fully utilised. To make the country less dependent on imports and also to meet the domestic demands, several steps have been taken. Necessary facilities are being given to the existing units to produce to the maximum extent possible. With a view to bring into existence additional capacity, new entrepreneurs are being induced to take up the production of rubber contraceptives in collaboration with well known foreign manufacturers.

3-32. Since indigenous production is very small as compared to demand pending creation of additional capacity, a liberal import policy for rubber contraceptives has been adopted. In view of the need for the creation of additional capacity for the manufacture of these items, new schemes and substantial expansions would receive sympathetic consideration provided the schemes are technically and otherwise sound. In order to ensure the success of the approved schemes, all necessary help would be given including the assistance required for the import of plant and machinery, raw materials, chemicals, etc. which are not indigenously available.

3-33. A number of firms in India are manufacturing foam tablets to meet the entire requirements. Manufacture of jellies and creams has also been started in the country. It is anticipated that the entire requirement will be produced in the country.

3-34. *Training Programme—Second Five Year Plan*—The following training programmes have been developed:—

- (i) Centre for training potential instructors.
- (ii) A rural Training, Demonstration and Experimental Centre.
- (iii) Touring training team.
- (iv) Development of selected clinics into Regional Training Centres.
- (v) Regional Training Centres for family welfare workers.
- (vi) Ad hoc training courses of short duration wherever trained personnel and clinical material are available.
- (vii) Incorporation of family planning in the normal training programme in teaching institutions for doctors and medical auxiliaries.

Stipends are given during the regular training period at the rate of Rs. 150 p.m. to doctors, Rs. 100 p.m. to social workers and public health nurses and Rs. 75 p.m. to health visitors and field workers. Travelling allowance is also paid to trainees from voluntary organisations. Each trainee receiving stipends is required to execute a surety bond to the effect that after completion of training he or she will serve the State Government/Local Body/Voluntary Organisation for a period of at least 3 years. The applications of trainees are required to be sponsored by the State Government/Local Body/Voluntary Organisation.

3-35. A Family Planning Training and Research Centre for potential instructors was established in Bombay on the 15th March, 1957, and another is being started at New Delhi. The Rural Training, Demonstration and Experimental Centre was developed at Ramanagaram and the first course of training was started on the 12th August, 1957. A grant for a pilot Touring Training Team was given to the Family Planning Association of India, Bombay, and ten additional teams will be started soon. Seven Regional Training Centres are functioning: two in the Punjab (Patiala and Amritsar), and one each in Assam (Shillong), Andhra Pradesh (Hyderabad), Madras (Madras), Kerala (Trivandrum) and West Bengal (Calcutta). Short term ad hoc training courses are being conducted in different places wherever facilities exist.

3-36. In view of the great difficulty experienced in finding social workers for rural areas, a scheme to train family welfare workers has been approved and grants have been given to the Andhra Mahila Sabha, Madras, the Matru Seva Sangh, Nagpur and the Kamla Nehru Memorial Hospital, Allahabad, for conducting the training courses.

3-37. During the First Five Year Plan period 67 persons were trained in Government sponsored courses in addition to about 300 persons trained by the Family Planning Association of India. 2,589 persons have been trained in family planning in varied courses during the Second Five Year Plan period (upto October 1959), (Appendix XV). The details regarding the staff and expenditure of the different training centres is at Appendix XVI.

3-38. *Education Programme—Second Five Year Plan*—The education programme carried out includes the following:—

- (i) Projects to collect detailed information regarding factors responsible for community and family attitudes, beliefs and behaviour patterns;
- (ii) Identification of natural groups and natural group leaders and the use of these as a channel of communication;
- (iii) Preparation and testing of basic materials and methods for (a) mass communication; (b) community education; (c) imparting specific technical knowledge and skills;
- (iv) Training a corps of competent workers.

The education programme is being developed at the Centre [with the co-operation of the Central Health Education Bureau, Directorate General of Health Services, and the Ministry of Information and Broadcasting.

3-39. The education material produced includes 5,10,000 copies of posters 6,96,000 of pamphlets and folders, one film (under production) and 377 cinema slides. A number of talks, discussions, interviews and features were broadcast over All India Radio. A monthly "Family Planning News" is now issued by the Directorate General of Health Services. Grants were sanctioned to the Family Planning Association of India for its quarterly publication the "Journal of Family Welfare" and monthly bulletin, "Planned Parenthood". Grants were also sanctioned for "Parivar Niyojan" a quarterly journal in Hindi, and other publications. Honorary Family Planning Education Leaders have been appointed for motivating the people and mobilising opinion in favour of family planning. The latest development in the educational programme is that the Population Council, U.S.A. is to send pilot Health Education Units for family planning education. The Ford Foundation has offered assistance for family planning motivation programme. Fourteen Orientation Training Teams have also been sanctioned. Orientation camps are proposed to be conducted by peripatetic education teams, each team consisting of a one doctor (Asstt. Surgeon Grade I), one health educator and one attendant (peon). The aim is gradually to have groups of persons in each village and town as voluntary Family Planning Education Pracharaks. The publicity programme is being carried out with the assistance of the Ministry of Information and Broadcasting.

3-40. The Committee on Health Education and Nutrition Education set up by the Ministry of Education is now preparing revised syllabi on health education for primary and secondary schools and teacher's training institutions. This Committee is of the view that sex education should find a place in the educational curriculum in schools. The syllabi will be referred to State Governments and Universities for their views before finalisation. The syllabi will also be listed on an experimental basis in selected schools.

3.41. *Medical and Biological Research—Second Five Year Plan—* Medical and biological research is being conducted mainly under the Indian Council of Medical Research, under the guidance of the Physiology of Human Reproduction Committee (Appendix XVII). Investigations on contraceptives are being carried out at the Contraceptive Testing Unit, Indian Cancer Research Centre, Bombay, the All India Institute of Hygiene and Public Health, Calcutta, the Central Drug Research Institute, Lucknow, the Institute of Post-Graduate Medical Education and Research, Calcutta, the Bacteriological Institute, Calcutta, and the Pharmacology Department of the Lucknow University. Fifty-nine mechanical and chemical contraceptives have been tested and 22 have been found satisfactory. A number of oral contraceptives have been investigated. The results of research on meta-xylohydroquinone appear encouraging.

3.42. *Demographic Research Programme—Second Five Year Plan—* Demographic Research is being conducted under the guidance of the Demographic Advisory Committee (Appendix XVIII). The Demographic Training and Research Centre, Bombay, was started in 1956 by the Government of India in collaboration with the United Nations and Tata Memorial Trust, as a regional institution to serve the needs of Asian countries included in the ECAFE region. The provision made by the three constituent sponsors is shown below—

	Share of Govt. (Rs. lakhs)			Tata Trust (Rs. lakhs)	U.N. (\$)		
	N.R.	R.	Total				
1956-57	2.92	1.23	4.15	0.25	51,000
1957-58	3.20	1.26	4.46	0.25	41,000
1958-59	1.46	1.46	0.25	41,000
1959-60	1.48	1.48	0.25	41,000
1960-61	1.57	1.57	0.25	41,000
			6.12	7.00	13.12	1.25	2,15,000*

* (Rs. 10.20 lakhs)

The Centre functions in collaboration with the following institutions:—

The Department of Economics of Bombay University, Bombay.

The Department of Sociology of Bombay University, Bombay.

Two Divisions in the India Cancer Research Centre, Bombay, dealing with Human Variation and the Physiology of Human Reproduction respectively.

The Tata Institute of Social Sciences, Chembur, Bombay.

The Departments of Economics and Statistics of the Government of Bombay, and

The Gokhale Institute of Politics and Economics, Poona.

The Centre is provided with staff consisting of a Director, a Statistician, and junior technical and secretarial personnel as well as experts assigned by the United Nations. The administrative control is vested in a Governing Body (Appendix XIX). The inaugural conference of the Centre took place in 1957 at which a number of delegates from India and other Asian countries were present. The conference made a series of recommendations regarding the training and research programme of the Centre. As recommended by the conference a Standing Advisory Committee consisting of a Chairman nominated by India was constituted (Appendix XX). The aim of the training program at this Centre is to help to build up over a period of years, a nucleus of persons in each country of the region who have sufficient knowledge of demography to plan and carry out population studies and undertake demographic training in their respective countries. Since 1957, nine Indian and twelve foreign fellows have been admitted for training. Fellowships at the rate of Rs. 540 per month for a period of 12 months are offered to the foreign students by the United Nations in addition to travel expenses to and fro. In addition free furnished hostel accommodation is provided. The Government of India offers a monthly stipend of Rs. 250 to each Indian student for a period of two years. The expenditure for study tours undertaken by the students inside the country is met by the Centre. The minimum qualification for the foreign fellows is B.A. or its equivalent. The minimum qualifications for the Indian fellows is a Masters Degree in Mathematics, with preference for those who took statistics as a special subject, statistics, economics, sociology, biology, psychology, and anthropology, or a degree in medicine with preference for those who have had experience of public health work. The Centre offers two types of training—General and Special. The main training programme is the General course. Special courses are intended to meet the needs of individual candidates. The General course is for the duration of one year, starting in July. The training programme is carried out jointly by the Centre and the co-operating units. The subjects taught are substantive demography, technical demography, statistics, economics, sociology, field survey techniques, human genetics, physiology of human reproduction and a family planning seminar occupies an important place in the teaching programme of the Centre. Each student is also required to take up a special topic for more intensive study under the guidance of a member of the staff and write a report before he finishes the first year course. Periodical assessment of the students' progress is done by the instructors. Highly qualified and experienced persons are given facilities for specialised study and research in demography in suitable cases. A Certificate is awarded to the student undergoing the General or Specialised course. The second year of training which is only for Indian students, is devoted mainly to research. Proposals are under consideration for providing higher training in foreign universities for selected students who have undergone training in the Centre. Provision also exists for a Ph.D. course at the Centre. A survey of about 500 school children of Bombay city for obtaining estimates of the intelligence quotient, physical measurements, physical efficiency etc., is being carried out, which may serve as base line data to compare future changes in respect of these characteristics among the school children in Bombay. Internal migration between States in India based on the census data, future growth of population in Ceylon and its impact on the economically active sections of the population, and an analysis of the data collected in the fertility survey

in connection with the Burmese censuses of 1953 and 1954, are some of the research programmes that are being carried out by the Centre. A project has also been jointly undertaken by the Centre and the Family Planning Training and Research Centre, Bombay, to try out different education techniques in regard to family planning amongst a group of railway workers. There is a well equipped library for this Centre.

3.43. The Demographic Research Centre was established in the Delhi University in 1957 to carry out research and field studies on problems relating to the Indian population. The staff employed at the Centre consists of field survey staff, research staff and clerical staff. The Centre is financed by the Government of India and has an annual budget of Rs. 62,000. The Centre has undertaken two types of research activities; (1) those relating to the collection of primary data and (2) those relating to the production of demographic information from secondary data. Under the first head are included field surveys carried out by the Centre in some villages around Delhi for the purpose of collecting information of demographic significance as on birth, death, mortality, migration, fertility, age at marriage, age at widowhood, interval between age at marriage and widowhood, etc. Under the second head may be included the estimation of the mean ages at marriage and widowhood in India, the mean duration of fertile union in India, decade interval migration in different cities and States in India, the rate of urbanisation in India etc., all from census data and the collection and analysis of data in the case cards of visitors to family planning clinics in Delhi.

3.44. A Demographic Research Centre has been established at the Indian Statistical Institute, Calcutta. The research programme consists of three parts—

Part 1—

Study of demographic statistics relating to fertility and mortality differentials from published reports.

Part 2—

- (i) Tabulation of data already collected relating to same subjects. Calculation of all-India and zonal estimates of birth and death rates, social classes, age, etc., based on data collected in the N.S.S. 7th round.
- (ii) Tabulation of data of a social mobility survey conducted in rural West Bengal and Calcutta city in 1956.
- (iii) Tabulation of data collected in the N.S.S. 12th round on occupational shifts and their impact on the fertility pattern.
- (iv) Analysis of data collected on the prevalence and changes in contraceptive practices among Calcutta couples, their effect on fertility patterns and social factors associated with them.

Part 3—

Collection of such data as may be necessary to supplement the study based on Parts 1 and 2 to yield an integrated picture of the prevailing fertility and mortality patterns (under this, a special demographic survey was envisaged).

The work relating to the tabulation of the data of the N.S.S. 7th round demography schedule, the social mobility survey and the family planning survey in Calcutta city were taken up during 1957-58. In the year 1958-59 the Institute was engaged with the schemes under Parts 1 and 2 of the proposal. The reports of the social mobility survey and the family planning survey in Calcutta city have been published.

3.45. The Demographic Research Centre in the Department of Statistics, Kerala began functioning from the 14th August, 1958, with an Assistant Director and other staff.

During 1958, the unit began a survey on attitudes towards family planning. A pilot survey was first conducted in Trivandrum city and then extended to other district headquarters.

The survey aims at estimation of (i) the percentage of people who favour family planning, (ii) the percentage of the people who favour known methods of birth control (iii) differential fertility according to income and occupation and (iv) spacing of births. For the pilot survey, the houses in Trivandrum city were divided into four strata according to their annual value and from each stratum 380 houses were thus selected. Data was collected on (1) particulars of households (2) particulars of individual members (3) couple particulars and spacing of births (4) particulars of the mother of the female member of the couple (5) attitude to family planning giving age of the partners (6) knowledge of contraception (7) practice of contraception (fertility history) (8) attitudes and preferences.

3.46. *Co-ordination*—The family planning programme is being conducted with the close co-operation of the Planning Commission, the concerned Ministries, State Governments and other governmental and non-governmental agencies.

(a) *Central Social Welfare Board*—Shrimati Durgabai Deshmukh, Chairman and Shrimati Dhanvanthi Rama Rau, member of the Central Social Welfare Board, are members of the Central Family Planning Board and its Standing Committee. A close collaboration between the two boards is being intensified.

(b) *Ministry of Community Development*—Health is an integral part of the multipurpose Community Development Programme. The country has been divided into approximately 5,000 Blocks to cover the entire area. Each Block has a population of about 66,000 with, approximately, 100 villages. According to the pattern of development, each Block should have a Primary Health Centre and three sub-centres. This is the minimum requirement according to the pattern, but if the State Government has additional funds and staff it can augment these services. Family Planning is considered an integral part of the health programme in the Community Development Block. Nearly two-thirds of the country is covered by this health programme and it has been decided to cover the entire country by the end of March 1963. The health programme in Community Development areas is of an integrated pattern, combining both the curative and preventive aspects, with emphasis on prevention. There were 1,624 Primary Health Centres on 31st March, 1959, and it is presumed that many more have been added by now. As regards staff, according to the pattern, there should be a minimum of 1 doctor, 1

compounder, 1 lady health visitor, 1 sanitary inspector/health inspector, 4 midwives/auxiliary nurse midwives, and a few Class IV officials. This staff is in addition to the existing staff in the Block. Instructions have been issued to the State Governments to see that the staff posted in the Community Development Blocks receive orientation in the basic philosophy and concepts of this programme and further that the staff receive training in family planning work. In both training and orientation, the health education of the people is of fundamental importance. Most of the Primary Health Centres have a transport at their disposal, which facilitates the movements of the staff to carry medical care to the homes of the people. It may be mentioned that during the first three years of the Second Plan period, UNICEF have agreed to supply a vehicle to all the Primary Health Centres developed during this period and also one for each District Health Officer who is responsible for supervision and guidance. The responsibility for the initiation and development of the health programme is entirely with the Health Department of the State concerned. The Department is responsible for training, supervision posting, etc. The Development Department in the State is only a co-ordinating authority. Apart from the technical staff mentioned above, there are 10 village level workers (Gram Sevaks) 2 Gram Sevikas who are trained in home economics and 2 Social Education Organisers, (male and female) in each Block. All State Governments have agreed to give training to these field workers in family planning work also. The intention is that these workers should carry on educational programme for the acceptance of family planning as a vital factor for the improvement of health and socio-economic conditions, and those who agree to plan their families are directed to visit the Primary Health Centres or sub-centres, where trained personnel are available to give advice regarding the method to be adopted. The Development Commissioners have unanimously agreed to include family planning in the syllabus for the training of Gram Sevikas and Social Education Organisers. In view of the fact that a decision has been taken to decentralise administrative authority and ask the people's organisations, particularly Panchayats at the village level, to take up development work, efforts are being made to bring Panchayats into the picture. This would mean that the Panchayat should explain to its people the utility of family planning and encourage them to seek advice on family planning through the health services in the Block. It is felt that every field worker in the community development area should be a potential health educator irrespective of the fact whether he is a technical man or not, or an official representative or unofficial member of the public, because the effort has to be a massive one in which every citizen has a part to play in bringing about an improvement in the health and socio-economic conditions of the people.

(c) *Ministry of Labour and Employment*—The Employees' State Insurance Corporation, Ministry of Labour and Employment, have recommended the implementation of the family planning programme in association with their medical benefit scheme. Under this scheme, the Medical Officer of the State Insurance dispensaries will offer advice on family planning as a part of his work. In the panel areas, the family planning programme will be carried out in medical institutions where arrangements for pre-natal and post-natal care are made. Family planning services for the Coal Mines Labour is under consideration.

(d) *Ministry of Home Affairs*—The Ministry of Home Affairs have provided funds for the family planning programme in the Centrally Administered Areas. There are eleven family planning clinics functioning under the administration of the Union Territories. These include eight clinics in Himachal Pradesh, and one each in Manipur, Tripura and Pondicherry Territories.

(e) *Ministry of Defence*—Family planning in the Army was introduced in 1951 when planned parenthood centres were opened in Unit Welfare Centres. The programme was expanded in 1954 by establishing planned parenthood centres in military hospitals. A sum of Rs. 15,000 was sanctioned in 1956-57, to the Director General of Armed Forces Medical Services, for family planning centres in the units of the Army, Navy and Air Force. In September, 1958 another grant of Rs. 1,03,200 was sanctioned for the opening of eight new family planning clinics in association with M.C.H. Centres and for the maintenance of 64 family planning clinics already established in M.C.H. Centres.

(f) *Ministry of Information and Broadcasting*—At a meeting of the representatives of the Ministry of Health and the Media Units of the Ministry of Information and Broadcasting, convened on August 24th 1957, details of the publicity programme were discussed. It was decided to undertake a phased programme for the production of educative and informative publicity material in the form of posters, folders, pamphlets, films and film strips besides organising exhibitions and putting out special programmes relating to family planning from various A.I.R. stations. For the production of this material through the various Media Units, the Ministry of Health had made financial provision. This concerted publicity drive was initially launched in 1957-58 and accelerated in 1958-59 and 1959-60. Close co-ordination was maintained all along between the Ministries of Health and the Media Units of Information and Broadcasting. In 1957-58 when the campaign was first launched, two posters entitled; “Results of too many children” and “Happiness through Family Planning” and one brochure, were produced. 377 cinema slides were also released for exhibition in the commercial cinema houses throughout the country. The campaign was continued in 1958-59 when 3 posters, 3 folders, 2 brochures and a booklet were produced. A poster competition on the theme of family planning was undertaken during the same year and 108 cinema slides were released. A phased production programme has also been undertaken during the financial year 1959-60 for which a provision of Rs. 8 lakhs has been made in the budget of the Directorate of Advertising and Visual Publicity. The publicity material produced for this campaign is distributed widely. The material is produced in English, Hindi and the major regional languages. The campaign was stepped up on Family Planning Day which was observed for the first time on December 18, 1959. Special tie-up posters were also brought out on the occasion of the Children's Day celebrations (November 14th). Besides the usual press publicity, the Press Information Bureau has also been asked to issue illustrated feature articles on the subject. The radio has been one of the most important means through which the family planning programme has been publicised. As recommended at the meeting between the representatives of Media Units and of the Ministry of Health, the Director General of All India Radio has issued instructions to all All India Radio Stations to arrange a series of features, talks, dialogues, interviews and other programmes on family planning.

The theme of family planning is included in the quarterly programme-schedules of all the Stations and the programmes put out in each quarter are also brought to the notice of the Director, Family Planning. The number and variety of the programmes put out by the various Regional Stations in the local languages during the quarters ending March 31st and June 30th 1959 were as follows:—

Programmes	Quarter ending March 31, 1959	Quarter ending June 30, 1959
Talks	37	30
Discussions	19	19
Dialogues	22	21
Interviews	3	5
Features	8	7
Miscellaneous	20	11
	109	93

On an average each of the 26 Stations of the A.I.R. has been putting out one programme in a fortnight on the subject of family planning since the inception of the campaign. It is proposed to utilise also the medium of song and drama in both rural and urban areas for family planning education. The Field Units have often screened the films already available on the subject and emphasised the need for family planning in their post-film-show talks, group-discussions etc. The material put out by the D.A.V.P. on family planning is also being displayed on suitable occasions. An Exhibition devoted entirely to family planning was set up in New Delhi in February 1959 in connection with the sixth International Conference on Planned Parenthood. About 90,000 persons visited the Exhibition which included exhibits from several other countries also. Reference cards were also made available to the visitors at the Exhibition. The Exhibition was set up again in Delhi in April 1959 for the benefit of even larger audiences. This prototype Exhibition has since been seen in Simla, Lucknow and Allahabad. A number of requests have been received from other States for setting up this Exhibition.

Apart from this Exhibition, publicity has been arranged for family planning in the Five Year Plan Exhibitions and also through posters and the distribution of literature on the subject. A special distribution list was drawn up for Family Planning Day 1959. (Details of materials so far produced are indicated in the Appendix XXI). To intensify the publicity on family planning, it is proposed to supply self-contained sets of exhibits to State Governments for arranging exhibitions. Out of the total provision of Rs. 8,00,000 a sum of Rs. 2,37,000 has been earmarked for exhibitions and exhibits on family planning. It is proposed to utilise the medium of film strips for family planning publicity and 12 films strips on the subject have been proposed. Raw film has been made available in Bombay to prepare the strips. The copies will be printed by the Films Division.

A 20-page booklet entitled "Why Family Planning" produced by D.A.V.P. in English, Hindi and all regional languages deals with the subject in a fairly exhaustive manner and nearly 4,40,000 copies of the booklet have since been distributed. It is proposed to include suitable articles on family planning from time to time in magazines like "Yojana" or "Kurukshetra" published by Government. The Films Division released in 1949 a film entitled "Planned Parenthood" in English, Hindi, Tamil, Telugu and Bengali and another film in 1954 entitled "Family Planning" also in the various regional languages, which were shown at the cinemas throughout the country, in addition to special shows. A film on family planning in animated cartoon form is under production.

(g) *The Medical Council of India*—The Medical Council of India in October 1958 recommended that "medical students should undergo a short course of training in family planning during the period of their internship which they are required to spend in a health unit for participation in practical public health administration. Such health units should have at least one well-developed family planning centre for carrying out this training programme, the centre being under the charge of a Medical Officer trained in the Central Government's family planning training institute and with an adequate number of social workers attached to it to promote a sound system of home visiting and follow-up, and the training should consist of about 6 lecture-demonstrations at the family planning centre attached to a medical college or to a recognised health centre, provided that this training be undertaken during the post-examination period."

(h) *The Inter-University Board*—The Inter-University Board at its meeting in Chandigarh in 1959, has supported the recommendations of the Medical Council of India.

(i) *The Indian Nursing Council*—The Indian Nursing Council at a meeting in November, 1957 approved of the proposal to include training in family planning in the basic courses for nurses, midwives and health visitors. It has recommended this measure to all the State Nurses Registration Councils. Most schools for nurses and midwives and all schools for health visitors having the necessary facilities, are now giving instruction in family planning.

(j) *Voluntary Organisations*—Among non-governmental organisations, mention must be made of several all-India bodies which have actively supported the family planning programme. The Family Planning Association of India is the national, voluntary organisation specialising in family planning work, and with its 22 Branches in different parts of the country has carried out, since the last ten years, a comprehensive programme covering clinical services, training, publicity and education, and support to research projects. It has helped numerous other voluntary associations to undertake family planning activities and take advantage of the Government grants available. It publishes a quarterly Journal and a monthly Bulletin devoted to family planning, in addition to periodic reports, pamphlets etc. It runs a Supplies Department for providing contraceptives at clinic rates to welfare clinics. It has organised three all-India and two big International Conferences on Planned Parenthood, an International Scientific Seminar on Family Planning and Seminars on Marriage Guidance. The Indian Medical Association has brought up the subject at its Conferences and frequently publishes family planning news in its Journal. The Red Cross Society is conducting family planning clinics through some

of its Branches and proposes to extend this service to all its maternity and child welfare centres. The Indian Council for Child Welfare has passed resolutions in favour of family planning including sterilization of the unfit. The Indian Conference of Social Work has also discussed the subject at its Conferences and affirmed its support to the movement. *The All-India Women's Conference* was one of the earliest organisations to work for family planning and some of its Branches are running family planning clinics in various areas. The Bharat Sewak Samaj has also undertaken family planning clinical services, both rural and urban, in the States of Bombay, Kerala and U. P. There are about a hundred other voluntary organisations in the different States which have been given financial assistance for the opening of 46 rural and 10 urban family planning clinics.

Press—The Press has given much-needed publicity to the urgent need for family planning and to the family planning programme from time to time.

3·47. The Central Family Planning Board has recommended the observance of Family Planning Day by all clinics and the first observance took place all over the country on 18th December, 1959. The observance of Children's Day by family planning clinics is also recommended and took place for the first time on 14th November, 1958.

3·48. *Progress in States*—Family Planning Boards have been formed in all the States except Jammu and Kashmir. Full-time State Family Planning Officers have been appointed in Andhra Pradesh, Bombay, Kerala, Madhya Pradesh, Madras, Mysore, Orissa, Punjab, Rajasthan, Uttar Pradesh and West Bengal. Family planning work is being looked after by M. C. H. Officers in Assam, Bihar, Delhi, Himachal Pradesh and Jammu and Kashmir, (See Appendix XXII for the scales of pay). The progress of the family planning programme in the different States is at Appendix XXIII.

3·49. *Observations on progress*—To summarise briefly the progress made so far in the family planning programme, certain factors stand out prominently. First and foremost, the responsibility of the Government for the establishment and spread of family planning facilities has been firmly established. The programme itself has been evolved on lines that are rational, scientific, wholesome and ethically sound. Public opinion in favour of family planning has been created to a noticeable extent among those sections of the people who are susceptible to communication media, and a systematic attempt is now being made to reach out to those who are not as yet in touch with new ideas. Basic research work has been initiated. The programme has been launched on the basis of countrywide services and presents a positive, constructive, and evolving field of work.

3·50. On the other hand, there has been a noticeable shortfall in the actual expenditure as related to the Plan provision, but after 1956-57, the expenditure is showing a steady increasing trend and the actual budget provisions are beginning to be adequately utilised. In terms of physical targets, that for urban clinics has been exceeded. The number of rural clinics still falls considerably short of the target, and a great effort will be required if the rural target is to be fulfilled by the end of the Second Five Year Plan period. The performance of each clinic varies widely and this aspect will need particular attention now.

It must be noted, however, that the off-take of contraceptives increased six-fold between 1956 and 1958, and the number of sterilizations have increased by three times between 1956 and 1958. As far as the training programmes are concerned, although fair progress has been made, the need for trained personnel still remains largely unfulfilled.

3·51. Important research projects, both demographic and medical, have been instituted which will yield very valuable material in due course. This aspect of the work must now be expanded considerably.

3·52. Production of educational material has been taken in hand, but has barely scratched the surface so far and offers a big scope for action during the Third Plan period.

3·53. It would be premature to evaluate the impact of the family planning programme on the birth rate at this stage. In fact, the present trend is towards an acceleration of population growth as health measures continue to expand. But there are firm grounds for believing that, if a vigorous and intensive family planning programme rapidly swings into full action throughout the country, noteworthy results will be discernible—though within how short a period of time, it would be difficult to predict.

CHAPTER IV

RECOMMENDATIONS BY THE COMMITTEE

4.1. *Priority*—The facts and figures dealt with in the previous chapters lead up to the inescapable conclusion that, if present fertility trends continue, the population of India will have nearly doubled within the next 30 years. In order to achieve even a minimum standard of living, the people are already exerting every effort. If, in addition to the sustained endeavours required to increase such standards, provision also has to be made for nearly twice as many people, life and living in this country will tend to narrow down to the all-consuming and basic effort to keep nearly 800 million human beings just fed and clothed within an orderly society. In the face of such a demographic situation, therefore, the Committee is strongly of the opinion that the programme for population control should be placed among the highest priorities under the Third Five Year Plan.

4.2. *The Scope*—The family planning movement in India, since it was launched in its present form, has been organised on the basis of promoting the health, economic stability and general well-being of the family. As such it has had a strong family bias, with an inclusive scope where the planning of family size has meant not only the spacing or limitation of births, but also help to childless couples to achieve parenthood where medically possible, and the provision of guidance on problems arising out of marriage or family relationships. In other words, the family planning movement in India is concerned with the promotion of the happiness of married couples in relation to each other and as regards the well-being and development of their children wherein the creation of a sense of family unity and wholeness, and the self-expression of each individual member, can blend together harmoniously to enrich daily living. It is these underlying ideals of the family planning movement which have appealed to large numbers of people who have been quick to appreciate their relevance and potentialities.

4.3. *Main Aim at Present*—These ideals must continue to inspire the movement. At the same time, the Committee strongly feels that, in carrying the programme into the Third Five Year Plan period, it must also be affirmed unequivocally that, in view of the demographic situation prevailing in India, a reduction in the birth rate with a considerable slowing down of population increase is a main and fundamental goal to be achieved by the conscious planning of families. Thus, family planning is a measure not only of "welfare" in the usual meaning of the word but one which is pivotal to the whole plan of economic and social progress.

4.4. The Committee, in passing, may refer to the historical process which occurred in countries where, in evolving into industrial developed nations, they experienced falling birth (as well as death) rates helping towards the raising of living standards. However, under modern (and particularly post World War II) conditions where death rates are rapidly falling, it is doubtful, to say the least, whether and when such a change would occur in the countries presently undergoing developmental processes. Certainly all the evidence points against such a

change as a result of industrialisation alone taking place in India which will be timely enough, and definite enough, to prevent a rapid growth of population within the next few years. And, it cannot be forgotten that even in the case of countries which, in the process of development had such "built in" safeguards against the adverse effects of rapid population rises, the conscious practice of family limitation had a positive part to play in lowering the birth rates. This is true of countries such as the U.K., Scandinavia, the U.S.A. and others.

4.5. As far as India is concerned, the Committee stresses that India's population policy must be directed towards achieving a substantial reduction in the rate of population increase within a given period of time, with an emphasis on quality in preference to quantity. It is appreciated that, even with the most sustained efforts, it will be many years before the small family becomes the average family, with a consequent easing of some of the difficulties lying in the way of achieving fair standards of living and family welfare. But in fact, without population control, a healthier, happier and fuller family life can hardly be expected for the millions of the nation's families within the foreseeable future.

4.6. *The Target*—In the light of all the available data regarding present and future trends of population growth and economic and social development, India's population policy may well be aimed at effecting a 50 per cent reduction in the present birth rate of 40 per 1,000 by the year 1986. The success in achieving this target will depend primarily upon how practical a programme of family planning can be devised, and with what degree of effectiveness and rapidity it is implemented throughout the country, leading to the adoption of regular family planning practices by large sections of the population throughout the country. India cannot afford to wait and must take positive and constructive action in this as in other spheres.

4.7. *Family size*—In planning families, the question as to family size naturally arises. It is almost impossible to define a theoretical "ideal" size. Also, the consideration of family size brings in some very real, though not quantitatively measureable influences such as options regarding size, hopes for the future, belief in a particular national way of life, the status accorded to women and children, the goals of social living and many others.

These undefineable factors can find expression largely through processes of education and living example. The phrase "average size of the family" has several different meanings. In the biological sense it indicates the average number of live births to a marriage of "completed fertility" where the wife has passed the child-bearing age. In the social sense it refers to the number of persons in a family or to the number of dependent children. In discussing the average size of the family in the present (demographic) context, the Committee has noted with interest a number of suggestions received from experts. Shri A. Mitra, the Registrar-General, considers that: "the average size of a nuclear family should hardly be more than five, the parents and a total of three children born inclusive of casualties." Dr.P.S. Lokanathan (also representing the views of the National Council of Applied Economic Research) feels that the average size of the family in India should be 4 to 5 including the parents. This should perhaps mean three to four births in the family so that the number of children under 15 years may be about three. The assumption of four adult consumption units for the purposes of minimum wage legislation is suggested as the optimum size and

this number would mean the parents plus three to four children under 15 years. Assuming the average number of two children, there would have to be a birth rate of more than two, for in order to have the current size of 5·5 family, i.e. the parents plus 3·5 children. The average number of children born is about 6·5 (Mysore Survey Table 6·57). The birth rate now suggested here is half the current rate.

There seems to be general agreement that three should be the average number of children in a family.

4·8. To bring about such a reduction in the birth rate, various measures have been suggested by various persons and the Committee took note of the following:—

4·9. *Birth Tax*—One suggestion has been to levy a birth tax on parents after the third child. A birth tax involves (a) control of births to avoid the tax, (b) registration of births, and (c) payment because of births. Even where registration of births is compulsory, all births are not registered at present. In a country of India's size and tradition and with 7 to 8 million births a year, collection of the tax on birth would be quite impracticable, except perhaps among a very few cities and in cases of births in hospitals and nursing homes. Instead of acting as a limitation on births, such a tax is likely to lead to evasion and an enormous administrative problem. The birth tax, if instituted, would fall most heavily on those whose economic condition is already low and whose fertility is high and who are the least able to bear the burden of any tax. It would also seriously affect the fulfilment of the objectives of a fuller, healthier and happier life in the family. Furthermore, a birth tax on the fourth or subsequent child would tend to place a kind of stigma on that child. The Committee therefore, considers that a birth tax is neither justified nor practicable.

4·10. *Economic Incentives*—The Committee feels that instead of adopting a punitive attitude (such as imposing a birth tax) towards improvident parenthood, one of providing incentives in favour of small families would be justifiable and may lead to good results if a practicable scheme can be evolved. It has received and considered some interesting suggestions in this regard. One is to provide some tangible benefits for the first two or three children; presumably, for example, a reduction or exemption in their school fees, or the free provision of some needed item. Another suggestion has been to work out a "no birth bonus" scheme wherein a bonus can be earned by those fertile couples who observe specific intervals between successive births and then limit their families. It remains to be examined whether such a bonus scheme is practicable, both from the point of view of the expenditure that would be involved (in relation to the savings effected by the nation through smaller families), and that of equitable implementation. The Committee feels that it might be possible to work out a pilot scheme in a limited group, such as under the Contributory Health Services Scheme, or in a selected Development Block. The scheme would envisage the offering of a bonus to a married couple where the mother (who is known to be fertile) attends a family planning clinic regularly every six months for a general clinical examination and is found not to have become pregnant during the period of not less than three years. This bonus would be given to help her to bring up her children well. Three types of intervals are suggested for payment viz. three to four years, four to five years and above

five years. The amounts of payment could be on a rising scale, namely, Rs. 50, Rs. 100 and Rs. 200 respectively. The demonstration of tangible results in such a scheme would easily take 5 to 7 years and in view of the urgency of the situation, if it is decided to introduce a short-term project, and it can be demonstrated that such scheme can be operated, the pilot study might be extended to cover much larger areas.

4.11. *Abortion*—The question of abortion has been brought up from time to time and the Committee has examined the literature on this subject, especially as concerns abortion legislation in other countries including Japan and Sweden. In Japan, under the Eugenic Protection Law of 1948 (amended in 1952) the door was opened to legal abortions in the case of women who stated their need for it on grounds of health or economic stringency. The subsequent events have shown that the same person resorted to abortion several times in the same year. Thus, the frequency of abortion in each case has given rise to anxious consideration. (For instance, a news item mentions the case where, among 26,000 employees of a large industrial concern, many of the wives of these employees with 3 children had had 8 abortions while still only in their early thirties). On the other hand, the programme of abortion has assisted considerably in bringing down the birth rate in Japan within a short period. It must be noted, however, that now, the effort to disseminate contraception methods of family planning is being intensified in that country. As Prof. Kitaoka stated in his paper presented at the Sixth International Conference on Planned Parenthood in New Delhi in 1959, public opinion in Japan has become very critical of the practice of abortion and at the Third National Conference on Planned Parenthood in Japan in December, 1958, a resolution was passed requesting that legislation regarding induced abortion be rescinded and contraception encouraged. As far as Sweden is concerned, the legislation governing induced abortion rests on considerations other than those of population control and is directed towards the prevention of illegal abortions which, as in many other countries, were very prevalent in Sweden.

4.12. In India, information regarding the incidence of illegal abortion is not readily available though authoritative sources indicate that the practice is widely prevalent and that too under the most deplorable conditions. Legally, abortion is permitted to be induced under certain stringent medical indications such as danger to the mother's life. [Though this is a little outside the purview of family planning, the Committee feels that serious consideration should now be given to the view that induced abortion should also be legally allowed in those cases where the pregnancy has been the result of rape, especially in the case of minor girls.]

4.13. Apart from the medical reasons, the Committee carefully considered the question of whether socio-economic reasons should be admissible within the range of legally allowable abortions and if so, to what degree. The view has been expressed that due to the urgent necessity to lower the birth rate, India cannot afford to ignore the possibilities of abortion as a means of population control. It is added that if performed by trained medical practitioners under hospital conditions, such abortions will not cause any grave damage to the mother's health. Another view is that "liberalised" abortion be legally permitted where the mother would be allowed to have one abortion (especially in cases where a contraceptive method has failed) and would be educated at that time to resort

to the practice of contraception so that no more abortions would be required or be allowed in her case. The Committee however, feels that even assuming that the law permitted one abortion, it would be very difficult to make the patient understand that she can have only one and no more, and the likelihood is, she may have another unwanted pregnancy and seek another abortion, perhaps at some other abortion centre.

4-14. The Committee is of the opinion that even though the demographic situation in India is serious, resort to abortion as a method of population control would lead to very undesirable results. It cannot be forgotten that the whole family planning movement in India has been founded on an ethical, rational and scientific basis where medical knowledge has been utilised to prevent conception and not to interfere with an established pregnancy. That basis should continue unimpaired. Secondly, even assuming that the ethical objections could be brushed aside, the organisation of medical services for legalised abortion would present a most difficult situation in view of the paucity of qualified medical practitioners and the necessary medical services in the rural areas.

4-15. *Sterilization*—Sterilization as a means of preventing further births to a family has been much debated in India and there is a section of public opinion which is strongly in favour of sterilization on a very widespread scale in the country. The great advantage of this measure is that it is a sure means of permanently limiting births, when carried out by competent surgeons. The very fact, however, that, it brings about a permanent stoppage of births when one of the parents is sterilized, puts it in a category by itself, and it cannot be treated in the same way as family planning methods proper; for example, it cannot be recommended normally to newly married couples or those with, say, one or two small children. Cases have been noted where a sterilization has been reversed by another operation performed by expert surgeons, but these are still rare.

4-16. The Committee has carefully considered the literature available on sterilization. It realises that with the exception of Japan, this measure has not been used to any degree as a means of population control although persons in many countries have individually sought it for limiting their own families. In fact, on the continent of Europe, there is a very strong aversion to this measure for very understandable reasons. Nevertheless, the experience so far available in India has shown that, under the right conditions, sterilization has a very useful part to play both from the view point of population control, and for relief from further unwanted progeny. The Committee considers therefore, that sterilization under certain safeguards is a necessary and valid measure in India until such time as contraceptive methods are universally in practice among married couples.

4-17. The question has been raised whether there is a need to legislate for compulsory sterilization in certain cases such as those of transmissible physical or mental diseases. It is difficult, scientifically, to draw firm conclusions as to what diseases are definitely transmissible or incurable. But even apart from this, it is felt that having regard to the prevailing circumstances, compulsory sterilization might lead to abuses and is not desirable. Compulsion in the field of social action appears to be against the public sentiment in a country like India and greater success would be achieved by voluntary and regulatory

measures. It would be appropriate, however, if energetic steps were taken under the existing medical and health services, to draw in all such cases for treatment and to provide specially trained workers who would actively persuade them to accept voluntary sterilization in the interests of themselves and the community. In the case of voluntary sterilization, sterilization for medical or eugenic reasons stands in a separate category and should be carried out, as heretofore. Questions of age, marital status and number of offspring do not come in here to any extent.

4.18. *Criteria for sterilization cases*—In the case of voluntary sterilization for socio-economic reasons, however, the Committee feels that certain criteria should be laid down so that on the one hand, those surgeons who perform the operation can receive adequate guidance in the selection of cases and, on the other hand, the persons seeking the operation would have an idea whether they are within the eligible limits or not. Such criteria should be laid down by a national panel of experts after full consideration of the therapeutic, eugenic, psychological, socio-economic, familial and legal aspects. In laying down the criteria for the eligibility of parents seeking voluntary sterilization, consideration must be paid to (i) the number of living children and their ages and sex (ii) the ages of the husband and wife (iii) the socio-economic prospects of the couple and (iv) the emotional and mental attitudes and preparation of the couple towards permanent birth limitation. The couple should have some time to think it over so that they fully understand the meaning of voluntary sterilization and decide whether it is the husband or the wife who could best have it, and the consent of both partners can be given in writing.

4.19. The Committee also noted that there are doubts in a number of countries regarding the legality of the operation. As far as India is concerned the Committee feels that, if necessary, appropriate legislation could be introduced to help in the sterilization programme outlined above.

4.20. *Facilities for sterilization*—The Committee is of the opinion that facilities for sterilization should be available free of charge at hospitals and other medical institutions undertaking surgical work. Where necessary, the staff at such hospitals or institutions should be augmented in order to undertake this service and the surgeons given additional training in sterilization techniques. The Committee also considers that it would be helpful if patients could be provided free transport facilities to and from the Primary Health Centre level to the Taluqa or District Hospital level for the operation. Also, the surgeons from the District Hospitals could go to the Primary Health Centres for performing the operations. Information on sterilization, as on family planning in general, should be widely disseminated both to the medical profession and the lay public. Facilities for sterilization through mobile clinical units might also be considered, provided that proper safeguards are observed not only in the operation itself, but in the selection of the cases, their emotional and mental preparation and understanding of the nature of the operation and their follow-up.

4.21. With regard to the question of financial incentives for popularising sterilization, it has been suggested that such incentives should be provided, and extend to the patients willing to undergo the operation, to the field workers who successfully persuade people to undergo the operation, and to the surgeons performing the operation. The Committee feels that it is neither feasible nor desirable to offer such incentives only to persons undergoing sterilization.

Persons subjecting themselves to a commendable self-discipline by taking regular contraceptive precautions to space or limit birth surely have as great a claim to incentives as those who are ready to be sterilized once and for all. If economic incentives are to be provided on an equitable basis, the couples regularly practising contraception should not be ignored. Some financial assistance, however, may be considered in the case of patients to cover loss of wages or any incidental expenditure due to undergoing a sterilization operation. As regards incentives to those who bring in sterilization patients, this is undesirable. Such field workers are already paid to do their job and there should not be a necessity to pay extra for doing it competently. As regards the third category, it would be reasonable to provide an honorarium to those surgeons who have to work outside their normal range of duty to undertake sterilization operations. Such an allowance should be paid on a monthly basis where a sufficient case-load is expected, and not per case.

4-22. The decision whether the husband should be sterilized or the wife will depend on the circumstances of individual case. It is probable that vasectomy, being the simpler operation of the two, would be more widely available.

4-23. *Contraceptives*—As sociological studies have shown in various areas of the world, the small family pattern has usually been the result of deliberate planning. Except at those times when large families are deliberately encouraged for special purposes, for example, war or colonisation, the biological maximum does not usually correspond to the socially prevailing pattern, due to various checks arising out of cultural and socio-economic conditioning. In older times, the crude natural phenomena of famine, disease and pestilence took their toll of large families, aided by man-made checks such as infanticide, abortion and certain cultural practices. In modern times, millions of people have been moved to take action to establish a planned family tradition where, by deliberate choice, they can regulate the number of children, such regulation having ranged all the way from one to even, perhaps, a dozen children. But, on the whole, the regulation has been utilised to have a "small" family of three to four children. The means of such deliberate regulation have been the use of the rhythm method, of coitus interruptus and of mechanical and chemical barriers to conception. (Abortion also operates as a means but is mostly a clandestine practice with some exceptions). Abstinence, of course, is the obvious way of preventing conception, but it is demonstrably not widely practised.

4-24. The rhythm method as a means of lowering the birth rate has a very limited scope as was demonstrated in the Government of India, Ramana-gram Study from 1952 to 1955 where it was shown that the method could be practised efficaciously by about 5% of a given population. The Committee however, feels that information and guidance on the rhythm method should be readily available to those couples who seek it.

4-25. Coitus interruptus is a widely used method, and where it suits a couple, has proved to have a certain degree of effectiveness. In this case too, information regarding the method should be readily available.

4.26. The mechanical and/or chemical methods of family planning at present available under medical approval are varied. They are all safe to use, efficacious (though in varying degree), acceptable, and if a new pregnancy is desired, they only need to be discarded from use. These methods are fairly inexpensive, though not as yet cheap enough for the masses. It is ultimately the patient's choice as to which method should be adopted in the particular case. From the viewpoint of clinical effectiveness, the diaphragm and jelly method would appear to be the method of choice, followed by condoms, gel alone and foam tablets.

4.27. The Committee is of the opinion that information and assistance on contraceptive methods should be very widely disseminated so that eventually all married couples can adopt the habit of planning their families according to their own choice.

4.28. *Simpler methods and their distribution*—It is obvious, however, that as far as the rural areas are concerned, the more complicated methods like diaphragm and jelly, even though almost 100% efficacious, may not find wide favour. Therefore, an extensive dissemination of the simpler methods will be required. Such methods are simple to use, and instruction in their use can be given by trained social workers or health visitors in the absence of doctors. The wider coverage acquired by the simpler methods could help to overcome their lesser degree of effectiveness, as far as the probable slowing down and lowering of the birth rate is concerned. The point about the handling of simpler methods in the absence of doctors is important because, if family planning services are to be circumscribed by the availability of doctors, the extension of the programme will be gravely retarded. The Committee feels, therefore, that what might be termed a "non-clinic approach" is becoming both necessary and feasible. Such an approach would envisage the giving of family planning advice and supplies of the simpler methods, by trained personnel such as health visitors, auxiliary nurse-midwives or social workers, after ascertaining the necessary details of the patient's history, but without an internal examination being carried out. The doctor, therefore would not be essential in such a procedure. These simpler methods include the sheath and foam tablets which in any case do not involve a medical examination. So far, foam tablets have been given after a medical examination as a precautionary measure. Now, after nearly 8 years of an official programme of family planning, during which useful data on this method has been gathered, it does not seem necessary that such an examination should precede the use of approved tablets. It is understood that the Committee on the Physiology of Human Reproduction of the Indian Council of Medical Research has recently recommended that foam tablets can be so distributed without a prior medical examination, and in view of this expert opinion the distribution of both sheaths and foam tablets can come under the "non-clinic approach".

4.29. *Mobile Family Planning Units*—The Committee also is of the opinion that mobile family planning units can be put into the field to reach out to the remoter areas. Trained staff can travel with the fitted mobile van to give both advice and assistance in family planning with arrangements for a regular follow-up and distribution of supplies to the patients covered by the mobile units. Such units can be attached to the Primary Health Centres or District Headquarters as the case may require.

4.30. *Contraceptives, free and subsidised*—The Committee recommends that contraceptives may be given free to persons whose monthly income is Rs. 300 and below, at half rates to those with incomes between Rs. 300 and Rs. 500, and at cost price to those with an income above Rs. 500. The Committee further recommends that in rural areas, foam tablets, sheaths and jellies be given free irrespective of income. The opinion has been expressed that free supplies are not appreciated, and there may be some patients who consider free supplies as something to be thrown away or wasted. The Committee has seriously considered this aspect but feels that the purchasing power of low-income groups is so low that provision for free distribution for these groups should be continued. Those who are given free supplies may be allowed to contribute whatever they like to a Welfare Contribution Box, for even very poor patients are quite prepared to do this.

4.31. *Name of the Centre*—A variety of views have been expressed regarding the title that should be given to the centres where family planning advice is given. One view holds that "Family Planning Clinic" is suitable. Others feel that family planning in the minds of simple people may be associated with economic planning; still others feel that "Family Planning Clinic" is considered by the people to be a birth control clinic only and that patients would hesitate to visit such clinics; they suggest that the clinics should be called "Family Welfare Centres". The Committee considers that this is not really an important problem. The centres may be called "Family Welfare Centres", but in such cases there should be a clear indication to show that family planning advice is available there. The Committee also considers that a stage has now been reached where all medical and health centres, hospitals and dispensaries in the country, governmental and non-governmental, should display a board boldly stating that family planning advice is available there.

4.32. *Pattern of Expenditure for Rural and Urban Clinics*—During the Second Five Year Plan period non-recurring expenditure of Rs. 1,000 for rural and Rs. 2,500 for urban clinics was provided. These amounts included a provision of Rs. 500 for stocking of contraceptives. (This provision was made with a view that Rs. 500 would be available as imprest money at all times with the clinics to ensure that they would always have funds available for the purchases of contraceptives). The experience during the Second Five Year Plan period has shown that provision for furniture and equipment in rural and urban clinics should be about the same. Also, that separate provision should be made for educational aids, transport and accommodation, and provision for contraceptives should be made in the recurring expenditure only.

4.33. In the Second Five Year Plan period a clinic was required to serve a population of 50,000 if urban and of 66,000 if rural. A provision was made of Rs. 5,500 for rural and Rs. 11,000 for urban clinics. In the case of urban clinics one woman doctor, a part-time male doctor, a social worker or health visitor or field worker, and a clinic attendant were provided. In the rural areas, provision was made only of Rs. 3,000 for a social worker or a health visitor. Such social worker or health visitor was required to strengthen the existing staff of the Primary Health Centre. The Committee feels that the staff pattern and the amount granted for recurring expenditure for both rural and urban clinics should further be increased to provide for male field workers, conveyance charges, accommodation (where not provided in the non-recurring grant)

education and publicity material, contraceptives, contingencies and clerical assistance in cases where the workload is heavy.

4.34. So far as the rural areas are concerned, the Committee feels that one worker cannot adequately cover a population of 66,000. A population of 22,000 would be a convenient size if it is compact, but generally speaking, a population of 10,000 is nearer the mark if it is to be fully covered by a worker (and may be even less in the case of hilly or widely spread-out areas).

The Committee therefore, suggests that there should be one main family planning centre in each Primary Health Centre with five sub-centres, so that the main centre could cover a population of 16,000 and each of the sub-centres a population of 10,000. At present, there are only three sub-centres with each Primary Health Centre. Three of the new family planning sub-centres could be opened in these three sub-centres of the Primary Health Centre and the remaining two sub-centres may be located in suitable places until additional sub-centres are also opened under the Primary Health Centre scheme.

4.35. The staffing pattern for each Primary Health Centre consist of 1 Male Medical Officer, 1 Public Health Nurse/Lady Health Visitor, 4 Midwives/Auxiliary Nurse Midwives, 1 Sanitary Inspector, 1 Compounder, 1 Driver and other Class IV staff. For running the main family planning centre this staff of the Primary Health Centre should be strengthened by the addition of 1 Female Medical Officer (where a whole-time woman doctor is not available, one for about three main centres), a Public Health Nurse, 1 Male Social Worker or Sanitary Inspector, 1 Ayah, 1 Clinic Attendant and 1 Driver. The sub-centres may each have additionally 1 Midwife or Auxiliary Nurse Midwife, 1 Ayah and 1 Clinic Attendant who will work under the supervision of the Medical Officer at the main centre. The main centre may be provided with a van and the sub-centres with cycles. Each centre and sub-centre may also have a voluntary social worker who may be given some honorarium. While recommending the provision for a woman doctor, the Committee took note of the fact that in many cases there is no woman doctor at the headquarters of the Primary Health Centres.

4.36. Taking into account all the above factors, the Committee recommends the following non-recurring and recurring expenditure for rural and urban clinics:—

Non-recurring	Rural	Urban
Equipment, furniture	1,500	2,000
Educational Aids	300	300
Film strip projector	450	450
Film Strips	450	450
Bicycles (2)	500	500
Total ..	3,200	3,700

In addition, Rs. 18,000 may be provided for a van at the headquarters of each Primary Health Centre for the main rural family planning clinic and Rs. 6,000 for accommodation at each headquarters centre and sub-centre in rural areas and Rs. 10,000 in urban clinics.

Recurring	Rural	Urban
(i) Full time female doctor Rs. 250—10—300—15—450— 25—500+25% N.P. A., D.A. & car allowance.	..	5,000
(ii) Part-time male doctor at Rs. 200 p.m.	.. ..	2,400
(iii) Female social worker Rs. 180—330+allowances	.. ..	3,000
(iv) Public health nurse .. .. .	.. ..	3,000
(v) Male social worker .. .. .	.. ..	3,000
(vi) Auxiliary nurse midwife/field worker	3,000	..
(vii) Clinic attendant	1,000	1,000
(viii) Ayah	1,000	..
(ix) Contingencies including rent	500	1,000
(x) Conveyance allowance	1,000	1,000
(xi) Other welfare activities like distribution of milk, cele- bration of F.P. Week, etc.	1,000	1,100
(xii) Distribution of contraceptives in rural and urban areas as given below:—	1,500	1,500
To those drawing less than Rs. 300—free.		
To those drawing Rs. 300 to Rs. 500—at half price.		
To those drawing more than Rs. 500—at cost price.		
In rural clinics, in addition, sheaths, foam tablets and jellies to be distributed free, irrespective of income.		
Total ..	9,000	22,000

In addition to the above the following extra expenditure is suggested for the rural clinics at the headquarters of the Primary Health Centres—

	Rs.
Additional Sanitary Inspector	3,000
Female Doctor	5,000
Driver	1,500
Maintenance of Van	700
Total ..	10,200

4.37. The Committee recommends that the pattern of Central assistance to State Governments, local bodies and voluntary organisations should be as follows:—

	State Govern- ments and Local Bodies	Voluntary Organisations		Medical Teaching institutions
		Urban	Rural	
	%	%	%	%
<i>Non-recurring</i>	100	100	100	100
<i>Recurring—</i>				
First Year	100	100	100	100
Second Year	100	90	100	100
Third Year	100	90	100	100
Fourth Year	100	90	100	100
Fifth Year	100	90	100	100

Grants for contraceptives to be at 100 per cent throughout the Plan period.

It will be noted that the contribution of voluntary organisations has been reduced by 10 per cent compared to the pattern during the Second Five Year Plan period as the Committee feels that the services rendered by these voluntary organisations should be taken into account.

4.38. *Shortage of medical personnel*—The Committee noted that the estimated number of doctors in the country is 80,000 including about 7,000 women doctors, the annual output from medical colleges is 3,800 and the likely increase during the Third Five Year Plan may be 20,000. The Committee recommends that until a sufficient number of doctors are available, one woman doctor be appointed to look after a number of centres.

4.39. By 1961, it is estimated that the country should have one doctor per 6,100 inhabitants and assuming that this ratio would be progressively increased to one doctor for 5,500 inhabitants by 1966, for 5,000 inhabitants by 1971, for 4,500 by 1976 and for 3,500 by 1981, it is estimated that the number of doctors required during these periods would be 98,000, 1,35,000 and 1,97,000 respectively. It is quite evident that additional facilities for increased numbers must be provided during the Third and subsequent Plans. This would mean increasing the admission strength (which is at present at the level of 4,700 per annum) to 9,500 per annum by the end of the Third Five Year Plan, to 11,500 by the end of the Fourth Plan, and to 14,000 by the end of the Fifth Plan. It will be necessary (for making available more doctors in general and women doctors in particular, in the public sector especially in rural areas) to take a decision on certain fundamental issues *viz.*, the admission policy in medical colleges, both in regard to total numbers and to sex ratio in admissions; the conditions governing service in the rural areas for a period ranging between

two to four years for every doctor in State employment; unification of the cadres of medical officers in each State where every one would take his or her turn of service in the rural areas; interchange between rural-urban assignments; rural allowance, pay scale, employment in and crossing of efficiency bars in health services being made conditional on a minimum period of service in the rural areas; liberal facilities for study leave for higher training of medical personnel in rural areas, and other basic amenities, etc.

4.40. The Committee also feels that utilization of the services of the graduate women of integrated colleges of medicine, after requisite training in family planning, may be considered for family planning work in view of the acute shortage of women doctors.

4.41. The Committee noted the views of Miss Adranvala, Adviser in Nursing, that the aim of future training schemes in nursing should be to reduce the multiplicity of workers, and that the Nursing Council has recommended that there should be only two grades of basic training: (i) courses in nursing and (ii) courses of auxiliary nurse midwives. The number of auxiliary midwives required for work in Primary Health Centres including family planning should be increased. This will be possible if the training programmes of this category of personnel are so extended that the number of students is increased from 4,000 to 20,000 each year. This would require the opening of 100 new centres each year, each enrolling 40 students. This could be done if a training centre was attached to every District Headquarters Hospital and institutions where training facilities are adequate. The increase of such trainees will necessarily involve also an increase of training centres for teachers for the Auxiliary Nurse Midwifery Courses *i.e.*, training centres for Public Health Nurses. Each State Government could open one or more centres for Public Health Nurses with the aim of training 100 Public Health Nurses each year for the family planning programme alone.

4.42. Considering the shortage of health personnel for the expansion of family planning work quickly and effectively and also realising that Public Health Nurses will not be available in adequate numbers for some years to come, the Committee was strongly of the opinion that the existing integrated Health Visitors' Courses should be continued for the next five years. These workers can supervise the work of Auxiliary Nurse Midwives.

4.43. *Family Planning Services in Medical and Health Centres*—During the Third Plan emphasis should be laid to provide family planning services at all hospitals, maternity homes, M.C.H. and Primary Health Centres, medical colleges, medical teaching institutions for doctors and medical auxiliaries. Each medical teaching institution for doctors and medical auxiliaries and well-developed hospital and maternity home should have a family planning clinic. The pay of staff for this purpose should not exceed the scales of pay and allowances prevailing in the respective States.

4.44. *Indian Medical Association*—The Committee considered the proposal (Appendix XXIV) of the Indian Medical Association and noted that the Ministry of Health has approved the part-time employment of the members of the Association at the scale suggested by the Association. The Committee suggests that the opening of clinics by the Indian Medical Association be considered on the same basis as by other voluntary organisations and in places where there

are no clinics or not, an adequate number of clinics. The Committee also recommends that the Secretary and/or President or his nominee of every State Branch of the Indian Medical Association should be included on every State Family Planning Board. The Secretary or President of the local Branches should be included in the District Committees. Prominent doctors who have shown conspicuous and active interest in family planning in the State and District Boards may also be included.

4.45. *Central Social Welfare Board*—The Committee considered the proposal of the Central Social Welfare Board (See Appendix XXV) and strongly recommends that the facilities of the Central Social Welfare Board should be utilised wherever possible, keeping in view that there is no duplication of work by making such arrangements. The Committee suggests that the members of the State Social Welfare Advisory Boards in the first instance may discuss with the Administrative Medical Officers in their respective States how this can be accomplished. Supervision and administration of the centres where the staff of the Social Welfare Board is to be augmented to include family planning services, should be undertaken by the Medical Officer-in-Charge of the Primary Health Centre. In the case of centres which are not near the headquarters of the Primary Health Centre, the part-time employment of a trained medical officer from a nearby station on an honorarium to be fixed in consultation with the Indian Medical Association should be considered. It is most desirable that staff employed by the units of the Central Social Welfare Board and other agencies working in the rural areas, especially the field workers of the Ministry of Community Development, should participate in the family planning programme; orientation courses in family planning should be arranged for them. Wherever the State Government does not propose to have a Primary Health Centre, provision of funds for a building for a family planning centre may be favourably considered for short-term planning. A grant of Rs. 6,000 for such a family planning centre would be suitable. Provision should be made for equipment for selected MCH Centres for the incorporation of family planning services. Grants for these purposes should be given once a year. Grants may also be given to the regional journals of the Central Social Welfare Board for the purpose of publishing family planning news and information.

4.46. *Role of Voluntary Organisations*—The role of voluntary organisations in the implementation of the family planning programme is an invaluable one. Without the enthusiastic participation of voluntary social or medical welfare agencies the programme would lose its popular character. Voluntary workers through their organisations can help to (i) keep alive popular interest and discussions on family planning; (ii) reach out to ever-widening circles of people in order to motivate them; (iii) through a public avowal in its favour, impart a sense of confidence and security to couples who want to practise family planning but have qualms about whether it is entirely "respectable" or not; (iv) undertake pilot studies and experimental schemes with a much freer hand than government agencies; (v) promote national and international contacts, and make available information and experts from such sources, and (vi) act like catalytic agents to prevent a dull complacency creeping up among the workers, whether they be governmental or voluntary.

4.47. The Committee, however, feels that there is the possibility of mushroom voluntary groups cropping up. The bona fides of all organisations should be carefully scrutinised before any grants-in-aid for family planning work are given to them. There may be groups who, knowing there are funds to be had, take up the work and pay out salaries to persons around them without being really sincere about the work. The Committee is conscious of the fact that family planning work cannot be carried on without a regular paid staff and such voluntary organisations may find difficulty in raising funds.

4.48. The Committee suggests therefore, that it might be useful to draw up two lists of voluntary organisations: Category A and Category B. Those in Category A would include the national organisations and their branches like the Family Planning Association of India, the Indian Red Cross Society, the Indian Medical Association, the Bharat Sevak Samaj, the All India Women's Conference, the Indian Conference of Social Work and other big welfare organisations, with notable records of social or medical welfare work in their respective States for the last five years. Category B may include the smaller social and welfare organisations of a local character with satisfactory bona fides.

Organisations placed in Category A can receive grants according to the approved regular pattern, whereas those in Category B may be given grants mainly for family planning education and propaganda, so that they can help to increase the patient-load at the already existing nearby clinics.

4.49. The Committee recognises that many voluntary organisations have a very limited membership and depend mainly on financial support from a few philanthropists or from the Government for their welfare schemes. The Committee agrees with the views expressed by the Study Team on Social Welfare and the Welfare of Backward Classes that : "Voluntary organisations will have to continue to exert themselves a good deal to raise a major part of the growing expenditure on maintenance. The grants-in-aid system can at best supplement but can never supplant the efforts of the voluntary organisations. It is also imperative that for the preservation of their voluntary character the organisations should not develop undue dependence on State aid; the expansion of community support would further indicate the success of the organisation".

4.50. *Manufacture of Contraceptives*—The Committee noted that the Ministry of Commerce and Industry has initiated action to make India self-sufficient in respect of the production of contraceptives. The Committee strongly recommends that every effort should be made to produce locally all the contraceptives required for the country within the next three years. In the interim period, the import policy for contraceptives should be liberal. Import licences for approved contraceptives should be given freely.

4.51. *Training*—Satisfactory standards of work in the family planning programme as in any other programme, require trained personnel. The number available of the various types of persons required for the family planning programme is very limited and it is very necessary that training programmes should be rapidly extended. Training should include instruction to (i) all doctors and medical auxiliaries already employed by State Governments, Local Bodies and Voluntary Organisations and in private employ or practice,

(ii) all personnel undergoing instruction in medical training institutions, (iii) doctors and medical auxiliaries working in special establishments, employed exclusively for the family planning programme, (iv) those engaged in general administration in community development, agriculture, education, etc. (v) social scientists and those undergoing instruction in social sciences and (vi) voluntary social workers.

4.52. The Committee recommends that, in addition to the Centre for training and research in family planning at Bombay and the one that is being developed at Delhi, it will be desirable for each State to develop a training centre at which research could also be encouraged. Each of these centres, in addition to training applicable to urban areas should also be orientated towards rural problems.

4.53. An adequate number of touring training teams should be provided for the training of doctors and medical auxiliaries and to conduct orientation camps for the training of social workers in the field. Ad hoc orientation training courses of short duration may be held wherever trained personnel and clinical material are available. Selected clinics should be developed as centres to impart orientation in family planning. The recommendations of the Medical Council of India, the Inter-University Board and the Indian Nursing Council need to be implemented expeditiously by the Universities and other medical teaching institutions. The State Governments should arrange for the orientation in family planning of all health and welfare workers in their respective States. The Ministry of Community Development should provide orientation in family planning to all categories of workers, both official and non-official. The Ministry of Home Affairs also can arrange for a few lectures in their training centres, including those for I.A.S. Officers so that they may have the opportunity to appreciate the importance of the programme and their responsibility in extending it.

4.54. The Committee feels that it is time now to work towards uniform standards in training courses, in conducting examinations, and awarding certificates. A certain minimum basic standard curriculum should be evolved which should be incorporated in all training courses. Also, a Central Examining Board could be formed to conduct examinations at the different training centres.

4.55. The Committee feels that in view of the necessity for producing the maximum number of trained people in the shortest possible time, training courses should be intensive and their duration should not exceed two months.

4.56. There could also be a short-term training programme for medical personnel, normally for 2 weeks, covering lectures, clinical demonstrations of contraceptive techniques and also other subjects such as motivation for family planning, the use of audio-visual aids and including three days of field work and a two-day seminar. The number of trainees in each course could be about 20. The course can be organised at the State level on a systematic basis by the State or District Family Planning Officer in co-operation with Health Departments, hospital authorities and social welfare agencies in the areas.

4.57. For regular training at the medical teaching institutions the Government of India has already accorded sanction for 100 per cent financial assistance to medical colleges and teaching institutions for doctors and medical auxiliaries for family planning clinics. Each medical college and training centre may now have a section for family planning in its Gynaecological and Midwifery Departments. This section should work in close co-ordination with the Department of Social Medicine of the College. Having regard to the fact that the family planning clinics normally have junior Officers-in-Charge who have not the requisite experience to teach undergraduates and post-graduates, and that Professors and Heads of Departments in Gynaecology and Midwifery and Social Medicine are normally extremely busy with other commitments, the Committee feels that for providing proper facilities for training in family planning for undergraduates and post-graduates, provision should be made for a grant for the post of an Associate Professor in the Department of Gynaecology and Obstetrics in close co-operation with the Department of Social Medicine, to help in the family planning programme.

4.58. In the Schools of Social Sciences, orientation in family planning could be given by the existing staff. The staff of a reorganized family planning clinic or family planning section of a medical college or a family planning training centre should be asked to provide the necessary assistance for these orientation courses.

4.59. In the Community Development programme two types of programmes can be undertaken :—

(i) Short term, ad hoc, in-service courses for those already working in the programme. There should be 10 days' refresher courses for Social Education Officers, Mukhya Sevikas, Gram Sevikas and Gram Sevaks. For the other workers i.e. the Administrators, B.D.Os., school teachers and District Panchayat Officers, three-day seminars could be arranged. Family planning instruction should also be provided in teachers' training schools and colleges and in training centres for Basic Education and medical and health staff.

(ii) For those now under training and for the future programme more intensive work is needed. The table below gives the suggested period of training for Community Development personnel and the curriculum for family planning.

Category of Worker	Present Training Course	Suggested period for family planning
Administrators	4 weeks	6 lecture-discussions.
B.D.O.	3 months	10 lecture-discussions.
S.E.O.	5 months	40 hours
Mukhya Sevika	10½ months	40 hours
Gram Sevika	1 year	30 hours
Gram Sevak	2 years	40 hours
District Panchayat Officer	6 weeks	3 day seminar
Other workers i.e., in Agriculture, Cooperatives and other Extension Officers etc.	3 days' session	

4-60. Three Centres for the training of Family Welfare Workers have recently been started, one each at Madras, Nagpur and Allahabad. The one year's training course for these should be continued. With the increased facilities now proposed for training, the extension of these courses can be considered at a later stage, after the performance of the present batch has been evaluated.

4-61. The main functions of a family planning worker will be to educate the people in the acceptance of the practice of family planning by means of home visiting, individual and group education, to follow up family planning assistance by doctors, and to carry out other activities connected with keeping records, and health education. These functions can be adequately performed by the Public Health Nurse or Health Visitor or Auxiliary Nurse Midwife if she is given training in family planning.

4-62. *Demographic Training & Research*—The level of living is invariably linked with economic development and the population situation. A national population policy and action programmes to raise the level of living can be undertaken only with adequate knowledge of the population problems in general and trends of population increase in particular and with a full understanding of numerous variables including rural to urban migration and other socio-economic factors.

4-63. The Committee considered the following views expressed by Dr. C. Chandrasekaran, Director, Demographic Training & Research Centre, Bombay :—

(a) One of the universal by-products of economic development is rapid urbanisation mainly due to industrialisation. This was seen in Europe and America and now is manifesting itself in Asia, Latin-America and Africa. Almost all major cities on these continents now appear to be 'bursting at the seams' with population growth which has resulted from a rapid and huge influx of migrants from rural areas, continued with high fertility rates within the cities themselves. This development deserves intensive research for a variety of reasons. Broadly speaking such a research programme should include the study of the effect of urbanisation upon the economy, society and fertility.

(b) In view of the immense practical implications, it appears to be also very essential to explore the array of social, demographic and economic implications of rural to urban migration, especially at this time when the nation is undergoing economic development and to place special emphasis upon the effect of urban living and migration upon fertility. The following are the types of questions that need to be explored :—

- (i) What are the demographic facts about rural to urban migration in a nation undergoing economic development?
- (ii) What are the economic and social characteristics of the rural to urban migration?
- (iii) How rapidly do the socio-economic characteristics of migrants change after their arrival in the city?
- (iv) What are the forces that are attracting migrants into city?

- (v) What are the major difficulties migrants into the city find in getting adjusted and becoming assimilated into city life?
- (vi) How does migration affect attitudes toward custom and traditional beliefs?
- (vii) What is the change, if any, in the fertility pattern of the rural to urban migrants after they arrive in the city?
- (viii) What groups of urbanites plan their families and which do not and for what reasons?
- (ix) Through what channels of communication do people in the city come to acquire knowledge about family planning?
- (x) When couples in the city (both migrants and non-migrants) do restrict the size of their families, what are their motives?

(c) The fertility and family planning topics in need of research in countries with under-developed economic development may be grouped into the following broad categories:—

- (i) The actual facts of the fertility situation in India and in the various regions of the country.

Fertility studies have been conducted in selected areas of a few states and the picture of the fertility situation in the country is very incomplete. The fertility measures reported from many of the studies seem to be in error by a substantial margin. There is need for obtaining a complete picture of fertility in India as also for having accurate measures of fertility differences between regions and trends in fertility. Internal variation in fertility by states, sub-populations and urban-rural residence need also to be measured in such a way that the resulting studies in different regions may be comparable.

- (ii) Measurement of differences in fertility between various social and economic groups in the population and changes in these differentials.

Fundamental to an appreciation of fertility trends is the collection of data on differentials between various social and economic groups of the population. As the fertility of a country changes, the magnitude of such change may be much greater in some socio-economic groups than in others. Information on the nature of these differentials and their size can guide not only family planning experts but also over-all planning in a number of ways.

- (iii) Voluntary and quick adoption of family planning methods by individual couples is an essential part of the planned economic and social development in many countries. There is very little information available about the sociological factors that motivate the people to adopt or not to adopt family planning methods.
- (iv) Studies of channels by which family planning information is most readily communicated and adopted.

A variety and number of experimental studies of socio-psychological nature need to be undertaken to find out the method of communication and motivation that would lead to greater effectiveness, more rapid results and at lesser cost.

- (r) Family Planning Inventory *i.e.* a periodical measurement of the following basic facts about family planning should be obtained through National Sample Surveys:—extent and intensity of desire to plan family size; extent of nature and intensity of resistance to family planning; extent of knowledge of family planning already possessed by the people; percentage of couples and characteristics of couples who are actually trying to plan their families; methods used by couples who are planning their families and reasons for preference; reasons for not practising family planning by those who have knowledge but do not practice family planning; study by models of the effect of differential fertility patterns on changes in birth rates as a guide to the development of the family planning programme. Although the need for family planning is being increasingly recognised, there is not enough knowledge of how the programmes may be operated to give maximum results. Some attempts has been made to consider the types of contraceptive methods that may be recommended and their acceptability and effectiveness in various cross-sections of the population. Some of the subjects given above are also of value. While such attempts are to be further encouraged, there is need for understanding how fertility patterns may be reasonably changed so that a desired reduction in birth rate can be achieved. While a number of methods of change can yield the same or similar result as, for instance, postponement of first birth, decreasing of or complete stoppage of births after a certain number has been born, the degree of acceptance of any of these methods and the results to be expected will be determined by economic, social and cultural factors. Model studies with different fertility patterns can show not only the results which may be expected under different types of changes but also would assist in selecting the ones which may be most practicable in a particular cultural context and can also be used in the educational programmes. The relative advantages of programmes of contraception and sterilization may emerge from such studies.

(d) Measurement and analysis of the reciprocal effects of fertility and economic development.

The following important topics need detailed study :—

- (i) Effect of fertility levels upon labour force and unemployment.
- (ii) Changes in fertility levels and changes in levels of living and per capita income.
- (iii) Levels of fertility and national expenditure for education and child welfare advice.
- (iv) Levels of fertility and their effects upon housing needs.

- (v) Levels of fertility and their effects upon a national programme of capital formation.
- (vi) Effects of economic development upon fertility of sections of population that have been living at very low levels of birthhood.

4.64. The Committee noted that the Demographic Advisory Committee have been considering the problem of training and research in this field and have recommended that an *ad hoc* provision of Rs. 50 lakhs be made for this purpose in the Third Five Year Plan. (Appendix XXVI). The Committee recommends that the proposals of this Committee should be given early consideration by the Government.

4.65. *Research on medical aspects of family planning*—Research on the medical aspects of family planning and the biology of human reproduction is obviously of primary importance. There are many unsolved problems of human reproduction that require immediate investigation. The Committee recommends that the following medical and biological research programmes be given high priority :—

- (i) Development of suitable oral contraceptives, either synthetic or extracted from indigenous plant material.
- (ii) Development of more effective local contraceptives.
- (iii) Development of operative techniques for temporary sterilization.
- (iv) After-effects of sterilization.
- (v) Immunological and biological studies of human spermatozoa with a view to the development of a contraceptive serum.
- (vi) Further investigation of the mechanism of spermatogenesis and ovulation, fertilisation, and cytological studies.
- (vii) Other studies in the physiology of human reproduction such as fertility.
- (viii) Effect of family planning programme on the quality of the population.

4.66. Medical and biological studies may be continued under the auspices of the Indian Council of Medical Research. The Committee does not consider it necessary for a separate Central Medical and Biological Institute to be set up, for it would be difficult to organise research in different subjects in one Institute. Research schemes on the lines indicated above could be sponsored at the existing institutions having facilities for biological and medical research. An annual progress report can be prepared by the Indian Council of Medical Research and presented to the Central Government.

4.67. *Qualitative aspects of population*—Interest in the study of human genetics has been aroused very recently and was intensified during the last decade when the long-term effects of radiation began to be discussed. Major gaps in knowledge in this field have made it necessary to set up a number of laboratories in the different countries where family planning programmes are being actively promoted with Government support. In India, too, it would be desirable to study the effects of such programmes on the qualitative aspects

4.68. There are several directions in which the Human Variation Unit established in Bombay can be developed to undertake research and training on the qualitative aspects of population during the Third Five Year Plan period.

(i) The Unit has carried out extensive work on the distribution of genes in representative populations in Maharashtra and Gujerat. This work has thrown light on the genetic structure of populations and has shown a wide genetic diversity among the castes and tribes of the region. This work can now be extended towards an understanding of differential fertility and mortality trends and a new section could be organised to deal with the subject.

(ii) The long-term study on twins and consanguinity started by the Family Planning Research and Programmes Committee in 1954 and now continued under the Indian Council of Medical Research has already contributed some important results. A continuance of this study will help to throw light on the effects of inbreeding in our populations. To train workers in the field of human genetics, the Committee recommends that the Unit be provided with two fellowships, one for a medical candidate and the other for a candidate in basic sciences.

(iii) A Heredity Counselling Clinic in conjunction with the Human Variation Unit may be organised to assist families with genetic abnormalities and allied problems.

4.69. With the Human Variation Unit established as a service, research and training centre, pilot units might be set up in different regions in India, as it would be worthwhile to carry out qualitative studies of the population in connection with a large scale family planning programme. The Committee also considers that more Indian workers should be trained in this subject both in India and abroad.

4.70. *Sterility*—For the present, central assistance for work on infertility and sterility is being given mainly to the Family Planning Association of India to run its Family Welfare Bureau. This Bureau has done commendable work. There appears to be a great demand for advice on sterility and infertility although the numbers of infertile couples are not high. There is not as yet an extensive programme in this field so far, as India's main and urgent problem is the reduction of the birth rate. It is felt, however, that the provision of advice and treatment for infertility as a part of the family planning programme would help to make that programme itself more popular, since it would be demonstrative of the fact that family planning means planning for children and includes help to childless couples who desire to have children. The Committee, therefore, recommends that financial assistance should be made available for one well-developed clinic in each medical teaching institution and that State Governments be requested to provide similar facilities in their selected hospitals.

4.71. *Family Life Education*—Family life education, including sex education, education for marriage, parenthood and home-making is obviously necessary for a fuller family life. The Committee recommends that the Ministry of Education should examine this question and evolve appropriate measures as soon as possible. Family life education, in the Committee's opinion, should start from an early stage, along with such subjects as hygiene, in schools and should be graduated according to the age and understanding of the pupils. It should aim at inculcating wholesome and healthy attitudes and promote an understanding of the all-round aspects of human inter-relationships and not merely be confined to sex questions. These must come in their due order in the larger context of family and community educational and other experts would have to work out the steps and content of such an education.

4.72. *Marriage guidance and counselling*—As regards marriage guidance and counselling the general opinion appears to be that if at all considered, these should, for the present, be made available at, or in co-operation with selected family planning clinics where comprehensive services are available. These would be pilot schemes. A good family planning worker is bound to have to give some marriage guidance in the course of her work, and so training in this branch may be made available to workers as soon as possible.

4.73. *Education and motivation in family planning*—The success of the family planning movement depends on the creation of a new approach to family responsibility, a keener awareness of the rights of children to adequate food, clothing, health, education, housing and recreation and a determination to work for the welfare and economic stability of the family through regulating its size to the number of children towards whom these responsibilities can be fairly fulfilled. To create such an approach among the masses requires a massive and sustained educational effort and an all-round programme should be intensified and spread throughout the country. In framing such a programme, account must be taken of the practical circumstances affecting family life and of community patterns of marriage and family living, to avoid resistance due to orthodoxy or a feeling that old established codes are being upset. In actuality, family planning education can form a bridge between old ideals and new needs and responsibilities. It is fitting, therefore, that it should emphasise the positive aspects of maternal health, child care, economic standards and welfare of the family, and an awareness of parental morality and responsibility to each other and the children respectively. The interests, not of the isolated individual so much as of the family as a unit, will form the basis of motivation for family planning and that too as a part of the community amongst whom new values, and a new approach to life, may become a matter of pride and achievement, engendered by married couples intelligently spacing and limiting the number of their children.

4.74. A strong motivation is needed to change set behaviour patterns and for the individual parents, this can be articulated in terms of fewer children and more family security and prosperity, reversing the present (centuries old) trend where numerous children are regarded as security for old age—no easy task. As far as motivation is concerned, emphasis on the need to restrict population growth and to raise the national standards of living would hardly provide the mainspring for action, but might help to some extent to back up the personal desire for security.

4.75. The methods and media through which family planning education can be carried out must be related to the particular situation. The educational media should be simple and comparatively inexpensive, indigenous to the culture and art of the locality where possible, and with a direct appeal for the people. It has to be borne in mind that it is the skill of the educator that ultimately counts and not any elaboration of audio-visual aids for, in the hands of an unskilful person, such aids would only have the effect of gadgetry and not register an appeal to the minds and hearts of the audience. This does not mean, however, that audio-visual aids should be neglected. These must be made available in ample supply and should be prepared and issued in a continuous stream so that fresh material is regularly forthcoming, based on accumulating experience in the field. Adequate educational material should be produced in all the regional languages including films, film-strips, posters, pamphlets, flip charts, flannel-graphs, etc. The media of radioplays, dramas, poetic recitations, puppet shows, and other graphic presentations still await exploitation for the family planning programme and can be brought into systematic use.

4.76. There has been no scientific assessment as such of the efficacy of the different methods and media to be used in family planning education but the practical experience gained by family planning workers during the last 8 to 10 years shows that the personal approach through individual home visits and small group contacts is essential. Such an approach would also extend to the community as a whole, drawing in influential members therein to help in creating a favourable climate for family planning ideas to take root.

4.77. It is necessary to stress that results from the educational programme will emerge only where education and services go hand in hand, so that those who are motivated do not suffer a set-back due to a lack of clinical help where needed, or the availability of adequate supplies.

4.78. Family planning education, being a part of education for a fuller and better life, must be interwoven with all those other phases of constructive endeavour directed towards raising the standards of living. The underlying urge behind all these activities is the same, whether they be in the sphere of agriculture or community development or education or health, or new employment opportunities or family planning, and therefore the educational approach too should be integrated. A multiplicity of workers, approaching the villager separately for each item, would probably arouse resentment rather than interest, whereas a co-ordinated approach would help to set each facet of the total developmental programme in its proper setting.

It is very desirable, therefore, that family planning education work should be co-ordinated with the activities of workers in the primary health centres, Community Development Blocks, Social Welfare Board, etc. All such workers must receive an orientation in family planning. The Gramsevikas and Gramsevaks and the MCH staff of primary health centres should be entrusted with family planning education as one of their main responsibilities at the local level.

4-79. Among the special educational programmes that can be taken up for family planning the following might be included:—

(i) The organising of Orientation Camps for a large number of voluntary persons from all walks of life who would subsequently carry out propaganda and education in their own localities. Among those attending these camps would be members of village panchayats, teachers, social workers and men and women who have the confidence of the community.

(ii) It may also be desirable to introduce sections on family planning, in all other types of camps and courses on an organised scale, for example, social education training courses and other courses for all kinds of constructive workers.

(iii) The setting up of mobile education teams of trained personnel to visit given areas from time to time for repetitive education in family planning. A few pilot schemes on these lines may be tried out in the beginning.

It would be desirable that work of this nature be undertaken in areas where family planning clinics have either been already established, or are to be opened within a short time, so that the interest and enthusiasm aroused may be met forthwith with adequate services.

(iv) Family planning education should also form a part of all exhibitions, gatherings, melas, market days etc. where large assemblies foregather.

(v) The scheme of having honorary family planning education leaders should be continued, ensuring that their work is integrated with the other educational programmes. They can help to mobilise public opinion in favour of family planning and draw in the people's participation through contacting local organisations. The work of such leaders can extend to the creation of a net work of small groups of people (including village panchayat members), in different areas who can, on a fairly simple level, study the family planning programme and themselves undertake motivational work in their own local areas. Such small study circles on family planning, if judiciously helped with a little money and an adequate amount of information and educational material, can have some permanent effect in local areas. The health educators at district and tehsil level could also help in this work.

It must be emphasised again that the workers should be equipped with adequate educational materials in order to aid them in their motivational work.

(vi) On the academic side, university extension lectures on family planning would be very useful. The social, economic, national and international implications of family planning can be dealt with in these lectures, embracing the demographic and social aspects and the developments in medical and biological research. The implications of family life can also be brought out, such as the acceptance of a sense of mutual consideration between the spouses for their physical and emotional well-being, the consciousness of a responsibility as parents so that the off-spring are planned, wanted and loved, the closeness and love of a family unit which can prevent misuse of contraceptive knowledge,

4.80. In order to strengthen and consolidate the work for family planning at the District and Taluqa level, certain posts should be established as follows:—

(i) *Tehsil family planning educator*—Lack of supervision and co-ordination at different levels is one of the major draw-backs in successfully implementing national programmes, especially in a programme which needs to be intensified and extended over the entire population. Prompt and continued supervision and supplies are absolutely essential for the success of the family planning programme. It is proposed to have a well-trained Health Educator to perform supervisory duties at the Tehsil or Taluka level. She or he should be assisted by the social education organiser, gramsevaks and gramsevikas, who will also work as reserves. The health educator will work under the overall supervision of the family planning clinic attached to the tehsil hospital or health centre.

(ii) *District health educator*—For maximum utilisation of rural health services, health education work in the district will have to be strengthened. There is a need for assisting the district health organisation by a district health education officer for planning and conducting comprehensive health education work. The district health education officer should not only be responsible for the health education services but also for conducting various training activities for the health workers in the district. As family planning will be one of the major public health programmes, the district health education officer should devote much of his time to the guiding and training of family planning education workers. The district organisation should be equipped with teaching and other audio-visual aids.

(iii) *Divisional honorary leaders*—The State Family Planning Officers require assistance in carrying out their educational responsibilities. One or two trained health educators should be appointed who would be required to identify, define, and find solutions for educational problems connected with family planning. The state family planning health educator would work under the technical guidance of the state health education bureau and function under the administrative direction of the state family planning officer. The needs for educational material will be assessed by this officer who would get them produced and distributed by the State Health Education Bureau. The State Health Education Bureau itself would have a family planning unit consisting of health educator, publicity officer, editor, artist, photographer, craftsmen, etc.

(iv) *Regional supervision and co-ordination*—The Family Planning Directorate at the Centre will have to be assisted by five or six Regional Health Educators who should assist in the planning and co-ordination of health education work and maintain a continuous flow of supplies in the region.

(v) *National director*—At the Centre itself, the Director of Family Planning should have the assistance of a senior family planning educator in order to implement the educational policies and directives of the Ministry. The Central Health Education Bureau should have a Family Planning Unit to plan, prepare and produce typical educational materials needed for the programme, develop suitable curricula for the training of personnel and evaluate educational activities. The senior family planning educator would have the technical guidance and help of the Bureau but would be administratively responsible to the Director, Family Planning.

(vi) *Central Health Education Committee*—In order to advise and co-ordinate health education activities conducted by official, semi-official and voluntary organisations at the national level, it would be useful to constitute a Central Health Education Committee consisting of representatives of all Central Ministries which are either concerned with the media of mass communication or involved in the people's participation. The major voluntary organisations active in this field should also be represented on the Committee. The Secretary of the Central Health Ministry or the D.G.H.S. and A.D.G. (H.E.) should be members of the Committee.

4.81. *Personnel Recruitment and Training*—As mentioned earlier, the family planning programme must be carried out by mobilising and channeling all available voluntary effort with the support of technical personnel and officials at the key levels.

The tehsil family planning educator will be recruited from the ranks of mukhya sevikas, social welfare workers, teachers, etc., possessing a Bachelor's degree in social sciences or education. It will be an encouragement if senior mukhya sevikas are given chances to become tehsil family planning educators. These workers will have to be given training in family planning, extending over 3 to 4 months, at State headquarters. The training could be started from 1960 and continued subsequently in 3 batches of 20 candidates per batch per year per State. For effective working of the programme, these educators will have to be in position in all tehsils by the end of the year 1962-63.

District Health Education Officers can be recruited from candidates possessing a Master's degree in social sciences, or post-graduate degree in education and having 2 to 3 years' experience in their respective fields of work. They should be sent for one academic year's training in health education to the All India Institute of Hygiene and Public Health, Calcutta, or to other institutions and colleges that may start giving similar courses.

To have an adequate number of this class of personnel, it is proposed to start three more health education departments in the existing colleges and institutes which are now providing post-graduate degrees in public health. Each of these departments could train 30 candidates a year. The health educators at the State, regional and national levels will also be selected from the trainees coming out of these colleges.

Appendix XXVII gives details of the personnel, their responsibilities and the training required.

4.82. *Finance and Phasing*—Gramsevikas and Mukhya Sevikas will have to utilise the local media for motivating people to accept and practise family planning. It is proposed to provide them with Rs. 100 and Rs. 150 per year respectively as contingency. It is estimated that there will be 10,000 gramsevikas and 3,000 mukhya sevikas by the end of 1960-61 and they will require Rs. 14.5 lakhs per year or 72.5 lakhs for 5 years. The staffing pattern of the Family Planning Education Unit at the tehsil level is given in Appendix XXVIII. The expenditure on this account will be Rs. 6,000 recurring and Rs. 1,000 non-recurring per year. To cover the entire country, 1,800 Tehsil Family Planning Education Units are required. If the training programme is started in the middle of next year as suggested, it may be possible to have 600 family planning educators to start the work in the first year of the Third Plan period.

The total number of workers required i.e. 1800 could be had by the end of 1962-63. This will involve an expenditure of Rs. 486 lakhs recurring and Rs. 18 lakhs non-recurring for 5 years. The District Health Education Section of the District Health Office will cost Rs. 9,600 recurring and Rs. 2,000 non-recurring. Thirty sections could be started during 1961-62 with the addition of 60, 90, 90 and 50 sections respectively during the succeeding four years. The expenditure will have to be met from the provision for the General Health Education Project. It is also proposed to provide a mobile audio-visual and exhibition unit attached to the District and the Divisional level at an estimated cost of Rs. 4,500 per year recurring for the staff and maintenance of the van and Rs. 40,000 non-recurring for the van and equipment. There will be 50 such divisional family planning mobile audio-visual units during the Plan period. Ten units could be started each year. The total cost will be Rs. 20 lakhs non-recurring and Rs. 6.50 lakhs recurring. Honoraria to lay Educational Leaders for each Division at the rate of Rs. 4,000 per year per Leader have been sanctioned and the expenditure for 50 such leaders will amount to Rs. 10 lakhs during the Plan period. The pattern of organisation at the State level is given in Appendix XXVIII. It is proposed to set up these Units in the year 1962-63 except one trained Health Educator who will be added on during 1962-63. Each of these State units will cost Rs. 50,000 recurring and Rs. 5,000 non-recurring. All the 15 State Units will cost Rs. 30 lakhs recurring and Rs. 0.75 lakhs non-recurring. The regional health educator and his staff will incur an expenditure of Rs. 0.75 lakhs per year or Rs. 3.75 lakhs for 5 years.

The Education Unit at the Centre will require an expenditure of Rs. 3 lakhs recurring per year and Rs. 0.5 lakh non-recurring.

							(In lakhs)	
							Rs.	
1st year	..	..	..	..	..	..	89.00
2nd year	..	..	..	..	..	..	149.75
3rd year	..	..	..	..	..	..	141.25
4th year	..	..	..	..	..	..	142.25
Total							..	653.00

4.83. Intensive and extensive education embracing all sections of the population is the *sine qua non* of any programme which involves the social and personal well-being of the people. The proposals put forward in the foregoing paragraphs are aimed at reaching out to that section of the population which is not usually covered in this country through mass communication media. The motivation of the rural population to take measures to stabilize family size will have to be brought about by a "face-to-face" approach, involving all the available voluntary leadership and official resources. The above recommendations are intended to pinpoint this aspect at all levels and the success of the proposals depends in the first instance upon the early recruitment and training of suitable personnel.

CHAPTER V

IMPLEMENTING AGENCY

5.1. The problems dealt with in this Report so far make it abundantly clear that the family planning programme during the Third Five Year Plan period will have to be put through in such a way as to initiate a definite downward trend in the birth rate with the least possible delay. The Committee feels that "an original, dynamic, sustained, vital and popular drive" has to be made to achieve this. The Committee discussed at great length the organisation that would be required to implement a well-constructed and swiftly-paced programme of birth limitation throughout the country. It took serious note of the view which has been strongly expressed that the present arrangement of having an advisory Family Planning Board with a small Directorate and a minor financial allocation in the Ministry of Health was most inadequate having regard to the dimensions and urgency of the problem, and that it was essential to set up an implementing agency of the highest standing, power and authority to undertake the expansion of the programme under the Third Five Year Plan. The Committee noted that a Ministry of Population has been called for at various times. It also noted the suggestion that at least a Commission or an autonomous, statutory Family Planning Board with a non-official as Chairman be constituted.

5.2. *Ministry of Population*—As regards the suggestion for a separate Ministry, the Committee felt that this would mean the building up of a rather top-heavy organisational structure involving an appreciable expenditure and delay, while there was no guarantee that the results would prove to be commensurate with the money and effort expended. The proposed Ministry would inevitably have to deal with other Ministries, especially those of Health and Finance, and with State Governments and their Health Departments, and the consequential delays would continue to occur. Therefore, the Committee did not feel that this suggestion would help to overcome the basic difficulties, i.e., the administrative and financial hurdles in the way of speedy action and the decentralisation of responsibilities.

5.3. *Autonomous Board*—The other proposal, namely, to have a Commission or an Autonomous Board was carefully considered by the Committee. This proposal had been made on the ground that the setting up of an implementing agency with autonomous powers would be conducive to speed and efficiency and could draw in popular participation in the family planning programme to a much greater degree than the present advisory Board had been able to achieve.

5.4. The Committee discussed some of the difficulties that might be met with even with an autonomous body. Family planning, although a subject of tremendous socio-economic importance is one that, as a movement, has to be implemented mainly through the Health Services. The medical and health centres are the natural venue for receiving family planning advice and assistance and they are being mainly run by the State Governments—almost entirely so far as the rural areas are concerned. Thus, there is, no doubt, some possibility

that, where an autonomous body is working with government centres, difficulties might arise at various levels in the States, perhaps even leading to the paradox where the autonomy provided to facilitate the programme may in fact become an impediment. An Autonomous Board that is required to give grants and implement the programme entirely or mainly through voluntary organisations (as in the case of the Central Social Welfare Board) is not likely to encounter such problems. In this connection, the Committee invited Smt. Durgabai Deshmukh, Chairman of the Central Social Welfare Board, to give her opinion and noted her views with great interest. It was her opinion that it was possible to arrange for certain matters to be dealt with departmentally, and others, which required the people's participation (for example, training), to be handled directly by the Autonomous Board. The members of the Board themselves could be allotted certain duties and powers. This had worked satisfactorily in the case of the Central Social Welfare Board, which, she pointed out, although dealing extensively with voluntary agencies, also had to work through the Ministries of Education and Community Development.

5.5. The Committee members also had the benefit of discussing this point with the Director General of Health Services, and the Advisor, Health and Social Services, Planning Commission. These discussions served to strengthen the Committee's view that even in a situation where a great part of the implementing machinery is government-controlled, it is entirely feasible to work out procedural regulations to ensure the smooth expansion of the programme at both official and unofficial levels, under an Autonomous Board. There are certain distinct advantages to be derived from the setting up of an Autonomous Board. A body of this authoritative nature can quicken the pace and widen the expansion of the family planning programme through many different means. In the first place, it can create and sustain a fresh and powerful momentum so that the programme could be further intensified. Such a Board can forge direct links with other Ministries such as those of Food and Agriculture, Community Development, Education, Information and Broadcasting, Labour and Employment, Home Affairs, Defence, etc. This would help to co-ordinate the welfare services available under the developmental plans and increase the efficiency of the workers and schemes through avoiding duplication. Such an autonomous Board can give a fillip to voluntary effort in the field and help to recruit and train large numbers of volunteers who would be of the utmost help in carrying the ideals and philosophy of family planning right into the homes of the people. An official programme, however benevolent, cannot reach out to the masses, unless and until the people's participation has been won. This is particularly the case with regard to a subject like family planning for, as Prof. Arnold Toynbee recently remarked: The death rate can be reduced by public action taken by the few; the birth rate can be reduced or stabilised only by private action by the many.* The task of educating the people in what is really a new attitude of parental responsibility is formidable, and cannot be handled by officials but must be undertaken by social workers animated by a strong personal conviction. The autonomous Board can also exercise considerable initiative in introducing pilot schemes and experimental studies with regard to the demographic, medical, sociological and organisational aspects of the programme.

*Mc. Dougall lecture at FAO Rome, November, 1959.

5-6. After due consideration, therefore, the Committee is of the opinion that an Autonomous Central Family Planning Board with adequate financial resources and powers, and with an unofficial Chairman, functioning under the Ministry of Health is essential. The Committee recommends that such a Board be set up at the Centre and that there should be similar State Boards which may have District Committees functioning under them.

5-7. Some members, however, felt that the formation of a separate Ministry or an Autonomous Board might not be the solution for the expeditious extension of a programme which was mainly to be implemented through Medical and Health Services of State Governments. The desired results might be achieved by simplifying administrative and financial procedures and decentralization of financial and administrative authority.

5-8. In view of the greater responsibilities and powers of the Autonomous Board, it would be necessary to strengthen the expert assistance and staff needed to carry out the family planning programme. The setting up of an education and publicity organisation, an inspection and counselling section and an evaluation unit are some of the needs which require to be met. Also, the Director, Family Planning (or the equivalent official if this designation is changed) urgently needs an adequate staff for expeditious administration.

5-9. *Organisation in States*—The Committee noted that in some States there are two Administrative Medical Officers. Family Planning Officers in some States are under the Director of Medical Services, in other States under the Director of Public Health. The Committee suggests that Family Planning and M.C.W. Officers should be under the administrative control of the same Administrative Officer, preferably the Director of Public Health.

5-10. The State Maternity and Child Welfare and Family Planning Officers should be closely associated with both Medical and Public Health Departments and the Director, Public Health, should arrange with the Director of Medical Services to allow them facilities to visit medical institutions where the family planning and maternity and child welfare programme can be developed. It may be helpful if the Director of Public Health could have a Deputy Director (M.C.W. and Family Planning) with three Assistant Directors—one for Family Planning, the other for M.C.W., and the third for School Health. The Committee noted that the Family Planning Officers are of different grades in different States. The Committee suggests that the status of State Family Planning Officers should be that of at least Deputy Director, Public Health. These State Governments which have still part-time Family Planning Officers should appoint whole-time Family Planning Officers with the least possible delay. With the increased commitments involved in the expanding family planning programme, it is considered essential that State Family Planning Officers should have adequate staff.

5-11. The District Health Organisation should be strengthened by appointing a full-time Medical Officer, well-trained in M.C.W. and Family Planning, to assist the District Officer for these services in the district. Such an Officer may be in overall charge of the M.C.W. and Family Planning Programme in the entire district and maintain close co-operation with the primary health centres and hospitals in the district.

5.12. At the primary health centres, one woman doctor may deal with both family planning and the M.C.W. programme. However, if the caseload is heavy, additional medical officers should be appointed to strengthen the existing staff, who may take up both M.C.W. and family planning work. Similarly, medical auxiliaries may generally carry out both family planning and M.C.W. work and where the caseload demands additional medical auxiliaries, they should be employed for family planning and M.C.W. work. In making these adjustments, it should be borne in mind constantly, that every effort must be exerted to increase the caseload for family planning, and in no case should it be pleaded that the staff is so busy with M.C.W. work that it has very little time to make the special effort necessary for expanding the family planning work.

CHAPTER VI
FINANCIAL CONSIDERATIONS

6.1. The Committee recommends a provision of Rs. 100 crores for family planning in the Third Five Year Plan. The proposed expenditure may be made for the following purposes—

	in crores.
Item	Rs.
(i) Continuation grant for 2,031 rural and 650 urban clinics started during the first two Plans	7.79
(ii) Opening of 3,500 urban clinics (3,000 in M.C.H. centres and 500 in teaching institutions)	13.20
(iii) Family planning service at the head-quarters of 4,500 primary health centres and 22,500 sub-centres ..	48.09
(iv) Strengthening the staff of hospitals for sterilization ..	8.16
(v) Sterility and infertility service	0.24
(vi) Distribution of contraceptives at the clinics and at the medical institutions having no family planning clinics ..	10.17
(vii) Training	2.00
(viii) Education (including research on education and motivation)	7.94
(ix) Demographic research	0.50
(x) Organisation—	
(a) Central	0.26
(b) State and District	1.65
Total ..	100.00

6.2. Provision for medical and biological research including research on qualitative aspects of population it is assumed, will be made by the Indian Council of Medical Research.

PHASING OF TARGETS

Items	Number of units					Total
	1961-62	1962-63	1963-64	1964-65	1965-66	
1. Urban clinics ..	230	460	700	940	1,170	3,500
2. Rural main centres	250	500	900	1,250	1,600	4,500
3. Rural sub-centres	1 250	2,500	4,500	6,250	8,000	22,500
4. Strengthening the staff of hospitals for sterilization operations	300	400	600	800	900	3,000
5. Distribution of contraceptives at medical institutions	1,000	1,500	1,500	2,000	2,000	8,000
6. Sterility and infertility clinics	6	10	14	20	..	50
Expenditure (Rs. crores)	.. 6.10	9.91	16.75	26.84	40.49	100.00

*Minute of dissent to the Report of the Family Planning Third Five Year
Plan Committee*

BY Smt. SHAKUNTALA PARANJPYE

My main difference of opinion with the report is as regards the recommendations to set up an Autonomous Central Family Planning Board. (pp. 68)—

- (1) Autonomous Boards may be appropriate for some business activities but are not appropriate for administration of social welfare State activities.
- (2) There can be no delegation of administrative powers in relation to an activity of the State which is closely related to public policy making.
- (3) A board is a nominated close body which is not responsible or sensitive to public opinion. Therefore, any vital aspect of public policy cannot but put in commission with such a body.
- (4) A Central Board making policy in effect will entrench on the powers of each State in relation to pace, direction of the work in this important sphere.

My second point of difference is with respect to the training of family planning personnel (pp. 45)—

Considering the shortage of medical personnel local village 'dais' should be trained in fitting up normal cases with diaphragms. They enjoy the confidence of the public and a few preliminary questions easily help to detect the normal cases from the abnormal ones. The latter should be referred to medical authority.

My third point is about the F.P. Educators (pp. 63)—

Considering that Community Development Block and Social Welfare Board personnel is to be oriented in F.P. Work, Tehsil and District F.P. Educators in addition are unnecessary. An educator for a Revenue Division will be sufficient provided he is attached to a Mobile F.P. Unit which is competent to give contraceptive advice and to perform male sterilizations.

GOVERNMENT OF INDIA
MINISTRY OF HEALTH

APPENDIX I

RESOLUTION No. F. 4-38/59-F.P.

New Delhi, the 29th September, 1959

Consequent upon the recommendations made by the Central Family Planning Board at its Seventh meeting held at New Delhi on the 31st August, 1959, the Government of India is pleased to constitute a Committee to review the working of the family planning schemes during the Second Five Year Plan period and to recommend proposals for inclusion in the Third Five Year Plan. The following will be the composition of the Committee—

- | | |
|---|-------------------------|
| 1. Shrimati Dhanvanthi Rama Rau, President, Family Planning Association of India and Member of the Central Family Planning Board— | <i>Chairman</i> |
| 2. Shrimati Shakuntala Paranjpye, MLA, Member of the Central Family Planning Board— | <i>Member</i> |
| 3. Shrimati Soundaram Ramachandran, Member of the Central Family Planning Board— | <i>Member</i> |
| 4. Dr. Kamala Ramaier, State Family Planning Officer, Kerala— | <i>Member</i> |
| 5. Dr. H. N. Unwalla, State Family Planning Officer, Rajasthan— | <i>Member</i> |
| 6. Lt. Col. B.L. Raina, Director, Family Planning Dte. G.H.S.— | <i>Member Secretary</i> |

The functions of the Committee will be as detailed below—

- (i) To review the Family Planning Programme.
- (ii) To make proposals for inclusion in the Third Five Year Plan.

The Committee is required to submit its proposals on items (i) and (ii) above by the end of October, 1959.

The members of the Committee and the others who may be invited by the Committee for discussion will draw T.A. and D.A. as admissible under S.R. 190 read with Ministry of Finance O.M. No. F. 6(4)-Est. IV/58 dated the 1st October, 1958. The expenditure involved will be debitable to the Account Head "39-Public Health E. Miscellaneous—E. 4 Expenditure on Family Planning" under Demand No. 44-Public Health, for 1959-60.

APPENDIX II
DIRECTORATE GENERAL OF HEALTH SERVICES
No. 4-38/59-F.P.

From

*Shrimati Dhanvanthi Rama Rau,
Chairman, Family Planning
Third Five Year Plan Committee.*

New Delhi, the

September 1959

Dear Friend,

In pursuance of the recommendations of the Central Family Planning Board, the Ministry of Health, Government of India has set up a Committee to review the progress of the family planning programme and suggest proposals for the Third Five Year Plan period by the end of October, 1959. This Committee can succeed in its task only with your co-operation. I have no doubt that your help will be readily forthcoming. I am forwarding questionnaire for your views on important problems concerning family planning, which will be of assistance to us in formulating proposals for the Third Five-Year Plan period. I will be grateful if you could kindly send the required information. I am conscious that the time available is very short, but I will be obliged if you could send the required information by the 20th October, 1959 to me c/o the Directorate General of Health Services, New Delhi.

Yours sincerely,
DHANVANTHI RAMA RAU

FAMILY PLANNING THIRD FIVE YEAR PLAN COMMITTEE

QUESTIONNAIRE

SUGGESTIONS FOR THIRD FIVE YEAR PLAN

Aim and content of family planning programme.

1. What should be the aim of the family planning movement ?
 - (a) Is its purpose solely to reduce the population of the country ?
 - (b) If not, what are the other purposes to be achieved ?
 - (c) If an important purpose to be achieved is reduction of population growth, what would you suggest regarding :—
 - (i) the average size of a family in the country ?
 - (ii) How long do you think that a reduction of 50 p.c. in the present birth rate of about 40 per 1,000 is likely to take.
 - (iii) What do you think should be the optimum total population of India, say in 1975 ?
 - (d) What method or methods would you advocate for family planning among the following as most effective and acceptable to the people ?
 - (i) Contraception.
 - (ii) Abortion.
 - (iii) Sterilization.
 - (iv) Use of the rhythm method.
 - (v) Abstinence.
 - (e) As regards contraception what method or methods among the following would you advocate.
 - (i) Foam tablets.
 - (ii) Condom.
 - (iii) Jelly alone.
 - (iv) Diaphragm and jelly.
 - (v) Any other.
 - (f) As regards sterilization, state whether—
 - (i) It should be voluntary or compulsory ?
 - (ii) Under what conditions would you advocate compulsory sterilization?
 - (iii) If it is to be voluntary what criteria would you advocate for selecting cases for sterilization ?
 - (iv) What are the incentives, financial or otherwise, which you suggest to promote progress in sterilization ?
 - (v) Which do you consider most desirable sterilization of the male or of the female ?
 - (vi) Are there any social dangers to be expected from an extensive sterilization campaign in the country ; if so, indicate what these dangers are ; how can they be overcome as far as possible ?
 - (vii) Is a sterilization campaign on an extensive basis practically possible if not, what are the difficulties and how can they be overcome ?

(g) Do you advocate abortion as a measure to promote family planning ?

If so, state—

(i) Whether you support legalisation of abortion :

(ii) If legalisation is to be done, under what conditions do you suggest that abortion should be permitted by law.

(iii) Do you consider that it is desirable to provide monetary or other incentives to spread the practice of abortion ?

(iv) If abortion is permitted by law, at what stage of pregnancy should the operation be resorted to ?

(h) What incentives would you suggest to promote the small family habit in the community—

(i) a birth tax,

(ii) a bonus for specific intervals between successive births, the amount being related to the length of the interval and at higher levels of payment during the first half of the reproduction period. If you approve of this proposal indicate clearly the scale of payment and the intervals of absence of pregnancy you propose for the working of the scheme.

(iii) Is it a workable scheme for the country as a whole ; if not, do you consider a pilot scheme in a few limited areas desirable ? If so, indicate broadly the criteria for selecting areas where pilot schemes of this nature may be tried out. Is such pilot scheme practicable ?

2. Do you consider that facilities should be provided under family planning programme for the treatment of sterility ? If so, to what extent and how should the facilities be provided ? Please give details.

3. Do you advocate the organisation of centres to offer advice on heritable defects and diseases so as to promote a voluntary acceptance of sterilisation or other effective means of preventing conception in a manner designed to cover cases where there is the possibility of such transference of disabilities from one or both of the prospective parents or given through the practice of inbreeding ?

4. Do you consider that the stage has been reached to start centres for giving marriage counselling and guidance as a part of family planning programme ?

5. Do you consider that the subjects 'Family Life Education' and 'Sex Education' should be included in the curriculum of teaching in schools or colleges ?

6. Coordination—

(a) What are your suggestions for coordinating family planning programme with maternity and child health, medical, health and other welfare services in the country, coordination between different Ministries, coordination of family planning with Central Social Welfare Board, Local Bodies and Voluntary Organizations ?

(b) What use could and should be made of technical workers in Community Development, Agriculture, Education etc., in developing family planning movement ?

(c) What should be the role of voluntary organizations in the implementation of family planning programme ?

7. Organisation and administration—

(a) What should be the central set-up ?

(b) What should be the administrative set-up for family planning programme at the State, District and peripheral level ? Please give details.

8. Title to be used for Centres—

Should we call the Family Planning Centres, Family Planning Clinics or Centres, or Birth Control Clinics or Centres or Family Welfare Centres ?

9. Family Planning Service—

(a) What should be the target of population for intensive coverage by a rural and an urban family planning clinic and what should be the staff and expenditure (recurring and non-recurring) pattern for a rural and urban clinic ? At present a clinic has to cover a population of 66,000 in rural areas and 50,000 in urban areas. The pattern of staff and expenditure for a rural and urban clinic are as follows—

	Rural	Urban
Non-recurring—		
Equipment, furniture and publicity material etc.	500	2,000
Stocking of contraceptives	500	500
Total ..	1,000	2,500
Recurring—		
One lady doctor and one part-time male doctor	..	5,000
Social worker or health visitor or field worker (Family Welfare Worker).	3,000	3,000
One clinic attendant/peon .. .. .	..	1,000
Contingencies	500	500
Conveyance allowance	500	..
Distribution of contraceptives	1,500	1,500
Total ..	5,500	11,000

(b) What should be the qualifications, terms and conditions of service for doctors, social workers, health visitors, family welfare workers, field workers etc. employed under family planning programme in urban and rural areas ? What should be precise definition and qualifications for family planning social worker ? Should they be placed in one category or several categories like qualified from school of social sciences and orientated in family planning and any other not so qualified ?

(c) Assuming that the main functions of family planning worker would be, educating people in the acceptance of family planning practice ; home visiting for individual and group education and to follow up cases of family planning ; assistance to doctors during clinic sessions ; and all other activities connected with keeping records and the health education ;

- (i) Do you consider that it is necessary to have a specialised category of worker and thus multiply the category of medical auxiliaries or could this work be carried out by the regular staff of a Health Centre or qualified Public Health Nurse/Health Visitor/Auxiliary Nurse Midwife who may be given orientation in family planning ?
- (ii) If you consider that such a worker is necessary, what should be her functions in relation to the Public Health Nurse/Health Visitor and Auxiliary Nurse Midwife in the Primary Health Centre or Sub-Centres ? Should she be expected to participate in the general work of the clinic, e.g. help in the general out-patients or treatment of minor ailments, or should she confine herself to family planning?
- (iii) If she is a multipurpose worker, would there be a danger of her not being able to perform the function of Public Health Nurse/Health Visitor, her period of training being short or is there likelihood of being too absorbed in work other than family planning?
- (iv) Should she be given an attendant to accompany her on home visits?
- (v) If her functions are to be limited to education for family planning and assistance at family planning clinic, what should be the period of training and content of training programme?
- (vi) What type of institutions, Governmental or non-Governmental would be best suited for such training?
- (vii) Should the emoluments of the Family Welfare Worker be on par with Social Education Organiser, the Public Health Nurse/Health Visitor, or the Auxiliary Nurse Midwife?
- (viii) Would the nature of the work and emoluments be sufficient to attract and retain an educated woman in such work in rural centres?
- (ix) If not, what is to be her future? If she is to be trained as a Public Health Nurse or as a S.E.O. should she be exempted from any part of training for courses of Public Health Nurse or S.E.O.?
- (x) What conditions of service and minimum educational standard do you suggest for such workers?

(d) What should be the pattern of financial assistance of the Central Government to the State Governments, Local Bodies and Voluntary Organisations for the implementation of family planning programme? The pattern of Central assistance in the Second Plan period is as follows—

	State Govt. & Local Bodies	Voluntary Organisation	
		Rural clinic	Urban clinic
Non-recurring	100%	100%	100%
Recurring			
First Year	80%	100%	100%
Second Year	70%	100%	80%
Third Year	50%	100%	80%
Fourth Year	30%	100%	80%
Fifth Year	20%	100%	80%

(e) Do you consider that the contraceptives should be supplied (i) free or (ii) free and at subsidised rates. or (iii) or at subsidised rates alone?

10. Production of Contraceptives—

What steps do you suggest to encourage indigenous production of contraceptives in India?

11. Education—

(a) What are your suggestions for family planning motivation education programme?

(b) Do you consider it useful to conduct short-term family planning orientation camps in different parts of the country in order to orientate a large number of voluntary persons from all walks of life, so that they can carry out family planning propaganda and education in their own localities or areas? If so, what should be the duration of each camp and content of training and what steps do you suggest for conducting the camps all over the country? What honorarium, if any, do you suggest for them for propagating family planning?

(c) Do you consider that natural group leaders/prominent persons in different areas may be appointed as honorary family planning education leaders for motivating people in favour of family planning. If so, what honorarium do you suggest for them and what should be their plan of work?

(d) Do you consider that it would be useful to conduct university extension lectures on family planning? If so, what should be the content and what should be the number of lectures?

12. Training—

(a) Should any financial assistance be offered to medical colleges for imparting family planning training to the medical post-graduates and undergraduates in their normal course of training? If so, please give details.

(b) What do you consider should be the duration and content of training for (i) potential instructors, who in turn have to conduct training programme, (ii) doctors and medical auxiliaries who are employed in family planning clinics, (iii) orientation of lay personnel (if you approve of such orientation)?

(c) In view of the shortage of qualified social workers do you consider it useful to train a category of family welfare workers? If so, (i) what should be the qualifications of the candidates to be trained and (ii) what should be the duration and content of the training imparted to them?

(d) In view of shortage of trained personnel do you consider that sufficient number of touring training teams should be formed so that the teams could tour and provide on-the-spot training to the personnel employed in the family planning clinics and doctors and medical auxiliaries already employed in private practice? If so, how many teams should be formed and what should be the duration and content of training?

13. Research—

(a) Medical and Biological.

- (i) What medical and biological research programme can be undertaken? Where can they be carried out? (Details may be given).
 - (ii) Should they continue to be done mainly by the Indian Council of Medical Research or through any other agency?
 - (iii) Should a Central Research Institute be established or existing medical colleges, medical and biological research centres should be developed?
 - (iv) Should we conduct research on qualitative aspect of population; if so to what extent?
 - (v) Should research on sterility be conducted ; if so to what extent?
 - (vi) Should we undertake research for improving sterilization techniques?
- (b) What are your suggestions for Demographic Trianing & Research?
- (c) What are your suggestions for research on motivation in regard to family planning practices?

14. Any other suggestions.

APPENDIX III

SUGGESTION FOR THIRD FIVE YEAR PLAN

(Analysis of replies to questionnaire)

275 out of 4,801 addressees sent replies to the questionnaire. The number of replies varies from item to item of the Questionnaire, from 38 to 270. The respondents were categorised into four broad groups representing Governmental Organisations (I) Voluntary Organisations (II) Medical Workers (III) and Academic Institutions (IV). The following important findings emerged from broad analysis of the replies.

While checking the population growth was considered by the majority as the major aim of the family planning programme, it was also suggested that the ultimate objective of the programme should be towards the betterment of standard of living. The ideal size of the family suggested by 71 per cent of the respondents is 5 or less including husband, wife and three children. The most effective and acceptable methods of family planning in the opinion of the respondents were contraception (39 per cent) and sterilisation (35 per cent). Abortion was favoured by only 11 per cent and rhythm method by 10 per cent of all the methods suggested.

Compulsory sterilization was advocated by only 15 per cent, as against 79 per cent for voluntary sterilization. The most favoured conditions for compulsory sterilization were health and the number of children; for voluntary sterilization the condition suggested was the number of children. According to about 41 per cent of the advocates of voluntary sterilization, willing persons having three children should be considered eligible for sterilization and another 17 per cent suggested that a person should have four children before submitting for sterilization. Provision of free operation facilities was suggested for promoting sterilization programme.

Legalisation of abortion did not find favour with 69 per cent of respondents. Opinion on birth tax was slightly more against its imposition and the majority of government officials, social scientists and voluntary workers were against this measure.

Treatment of sterility in the family planning programme and the provision for facilities thereof was advocated by more than 75 per cent of respondents.

Inclusion in curriculum of schools or colleges of 'Family Life Education' and 'Sex Education' was suggested by more than 85 per cent of respondents. The stages for imparting knowledge on these two aspects which the majority concurred with, were school and college stages respectively.

The opinion on the role of voluntary organisations in family planning programme endorsed by more than 85 per cent of respondents was that they should undertake only propaganda.

The title suggested for the Clinic was "Family Welfare Centre".

The majority of the respondents supported the idea of conducting short-term family planning orientation camps in different parts of the country, conducting of University Extension Lectures; and appointment of group leaders as honorary Family Planning Education Workers.

Training Courses of about eight weeks' duration for medical auxiliaries and lay personnel was suggested by more than half of the respondents. The idea of touring training teams was also supported by a predominant section of the respondents.

A striking majority of the respondents advocated research on qualitative aspects of population and sterility under family planning programme.

APPENDIX IV

LETTER FROM PRIME MINISTER

No. 2098-PMW/59.

PRIME MINISTER'S HOUSE

NEW DELHI

October 18, 1959

My dear Dhan,

I received your letter of the 4th October some days ago together with the questionnaire attached to it. I am afraid I have neither the competence nor the time to deal with this questionnaire.

You know that I am wholly in favour of family planning. Certainly one of its principal objects is to lessen the rate of population increase. This is very important. But there are other aspects also. To give a fuller life to the family and more particularly to the mother and the children. The standard of living, education, etc. in a large family is likely to be lower than that in a somewhat smaller family.

I think that there should be facilities for sterilization.

Any marked success in this movement will depend on two factors: (1) a widespread approach to our rural population, and (2) simple and cheap methods. We have heard much of oral contraceptives. Undoubtedly, if these are effective, they would go a long way to provide a suitable method.

If we have to approach the rural population, this means (1) a fairly wide-spread propaganda to create a background of acceptance, and (2) large numbers of clinics or centres where such information can be given. It would hardly be feasible to have separate family planning centres all over the country. This work will have to be coordinated therefore, with other centres for maternity, child health and various types of medical and health services.

In every thing that we do in India, it must be remembered that the organizational structure should not be top heavy and expensive. Otherwise it is limited in scope.

Yours sincerely,

JAWAHARLAL NEHRU

Shrimati Dhanvanthi Rama Rau,
Chairman Family Planning,
Third Five Year Plan Committee,
Directorate General of Health Services,
New Delhi.

APPENDIX V

RECOMMENDATIONS OF THE COMMITTEE APPOINTED BY THE PANEL OF HEALTH PROGRAMMES OF THE PLANNING COMMISSION TO REPORT ON POPULATION GROWTH AND FAMILY PLANNING, 1951

I. *Recognition of need for Family Limitation*

The Committee recorded that they recognise in principle:

A. That family limitation is necessary and desirable in the interests of the family—that is to say, family comprising the nation should take all suitable and practicable steps for securing that the occurrences of birth in the family are properly spaced in time and limited in number, so as to safeguard the health of mother and children and enable an adequate share of the resources of the family being applied effectively to the care and upbringing of children;

B. That in order to assure the success of plans and programmes designed to promote the health and welfare of the people and development of the national economy, it is essential that the national birth-rate should be reduced concurrently with the national death-rate, until the population is stabilized at a level consistent with the requirements of national economy. Family limitation (defined as in above) is necessary to secure this result also.

II. *Specific Governmental Measures in relation to Family Limitation*

A programme of family limitation must, in our opinion, be a social movement which would call for initiative on the part of individual families and general development of public opinion. The State, therefore, can only play a limited role in this respect. Measures to secure rapid progress in education and improvement of health and living conditions would in themselves be favourable to family limitation and we consider such measures should have the highest priority in State programmes of national reconstruction. So far as direct participation by the State in a family limitation programme is concerned, its nature and extent will have to depend upon public demand. In the existing circumstances, we would like to make the following recommendations:—

- (a) the State should provide facilities for sterilization or giving advice on contraceptives on medical grounds;
- (b) such help and advice should not be withheld from others who seek and need it on social and economic grounds. Such services, however, should be provided to the extent that personnel in hospitals and health agencies can undertake them consistent with their other duties;
- (c) the State should also, through financial aid and otherwise, assist in the establishment of Research and Information Centres organised for the following purposes viz:
 - (i) collection, study and dissemination of information based on scientifically-tested experience in our country and abroad in respect of all aspects of family limitation; and the countering of ill effects of incorrect information;

- (ii) research necessary for the development of inexpensive, safe and efficacious methods of birth control suitable for all classes of people; and methods of preparation of necessary appliances and materials based on raw materials available in the country.

III. *Improvement of Population Data and Systematic Study of Population Problems*

In view of the intimate connection which exists between the numbers, sex composition, age structure, physical and mental health and general quality of the people and the working of the economic and social systems and also of the need or establishing a continuous flow of accurate and complete information regarding the interrelated changes occurring in all the factors, it is necessary to draw up a programme of collection of demographic data and study of selected specific problems with a view to provide a basis for the formulation and execution of a positive and comprehensive programme relating to population.

It is necessary to provide and develop a permanent organisation for the purpose but pending the establishment of such an organisation, steps should be taken to use the existing agencies and personnel as effectively as possible to implement these recommendations”.

One member of the Committee however did not entirely support the recommendations and in a supplementary note emphasised that the social and economic factors prove decisive in this connection, and the State should not undertake population control through furtherance of contraceptives and the first priority was education and improvement of living conditions which could motivate the people to find out ways and means of limiting their families whether State offers any facilities or not and the utmost that could be asked of the State was that it should not interfere with any social agency which wishes to undertake such activities. .

APPENDIX VI

PLANNING COMMISSION RECOMMENDATIONS FOR FAMILY PLANNING PROGRAMME DURING FIRST PLAN

The recent increase in the population of India and the pressure exercised on the limited resources of the country have brought to the forefront the urgency of the problem of family planning and population control. The application of medical knowledge and social care has lowered the death-rate while the birth-rate remains fairly constant. This has led to the rapid increase in the growth of population. While a lowering of the birth-rate may occur as a result of improvements in the standard of living, such improvements are not likely to materialise if there is a concurrent increase of population. It is, therefore, apparent that population control can be achieved only by the reduction of the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of national economy. This can be secured only by the realisation of the need for family limitation on a wide scale by the people. The main appeal for family planning is based on consideration of the health and welfare of the family. Family limitation or spacing of the children necessary and desirable in order to secure better health for the mother and better care and upbringing of children. Measures directed to this end should, therefore, form a part of the public health programme.

All progress in this field depends first on creating a sufficiently strong motivation in favour of family planning in the minds of the people and, next, on providing the necessary advice and service based on acceptable, efficient, harmless and economic methods. But these presuppose (1) intensive studies about the attitudes and motivations affecting family size and techniques and procedures for the education of the public on family planning, and (2) field experiments on different methods of family planning as well as medical and technical research.

A programme for family limitation and population control should—

- (a) obtain an accurate picture of the factors contributing to the rapid population increase in India;
- (b) discover suitable techniques of family planning and devise methods by which knowledge of these techniques can be widely disseminated; and
- (c) make advice, on family planning, an integral part of the service of Government hospitals and public health agencies.

A sum of Rs. 65 lakhs has been allocated by the Central Government in the plan of the Ministry of Health for a family planning programme.

This programme includes—

(1) The provision in Government hospitals and health centres of advice on methods of family planning for married persons who require such advice. Medical Officers working at hospitals and health centres like maternity and child welfare clinics should give advice to women regarding family planning

when such advice is necessary for health reasons. If a doctor feels that a women patient cannot undergo again the strain of pregnancy and parturition without danger to health, it is obviously the duty of the doctor to give such advice as is necessary to enable the person to prevent conception. In these circumstances the doctor would be justified in suggesting any chemical, mechanical or biological methods of contraception or sterilization as may be indicated for the individual case. The giving of advice on birth control has been a procedure allowed by the Ministry of Health in U.K. in medical centres maintained by the local authorities.

Field experiments on different methods of family planning for the purpose of determining their suitability, acceptability and effectiveness in different sections of the population. If it can be demonstrated that our people, particularly those living in rural areas, can be educated to accept the rhythm method and use it as a practical method of limiting family growth. From the point of view of avoiding enormous expenditure as well as that of securing the ethical value that community life would gain by the self-imposed restraint which the rhythm method involves, it would seem desirable to try out this method fully and thus ascertain its practicability. Whether the rhythm method is capable of wide application in the community with adequate results or not, actual experimentation alone can tell. Research and experiments need not however be confined to a single method. There are numerous voluntary agencies which are currently propagating the spread of information on family planning and the use of chemical and mechanical contraceptives. Their activities would need support.

Development of suitable procedures to educate the people on family planning methods. Inexpensive means of rapidly educating the public in matters relating to family size will have to be evolved if large-scale deduction in the national birth rate is to be obtained. Scientific techniques are available to assess the effect of mass educational campaigns. These techniques should be used to develop educational programmes suitable for the different economic and social sections of the population.

Collection, from representative sections of the population of information on reproductive patterns, and on attitudes and motivations affecting the size of the family. The reproductive pattern in any population is largely determined by social and cultural factors which may differ from one area to another. A thorough investigation of the differences in attitudes and motivations towards family size and of the factors responsible for producing such differences is important. Research along these lines is necessary if we are to understand the particular sentiments and aspirations to which programmes of family limitation in various sections of the population should appeal.

Study of the inter-relationships between economic, social and population changes. The information obtained by such studies will form the necessary background for the formulation of a national population policy and the development of appropriate measures for population planning based on factual information.

Collecting and studying information about different methods for family planning (based on scientifically-tested experience in India and abroad) and making such information available to professional workers.

Research into the physiological and medical aspects of human fertility and its control.

It is considered that the problems of population and family planning may be divided into those relating to—

- (1) policy and approach, and
- (2) research and programmes.

Two committees have accordingly been constituted. It would also appear desirable to set up at a later date a population commission to assess the population problem, consider different views held on the subject of population control, apprise the results of experimental studies and consider measures in the field of family planning to be adopted by the government and the people.

APPENDIX VII

GOVERNMENT OF INDIA

No. 2637/P/53

MINISTRY OF HEALTH

New Delhi, the 5th May, 1953

FROM

SHRI S. DEVANATH, B.A. (HONS.),
Under Secretary to the Government of India.

TO

THE DIRECTOR GENERAL OF HEALTH SERVICES, NEW DELHI.

SUBJECT—*Family Planning Research and Programmes Committee*

SIR,

I am directed to say that the President is pleased to constitute a Family Planning Research and Programmes Committee with the following composition to make recommendations to the Government of India regarding research schemes and experimental and other programmes relating to family planning to be adopted and the nature and amount of assistance, if any, to be given to existing voluntary organisations in the field of family planning after a review of their present activities.

Chairman—

1. Director General of Health Services.

Members—

2. Dr. K.C.K.E. Raja, Officer on Special Duty, Ministry of Health, New Delhi.
3. Dr. C. Chandrasekharan, Director, United Nations Office for Population Studies, New Delhi.
4. Dr. M.V. Govindaswamy, Medical Superintendent, Mental Hospital, Bangalore.
5. Dr. B.S. Guha, Director, Department of Anthropology, Government of India, Indian Museum, Calcutta.
6. Dr. P.K. Malkani, Professor of Obstetrics and Gynaecology, Lady Hardinge Medical College, New Delhi.
7. Dr. S.S. Misra, Professor of Clinical Medicine, Medical College, Lucknow.
8. Dr. K. Mitra, Assistant Director General of Health Services, New Delhi.
9. Shrimati D. Rama Rau, President, Family Planning Association of India, Bombay.
10. Dr. Basudeva Narayana, Principal, Medical College, Patna.
11. Prof. P.C. Mahalanobis, Statistical Adviser to the Cabinet.
12. Dr. V.K.R.V. Rao, Director, Delhi School of Economics, Delhi.

13. Dr. L.D. Sanghvi, Research Officer, Indian Cancer Research Centre, Bombay.

14. Dr. Mukhta Sen, Professor of Maternity and Child Welfare, All India Institute of Hygiene and Public Health, Calcutta.

15. Dr. T. Lakshminarayana, Adviser in Health Programme Planning Commission, New Delhi.

Member/Secretary—

16. Dr. C.G. Pandit, Secretary, Indian Council of Medical Research, New Delhi.

2. The non-official members of the Committee will be entitled to the grant of travelling and daily allowances for attending meetings of the Committee in accordance with the orders issued by the Ministry of Finance from time to time.

3. It is requested that the Committee should submit its interim recommendations on the urgent steps to be adopted within a period of three months if possible.

4. The expenditure involved in the current financial year should be met from the sanctioned budget grant under the head 39-Public Health Demand No. 50-D—Public Health Expenses in connection with Epidemic Diseases—D-Family Planning.

Yours faithfully,

(Sd.) S. DEVANATH
Under Secretary

Copy with 3 spare copies forwarded to the Ministry of Finance for information and communication to the Accountant General, Central Revenues. The order has been issued with the concurrence of the Ministry of Finance *vide* their U.O. No. 2373-E.G.-III/53, dated the 4th May, 1953.

Copy forwarded to the Planning Commission/Ministry of Home Affairs (Registrar-General) for information.

Copy forwarded to each member of the Committee for information.

By Order

(Sd.) S. DEVANATH
Under Secretary

APPENDIX VIII

CONSTITUTION OF THE GRANTS COMMITTEE

The Government of India, on 28th May, 1954, set up a Grants Committee consisting of—

- (1) Director General of Health Services—(*Chairman*).
- (2) Deputy Secretary, Ministry of Health (Shri N.B. Chatterji).
- (3) Officer on Special Duty, Ministry of Health (Dr. K.C.K.E. Raja).
- (4) Deputy Secretary, Ministry of Finance, (Shri K.L. Rathee).
- (5) Deputy Secretary, Planning Commission, (Shri M.R. Kothandaraman).
- (6) Shrimati Dhanvanthi Rama Rau, President Family Planning Association of India, Bombay.
- (7) Shrimati Uma Nehru, M.P.
- (8) Secretary, Central Social Welfare Board (Shri C.R. Govindarajan).
- (9) Adviser, Health Programmes, Planning Commission and Additional D.D.G., Health Services (Dr. T. Lakshminarayana).

to scrutinize and recommend, for sanction, applications for assistance for family planning work as well as research.

APPENDIX IX

PLANNING COMMISSION RECOMMENDATIONS FOR FAMILY PLANNING PROGRAMME DURING SECOND PLAN

The problem of regulating India's population from the dual standpoint of size and quality is of the utmost importance to national welfare and national planning. The objectives set out in the first Five Year Plan were—

- (i) to obtain an accurate picture of the factors which contribute to rapid increase of population.
- (ii) to gain fuller understanding of human fertility and the means of regulating it;
- (iii) to devise speedy ways of education of the public, and
- (iv) to make family planning advice and service an integral part of the services in hospitals and health centres.

The family planning programme was primarily directed to the building up of an active public opinion in favour of family planning and the promotion of family planning advice and service on the basis of existing knowledge. At the same time demographic as well as medical and biological studies were taken up. Assistance in the shape of subsidies or grants was given to States, local authorities, voluntary organisations and scientific institutions for about 115 family planning clinics and for 19 research schemes relating to biological and demographic problem. It is proposed to develop this programme further during the Second Plan.

The family planning programme has now gone far enough to call for its further development on systematic lines, for continuous study of population problems and for a suitable central board for family planning and population problem. Such an organisation should be more or less autonomous in its working. The main constituents in the Central Board's programme will be—

- (1) extension of family planning advice and service;
- (2) establishment and maintenance of a sufficient number of centres for the training of personnel;
- (3) development of a broad based programme of education in family living, which should include within its scope sex education marriage counselling and child guidance;
- (4) research into biological and medical aspects of reproduction and of population problems;
- (5) demographic research, including investigations of motivation in regard to family limitation as well as studies on methods of communication;
- (6) inspection and supervision of the work done by different agencies, governmental and non-governmental to which grants are made by the Central Board.

- (7) evaluation and reporting of progress; and
- (8) establishment of a well equipped central organisation.

It is proposed to establish clinics, one for 50,000 population, in all big cities and major towns. As regards small towns and rural areas, clinics will be opened gradually, in association with primary health units. These clinics are intended to create a general awareness of the problem and to provide advice and service. The establishment of a central training and clinical institute and a rural training unit near Bangalore are under consideration. A contraceptive testing and evaluation centre is being developed at Bombay. It is necessary that training in family planning should be imparted to all medical and nursing students. All hospitals and an increasing number of dispensaries should develop in due course a family planning service. It is also proposed to promote actively medical, biological and demographic research. A provision of nearly Rs. 5 crores has been made for family planning programmes. It is expected that about 500 urban and 2,000 rural clinics will be set up in the course of the Second Plan.

APPENDIX X
CONSTITUTION OF CENTRAL FAMILY PLANNING BOARD
GOVERNMENT OF INDIA
MINISTRY OF HEALTH
RESOLUTION

No. F. 1-65/56-HII

NEW DELHI,

Dated, the 1st September, 1956.

The Government of India have made a provision of Rs. 497 lakh (Rupees 400 lakhs at the Centre and Rupees 97 lakhs in the States) for family planning. In order to effectively direct family planning programmes it is considered necessary to set up a high level Family Planning Board.

The Ministry of Health have accordingly decided to set up a Family Planning Board consisting of the following:

Chairman

1. The Union Minister of Health.

Members

2. The Minister of Revenue and Civil Expenditure.
3. Shrimati M. Chandrasekhar, Deputy Ministry of Health.
4. Shrimati Durgabai Deshmukh, Chairman, Central Social Welfare Board.
5. Dr. J. C. Ghosh Member of the Planning Commission.
6. Dr. John Mathai, Chairman, Governing Body, Demographic Teaching and Research Centre, Bombay.
7. Shrimati Dhanvanthi Rama Rau, President, Family Planning, Association of India, Bombay.
8. Shri Choitram P. Gidwani 127, Mahatma Gandhi Road, Fort Bombay.
9. Shrimati Anasuyabai Kale, Anand Bhavan, Dhantoli, Nagpur.
10. Shrimati Savitri Nigam.
11. Dr. S. C. Sen.
12. Prof. P. C. Mahalanobis.
13. Shrimati Soundaram Ramchandran.
14. Secretary, Planning Commission.
15. Joint Secretary, Ministry of Finance.
16. Secretary, Ministry of Health.
17. Director General of Health Services.

Secretary

Family Planning Officer, Ministry of Health.

The Board may Coopt additional members for ad hoc purposes.

Members of the Board shall normally held office for a period of five years.

Functions

The Family Planning Board will advise on the following matters:

- (i) Research and studies on inter-relationship between economic, social and population changes, on reproductive patterns, attitudes and motivations affecting the size of the family.
- (ii) Educating public opinion on matters of family planning.
- (iii) Advice and necessary service in family planning as an integral part of the public health activities through hospitals, health centres and clinics.
- (iv) Facilities for the training of personnel in family planning.
- (v) Formulation of schemes for the improvement of the health of mothers and children and for bringing about better conditions for family living.
- (vi) Research on and the production of contraceptives.
- (vii) Literature and periodical in furtherance of the objectives of the scheme.

The recommendations of the Family Planning Board will be implemented by the Ministry of Health.

With the setting up of the Family Planning Board, the Family Planning Research and Programmes Committee and the Family Planning Grants Committee constituted by the Government of India in the Ministry of Health letters No. 2637-P/53, dated 6th May, 1953 and No. F. 15-10/54-P, dated 28th May, 1954 respectively stand dissolved.

Ordered that a copy of the resolution may be communicated to all the State Governments, all the Members of the Board, all the Ministries of the Government of India, the Comptroller and Auditor General of India, Planning Commission, Cabinet Secretariat, Prime Ministers' Secretariat, Parliamentary Secretariat and Department of Parliamentary Affairs.

Ordered also that it be published in the Gazette of India and that State documents be requested similarly to publish it in the State Committee for general information.

(Sd.) V. K. B. PILLAI
Secretary

APPENDIX XI

CONSTITUTION OF STANDING COMMITTEE OF CENTRAL FAMILY PLANNING BOARD

Copy of letter No. F. 1-189/56-H, II, dated the 2-1-57 from the Ministry of Health, New Delhi addressed to the Director General of Health Services, New Delhi.

SUBJECT—*Standing Committee of the Family Planning Board.*

I am directed to say that the Family Planning Board at its first meeting held on the 27th October, 1956, recommended the setting up of a Standing Committee to undertake scrutiny of various proposals relating to family planning and to deal with other cognate matters on behalf of the Board. In the interest of speedy action the Standing Committee will directly submit their recommendations to the Government, but place a copy of such recommendations before the Board at its next meeting. The Government of India have accordingly decided to constitute the Standing Committee of the Family Planning Board with immediate effect. The Committee shall have the following constitution—

Chairman	..	Secretary, Ministry of Health	
Members	..	Director General of Health Services	.. Ex-Officio.
		A representative of the Ministry of Finance.	
		A representative of the Planning Commission.	
		A representative of the Min. of Community Development.	
		Smt. Durgabai Deshmukh, Chairman, Central Social Welfare Board.	
		Smt. D. Rama Rau, President, Family Planning Association of India, Bombay.	
		Shri Choitram P. Gidwani, Member of Parliament.	
		Family Planning Officer, Director General of Health Services.	Ex-Officio-Secretary.

2. The Committee shall have the power to co-opt one or more members for ad-hoc purposes.

3. Non-official members of the Committee shall be entitled to the grant of travelling and daily allowances for attending the meetings of the Committee as are admissible to an officer of the highest grade in Class I of Central Services. Members of the Committee who are Government servants will draw travelling and daily allowances as are admissible to them, from the same source from which they get their pay.

4. The expenditure involved will be met from the sanctioned budget grant under the Head "39-Public Health—Family Planning Programme" of the Ministry of Health.

APPENDIX XII
FAMILY PLANNING STAFF AT CENTRAL ORGANISATION

Serial No.	Designation	Number
1	Director	One
2	Statistician	One
3	Section Officer	One
4	Investigators	Three
5	Propaganda Assistant	One
6	Technical Assistants	Five
7	Assistants	Two
8	Computers	Two
9	U. D. Clerks	Two
10	L. D. Clerks	Four
11	Editor	One—Part-time.

APPENDIX XIII

TERMS AND CONDITIONS REGARDING "PROCEDURE FOR FINANCIAL ASSISTANCE TO LOCAL BODIES AND VOLUNTARY ORGANISATIONS FOR FAMILY PLANNING PROGRAMME

I. Procedure for Submission of Applications

Applications on prescribed form (copy attached) should be submitted (in triplicate) through the Family Planning Officer of the State concerned in which the institution is situated. Separate applications should be submitted for each project.

The State Family Planning Officer will scrutinise the application carefully and will forward the same to the Director General of Health Services, New Delhi with his/her recommendations after consulting the State Administrative Medical Officer. In making his/her recommendations the State Family Planning Officer will certify that—

- (a) the institution is of recognised competence and ability;
- (b) the estimates have been checked and found reasonable;
- (c) the institution concerned is in a position to meet its share of the expenditure;
- (d) the establishment of a Family Planning Clinic in the locality proposed is necessary.

In States where Family Planning Officers have not been appointed the applications will be sent through the Administrative Medical Officer concerned.

II. Documents to be sent along with the application by Voluntary Organisations

Each application should be accompanied by the following documents.

- (i) A certificate stating:
 - (a) that the organisation is registered under the Registration of Societies Act, 1860 or other appropriate Act or is a regularly constituted branch of registered organisation; (The name of the Act under which the organisation is registered should be stated.

NOTE—An institution which is merely affiliated to a Registered Organisation without being the branch should get itself registered separately. In case an institution is not registered at the time of the application, it should get the registration completed before the grant can be allowed to be drawn.)

- (b) that the organisation has a regularly constituted managing committee;
- (c) that the organisation does social welfare work for the public on no-profit basis;
- (d) that the grant-in-aid will be utilised for the purpose for which it is sanctioned;

- (e) that the services to the public will be provided free of charge except for the sale and distribution of contraceptives which will be according to prescribed instructions;
 - (f) that the organisation will be able to contribute their matching contribution of the total expenditure incurred according to the prescribed pattern of assistance;
 - (g) that the audited statements of accounts will be sent at the end of each financial year;
 - (h) that monthly, half-yearly and annual progress reports will be sent regularly as desired.
- (ii) that the organisation will faithfully carry out the undermentioned and any other conditions that may be laid down by the Government of India for the efficient working of the family planning programme from time to time.
- (iii) A certificate from the District Magistrate/Local Administrative Authority to the effect that statements made in the application as well as in the above certificate are correct as far as he is aware, that the bonafides of the organisation and its financial position are satisfactory and that there is nothing against the organisation or its office bearers/staff which should disqualify them from receiving financial assistance from the Government of India.
- (iv) Latest annual report and a copy of the constitution of the institution.
 - (v) Copies of audited statements of accounts for the last three years.
 - (vi) Any other documents which may give information on the activities of the institution and its financial position.

III—Conditions for Sanction of Grant

- (i) The institution must be open to all citizens of India without distinction of caste, creed, area of origin etc.
- (ii) No grant for opening new clinics will normally be given if a family planning clinic already exists in the area serving a population of 50,000 (if urban) and of 66,000 (if rural).
- (iii) The family planning clinic should be run on the lines that may be indicated by the Government of India and function under the guidance of the State Director of Health Services/Director Public Health/Director Medical Services.
- (iv) The clinic should be open for inspection by the State Director of Health Services/Director Public Health/Director Medical Services/ the State Family Planning Officer or any other officer deputed or nominated by him or by the Director General of Health Services or his representative.

(v) The Officer-in-charge of the organisation to whom the grant is paid should send monthly, six monthly and annual reports and any other information asked by the Director General of Health Services and/or the State Director of Health Services and/or the State Director of Health Services/Director Public Health/Director Medical Services.

(vi) The staff employed will include Medical Officers, a Family Welfare Worker (i.e. Social Worker, Health Visitor or Public Health Nurse or Family Welfare Worker especially trained for family planning) and Clinic Attendant (instead of peon) and will possess qualifications prescribed by the Government of India. Their scales of pay and allowances shall not exceed those prescribed by the State Government for similar category of posts *except* with the prior approval of the Director General of Health Services.

The staff employed should have sincere belief in the necessity of the Family Planning Programme and genuine interest in its propagation and the implementation of the scheme.

(vii) The clinic staff should give not only the family planning advice (*which will be the main function*) but should also give advice on home nursing ante-natal, post-natal, child welfare and other problems of the family.

(viii) The following are the prescribed qualifications for the various categories of posts sanctioned for the family planning centres:—

(a) *Doctors—Registered Medical Practitioner in modern medicine*—The registered medical practitioner for this purpose means a person who holds qualifications granted by an authority specified or notified under section 3 to the Indian Medical Degrees Act, 1916 (VII of 1916) or in the schedules to the Indian Medical Council Act of 1933 (XXVII of 1933).

Scale of pay—Rs. 260—15—440—20—500 plus usual allowances as for Assistant Surgeon, Grade I.

(b) *Medical Social Workers*—M.A./Diploma in social work from any recognised university or institution.

Scale of pay—Rs. 150—7—185—8—225 plus usual allowances *including* conveyance allowance.

(c) *Public Health Nurse*—B.Sc. in Nursing from a recognised university.

Scale of pay—Rs. 150—7—185—8—225 plus usual allowances *including* conveyance allowance.

(d) *Health Visitors*—Certificate from a recognised health school for training of health visitors under the All India Nursing Council Act.

Scale of pay—Rs. 100—5—150 plus usual allowances *including* conveyance allowance.

NOTE:—If persons with the above qualifications are not available, the possibility of reducing the qualifications with a view to attracting candidates for the posts and giving suitable training in family planning may be considered. In such cases the qualifications prescribed above may be relaxed to the following extent :

	Urban Clinics	Rural Clinics
	Social Workers	Field Workers or Health Visitors
Qualifications	Graduate preferably in science. Experience in social work, teaching, community or family planning services.	Passed Matriculation. Experience in community work, teaching or community or family planning services. If matriculates are not available the minimum qualification may be relaxed upto VIII standard of any recognised institution.
Age	25 years and over (preferably married).	25 years and over (preferably married).
Pay and allowances	Rs. 150—7—185—8—225, plus usual allowances including other allowances.	Rs. 100—5—150 plus usual allowances and free accommodation or house rent allowance in lieu thereof and conveyance allowance.

(e) The pay scale indicated above are the maximum admissible and should not generally exceed the scales of pay prescribed by the local State Government for similar category of posts.

(f) In exceptional cases, where the staff with the above prescribed qualifications are not available for employment in urban clinics, persons with qualifications laid down for rural clinics may be employed under intimation to the Director General of Health Services, New Delhi.

(ix) The staff of the family planning clinic should be trained at the Family Planning Training Centre or by Family Planning Training team established by the Government of India or by the State Government before or immediately after their employment.

(x) Part-time doctors may be employed in clinics wherever necessary provided the expenditure does not exceed the amount sanctioned on this account. The doctors so employed will also normally be required to undergo training in family planning as mentioned above.

(xi) A number of part-time or full time persons belonging to any category may be employed provided the expenditure does not exceed the ceiling of the amount sanctioned in the prescribed pattern for that category of post. Extra staff like part-time clerk or accountant aya or sweeper may also be employed provided the total amount sanctioned for the staff is not exceeded.

(xii) Flexibility in employment of staff and expenditure is permissible with the prior approval of the Director General of Health Services, New Delhi to the extent that the expenditure in the approved pattern against each item is not exceeded.

(xiii) The family planning clinic should function in coordination with the family planning programme of the State Government and Local Bodies.

(xiv) The family planning centres in the rural areas should be established in association with M.C.H. Centres/primary health units and in urban areas in association with M.C.H. Centres, maternity homes/hospitals/dispensaries.

(xv) The clinic should not be established in association with a private dispensary/clinic etc.

(xvi) The staff employed should not be associated with any commercial establishment concerned with the manufacture or sale of contraceptives appliances for profit and should not have any financial interest in their sale etc.

(xvii) Contraceptives advised will be those which are included in the list of approved contraceptives issued by the Director General of Health Services and will be distributed in accordance with the instructions laid down by the Government of India.

(xviii) Subject to the acceptance of the conditions detailed above, grants-in-aid will be paid for a period of six months in advance of the anticipated expenditure. The presentation of the bill in form T.R. 42 for drawal of the amount of the grant will be construed to mean that all these conditions and those laid down in the letter of sanction have been accepted by the grantee without reservation.

(xix) The amount of the grant will be refunded to Government, if the work for which the grant is sanctioned, is not started within 4 months of the drawal of the amount, or where the State Government/Government of India have reason to believe that the affairs of the institution are not being properly managed or that the sanctioned money is not being utilised for approved purposes.

(xx) Family welfare activities will be developed around each family planning clinic.

(xxi) If the Ministry of Health or the Directorate General of Health Services requires clarification on any point not contained in the statement, the institution should supply it within the time specified, failing which the application will not be considered.

IV—Utilisation of Grant

(i) The institution should exercise utmost economy in its expenditure.

(ii) The institution should keep separate accounts of the grant paid for family planning in a recognised bank to facilitate inspection of accounts. The accounts of the institution should be maintained properly and submitted as and when required. It should always be open to check by an officer deputed by the Government of India or the State Government.

(iii) An audited statement of accounts will be sent at the end of each financial year (for the period April and March) giving details of each item of expenditure sanctioned together with full particulars of—

- (a) the staff employed and their scales of pay and allowances;
- (b) the actual expenditure incurred against each sanctioned item of expenditure; and
- (c) the Government of India's share thereof and of the organisation concerned according to the approved pattern; and
- (d) a report of the work done should be submitted to the Director General of Health Services before the next instalment of the grant-in-aid is applied for.
- (e) Report of the State Family Planning Officer/State Administrative Medical Officer.

V—Continuation of Grant

(i) The applications for continuation grant will be sent six monthly (April & October) receipt of statement of account in October countersigned by State Family Planning Officer/State Administrative Medical Officers and audited statement of accounts at the end of financial year and other documents referred to in sub para (iii) of para IV above, and utilisation certificate by the head of the organisation to which the grant was sanctioned that the entire amount of the grant has actually been utilised for the purposes for which it was intended.

(ii) Grants will not be renewed if the progress is found *NOT* to be satisfactory.

(iii) If for, some reason the audited statement of accounts in respect of the past expenditure against the grants sanctioned cannot be readily submitted, 50% of the grant due may be sanctioned on submission of a statement of accounts countersigned by the Administrative Medical Officer or the State Family Planning Officer concerned.

IV. Equipment required _____
 showing cost of each item and total cost (excluding the cost of building and rent) _____

V. Details of the proposed training programme and the estimated expenditure _____

VI. Proposed staff—

Name and number of posts	Qualifications prescribed for the posts	Pay, Scale & allowance per month (in Rs.)	Nature of employment Part time or full time	Qualifications of persons employed in each post

VII. Details of other recurring expenditure per annum, if any _____

VIII. Total expenditure :—Non-recurring : Rs. _____

Recurring p.a. Rs. _____
 Total Rs. _____

IX. Estimated annual income and sources thereof (recurring and non-recurring separately) of the organisation during the current and the previous financial year _____

X. Amount of central assistance required for implementing the scheme for one year (showing recurring and non-recurring items separately) _____

XI. Additional details, if any. _____

I on behalf of the management declare

- (a) that the organisation is registered under the Registration of Societies Act, 1860/or _____ (The name of the Act under which the organisation is registered should be stated).
- (b) that the organisation has a regularly constituted managing committee.
- (c) that the organisation does Social Welfare work for the public on non-profit basis.
- (d) that the grant-in-aid will be utilised for the purpose for which it is sanctioned.

**RECOMMENDATIONS OF THE STATE FAMILY PLANNING OFFICER/
ADMINISTRATIVE MEDICAL OFFICER.**

The application from _____
(institution) is forwarded duly recommended to the Directorate General of Health Services, Government of India, with the following comments;

1. That the institution is a recognised one.
2. The application has been examined and it is found that it is covered under the scheme.
3. The scheme for which the application is being recommended is absolutely essential for the development/expansion of the family planning programme.
4. That the estimates have been checked up and are found reasonable.
5. That the institution is of outstanding character.
6. That a senior officer of the State Govt. has visited the institution and the certificate required part II (i) and (ii) are enclosed and have been checked and found in order.
7. The institution is in a position to meet their share of expenditure.

The State Administrative medical officer, therefore, recommends that the following grant may be given by the Ministry of Health.

Item	Recurring	Non-recurring
	Rs.	Rs.
(a)		
(b)		
(c)		
(d)		

(Signature)

Designation

Stamp

No. F. 1-30/58-HII
 GOVERNMENT OF INDIA
 MINISTRY OF HEALTH
 New Delhi-2, the 29th October, 1959.

From

SRI S. IFTIKHAR HUSAIN, I.A.S.
 DEPUTY SECRETARY TO THE GOVT. OF INDIA.

To

ALL STATE GOVERNMENTS/UNION TERRITORIES.

SUBJECT—*Grant of financial assistance to Voluntary Organisations for the implementation of Family Planning Programme during the Second Five Year Plan.*

Sir,

In partial modification of para 3 of this Ministry's letter No. 34-55/56-MIV(HII), dated the 16th November, 1956, on the subject mentioned above I am directed to say that the President is pleased to decide that grants to voluntary organisations for the opening maintenance of family planning clinics in rural areas, according to the approved pattern of expenditure, will be sanctioned at the rate of 100% of the actual expenditure incurred, during the entire period of the Second Five Year Plan.

As regards the family planning clinics established in urban areas by Voluntary Organisations, the grants will be sanctioned at the rate of 100% for the first year and at 80% for the subsequent years of the Plan period.

Yours faithfully,

(Sd.) S. IFTIKHAR HUSAIN
Deputy Secretary

No. F. 1-30/58-HII—

Copy forwarded to—

1. The Finance Branch (Min. of Health) (3 copies).
2. The Planning Commission (Health Division).
3. The Accountant General Central Revenues, New Delhi.
4. The Director General of Health Services, New Delhi (with 50 spare copies).
5. Press Information Officer.
6. All Members of the Family Planning Board and the Standing Committee.

By Order,
 (Sd.) S. IFTIKHAR HUSAIN
Deputy Secretary

No. F. 1-5/58-HII
 GOVERNMENT OF INDIA
 MINISTRY OF HEALTH

New Delhi-2, dated the 18th March, 1958.
27 Phalgun, 1879.

From

SHRI S. IFTIKHAR HUSAIN, I.A.S.
 DEPUTY SECRETARY TO THE GOVT. OF INDIA.

To

ALL THE STATE GOVERNMENTS/UNION TERRITORIES.

SUBJECT—*Family Planning Scheme—Free or subsidized supply of mechanical contraceptives to lower income groups of people of family planning clinics established with Central assistance.*

SIR,

I am directed to invite attention to para 3 of this Ministry's letter No. 34-55/56-MIV(HII), dated the 13th September, 1956, which states that 'in addition contraceptives worth Rs. 1,000 will be supplied every year during the period of the Plan (Second Five Year Plan) to each urban and rural clinic for free distribution'. It was decided in this Ministry's letter No. 1-70/57-HII, dated the 25th June, 1957, that approved foam tablets may be distributed to those whose income does not exceed Rs. 100 per month out of the grant of Rs. 1,000 mentioned above.

2. The question about the supply of mechanical contraceptives also to the lower income groups of people was considered at the last meeting of the Standing Committee of the Family Planning Board held on the 18th December, 1957, and it was decided that sheaths and foam tablets should be distributed free by the Family Planning Rural Clinics. As regards urban clinics it was decided that all contraceptives should be distributed free to people with income below Rs. 100 per month at half price to those with income between Rs. 100 to Rs. 200 per month and at cost price to those whose income is above Rs. 200 per month.

3. I am to add that the above recommendations of the Standing Committee have been accepted by the Government and it has been decided that mechanical contraceptives included in the approved list may now also be distributed free or at subsidized rates according to the above recommendations of the Family Planning Standing Committee through the family planning clinics established with Central assistance. In order to cover the additional expenditure involved, the Government of India is further pleased to increase the amount of Rs. 1,000 for free distribution of contraceptives of Rs. 1,500 per annum for free/subsidized distribution of contraceptives.

4. A copy of the proforma for the register in which the accounts about the contraceptives which are distributed according to the above proposal together with a copy of the set of rules governing such distribution is sent herewith.

5. I am to request that action may now be taken for the purchase and distribution of approved mechanical contraceptives and foam tablets through each family planning clinic which is maintained with grants from the Government of India and the expenditure involved on this account included in the statement of expenditure of the clinic. A copy of the consolidated statement of accounts in respect of the distribution of contraceptives prepared in the prescribed form should be forwarded every month to the Director General of Health Services, New Delhi.

The receipt of this letter may please be acknowledged.

Yours faithfully,

(Sd.) S. IFTIKHAR HUSAIN

Deputy Secretary

CONSOLIDATED STATEMENT

Issue of free and subsidized supply of contraceptives.

Period: From _____ To _____
 Sponsor _____ Location _____
 Rural/Urban _____ Address _____

I. Grant-in-aid received (for free and subsidized distribution of contraceptives). Amounting to Rs. _____.

For the period: From _____ To _____

II. Quantity and cost of contraceptives purchased during the period—

Contraceptive and brand	Stock at the beginning of the period	Quantity purchased during the period	Cost price
1. Foam Tablets—			
(i)			
(ii)			
(iii)			
Sub-Total			
2. Sheaths—			
(i)			
(ii)			
(iii)			
Sub-Total			
3. Jelly—			
(i)			
(ii)			
(iii)			
Sub-Total			
4. Diaphragms—			
(i)			
(ii)			
(iii)			
Sub-Total			
GRAND TOTAL			

**QUANTITY AND COST OF CONTRACEPTIVES ISSUED DURING THE PERIOD TO PERSONS OF
VARIOUS INCOME GROUPS**

Contraceptive and brand	Income below Rs. 100 p.m.				Income Rs. 100 to Rs. 200 p.m.				Income above Rs. 200 p.m.			
	Quantity	Price	Price charged	Amount subsidiz- ed	Quantity	Price	Price charged	Amount subsidiz- ed	Quantity	Price	Price Charged	Amount subsidiz- ed
1. <i>Foam Tablets</i> —												
(i)												
(ii)												
(iii)												
Sub-Total												
2. <i>Sheaths</i> —												
(i)												
(ii)												
(iii)												
Sub-Total												
3. <i>Jelly</i> —												
(i)												
(ii)												
(iii)												
Sub-Total												
4. <i>Diaphragms</i> —												
(i)												
(ii)												
(iii)												
Sub-Total												
GRAND TOTAL												

Remarks : (Experience regarding contraceptives).

Signature of O, O

Dated

ISSUE REGISTER

Free and Subsidized Supply of Contraceptives

Date	Name	Case Card No.	Income per month	Name of con- traceptive supplied	Quantity of con- traceptive supplied	Cost Price	Price Charged	Amount Subsidized	Signature or Thumb Impression of the Recipient
1	2	3	4	5	6	7	8	9	10

The following instructions may please be noted for the guidance of the Officer-in-Charge of the family planning clinic etc. in respect of free and subsidized issue of contraceptives.

(i) Foam tablets and sheaths are to be given free of cost to all individuals in rural clinics; and all contraceptives free of cost to the individuals whose income is below Rs. 100 per month; at half of the cost price to those with income between Rs. 100 and Rs. 200 p.m.; and at cost price to those whose income is above Rs. 200 p.m. in urban clinics.

(ii) Normally not more than 12 tablets/12 sheaths/One tube of jelly with applicator/one diaphragm should be supplied to a couple at a time and not more than 25 tablets or 12 sheaths or one tube of jelly per month or one diaphragm per year.

(iii) An entry of the quantity of the contraceptives issued every time to each individual will be made in the issue register, which will be maintained by each clinic or in the personal follow-up case card according as the supply is made at the clinic or at the residence of the person. Any complaint regarding the use of contraceptive should be noted in the case card.

(iv) Normally signature or the thumb impression of the recipient shall be obtained on the issue register of the follow-up case card each time a supply is made.

(v) A follow up at regular intervals to evaluate the effectiveness, acceptability and harmlessness of the contraceptives shall be made by the officer-in-charge.

(vi) A report should be submitted on the experience of different contraceptives, with the half yearly progress report of the clinic and consolidated statement of the free subsidized issue of contraceptives must also be submitted half yearly.

(vii) Any untoward effects of the contraceptives which may come to the notice of the medical officer should be brought to the notice of the State Administrative Medical Officer and to the Director General of Health Services, New Delhi immediately.

(viii) The officer-in-charge of the clinic is responsible for the free and subsidized issue and proper accounting of the contraceptives.

(ix) All questions with regard to deterioration, non-efficiency or otherwise of the contraceptives should be referred to the State Administrative Medical Officer and Director General of Health Services, New Delhi.

(x) Only approved contraceptives should be purchased for the free and subsidized distribution.

A copy of letter No. 1-5/58-HII, dated the 14th July, 1958 from the Deputy Secretary to the Government of India, Ministry of Health, New Delhi to all State Governments

SUBJECT—*Family Planning Scheme—Free or subsidized supply of contraceptives to lower income groups*

I am directed to say that no central arrangements for the supply of contraceptives have been made by the Government of India. A non-recurring grant of Rs. 500 for stocking of contraceptives for sale and annual grant of Rs. 1,500 for each Centrally-aided clinic, is, however, sanctioned. The purchase of the contraceptives is to be made by the competent authority responsible for the administration of the clinic according to the prescribed rules of procedure.

2. I am to add that out of the grant mentioned above, sheaths and foam tablets will be distributed free by the rural clinics. All kinds of approved contraceptives other than sheaths and foam tablets will, however, be distributed by both the rural and urban clinics, free to people with income below Rs. 100 p.m. at half price to those with income between Rs. 100 to Rs. 200 p.m. The amount realised from the sale proceeds of the contraceptives will be adjusted at the time of the sanction of the next instalment of the grant.

No. 1-5/58-HII—

Copy to —

1. The Secretary to the Government of West Bengal, Deptt. of Health, Calcutta with reference to his No. PH/1885/5F-2/56-Pt. II, dated the 7th May, 1958.
2. The Director General of Health Services for information and communication to all A.M.O.'s, Local Bodies and Voluntary Organizations receiving Central assistance.

Government of India, Ministry of Health, Letter No. 1-5/58-HII, dated the 5th Sept. 1958.

14 Bhadra, 1880.

SUBJECT—*Family Planning Scheme—Free or subsidized supply of contraceptives to lower income groups.*

Para 2 of this Ministry's letter No. 1-5/58-HII, dated the 14th July, 1958 may be amended to read as under :—

“I am to add that out of the grant mentioned above sheaths and foam tablets only will be distributed free by the rural clinics to all without reference to their income and all other kinds of approved contraceptives will be distributed by the rural clinics free to people with income below Rs. 100 per month at half price to those with income between Rs. 100 to Rs. 200 per month and at least cost price to those whose income to Rs. 200 per month. All contraceptives including sheaths and foam tablets will be distributed by the urban clinics free to

people with income below Rs. 100, at half price to those with income between Rs. 100 to Rs. 200. The amount realised from the sale proceeds of the contraceptives will be adjusted at the time of the sanction of the next instalment of the grant”.

(Sd.) S. IFTIKHAR HUSAIN
Deputy Secretary

To
All State Governments.

APPENDIX XIV

STATEMENT SHOWING NUMBER OF STERILIZATION OPERATIONS DONE IN STATES DURING

Name of State	1956			1957			1958			1959*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Andhra Pradesh	252	179	431	319	189	508	346	418	764	554	507	1,061
Assam	5	107	112	13	248	261	19	365	384	16	603	619
Bihar	1	733	734	128	998	1,126	191	1,244	1,435	236	1,992	2,228
Gujarat .. .. .	..	..	..	40	373	413	185	1,300	1,485	418	2,405	2,823
Kerala	24	174	198	158	909	1,067	2,349	2,928	5,275	2,567	1,885	4,452
Madhya Pradesh	258	325	583	484	605	1,089	525	700	1,225	462	565	1,027
Madras	25	670	695	231	1,573	1,804	986	1,864	2,850	1,330	2,013	3,343
Maharashtra	4	..	4	257	606	863	1,783	2,774	4,557	3,932	6,911	10,843
Mysore	853	725	1,578	890	986	1,876	498	754	1,252	881	782	1,663
Orissa	21	109	130	132	36	168	108	159	267	94	73	167
Punjab	107	137	244	189	193	382	652	327	979	887	393	1,280
Rajasthan	513	109	622	512	184	696	394	225	619	468	176	644
Uttar Pradesh	171	1,273	1,444	194	2,000	2,194	585	1,879	2,464	453	2,612	3,065
West Bengal	13	637	650	22	632	654	155	1,302	1,457	511	276	787
Jammu & Kashmir .. .. .	..	..	..	..	41	41	238	402	640	171	399	570
Delhi	72	207	279	93	197	290	18	41	59	29	63	92
Himachal Pradesh	13	103	116	8	76	84	37	106	143	43	61	104
Manipur .. .. .	..	..	..	..	2	2	2	10	12	6	..	6
Tripura	1	2	3	1	11	12	1	5	6	..	..	..
Military Hospitals .. .. .	..	..	..	..	..	..	..	..	..	867	81	948
Total	2,333	5,490	7,823	3,671	9,859	13,530	9,072	16,801	25,873	13,925	21,797	35,722

*Information in-complete,

APPENDIX XV

STATEMENT SHOWING NUMBER OF PERSONS TRAINED STATE-WISE IN FAMILY PLANNING DURING 1ST PLAN PERIOD AND SECOND PLAN PERIOD UPTO NOVEMBER, 1959

Name of State	Number of persons trained during 1st Plan period					No. of persons trained during Second Plan period upto Nov. 1959				
	Doctors	Health Visitors	Social Workers	Others	Total	Doctors	Health Visitors	Social Workers	Others	Total
Andhra Pradesh	9	11	5	1	26
Assam	289	5	3	7	304
Bihar	2	2	..	..	4
Bombay	96	87	92	191	466
Kerala	10	11	..	21	38	18	27	33	116
Madhya Pradesh	12	4	33	..	49
Madras	152	..	12	100	264
Mysore	41	20	14	354	429
Orissa	7	11	1	..	19
Punjab	11	29	1	1	42
Rajasthan	10	2	..	..	12
Uttar Pradesh	4	..	63	45	112
West Bengal	351	153	52	13	609
Jammu & Kashmir	3	..	..	..	3
Delhi	20	21	5	46	75	37	8	6	126
Himachal Pradesh	3	4	2	2	11
Manipur	8	4	8	19	35
Tripura	1	1	..	..	2
Total	30	32	5	67	1,112	334	320	773	2,589

APPENDIX XVI

STAFF AND EXPENDITURE OF FAMILY PLANNING TRAINING CENTRES

I. Family Planning Training and Research Centre, Bombay

(a) Staff

Name of post	Number of posts		Scale of Pay
	Sanc- tioned	Filled	
1. Officer-in-Charge, Family Planning Training and Research Centre, Bombay.	1	Filled	Rs. 600—40—1,000—50/2—1,150-
2. Asstt. Surgeon Grade I (Women)...	1	Filled	Rs. 260—15—440—20—500.
3. Instructors (Two in social work and one in Health Education).	4	Filled	Rs. 250—10—300—15—450— 25/2—500.
4. Male Social workers (Instructor)	1	Vacant	Do.
5. Head Clerk-cum-Accountant ..	1	Filled	Rs. 160—10—330.
6. Statistical Assistant	1	Filled	Rs. 160—10—330.
7. Computer	1	Vacant	Rs. 60—3—81—EB—4—125—5— 130.
8. Upper Division Clerk	1	Filled	Rs. 80—5—120—EB—8—200— 10/2—220.
9. Store Keeper	1	Filled	Do.
10. Stenographer	1	Filled	Do.
11. L. D. Clerk	2	Filled	Rs. 60—3—81—EB—4—125—5— 130.
12. Health Visitor	3	Filled	Rs. 100—5—125—6—185.
13. Driver	1	Filled	Rs. 60—5/2—75.
14. Projectionist	1	Filled	Rs. 150—7—185—8—225.
15. Peons	2	Filled	Rs. 30—1/4—35.
16. Clinic Attendants	2	Filled	Do.
17. Sweepers	3	Filled	Do.
18. Chowkidars	3	Filled	Do.
19. Laboratory Assistant	1	Vacant	Rs. 60—5—75—3—105.
20. Driver-cum-mechanic	1	Vacant	Rs. 60—5/2—75.
21. Ayah	1	Filled	Rs. 30—1/4—35.
22. Mali-cum-Cleaner	1	Filled	Do.

(b) Expenditure

Year	Expenditure
	(Rs. lakhs)
1956-57 .. .. .	..
1957-58	1.24
1958-59	1.74
1959-60 (Budget—lakhs)	1.26 (upto Feb. 1960)

*II. Family Planning Training, Demonstration and Experimental Centre,
Ramanagaram
(a) Staff*

Name of post	Number of posts		Scale of Pay
	Sanc- tioned	Filled	
1. Asstt. Surgeon Grade I	2	One Vacant	Rs. 260—15—440—20—50.
2. Women Field Workers	4	One Vacant	Rs. 150—7—185—8—225.
3. Men Field Workers	2	Filled	Do.
4. Social Worker	1	Filled	Do.
5. Public Health Nurse	1	Vacant	Do.
6. Technical Asstt.	1	Vacant	Rs. 160—10—330.
7. Upper Division Clerk	1	Filled	Rs. 80—5—120—EB—8—200— 10/2—220.
8. Lower Division Clerk	2	Filled	Rs. 60—3—81—EB—4—125—5— 130.
9. Driver	1	Filled	Rs. 60—5/2—75.
10. Peons	2	Filled	Rs. 30— $\frac{1}{2}$ —35.
11. Frash-cum-Chowkidar	1	Filled	Do.

(b) Expenditure

Year	Expenditure
	(Rs. lakhs)
1956-57	0.39
1957-58	0.37
1958-59	0.60
1959-60 (Budget Rs. 1.00 lakhs)	0.45 (upto Feb. 1960)

III. *Family Planning Training Centre, New Delhi*
(a) *Staff*

Name of post	Number of posts		Scale of Pay
	Sanc- tioned	Filled	
1. Officer-in-Charge	1	Filled	Rs. 350—350—380—380—30— 590—EB—30—770—40—850.
2. Asstt. Surgeon, Grade I ..	1	Vacant	Rs. 260—15—440—20—500.
3. Medico-Social Workers ..	2	Vacant	Rs. 160—10—330.
4. Health Visitor	1	Vacant	Rs. 100—5—125—6—185.
5. Stenographer	1	Vacant	Rs. 80—5—120—EB—8—200— 10/2—220.
6. Lower Division Clerk	1	Filled	Rs. 60—3—81—EB—4—125—5— 130.
7. Female Attendant	1	Vacant	Rs. 40—1—50—2—60.
8. Peons	2	Filled	Rs. 30— $\frac{1}{2}$ —35.
9. Sweeper	1	Vacant	Do.

APPENDIX XVII

ADVISORY COMMITTEE ON PHYSIOLOGY OF HUMAN REPRODUCTION OF INDIA COUNCIL OF MEDICAL RESEARCH

1. Dr. V.R. Khanolkar, Director, Indian Cancer Research Centre, Parel Bombay—(*Chairman*).
 2. Dr. B. K. Anand, Prof. of Physiology, Lady Hardinge Medical College, New Delhi.
 3. Dr. P.K. Malkani, Prof. of Gynaecology & Obstetrics, Lady Hardinge Medical College, New Delhi.
 4. Dr. B. Mukerji, Director, Central Drug Research Institute, Chattar Manzil Palace, Lucknow.
 5. Dr. V.N. Patwardhan, Director, Nutrition Research Laboratories, Coonoor.
 6. Lt.-Col. B. L. Raina, Directorate General of Health Services, New Delhi—(*Secretary*).
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APPENDIX XVIII

CONSTITUTION OF DEMOGRAPHIC ADVISORY COMMITTEE

(To be published in Part I of Section I of the *Gazette of India*)

GOVERNMENT OF INDIA

MINISTRY OF HEALTH

RESOLUTION

New Delhi, dated the 2nd April, 1959

No. F. 12-15/58-F. P.—The Government of India have made a provision of Rs. 30,00,000 for demographic training and research. A Demographic Training and Research Centre has been established in Bombay in collaboration with Sir Dorabji Tata Trust and United Nations. Three Demographic Centres have also been established, one each at Delhi School of Economics, Delhi University, Delhi and Indian Statistical Institute, Calcutta and Deptt. of Statistics, Government of Kerala, Trivandrum. In order to direct effectively such training and research, especially from the point of view of high birth rates and economic, social cultural and allied factors involved, it is considered necessary to set up a Demographic Advisory Committee. The Ministry of Health have accordingly constituted a Committee consisting of the following:—

- | | |
|---|------------------|
| 1. Dr. V.K.R.V. Rao, Vice Chancellor, Delhi University | Chairman |
| 2. Professor P.C. Mahalanobis, Indian Statistical Institute, Calcutta | Member |
| 3. Shri P.J. Thomas (Member Rajya, Sabha) | Member |
| 4. Shri Asoka Mitra, I.C.S., Registrar General, India, New Delhi | Member |
| 5. Lt. Col. B. L. Raina, Director, Family Planning | Member-Secretary |

The members of the Committee may coopt additional members for ad-hoc purposes. Members of the Advisory Committee shall normally hold office for a period of three years. The Demographic Advisory Committee will:

- (i) advise on research and studies on inter-relationship between economic, social and population changes on the reproductive pattern, attitudes and motivation affecting the size of the family;
- (ii) advise on programme of training and research keeping in view that such training and research will assist the Government to take economic and social action and thereby facilitate the sound national programme of reconstruction;
- (iii) coordinate demographic research schemes receiving financial assistance from the Government of India;
- (iv) review progress made in the Centres receiving financial assistance from the Ministry of Health, and

- (e) examine and recommend proposals which may be received by the Ministry of Health for financial assistance for conducting demographic research.

Non-official members of the Advisory Committee shall be entitled to the grant of travelling and daily allowances for visiting the Centres and for attending the meetings of the Committee as are admissible under S.R. 19 as amended from time to time read with the Ministry of Finance O.M. No. F. 6(4)-Est. IV/58 dated 1st October 1958. Members of the Committee, who are Government servants, will draw travelling and daily allowance as are admissible to them from the same source from which they get their pay. The expenditure involved will be met from the sanctioned budget grant under the Head "39—Public Health—B.2 Other grants—B2(19) Family Planning" under Demand No. "49—Public Health".

(Sd.) H. C. THAPAR
Deputy Secretary

To

The Publisher,
Gazette of India,
NEW DELHI.

APPENDIX XIX

GOVERNING BODY—DEMOGRAPHIC TRAINING & RESEARCH CENTRE, BOMBAY

The composition of the Governing Body is as shown below—

1. The Chairman	(nominated by Govt. of India.)
2. The Director of the Indian Cancer Research Centre, Bombay	Member
3. The Director, the Tata Institute of Social Sciences, Bombay	Member
4. The Head of the Department of Sociology, Bombay University, Bombay	Member
5. The Director of the Institute of Economics & Politics, Poona	Member
6. A representative of the Ministry of Health, Govern- ment of India	Member
7. A representative of the Ministry of Finance, Govern- ment of India	Member
8. The Director General of Health Services ..	Member
9. The Director, Indian Council of Medical Research	Member
10. The Coordinating Officer of the Demographic Centre	Member- Secretary

The Government of India nominated Dr. John Mathai as the first Chairman of the Governing Body.

APPENDIX XX

ADVISORY COMMITTEE OF DEMOGRAPHIC TRAINING & RESEARCH CENTRE

Chairman

- INDIA .. Dr. P.S. Lckarathan, Director General, Council of Applied Economic Research, New Delhi.
- BURMA .. Mr. U Than Maung, Additional Director, Census Division, Central Statistics and Economics Department, Rangoon.
- INDONESIA .. Mr. Ali Minoru Tech, Chief, General Affairs Division, Institute of Population Problems, Welfare Ministry, Tokyo.
- THE PHILIPPINES Dr. Amardo M. Dalisay, Director of the Statistical Centre and Professor of Economics, University of Philippines, Manila.
- THAILAND .. Mr. Jin Jaiprabha, Chief Statistician, Central Statistical Office, Bangkok.
- International Union for the Scientific Study of Population. Dr. C. Chandrasekaran, All India Institute of Hygiene and Public Health, Calcutta.

The Director, Demographic Training and Research Centre, Bombay will be the Member-Secretary of the Committee.

APPENDIX XXI

STATEMENT SHOWING THE FAMILY PLANNING EDUCATION MATERIAL PRODUCED DURING 1956—1959.

Published material	English	Hindi	Urdu	Assa- mese	Gur- mukhi	Bengali	Tamil	Oriya	Malya	Kan- nada	Gujrati	Marathi	Telugu	Total
Results of too many children (Poster).	10,000	14,000	2,000	1,000	2,000	3,000	3,000	2,000	2,000	2,000	2,000	3,000	4,000	50,000
Happiness through Family Planning (Poster).	10,000	14,000	2,000	1,000	2,000	3,000	3,000	2,000	2,000	2,000	2,000	3,000	4,000	50,000
Children's Day Poster (1958).	38,000	36,000	15,000	7,750	7,500	24,000	24,000	9,500	9,500	12,800	12,000	24,000	27,000	2,97,000
Children's Day Poster (1959).	5,000	..	..	..	..	..	..	..	..	..	..	..	..	5,000
Family Planning Brochure No. 1.	40,000	50,000	17,500	9,500	9,500	28,000	28,000	10,500	10,500	14,000	14,000	28,000	3,500	2,90,500
Family Planning Folder—Exhibition 1958.	70,000	30,000	..	..	..	..	..	..	..	..	..	..	..	1,00,000
Family Planning Folder—(Practice & Prosperity).	20,000	..	..	..	..	..	..	..	..	..	..	..	..	20,000
Why Family Planning.	20,000	10,000	..	..	..	..	..	..	..	..	..	..	..	30,000
Techniques of Conception Control.	10,000	20,000	..	..	..	..	..	..	..	..	..	..	..	30,000

Published material	English	Hindi	Urdu	Assa- mese	Gur- mukhi	Bengali	Tamil	Oriya	Malya	Kan- nada	Gujrati	Marathi	Telegu	Total
Family Planning Folder (If they could speak).	..	30,000	8,000	3,000	2,000	10,500	9,500	3,500	3,500	5,000	5,000	10,500	10,500	1,00,000
May We Help you (Folder).	50,000	50,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	10,000	2,10,000
Family Planning questions answered.	10,000	..	..	..	..	..	..	..	..	..	..	..	..	10,000
Family Planning Training and Research Centre.	5,000	..	..	..	..	..	..	..	..	..	..	..	..	5,000
Family Planning Plan & Progress.	10,000	..	..	..	..	..	..	..	..	..	..	..	..	10,000
Family Planning in India. (Reports).	50,000	..	..	..	..	..	..	..	..	..	..	..	..	50,000
A Playlet on Family Planning.	10,000	3,56,000	..	..	..	..	..	..	..	..	..	..	..	3,66,000

APPENDIX XXII

STATEMENT SHOWING THE NAMES, QUALIFICATIONS ETC. OF THE FAMILY PLANNING OFFICERS APPOINTED IN VARIOUS STATES

Name of State	Name	Qualifications	Scale of pay Rs.	Remarks
Andhra ..	Dr. (Mrs.) K. Janaki Subramanian	M.B.B.S., D.G.O.D.M.C.H.	600—100/2—1,000	
Assam ..	Dr. (Mrs.) T. Rynjah ..	M.B.B.S., D.M.C.W., (Calcutta)	400—30—550—EB—40— 750.	Maternity Officer Assam is working as F.P. Officer in addition to her own duties.
Bihar ..	Dr. (Miss) K. K. Padmawati	M.B.B.S.	350—750	
Bombay ..	Dr. K. T. Chitre ..	M.B.B.S., D.P.H.	350—30—650—EB—45— 1,110.	
Kerala ..	Dr. (Mrs.) B. Kamla Ramier (Retd. D.M.O.).	M.B.B.S. (Madras)	300—500	The present incumbent being re-employed on contract basis after superannuation is in receipt of Rs. 550.
Madhya Pradesh	Dr. (Mrs.) L. Pandit ..	M.B.B.S., D.M.C.W.	350—800 with NPA Rs. 100	
Madras ..	Dr. (Mrs.) P. Lakshmi ..	M.B.B.S.	400—25/2—500.	
Mysore ..	Dr. K.S. Nanjundaiah ..	M.B.B.S., D.P.H.	550—30—700—40—860.	
Orissa ..	Dr. (Mrs.) B. V. Surayabai	M.B.B.S., D.G.O.	600—40—960	
Punjab ..	Dr. Asa Singh	M.B.B.S., D.P.H. (London) D.T.M. and H. (England).	750—50—1,250.	

Name of State	Name	Qualifications	Scale of pay	Remarks
Rajasthan ..	Dr. (Miss) H. N. Unwala ..	M.B.B.S., D.M.C.W.	400—800.	
Uttar Pradesh	Dr. (Mrs.) S. L. Talwar ..	M.B.B.S., D.G.O.	500—50—1,000—EB—50— 1,200.	
West Bengal ..	Dr. (Mrs.) A. Bannerji ..	M.B.B.S., D.M.C.W.	600—50—1,200.	She is looking after M.C.H. work also.
Jammu & Kashmir.	Not appointed ..	..	..	..
Delhi ..	Dr. (Mrs.) D. Kulanday A.D.H.O. (M.C.W.).	..	..	Additional Deputy Health Officer (M.C.W.) Corpora- tion of Delhi is looking after the work of F.P.
Himachal Pradesh.	Dr. (Mrs.) A.C. Parmar ..	M.B.B.S. (Brussels), L.M. (Dublin).	600—40—1,000—50/2— 1,150.	Asstt. Director Health Ser- vices M.C.W. is performing the duties of F.P. Officer in addition to her own duties.

APPENDIX XXIII

PROGRESS OF THE FAMILY PLANNING PROGRAMME IN STATES

Andhra Pradesh

State Family Planning Board was formed on 13th June, 1957 with Chief Minister of the State as Chairman. A whole-time Family Planning Officer (Dr. Shrimati Janaki Subramanian) was appointed on the 9th December, 1957.

There are 87 rural and 32 urban family planning clinics, functioning in the State at present. The details are shown below—

Sponsor	No. of Clinics opened					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Government	6	86	23	86	29	
Local Bodies	1	..	..	..	1	
Voluntary Organisations ..	1	1	1	1	2	
Total	8	87	24	87	32	

The clinics opened cover a population of 62.66 lakhs. The number of persons contacted and actually given advice are 4,12,800 and 98,400 respectively.

Sterilisation—Facilities for sterilizations have been provided in several maternity hospitals in cities and districts. Vasectomy is done in several hospitals as a part of general surgery.

The number of sterilizations reported during 1956—59 are given below—

Year	Male	Female	Total
1956	252	179	431
1957	319	189	508
1958	580	565	1145
1959 (upto September, 1959)	148	404	852

Education—The Collectors of all the Districts of the State have been requested to form family planning committee in each district. During the year 1959, Family Planning Exhibition was arranged in the Industrial Exhibition which remained open for one month. During the exhibition, doctors were posted at the exhibition and free advice was given to all those who asked for it. About 5,000 persons attended the exhibition. Posters and pamphlets were distributed during this time. The Family Planning week was celebrated from 19-1-59 to 25-1-59 in Hyderabad and all the Districts of the State. A manual on Family Planning has been prepared in local language and is under print for distribution.

Training—A Regional Training Centre was started at Government Maternity Hospital at Hyderabad on 1st February 1959. The Centre has so far conducted 6 courses of instructions for 3 doctors, 4 social workers and 17 public health nurses. In addition, 3 doctors and 3 health visitors have received training at the Family Planning Training and Research Centre, Bombay.

The subject of family planning has been introduced in the syllabus of Health Visitors and 45 students have received such training so far.

Expenditure in 1956-59—The estimated expenditure on family planning programme reported to have been incurred in the State is as follows:—

Year	Expenditure (in lakhs)
1956-57	0.26
1957-58	0.54
1958-59	0.88
1959-60	0.89*

*Provision made by Central Government.

Assam

State Family Planning Board was formed on 27-6-1959 with Minister for Medical and Public Health as Chairman. Full time Family Planning Officer has not yet been appointed. Dr. T. Rynjah, Maternity and Child Welfare Officer looks after the work of family planning in addition to her own duties.

There are 47 rural and 11 urban Family Planning Clinics functioning in the State at present. The details are shown below:—

Sponsor	No. of clinics opened					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Govt.	45	8	45	8
Local Bodies
Voluntary Organisations	1	2	2	2	3
Total	1	47	10	47	11

The clinics opened cover a population of 5.5 lakhs. The number of persons contacted and actually given advice are 55,000 and 35,000 respectively.

The number of sterilization operations reported upto July 1959 is given below:—

Year	Number sterilised		
	Male	Female	Total
1956	5	107	112
1957	5	147	152
1958	13	248	261
1959 (upto July, 1959)	3	316	319

Education—11 copies of posters in English and the same number of pamphlets in Assamese were printed. Three exhibitions were held and each was visited by 6,000 persons. Two conferences were also held and were attended by 1,000 persons in each case.

Training—One Regional Training Centre was started in Shillong and one course of training has been conducted so far where 4 doctors, 2 health visitors and 3 public health nurses have been trained. In addition 13 Doctors, 1 Social Worker and 4 Health Visitors have received training at Family Planning Training and Research Centre, Bombay.

Expenditure—The estimated expenditure on family planning programme reported to have been incurred in the State is as follows:—

	Expenditure (in lakhs)
1956-57 .. .. .	..
1957-58	0.84
1958-59	1.40
1959-60	2.06*

* Provision made by Central Government.

Bihar

A State Family Planning Committee was formed on 12-4-54 and continues to function as the State Family Planning Board. The Assistant Director, Maternity and Child Health [Dr. (Miss) K. K. Padmavati] works as State Family

Planning Officer in addition to her other duties since 1958-59. The number of clinics opened in the State are as follows:—

Sponsor	First Plan		Second Plan		Total		Grand Total
	Rural	Urban	Rural	Urban	Rural	Urban	
State Govt.	20	22	6	22	26	48
Local Bodies
Vol. Organisations	1	..	1	1
Total	..	20	22	7	22	27	49

The target for this State was 252 rural and 21 urban clinics for the Second Plan period. The State Government proposes to open 282 rural clinics during 1959-60.

The clinics are reported to have covered a population of 4 crores. Average monthly attendance at the rural clinics is 100 and urban clinics 120.

Sterilization—It has been reported that during the period 1956—59 in all 1,967 persons have been sterilized in the State (57 males and 1,910 females).

Education—One Conference by National Planning and Information Association Bihar and 5 Public Meetings by the State family planning centres were conducted. 200 persons attended the conference and nearly 7,000 attended the public meetings.

Training—No Regional Training Centre has been opened in the State. Two doctors and two health visitors have received training in family planning at the Family Planning Training and Research Centre, Bombay.

The estimated expenditure reported to have been incurred in the State is as follows:—

								Expenditure
								Rs.
1956-57	..	..	..	..	..	..	..	6,474
1957-58	..	..	..	..	..	..	..	38,800
1958-59	..	..	..	..	..	..	..	66,200
1959-60	..	..	..	..	..	..	..	3,70,000*

*Provision made by Centre.

Bombay

Family Planning Board was formed in the State on 11-11-57 under the Chairmanship of the State Health Minister. Full time State Family Planning Officer (Dr. K. T. Chitre) was appointed on 22-7-58.

There are 156 rural and 65 urban family planning clinics functioning in the State at present. The details are shown below:—

Sponsor	No. of clinics opened					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Govt.		2	146	10	146	12
Local Bodies		2	..	14	..	16
Voluntary Organisations		6	10	31	10	37
Total		10	156	55	156	65

The clinics opened cover a population of 85.00 lakhs. The number of persons contacted and actually given advice are 4,31,411 and 39,725 respectively. The average monthly attendance at the rural clinic was 15 and urban clinic 75.

The number of sterilization reported to have been performed upto September, 1959 is as follows:—

Year	Number sterilised		
	Male	Female	Total
1956	4	..	4
1957	257	606	863
1958	1,873	4,052	5,925
1959 (upto September 1959)	1,091	2,504	3,595

Education—5,000 posters each in Marathi and Gujarati and 1.79 lakh pamphlets in English, Marathi and Gujarati were published by the State Government. 14,800 posters and 18,000 pamphlets sent by D.G.H.S./D.A.V.P. were also distributed. Six main exhibitions were held and about 3 lakh people visited. 2,781 general meetings 2,191 group meetings attended by 39,671 and 20,850 respectively were also held in the State.

Training—Four Regional Training Centres were sanctioned for the State but no Centre has been established so far. Ten days course in family planning was arranged in regional languages at Palghar, Padra, Sirur, Soonar, Sikka, Bavla and Aurangabad Centres and 290 persons were trained. Re-orientation in family planning has been given to 71 midwives, nurse midwives and public health nurses.

In addition 13 doctors, 2 social workers, 7 health visitors and 1 public health nurse of the State received training at Family Planning Training and Research Centre, Bombay.

Expenditure—The estimated expenditure on family planning programme reported to have been incurred in the State is as follows:—

Year	Estimated Expenditure (Rs. in lakhs)		
	Central Share	State Share	Total
1957-58	0.75	0.10	0.85
1958-59	2.11	0.71	2.82

Kerala

The Family Planning Board was formed on 10-9-1957 with the State Minister for Health as its Chairman. A whole time Family Planning Officer (Shrimati B. Kamla Ramier) was appointed on 28th January, 1958 to look after the progress of work in the State.

Clinics—There are 47 rural and 13 urban clinics functioning in the State at present. The following table shows the break up of the clinics opened by the various organisations during the First and Second Five Year Plan period.

Sponsor	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Govt. ..	10	..	24	10	34	10
Voluntary Organisations	1	1	12	2	13	3
Total ..	11	1	36	12	47	13

The State Government proposes to open 20 semi-urban clinics during 1959-60.

The population of the State is estimated to be 13.79 million in rural areas and 1.96 million in urban areas. Of this total population of 15.75 millions, the clinics already opened cover 2.85 million persons. The number of persons contacted and already given advice are 1,09,846 and 39,173 respectively.

Sterilization—Sterilization operations are now performed free of charge at all the District Hospitals, General Hospitals and Women and Children Hospitals. A benefit allowance of Rs. 15 for men and Rs. 20 for women is paid to those persons whose income is below Rs. 200 for undergoing such operations. The following table shows the sterilization operations conducted since 1956 in the State:—

Year	Male	Female	Total
1956	24	174	198
1957	158	909	1067
1958	2349	2926	5275
1959	1985	1374	3359

Education—Five booklets and pamphlets in Malayalam were published and distributed to the public. Four exhibitions have so far been held which were largely attended by the people.

Diaphragms are liked by the people in urban areas and foam tablets and jellies in rural areas.

Training—A Regional Training Centre was opened in S. A. T. Hospital Medical College, Ulloor, Trivandrum, on 1st May, 1959, where 25 social workers were trained in family planning.

Expenditure—During the period 1956—59 a sum of Rs. 2·34 lakhs was spent by the State Government which included Rs. 1·35 lakhs as central government's share.

A provision of Rs. 2·63 lakhs has been made at the Centre for the year 1959-60. The anticipated total expenditure for the same period is estimated to be Rs. 4·00 lakhs.

Item	Budget	Expenditure
1. Clinics	1·59	2·87
2. Training and Education	0·32	0·20
3. Research	0·62	0·83
4. State F.P.O.	0·10	0·18
Total	2·63	4·00

Madhya Pradesh

The Family Planning Board was formed on 1st October 1958 with the State Minister for Public Health as Chairman. A Full-time Family Planning Officer (Dr. Mrs. L. Pandit) was appointed on 1st March 1958 to look after the work of family planning in the State.

Clinics—Eighty-one rural and thirty-seven urban clinics are functioning in the State at present. The following table gives the numbers of clinics opened in First and Second Five Year Plan period.

Sponsor	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Government	7	81	26	81	33
Voluntary Organisation	4	..	4
Total	7	81	30	81	37

The State Government proposes to open another 70 rural and 5 urban clinics during 1959-60 against a target of 154 rural and 25 urban clinics for the whole of Second Five Year Plan period.

The estimated population of the State is 27.71 million, 24.21 million in rural areas and 3.50 million in urban areas. The clinics opened in the State cover a total population of 6.08 million. The total number of persons contacted and those given advice are 37,239 and 10,530 respectively. The average clinic attendance is reported to be 18 in rural areas and 25 in urban areas.

Sterilization—The number of sterilisation operations done in the State since 1956 is as follows:—

Year	Male	Female	Total
1956-57	457	400	857
1957-58	566	712	1,278
1959-60	642	755	1,397

Education—Two films “Family Planning” and “Planned parent-hood” were purchased by the State Government for exhibiting them throughout the State. 45 cinema slides in different languages have also been distributed to all the civil surgeons and district medical officers for exhibition purposes at the local cinemas. Hindi version of the “Family Planning Manual” of Madras Government was published and distributed. Three lakh copies of the folder on family planning were printed and distributed in all the villages through gram panchayats.

Cooperation of Development Department and Social Welfare is also sought to propagate family planning and also to distribute foam tablets.

Training—Eight doctors, one social worker and four health visitors have so far been trained in family planning at the Family Planning Training and Research Centre, Bombay. The Regional Training Centre has not been established in the State as yet.

Expenditure—The reported expenditure on family planning in the State for the period 1956—59 is as follows:—

Year	Expenditure	Central share
1956-57	31,507	18,346
1957-58	45,120	22,282
1958-59	80,110	77,786

Against an anticipated expenditure of Rs. 4.65 lakhs by the State during the year 1959-60, the Central share is Rs. 2.22 lakhs.

Item	Central share (Rs. in lakhs)	Anticipated expenditure (Rs. in lakhs)
1. Clinics	1.80	2.90
2. Training	0.32	..
3. Education .. .. .	..	1.26
4. State Organisation	0.10	0.49
Total ..	2.22	4.65

Madras

Family Planning Board was formed on 18th July 1957 with the State Minister for Health as its Chairman. A whole-time Family Planning Officer Dr. Smt. P. Lakhshmi was appointed on 14th February 1957 to look after the work relating to family planning programme.

Clinics—Against a target of 152 rural and 59 urban clinics the state has opened 71 rural and 15 urban clinics during the Second Plan period. The details of the clinics opened so far are as follows:—

Sponsor	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Government .. .. .	..	8	70	11	70	19
Local Bodies .. .. .	..	6	..	3	..	9
Voluntary Organisations	2	2	1	1	3	3
Total ..	2	16	71	15	73	31

The State Government do not propose to open any additional clinics during 1959-60 till such time the clinics already sanctioned are properly staffed and start functioning:—

The population of the State is estimated to be 33·14 million in 1958. The 15 urban and 70 rural clinics opened in Second Plan cover a population of 34·28 lakhs and 23·76 lakhs respectively. The number of persons contacted and those given advice were 3·46 lakhs and 2·11 lakhs respectively. Out of the 2·11 lakhs given advice 6,656 persons (males and females) actually underwent sterilization operations. It was observed that educated women preferred diaphragm and jelly whereas the masses were inclined towards foam tablets. The introduction of sheaths also became very popular with men.

Sterilization—The Government of Madras has formulated a scheme called “Madras City Public Employees Family Welfare Scheme.” The scheme is applicable only to persons who have attained the age of 32 in the case of men and 26 in the case of woman who have not less than 3 living children. A cash grant of Rs. 15 for vasectomy operations and Rs. 25 for salpingectomy operations is paid to those persons who volunteer themselves. The Government has also finalized a scheme for payment of subsidy to selected medical practitioners in Madras city for vasectomy operations at the rate of Rs. 25 per operation. Payment of special remuneration of Rs. 2 for each case is also made to the convassor/and tutors in family planning who send cases to approved surgeons.

The sterilization operations conducted in the State since 1956 are as follows:—

Year	Male	Female	Total
1956	25	670	695
1957	231	1,573	1,804
1958	986	1,864	2,850
1959 (upto date)	495	936	1,431

The State Government have laid more stress on surgical methods of family planning. Arrangements have also been made with the Fire Service Department to extend the help of their ambulance service to lift the intending sterilization patients, to hospitals.

Education—The “Family Planning Manual” published by the State Government has been received by the public with great enthusiasm and is in great demand. A “Happy Family Planning” calendar explaining on the obverse side the technique of rhythm method has also been produced and distributed to deserving mothers. To convey that technique of calculating the safe period string of beads has been produced and given to clinic staff for educating the people.

Family planning is included in the curriculum of studies for the training courses of medico-social workers public health nurses and health visitors in Medical and Public Health Departments. The State Government has published a One Act Play in Tamil explaining the safe period method. Two pamphlets one providing information regarding the facilities made available in Government Medical Institutions for surgical methods and the other furnishing instructions to persons who undergo vasectomy operations have been produced. Charts giving a comparative data on vital statistics, per capita income, population and land area etc. of India and other countries have been published and distributed to all the clinics in the State. Short films of 15 to 20 minutes duration are intended to be produced to be shown at fathers and mothers clubs.

The State Government proposes to start a Family Planning Propaganda Committee in all the places having family planning clinics, with a Chairman (preferably a lady) a Secretary (an influential person of the locality) and 5 members.

The meetings of the mothers are held periodically at all the Mothers' information Centres under the Corporation of Madras.

Family planning stalls were opened at 4 major exhibitions in the State during 1957—1959. Family planning stalls were also set up in all the other exhibitions, medical colleges, and during hospital courtesy weeks, Four meetings of State Family Planning Board, 6 meetings of Co-ordination Committee 2 meetings of Programme committee and 3 meetings of family planning staff have been held so far.

Training—Family Planning Training Institute attached to the Government Hospital for Women and Children, Madras, was started on 12th August 1957 to impart training to doctors, nurses, social workers, health visitors, and non-medical workers in the State. Necessary steps are being taken to up-grade the above Institute to the level of a Regional Training Centre. 168 medical officers, 132 nurses, 26 social workers, 27 health visitors and 134 others have been trained at the above centre. One medical officer and one social worker were trained at Family Planning Training and Research Centre, Bombay.

Expenditure—During 1956—59, a sum of Rs. 4.31 lakh has been spent on the family planning programme out of which the Central share amounts to Rs. 3.47 lakhs

Year								Total expenditure
1956-57	..	..	..	..	..	..	..	0.38
1957-58	..	..	..	..	..	..	..	1.32
1958-59	..	..	..	..	..	..	..	26.1

A budget provision of Rs. 5.16 has been made by the Centre for the year 1959-60. The anticipated expenditure by the State is estimated to be 6.50 lakhs.

Item	Central provision	Anticipated expenditure
1. Clinics	4.64	5.95
2. Training	0.32	0.30
3. Education Research	0.10	0.27
4. Family Planning Officer	0.10	0.17
Total ..	5.16	6.69

Mysore

Family Planning Board was formed on 27th August 1957 under the Chairmanship of State Minister for Public Health. A whole-time Family Planning Officer (Dr. K. S. Nanjundiah) was appointed on 30th October 1957 to look after the work of family planning.

Clinics—31 rural and 15 urban clinics were opened in the State against a target of 96 rural and 34 urban clinics during the Second Plan period. The details of the clinics opened so far are as under:—

Sponsor	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
1. State Government ..		3	31	13	31	16
2. Voluntary Organisation ..		3	..	2	..	5
3. Total		6	31	15	31	21

The State Government proposes to open additional 28 rural and 7 urban clinics during the year 1959-60. The population of the State is estimated to be 22.08 million; 17.37 million rural and 4.71 million urban. The clinics opened upto the year 1958-59 cover a population of 2 million. By the end of 1959-60 population of 3.5 million will have been covered by the clinics in the State. During the year 1959-60, 16,074 persons were contacted for family planning out of which 4,738 were given advice.

Sterilization—The Mysore Government has decided to pay a subsidy of Rs. 25 to private medical practitioners in Bangalore, Mysore, Mangalore Dharwar, and Belgaum for conducting vasectomy operations upto the end of Second Five Year Plan period. This subsidy is restricted to those whose income is less than Rs. 200 per mensem. The sterilization operations conducted since 1956 in the State are as follows:—

Year	Male	Female	Total
1956	853	725	1,578
1957	890	986	1,876
1958	496	754	1,250
1959	579	546	1,125

Education—‘A guide to family planning’ both in English and Kannada is under publication. Twelve exhibitions have been arranged in the State so far. 1954 posters and 8427 pamphlets have been distributed to the public.

Training—Most of the trainees of the State are sent to the Family Planning Training Demonstration and Experimental Centre, Ramanagaram. The Regional Training Centre has not been established in the State so far though arrangements are being made to open two centres at Lady Goschen Hospital, Mangalore and Chelvumba Hospital in Mysore. 31 doctors, 17 social workers, 11 health visitors, 9 public health nurses, 60 health inspectors and 13 other auxiliaries have been trained in family planning so far.

Expenditure—The expenditure on family planning programme during the Second Plan period is as follows:—

Year	Total expenditure	Central share
	(Rs.)	(Rs.)
1957-58	5,363	5,237
1958-59	32,605	30,051

A Central provision of Rs. 2.39 lakhs has been made during the year 1959-60. The anticipated expenditure is estimated to be Rs. 1.54 lakhs.

Orissa

Family Planning Board was formed on 24th April, 1958 with Minister for Health as Chairman. A whole-time Family Planning Officer (Dr. Mrs. B. Suraya) was appointed on 11th March, 1959 to look after the work of family planning in the State.

Clinics—27 Urban and 40 rural clinics were opened in the State against a target of 4 urban and 94 rural clinics during the Second Plan period. The details of the clinics opened so far is as follows :—

	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Govt.	..	3	40	27	40	30
Voluntary Organisations
Total	..	3	40	27	40	30

In addition to above advice on family planning is also given at 11 M.C.H. centres.

The State Govt. proposes to open another 15 rural clinics during 1959-60. The estimated population of the State is 14.67 million rural and 0.65 million urban. The clinics opened so far cover a total population of 1.48 million out of which 1.96 lakhs have been contacted for family planning education.

Sterilization—The number of sterilization operations done since 1956 in the State is as follows :—

Year	Male	Female	Total
1956	21	109	130
1957	7	53	60
1958	108	159	267
1959	94	73	167

Education—20,000 copies of a pamphlet in Oriya language were published and distributed.

Training—No Regional Training Centre has started functioning in the State as yet. However 6 doctors and 10 health visitors were trained at the F.P. Training and Research Centre, Bombay.

Year	Central share	State share
1956-57	21,461	2,064
1957-58	79,037	7,300
1958-59	89,177	89,176

A Central provision of Rs. 3.52 lakhs has been made for the year 1959-60.

Punjab

State Family Planning Board was formed on 24-7-58 under the chairmanship of the Health Minister for the State. Dr. Asa Singh was appointed as the Family Planning Officer on 13-11-57 to look after the work of family planning in the state.

Clinics—Eighteen rural and 14 urban clinics were opened in the State against a target of 88 rural and 24 urban clinics. The number of clinics opened so far is given below:—

	First Plan		Second Plan		Total	
	R	U	R	U	R	U
1. State Govt.	12	7	12	7
2. Local Bodies
3. Vol Organisations	1	6	7	6	8
	..	1	18	14	18	15

In addition to above family planning advice is available at 151 MCH clinics in the State. The population of the State is estimated to be 19·43 million—13·86 million rural and 5·57 million urban. The clinics opened cover a population of about 10 lakhs and upto June 1959 as many as 21,968 persons were contacted for family planning education and 21,018 persons given advice on family planning.

Sterilization—Sterilization operations are done free of charge at all the Govt. hospitals in the State. The number of sterilization operations conducted since 1956 is given below :

Year	Number of sterilization		
	Male	Female	Total
1956	107	137	244
1957	189	193	382
1958	652	327	979
1959 (August)	610	239	849
Total	1,558	896	2,454

Training—Two Regional Training Centres are functioning in the one at Patiala (28-10-59) and the other at Amritsar (December, 1958) Two courses of training were conducted at the Patiala Centre and 41 health visitors, were trained in these courses. In addition, 8 doctors, 2 health visitors and 1 public health nurse of the State were trained at the Family Planning Training and Research Centre, Bombay.

Education—Five hundred pamphlets each in Hindi, Punjabi and English on family planning were printed for distribution. Four exhibitions were held which were visited by 8,000 persons.

Expenditure—The expenditure on family planning programme for the period 1956—59 is given below :—

							(Rs. in lakhs)	
Year						Total Expenditure	Central share	
1956-57	..	..	..	..	..	..	..
1957-58	..	..	..	..	..	0.23	0.22
1958-59	..	..	..	..	..	0.72	0.57
Total					..	0.95	0.79	

A central provision of Rs. 1.72 lakhs has been made for the year 1959-60. The anticipated expenditure is expected to be Rs. 1.25 lakhs. The item-wise break up is given below :—

Item				Central Provision	Anticipated Expenditure
1. Opening of maintenance of old clinics ..	..	..	..	1.38	1.43
2. Training ..	..	..	..	0.24	0.32
3. State F.P.O.	..	..	..	0.10	0.18
Total				..	1.72

Rajasthan

The State Family Planning Board was formed on 18th October, 1957 with Minister for Health as Chairman, Dr. (Miss) H. N. Unwalla was appointed as full time Family Planning Officer.

There are 41 rural, 22 urban family planning clinics functioning in the State at present.

Sponsor	Clinics opened					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Government	6	41	14	41	20
Local Bodies
Voluntary Organisations	2	..	2
Total	6	41	16	41	22

The clinics opened cover a population of 17 lakhs 1.60 lakhs were actually contacted for family planning Education and during 1958 as many as 9,000 people were given advice. The average attendance per year was reported to be 100 in rural clinics and 500 clinics in urban clinics.

Sterilization—Vasectomy camps are being organised at various District Headquarters. Two Surgical Camps were organised at Jaipur and Ajmer and 175 vasectomy operations were done. 50 group talks were organised during the camps. Permission for doing operations has also been given to doctors in the district who can perform such operations and where such facilities exist.

The number of sterilizations operations performed during 1956—59 is given below :—

Year	No. sterilized		
	Male	Female	Total
1956	513	109	622
1957	512	124	696
1958	394	225	619
1959 (up to July '59)	345	108	453

Education—A Publicity Unit is attached to Directorate of Medical & Health Services and the same is doing publicity work all over the State. 5,000 posters and 5,000 hand bills were published by the State Govt. for distribution. 200 film shows were organised and average attendance at these shows was about 800.

Training—No Regional Training Centre has been established in the State so far. 13 doctors and 5 other personnel of the State have received training at Family Planning Training and Research Centre, Bombay.

Expenditure—The estimated expenditure reported to have been incurred on family planning programme by the State Government is as follows :—

Year	Expenditure
1956-57	Rs. 12,354
1957-58	58,039
1958-59	86,500
1959-60	2,25000

Uttar Pradesh

The State Family Planning Board was formed on 10-10-57 with State Minister for Health as Chairman. Full-time state Family Planning Officer [Dr. (Mrs.) S. L. Talwar] was appointed on 21st July, 1958.

There are 48 rural and 31 urban family planning clinics functioning in the State at present.

The details are shown below:—

Sponsor	No. of clinics opened					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
State Govts. ..	..	..	47	13	47	13
Local Bodies ..	..	8	..	..	..	8
Voluntary Organisations.	1	2	..	8	1	10
Total ..	1	10	47	21	48	31

The clinics opened cover a population of 16.15 lakhs—9.90 lakhs rural and 6.25 urban. The number of persons actually given advice are 58,277.

The number of sterilization operations reported to have been performed during 1956—59 is given below :—

Year	Number sterilized.		
	Male	Female	Total
1956	171	1,273	1,444
1957	194	2,000	2,194
1958	585	1,879	2,464
1959 (upto Sept. '59) ..	338	2,050	2,388

Education—State Family Planning Officer during her tours of various districts arranged seminars and meetings at the place of visit. Four such seminars and 9 meetings were held and about 1,000 persons attended the meetings. Exhibitions and conferences were held. 50,000 persons attended the exhibitions and 25,963 attended the conferences.

Training—No Regional Training Centre has been established in the State. So far 108 persons of the State were trained, in family planning. 100 were trained in the short term training courses held in the State from time to time, and the rest were trained at Family Planning Training and Research Centre, Bombay.

Expenditure—The estimated expenditure reported to have been incurred by the State Government is as follows :—

Year								Expenditure
								Rs.
1956-57	.	..	..	..	..	..	..	8,654
1957-58	.	..	..	..	..	..	..	47,388
1958-59	.	..	..	..	..	..	..	1,00,600
1959-60	..	..	..	..	..	..	..	5,52,000*

*Provision made in the Centre.

West Bengal

State Family Planning Board was formed on 27th August, 1958 with Minister of Food, Relief and Rehabilitation as Chairman. Dr. (Smt.) Anila Banerjee was appointed as Family Planning Officer on 13th February, 1959. She looks after the work of M.C.H. also.

Clinics—The number of clinics opened in the State so far is stated below:—

		No. of clinics					
		First Plan		Second Plan		Total	
		Rural	Urban	Rural	Urban	Rural	Urban
State Govt.	..	7	2	9	32	16	34
Local Bodies	..	..	..	..	1	..	1
Voluntary Organisations	..	..	11	5	10	5	21
Total	..	7	13	14	43	21	56

According to available information upto May, 1959, 90,623 persons were contacted for family planning education and 16,651 persons were given advice on family planning. The average monthly attendance at the rural clinics was 28 and at urban clinics 29.

Education—Two pamphlets in Bengali have been printed for distribution. 906 conferences and meetings have been held and 12,415 persons attended these meetings.

Sterilization—The number of sterilization operations reported to have been performed is shown below:—

Year							Number sterilized		
							Male	Female	
1956	..	..	..	..	..	..	13	637
1957	..	..	..	..	..	..	22	632
1958	..	..	..	..	..	..	155	1,302
1959 (June)	..	..	..	..	..	..	5	87
Total	..							195	2,658

The estimated expenditure on family planning is reported to be as follows:—

Year						Expenditure (Rs. lakh)
1956-57	..	..	..	..	..	0.33
1957-58	..	..	..	..	..	0.62
1958-59	..	..	..	..	..	2.79
1959-60	..	..	..	..	..	2.78 (Provision made by the Centre).

Training—One training centre consisting of 6 training institutes in Calcutta was functioning since 1955 and was converted into a Regional Training Centre in April, 1959. Seventeen courses have been conducted at this centre since 1955 and 212 doctors, 121 health visitors, 20 social workers and 18 nurses have been trained. In addition 4 doctors and 4 health visitors of the State received training at the Family Planning Training and Research Centre, Bombay and 5 doctors and social workers were got trained by Family Planning Association of India, Bengal Branch.

Jammu & Kashmir

The State Govt. opened 2 urban clinics during 1957-58. These are attached to Central Hospitals at Srinagar and Jammu. A whole-time lady doctor and part-time male doctor are incharge of these clinics. Doctor at Srinagar Centre was trained at Family Planning Training and Research Centre, Bombay.

Delhi

With the formation of Delhi Municipal Corporation the health services were reorganised and the family planning work is being looked after by Dr. (Mrs.) D. Kulanday, Deputy Health Officer (M.&C.W.) of the Corporation.

There are at present 31 urban family planning clinics functioning in the Union Territory as per details given below—

Sponsor	No. of clinics opened					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
Central Ministry of Health.	..	6	..	3	..	9
Local Bodies	..	0	..	9	..	19
Voluntary Organisations	..	2	..	1	..	8
Total	..	18	..	13	..	31

The 9 urban clinics opened by the Central Ministry of Health are in the Contributory Health Service Scheme. The clinics opened by Corporation of Delhi cover a population of about 15 lakhs. The number of persons actually contacted and given advice are 55,115 and 933 respectively. Average monthly attendance in clinics was 775.

The number of sterilizations reported during 1956-59 is shown below:—

Year	Number sterilized		
	Male	Female	Total
1956	72	207	279
1957	93	197	290
1958	6	130	136
1959 (upto June, 1959)	16	52	68

Education—One exhibition was arranged in the Town Hall and about 25,000 persons visited it. Mohalla talks were held by doctor/lady health visitors and about 90,000 people have been benefited by it. 900 posters and 16,000 pamphlets sent by D.A.V.P./D.G.H.S. were distributed.

Training—Four Health Visitors received training at Family Planning Training & Research Centre, Bombay. Five doctors and 5 health visitors were trained in other short term training courses held in Delhi from time to time.

Expenditure—The estimated expenditure reported to have been incurred is as follows:—

Year	Expenditure
	Rs.
1957-58	26,347
1958-59	64,540
1959-60	1,28,000*

*Provision made by the Centre.

Himachal Pradesh

Family Planning Board was formed on 15-11-1957. Full-time Family Planning Officer has not been appointed in the Territory and the work relating to family planning is being looked after by Dr. (Mrs.) A.C. Parmar, Assistant Director, M.C. & W.

Clinics—The details of the clinics functioning are as follows:—

Sponsor	No. of clinics					
	First Plan		Second Plan		Total	
	Rural	Urban	Rural	Urban	Rural	Urban
Union Administration	..	5	..	3	..	8
Total	..	5	..	3	..	8

Advice on family planning is available at 10 M.C.H. centres also.

The population of the Territory is estimated to be 1.15 million. The clinics so far opened cover a population of 1.60 lakhs of which 11,867 have been given advice.

Sterilization—The number of sterilization operations done since 1956 is as follows:—

Year	Male	Female	Total
1956	13	103	166
1957	8	76	84
1958	37	106	143
1959-(Sept)	37	77	114

Education—44,000 pamphlets and 800 posters were distributed in the Territory.

Training—There is no Regional Training Centre in Himachal Pradesh. Three doctors, 2 social workers 1 health visitor, 3 public health nurses and 1 staff nurse were trained at the Family Planning Training & Research Centre, Bombay.

Expenditure—Rs. 79,917 were spent during the year 1956—59 which was met from the sanctioned budget of the Union Ministry of Home Affairs.

A Central provision of Rs. 47,000 has been made during the year 1959-60 and the anticipated expenditure is also estimated to be of the same order.

Manipur

The population of Manipur area is estimated to be 0.64 million. Two urban clinics, one at a M.C.H. and another by the Family Planning Association, Manipur, were opened during the Second Plan period. Two additional clinics are proposed to be opened in rural areas during the period 1959-60. The clinics opened cover a population of 40,000.

Eight vasectomy and 12 salpingectomy operations were performed by the end of July, 1959.

There is no training centre in Manipur. However, 1 doctor and 1 health visitor were trained in family planning at Civil Hospital at Imphal.

Tripura

The population of Territory is estimated to be 0.77 million; 0.72 million rural and 0.05 million urban. One urban clinic was opened by Tripura Administration in V.M. Hospital, Agartala, on 2nd March 1956. The number of persons actually contacted and given advice are 300 and 145 respectively.

The number of sterilization operations reported during 1956-59 is shown below:—

Year	Number sterilized		
	Male	Female	Total
1956	1	2	3
1957	1	11	12
1958	1	5	6
1959 (upto Sept. 59)	..	31	31

One doctor and one health visitor of the Territory were trained at Family Training and Research Centre, Bombay.

The estimated expenditure incurred year-wise is shown below:—

Year	Expenditure	
	Rs.	
1956-57	4,000	..
1957-58	5,500	..
1958-59	5,700	..
1959-60	13,900	..

Pondicherry

One urban clinic was opened in the General Hospital by the Pondicherry Administration on 8th August, 1957. The clinic opened covers a population of 60,000. The number of persons actually given advice was 855.

The estimated expenditure incurred year-wise is shown below:—

Year								Expenditure
								Rs.
1957-58	..	..	..	..	..	..	..	2,000
1958-59	..	..	..	..	..	..	..	5,000
1959-60	..	..	..	..	..	..	..	6,300

APPENDIX XXIV

SCHEME RECOMMENDED BY THE INDIAN MEDICAL ASSOCIATION

The following scheme is recommended for the participation of the members of the Medical Association in the work.

(1) Clinics will be organised under the auspices of State Branches of the Association in areas which are not served by departmental clinics and are otherwise suitable from the point of view of population and availability of private practitioners.

(2) These clinics will be of the two types:

(a) General.

(b) Special.

(3) The main objectives of the clinics will be:—

(a) to conduct education programme impressing the necessity and need for family planning ;

(b) to advise the public about the technique of using various contraceptives and to explain their relative values;

(c) to distribute contraceptives; free of cost to the deserving poor and at cost price to those who can pay; and

(d) to do sterilization operations, vasectomy and tubal ligation, in properly equipped centres;

(4) *Staff*: Each clinic will have :—

(a) Medical Practitioner (1 to 3 number).

It will be advantageous to associate as many medical practitioners as are willing, with the clinic, subject to a maximum of 3. This will bring more families to the clinic and will be conducive to greater efficiency.

Honorarium—Rs. 50 per month for 3 hours work,
one day every week.

Where there are only two doctors, each may be paid Rs. 75 for 2 hours work, two days every week;

And where there is only a single doctor Rs. 100 for 3 hours work, twice a week.

(b) Full-time Social Worker with training in midwifery—Rs. 125.

(5) *Special Clinics*—These, in addition to the above, will have facilities for vasectomy and tubal ligation.

The clinic will be paid a minimum of Rs. 20 per case of vasectomy and a minimum of Rs. 50 per case of tubal ligation for indigent patients.

(6) *Management*—The clinics, in each State, will be under the State Branches of the Indian Medical Association. The financial grant will be placed at the disposal of the Central Office, Delhi, who will disburse it to the State Branches whose proposals are accepted.

The clinics will maintain day-to-day record of work, quarterly reports in prescribed forms will be sent to the State Branches with a copy to the Central Office. The State Branches will prepare consolidated quarterly reports for the whole State and send them not later than 20th of the month following to the Central Office with their comments, if any. Copies of the consolidated report will also be sent to the Director of Health Services of the State. The Central Office will consolidate all the reports and send them not later than the 30th of the month to the Director of Family Planning in New Delhi.

The clinics will be opened to the inspection of the Director of Health Service and his representatives, who will send copies of their inspection notes to the State branches of the Indian Medical Association.

(7) *Finance*—The average expenditure per clinic is estimated to be about Rs. 4,500 annually, distributed as follows :—

	Rs.
Honorarium for Medical Practitioners $50 \times 3 \times 12$	1,800
Whole-time social worker cum midwife 125×12	1,500
Total on staff per annum	3,300
Value of contraceptives to poor patients (this may be supplied in kind)	1,000
Stationery and other expenses	200
Total	4,500

In the first instance the Association should organise 100 clinics under its State Branches. The total annual expenditure on this will be :—

	Rs.
Rs. 4,500 \times 100	4,50,000
Grant for sterilisation operations	1,50,000
Initial equipment grant @ 400 for clinic wherever necessary	20,000
Total	6,20,000

This grant may be made available to the Indian Medical Association in advance in quarterly instalments.

The Indian Medical Association will constitute a Central Family Planning Committee (there is one already) and the State Branches will also constitute State Committees—The Director of Health Services or his nominee will be a member of the State Committee.

In the light of one year's experience the scheme can be amplified or amended.

(8) *Part time service in clinics run by government or other agencies*—One handicap to the extension of family planning, especially in rural areas has been the shortage of doctors. The members of the Indian Medical Association who live within a radius of five miles from such clinics will be available for part time work, both in departmental clinics and in clinics run by private agencies. They will have to be paid Rs. 60 per month for 3 hours a day, once a week and Rs. 100 for two days of 3 hours a week since these clinics will not be under the Indian Medical Association, the Medical Association will have no responsibility except to make the services of its members available to the management. When part time service of doctors is required, the management may be directed to contact the State Branch of the Indian Medical Association. The State Branch will keep a record of all such part time workers and an annual statement about their number will be sent to the Central Office.

(9) *Training*—Arrangements should be made for short-term training in family planning to members who are prepared to start clinics or do part time work. Arrangements should be made for imparting training at any centre where there are reasonable number of doctors (not less than 10) willing to avail of it.

(10) *General*—(i) The Secretary and/or the President or his nominee of every State Branch should be included in every State Family Planning Board. The Secretary and/or the President of local branches should be included in the District Committees. The inclusion of prominent doctors who have shown conspicuous interest in family planning in the State and District Boards for family planning will certainly be an advantage but that should not be a reason for omitting official representatives of the Association.

(ii) Family Planning weeks should be organized at District and Taluk levels in which the Health Department, the Indian Medical Association and the Education Department should co-operate.

(iii) The medical personnel of these clinics should be fully protected against any legal liabilities from any quarters.

(iv) *Health propaganda*—The Indian Medical Association places, its lay journals "YOUR HEALTH" (English) and "APKA SWASTHYA" (Hindi) for propaganda and publicity of family planning.

APPENDIX XXV

RECOMMENDATIONS OF CHAIRMAN CENTRAL SOCIAL WELFARE BOARD ON COORDINATION OF FUNCTIONS OF SOCIAL WELFARE BOARD CENTRES AND FAMILY PLANNING CLINICS

It was considered desirable that the rural family planning clinics set up by the Family Planning Board should be linked with the (Samaj Kalyan) Welfare Extension Project Centres of the Central Social Welfare Board in order that they may effectively fulfil their purpose and to avoid duplication and bring about greater co-ordination between the Central Social Welfare Board and the Family Planning Board. The Second Plan target for 2,000 rural family planning clinics but during the three years ending with March 1958 less than a quarter of that number only were actually started.

W.E.P. (C.D.) Number and Coverage—There are 444 projects of the original pattern and nearly 200 projects of the C.D. pattern with a total of 4,000 active centres throughout the country Working under the CSWB. Most of the projects of the old pattern would also be converted into the C.D. type sooner or later. There are 5 centres per project of the old pattern each covering a group of 6 villages and 10 centres per project of the C.D. pattern covering a group of 10 villages each.

Budget—The standard five year budget for each project of the C.D. type provides for a total expenditure of Rs. 2,08,000; Rs. 1,84,000 is shared in the proportion of 5 : 12 : 6 by the Block budget, CSWB and the State Government respectively and the balance of Rs. 24,000 is paid directly by the B.D.O. as salaries to one Mukhyasevika and 2 gramsevikas. Voluntary contributions would be in addition.

Staff—There is contingent of 26 specially trained workers, mostly residing at one or the other of the centres. They are :—

2 Mukhyasevikas (one of the CSWB and one of the Ministry of CD)
(85 per cent graduate trained).

8 gramsevikas (6 of the CSWB and two of the Ministry of CD).

4 Dais	}	CSWB
2 craft instructors.		
6 Balwadi teachers (part-time)		
1 accountant		
1 clerk		
1 peon		
1 driver		

In addition there are 4 midwives attached to each primary health centre located in each block, whose services would also be available. There is one jeep in each project to provide for the mobility of the staff within each block.

Project Implementing Committee—For each Project there is a project Implementing Committee consisting of 15 members, mostly non-official women workers of the area. The members are nominated partly by the C.D. Organisation and partly by the C.B. Organisation. Among the nominees of the Central Board on the PICs effort is made to include one or two Lady doctors whenever available; or the PICs enlist other lady doctors who are prepared to render honorary services at our centres, and the project provides the transport to them.

Programme—Thus there is a ready made set up into which the family planning clinics can easily be fitted. You will see that each of our centres serves a population of about 66,000 people in a compact area. There is at each centre a building, the construction of nearly 700 being completed by the PICs and the others taken on rent in which the multipurpose activities at each centre are carried on. The workers also reside in one part of the building. There is a balwadi run at the each centre, milk distribution is arranged. In addition to maternity and child welfare services, there are a number of activities for adult women, social education, adult literacy classes, recreational and cultural programmes are arranged. Craft training is provided and all these attract a number of women who regularly attend the centres. There are also small production units attached which provide work and wages for them.

Coordination—I would welcome a coordination of the work of the FPB with that of the CSWB in rural areas which would advance the FP movement. The FPB has a scheme under which it is proposed to establish one family planning centre and 5 sub-centres in each block (area served by a primary health centre). Each centre serves a population of about 10,000. Primary health centres have not been established in all the blocks, nor are there women doctors attached to all the primary health centres established. The Family Planning Board can take advantage of the Samaj Kalyan centres and post one family welfare social worker at each of our centres, and we can extend all the facilities already available at our centres to her also. She will have the advantage of the presence within easy reach of qualified women doctors, under whose supervision she can work. The project transport can be made available to her; and clerk and accountant can be used for keeping accounts. She will have the advantage of living with the workers employed in the project centres. The arrangement now proposed will help the Family Planning Board to reach the target of 2,000 rural family planning clinics within the Second Plan period. Not only that, the family planning clinic will be one among several activities at the centre and the women attending the centre will, the more readily, avail themselves of the clinic which they would not do if it were isolated. One of the recommendations of the Study Team on Social Welfare is to introduce mother craft and family planning orientation into the gramsevika training syllabus and they can also help in preparing the people to receive this new service. It should also be possible to take a representative of the Family Planning Board on each of our PICs.

Method of Coordination—I would like certain things to be clearly understood even at the outset.

The Family Welfare Social Worker should work under the general supervision of the PIC, though her salary may be paid by the Family Planning Board and she may be under their administrative control. Such an arrangement already exists with reference to the 2 gramsevikas and one mukhyasevika provided by the C.D. Organisation in the WEPs(CD).

2. The provision of Rs. 6,000 for building for each clinic made by the Family Planning Board should be placed at the disposal of the PIC, who would put up a couple of rooms, as an adjunct to an existing centre building, one for the residence of the FWSW and the other for the location of the clinics.

3. The provision for purchase of equipment and medicines should also be placed at the disposal of the PIC and earmarked for this programme.

4. The work of the FWSW and the family planning clinics may be inspected by the State and District Family Planning officers.

5. The Family Planning Board may provide an honorarium to the doctors, who are already working in the WEPS and whose services may be required in the family planning clinics.

Training—It is necessary to train a member of family welfare social workers. Such training should as far as possible be entrusted to voluntary organisations. While the Central or State Governments may arrange for the training of new medical personnel or for the Family Planning Orientation of the existing medical personnel, it must be remembered that the FWSW's training has a large welfare content, which can best be imparted by voluntary organisations only.

2. Three such organisations have been sanctioned grants so far. There is no provision for hostel accommodation in the scheme. The Ministry of Health should give grants for the construction of hostels for trainees to the extent of 75 per cent of the approved expenditure. The University Grants Commission gives grants on that basis for Girl's hostels.

3. The grants for training courses should be released well before the dates of commencement of training to enable the institutions to complete the arrangement in time. It is suggested, budget estimates may be invited by the end of January and releases may be made by the end of March for the whole course, though it may fall in two financial years.

4. Arrangements should be made for conducting the examination of trainees by outside bodies.

5. Institutions must be authorised to give certificates, which should be recognised.

6. Uniform standards must be prescribed for FWSW's training. At present many clinics are awarding certificates after short periods of employment in the clinics without reference to their educational qualifications or the content, quality or duration of training. A Committee should be set up to prescribe minimum standards and the duration of training.

7. There should be 4 more Regional Family Planning Training institutions in the Third Plan.

8. The present training institutes might be allowed to admit a greater number of trainees for the succeeding batches if they can undertake it.

APPENDIX XXVI

EXTRACTS FROM SUMMARY RECORD OF THE SECOND MEETING OF THE DEMOGRAPHIC ADVISORY COMMITTEE HELD ON 24TH NOVEMBER, 1959, AT 10-33 A.M. AT THE INSTITUTE FOR RESEARCH IN ECONOMIC AND SOCIAL GROWTH UNIVERSITY OF DELHI

1. The following members were present—Dr. V. K. R. V. Rao—*Chairman*, Professor P. C. Mahalanobis—*Member*, Shri Ashok Mitra—*Member*, Lt. Col. B. L. Raina—*Member Secretary*.

2. The following were also present by special invitation:—Dr. C. Chandrasekaran, Shri Rajeshwari Parsad, Dr. B. L. Ganguli, Shri R. B. Jai, Shri K. R. Nair, Dr. S. N. Agarwala, and Shri S. J. Pothi.

3. The Committee noted the recommendations of the Sub-Committee on Demographic Research and Training during the next 6 years and suggested the following programme—

- (i) Continuous survey of population situation in India including estimated projections of population and population structure.

(The Committee noted that short-term projections had been made by the Registrar General's Office in co-operation with the working group of vital statistics set up by the Planning Commission; also that several long-term projections had been worked out by various persons. The short-term projections for 10 years or so could comparatively be made with greater precision and were necessary for purposes of working out the Third and future Five Year Plans.

The Committee also wished that recommendations to be made for long term projections should be examined carefully. Each Demographic Research Centre should be asked to prepare a short paper on this subject to be examined in detail by Dr. V. K. R. V. Rao and Shri Ashok Mitra).

- (ii) Studies in internal migration with special reference to industrialization and urbanization.
- (iii) *Ad hoc* field studies on regional basis on attitudes and motivation affecting family size, on methods of communication and on base line data on attitudes towards family size and knowledge and practices of family planning methods, and evaluation of family planning programmes.
- (iv) Studies on inter-relationship between social economic and population changes, fertility and mortality patterns in different regions, national income and per capita income and vital statistics.

If a sample survey relating to Demographic Studies is to be carried out a question may be included to indicate caste and sub-caste of the family or person interviewed or investigated.

- (v) Development of existing Training and Research and Demographic Training Centres in universities.

- (vi) Dissemination of information on population problems and coordination in the field of demography.

4. *Further development of the Demographic Research and Training Centres*—The Committee recommended that the Chairman and Shri Ashok Mitra may visit different Demographic Training and Research Centres and suggest details of the development programmes. It was felt that expenditure incurred on different items should be uniform as far as possible and should be within reasonable limits.

5. *Dissemination of information*—(i) A pamphlet on demographic situation in India may be published and Dr. C. Chandrasekaran may be requested to prepare a draft for the same and an *ad hoc* grant of Rs. 1,000 may be made for this purpose.

(ii) University extension lectures may be arranged as indicated in the enclosure.

(iii) Short term orientation courses may be arranged by the demographic training and research centres wherever possible.

(iv) Two to three seminars may be held in different parts of India. Before such a seminar is held, there should be three good working papers prepared by the sponsors of the seminars and should be examined by a panel of experts. The Demographic Research Centres and Universities in India may be requested to consider the proposal.

6. The Committee agreed that no separate journal of demography may be published, and the Indian Population Bulletin proposed to be issued by the Registrar General's Office could, at this stage serve most of the objectives of the journal of demography. In view of the wider coverage of articles, which would now be included in the bulletin, it was felt that the bulletin should be published by an Editorial Committee, consisting of Dr. V. K. R. V. Rao, Shri Ashok Mitra, Dr. C. Chandrasekaran and Lt. Col. B. L. Raina.

7. *Evaluation*—The Committee suggested that a Sub-Committee consisting of Dr. Ganguli, Dr. Srinivas, Shri Nair and Lt. Col. B. L. Raina may be set up to go into the question of evaluation of the family planning programme. They may give their findings to the Chairman who may be authorised to make recommendation to the Government.

8. *Financial Consideration*—The Committee recommended that an *ad hoc* provision of Rs. 50 lakhs may be made for demographic training and research during the Third Five Year Plan for the present.

APPENDIX XXVII

FAMILY PLANNING EDUCATIONAL PERSONNEL, THEIR RESPONSIBILITIES AND TRAINING

Personnel	Responsibilities	Training
<p>1. Local Workers (Gram Sewak) (Part-time).</p>	<p>To utilize existing working pattern and methods for providing information and motivating regarding need for family planning practices.</p> <p>To follow up families and encourage them to continue the practice.</p>	<p>(1) Information as to family planning.</p> <p>(2) Assistance on reorganizing and making best use of present opportunities.</p>
<p>2. Block level Mukhiya Sevika (Part-time).</p>	<p>To assist and guide Gram Sevikas to carry on family planning education efficiently.</p> <p>To integrate family planning education in her day-to-day duties.</p>	<p>Information about family planning ways and means of utilising opportunities to promote family planning.</p>
<p>3. Tehsil—</p> <p>(1) One F. P. Educationist ..</p> <p>(2) One Mukhiya Sevika ..</p> <p>(3) Two Gram Sewaks ..</p>	<p>(1) To stimulate greater attention to family planning practice.</p> <p>(2) To supervise the work of the local staff and provide material and other assistance.</p> <p>(3) To work with community leaders</p>	<p>Generalized health education training with special application to these responsibilities.</p>

APPENDIX XXVII—*contd.*

Personnel	Responsibilities	Training
	(4) To follow-up opportunities provided by local workers for group meetings, etc.	Additional training in family planning consultation.
	(5) To provide help to family planning service workers in developing effective educational activities.	
	(6) To channel research findings to local staff and guide them in their application.	
	(7) To provide specific in—service experience as needed to groups in districts.	
	(8) To provide continuous analysis of programme ..	
4. District Health Education Officer.	To provide guidance, support to Tehsil Family Planning Educators.	General Health Education training with special service work on family planning.
	To stock and provide materials.	
	To plan and co-ordinate family planning activities in the district.	

To work with leaders—conference, meetings, etc.

To integrate family planning in overall public health evaluation.

To provide short refresher courses for field workers.

Supervise area-wise education programme including use of A.V.Teams and exhibits.

To mobilise and integrate the work of voluntary organisations in the district to promote family planning.

- 4a. District A.V. Team .. Provide services to support district and local workers as needed —under supervision of district health educators. Training in operation and use of educational media.
5. Division Voluntary Leaders .. Work with District Health Education Officer to support F. P. Programme with special emphasis on gaining general support of policy through direct contacts with community leaders and voluntary agencies. Special services, etc.
6. State Touring Team .. To provide necessary training and experience involving F. P. content under general coordination of Health Educator or Tr. Officer as necessary to support programme. Special training in regarding these responsibilities.
- 6a. State Materials Methods .. State Health Education Bureau Specialists in education writer, artists, etc.
Educationist assigned to F. P. Board—Provide leadership for educational phases of State F. P. Programme and assist in planning the service programme.
- Request desired material.
- Work through Asstt. Health Educators Trained Health Educators with special emphasis on family planning.
- Coordinate State research programme in Health Education.
- Training Assigned to F. P. Programme.
- Develop necessary experience for 11 workers.
- Coordinate work of touring teams Trained Health Educators.
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APPENDIX XXVII—*concl'd.*

Personnel	Responsibilities	Training
7. Regional Family Planning Educators.	To assist the Regional Deputy Directors of Family Planning.	
8. National F. P. Directorate and C.H. E.B.	To formulate general educational policies. To coordinate educational work including training and research. To develop and standardise training programmes. To encourage and conduct research.	

APPENDIX XXVIII

FAMILY PLANNING SECTION—ORGANISATION & EXPENDITURE AT DIFFERENT LEVELS

A. Local Family Planning Educator (Part-time)

Gram Sewak	..	Contingency for local media like puppet shows, katha, group meetings, etc.	Rs. 100 per year per Gram Sewak.
Mukhiya Sewak	..	Contingency for local media like puppet shows, katha, group meetings, village dramas, festivals, fairs, etc.	Rs. 150 per year per Mukhiya Sewak.

B. Tehsil Family Planning Education Unit—

1. Family Planning Educator (Rs. 300 per month)	..	..	..	Rs. 3,600 per year
2. Accounts clerk (one) (Rs. 100 per month)	..	..	..	Rs. 1,200 " "
3. Servant (One) (Rs. 50 per month)	..	..	..	Rs. 600 " "
4. Contingency including rent, postage, stationery (Rs. 50 per month)	..	..	..	Rs. 600 " "
				Rs. 6,000 " "

Non-recurring—————Rs. 1,000 (Furniture, equipment), Transport—Vehicles of Primary Health Centre and Community Development Block.

C. District Health Education Unit—

1. District Health Education Officer (One) (Rs. 275—20—475)	..	..	..	Rs. 4,500 per year
(Rs. 375 per month)	..	..	..	Rs. 1,500 " "
2. Clerk-typist (One) (Rs. 125 per month)	..	..	..	Rs. 900 " "
3. Servant (One) (Rs. 75 per month)	..	..	..	Rs. 1,800 " "
4. Local Media	..	..	..	Rs. 900 " "
5. Contingency (Rs. 75 per month)	..	..	..	Rs. 900 " "
				Rs. 9,600 " "

Non-recurring.....Rs. 2,000 (equipment and furniture) at District Health Education Unit at the Divisional Headquarters will have a Mobile Audio-visual and Exhibition Unit.

Recurring	..	..	..	..	..	..	..	Rs. 5,000
Non-Recurring	..	..	..	..	..	..	..	Rs. 40,000

D. Divisional Headquarters—

Honorary Health Education leaders (One per Division)	Rs. 5,000 per year
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E. State Family Planning Education Unit—

1. Health Educator, Family Planning (One) (Rs. 300—25—600)	Rs. 4,500 per year
2. Editor (One)	..	..	..	..	..	..	..	Rs. 2,400 " "
3. Artist-photographer	..	..	..	..	..	..	..	Rs. 1,800 " "
4. Proof-reader (One)	..	..	..	..	..	..	..	Rs. 1,200 " "
5. Clerk-typist (One)	..	..	..	..	..	..	..	Rs. 1,440 " "
6. Attendants (Two)	..	..	..	..	..	..	..	Rs. 1,800 " "
								Rs. 13,440 " "

Materials and exhibits	..	..	..	..	..	Rs. 15,000
Films	..	..	..	..	..	Rs. 12,500
Conference, seminar and training	..	..	..	..	..	Rs. 5,000
Travel	..	..	..	..	..	Rs. 2,000
Contingency, rent	..	..	..	..	..	Rs. 2,000
						Rs. 36,500

Total recurring cost	..	..	..	..	..	Rs. 0·5 lakhs
Non-recurring cost	..	..	..	..	..	Rs. 0·05 lakhs

F. Regional Family Planning Education—5

G. Central Family Planning Education Section.

Recurring—

Staff	..	..	..	..	..	Rs. 1·07 lakhs
Materials	..	..	..	..	..	Rs. 1·00 lakhs
Training, conferences and seminars, etc.	Rs. 1·001 lakhs

Total about	..	Rs. 3 lakhs
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For Five Years Rs. 15 lakhs.

Non-recurring—Rs. 0·5 lakhs.

APPENDIX XXIX

LIST OF PERSONS WHO RESPONDED TO QUESTIONNAIRE

Abhyankar, R.P.	..	..	F.P. Centre, Ratnagiri.
Acharya, S.N.	..	..	Retired Civil Surgeon, President, I.M.A., Piri Branch.
Achyut, Ranade	..	..	Hony. Secy., Navajeevan Mandal, 110 A, Parbhat Road, Poona.
Adranvala, J.K.	..	..	B.J. Medical College, Poona.
Agarwal, G. S. Jahria	..	..
Agarwal, K.S.	..	..	Municipal Borough, Dhulia.
Aggarwal, S.N.	..	..	Demographic Research Centre, Delhi University.
Aithala, K.L.	..	..	Member, F.P. Association, Manipur.
A. John	..	..	Hony. Secy., Red Cross, Kottayam Branch, Kerala.
Akim, Angnal	..	..	Manipur Social Welfare Advisory Board, Imphal.
Alladevi Sarabhai	..	..	National Council of Women in India, Ahmedabad.
Else, A.J.	..	..	Journalist, Udipi.
Ambike, P.K.	..	..	Honorary Secretary, I.M.A., Vengurla.
Ambuja, K.R.	..	..	Andhra Mahila Sabha Nursing Home and Free Dispensary, Madras.
Ambujammal, S.	..	..	State Social Welfare Advisory Board, Madras-4.
Amin, R.K.	..	..	Sardar V. Vidyapeeth Vallabh, Vidyanagar.
Awalegaonkar, V.A.	..	..	Chief Medical Officer, Birla Sarva-janik Hosp., Pilani.
Baig, Tara Ali	..	..	12, Willingdon Crescent, New Delhi.
Bai, J. Jamuna	..	..	Director, Women's Welfare Deptt., Hyderabad.
Bagchi, K.N.	..	..	Calcutta National Medical Institute, Calcutta.
Bagchi, N.C.	..	..	I.M.A., Dooars Branch, Birpara.
Bahl, R.R.	..	..	Joint Secy., Ministry of Home Affairs.
Bajaj, K.L.	..	..	Astley Hall, Dehra Dun.
Balakrishnan, T.A.S.	..	..	Dy. Secy., Ministry of Commerce & Industry.
Balla' Prabha	..	..	Medical College, Nagpur.
Banerjee, Anila	..	..	State Family Planning Officer, West Bengal.
Banerjee, H.K.	..	..	Director, C.D.L., Calcutta.
Banerjee, P.K.	..	..	I.M.A., Jamurihat, West Bengal.
Bar'at Narain	..	..	Adviser Health, Ministry of Community Development.
Benjamin, E.	..	..	AMMN. Factory (C.R. Office), Kirkee.
Bhagat, M.P.	..	..	Office of Chief Adviser of Factories.
Bhajan Kaur	..	..	I/c, F.P. Training Centre, Rajindera Hospital, Patiala.
Bhaskar, Kamla	..	..	F.P. Clinic, Quilon.
Bhandary, S.S.	..	..	I.M.A., Chopda Branch, East Khandesh.
Bharama', R.	..	..	Director of Social Welfare, Mysore, Bangalore.
Bharucha, N.N.	..	..	Principal's Bungalow, Baidin College, Junagadh.
Bhat, Asha, K.	..	..	Member, F.P. Association, Manipal.
Bhatnagar, Prakash Vatti,	..	..	S.M.S. Medical College, Jaipur.
Bhatia, S.P.	..	..	Director of Medical Services, Army Headquarter, DHQPO, New Delhi.
Birendrakumar Singh, N.	..	..	F.P. Association of Manipur, Imphal.
Bose, Marishseyca	..	..	West Bengal Council for Child Welfare, Calcutta.
Bose, S.C.	..	..	Principal, Medical College, Calcutta.
Bordia, N.L.	..	..	Director, National Tuberculosis Institute, Bangalore.
Boparai, M.S.	..	..	Health Officer, Municipal Corp., Delhi.
Brahma, R.N.	..	..	Minister for Health, Government of Assam.

Cariappa, K.M.	Coorg.
Cassey, R.C.D.	Flat 6, Ridgeway, 29A, Ridge Road, Bombay-6.
Chandrasakharan, Kanakam	Kasturba Maternity Hospital, Madurai.
Chatterjee, J.B.	School of Tropical Medicine, Calcutta.
Chatterjee, Indira	Hazra Road, Calcutta.
Chakrabarty, S.P.	F.P. Association, Jalpaiguri.
Chakrabarty, Usha	Ramakrishna Matri Mangal Pratisthan, Ariadah.
Chakarvarty, B.	Asstt. Secy. to Govt. of Rajasthan, Medical and Public Health, Jaipur.
Chaturvedi, K.L.	Asstt. Development Commissioner, Jaipur.
Chaudhury, B.N.	I.M.A., Gauhati.
Chaudhury, Biharilal	Director of Health Services, Assam.
Chaudhury, I.B.	Chief Medical Officer, Northern Railway, Gorakhpur.
Chitale, W.P.	Lakmi Road, Poona-2.
Chopra, P.L.	Member, F.P. Board, Madhya Pradesh.
Chopra, K.K.	27, Chakrata Street, Dehra Dun.
Choubal, Sulachanabai	Member, Managing Committee, Vanitha Samaj, Amravati.
Choudhary, Ranglal	Vice Chairman, District Board, Dhanbad.
Chowdhury, T.P. Roy	Gen. Secy., Gocharan Ramkrishna Servasram, 24 Parganas.
Craig, Margaretta	Christian Medical College Hospital, Ludhiana.
Damle, Leelavati	Organising Secy., F. P. Clinic, Wani Central Public Health Engineering Research Institute, Nagpur.
Danel, Lelavati	Wani Taluq, F.P. Steering Committee, Wani Dalvi Memorial Children Hospital, Central Avenue, Old Baged Ganj, Nagpur.
Das, A.K.	D.M.S. (Navy), Naval Headquarters, New Delhi.
Das, Amalprova	Vice-Chairman Assam, State Social Welfare Board.
Dass, A.N.	I.M.A., Contai Branch.
Das Gupta, Bani	Delhi Women's League, Delhi.
Das, S.O.	Section Officer, Central Water & Power Commission.
Dass, R.C.	Section Officer, Printing and Stationery Deptt.
Dasappa, H.C.	M.P., Chairman, Estimates Committee, New Delhi.
Datta, S.K.	Airport Health Officer, Airport Health Office, Bombay.
Dave, A.V.	Anand Vatica Bhagini Mandal, M. C. H. Centre, Bhavanagar.
Desa Souza, J.M.	Grant Medical College, Bombay.
Desai Tilotama, C.	Bombay State Social Welfare Advisory Committee, Bhuj.
Deshpande, P.S.	I.M.A., Sholapur Branch.
Deshpande, R.R.	Mahatma Garchi Road, Bijapur.
Desai, V.A.	Urban F.P. Clinic, Malad East, Bombay.
Desai, J.G.	Ramakrishna Sewa Mandal, Anand.
Devenport, H.	Director of Employment Exchanges, D.G. R. & E., New Delhi.
Devi, Urmilla	Rani of Masuda, Masuda House, Ajmer.
Dhakappa, K.P.	Haveri Dharwar.
Dhara, S.K.	General Smriti Matri Bhawan, Rajarampur, Distt. Midnapur.
Dharmadhikari, V.R.	I.M.A., Yeotmal Branch.
Dixit, Prabha	Modern Maternity Home, Surat.
Dixit, Vishakha	Social Welfare Advisory Board, 190 South Civil Lines, Jabalpure.
Dogra, Neera	Chairman, Assam State Social Welfare Board.
Dutta, N.K.	Dte. of Extension, Ministry of Food & Agriculture. Krishi Bhavan, New Delhi.

Fairbank, R.W. ..	..	..	Hartland Bungalow, Sholapur.
Frank, I. Torey ..	..	..	The Norycalret Holdsworth Memorial Hospital, Mysore City.
Garudachar, B.N. ..	..	..	Supdt. of Police, Tumkur.
Gharpure, Vasundhara ..	..	..	President, Poona Women's Council.
Ghosh, B.K. ..	..	..	95, Hospital Road, Barrackpore.
Ghosh, J.N. ..	..	..	Director of Health Services, and Ex-officio Secretary, N. E. F. Agency, Shillong.
Ghosh, Malika ..	..	..	Delhi State F. P. Association., New Delhi.
Ghosh, Sourin ..	..	..	15/1, London Street, Calcutta 16.
Gokhale, G.K. ..	..	..	N. M. Wadia Hospital, Shanwar Peth, Poona City.
Gokhale, Kamlabai ..	..	..	Member, Managing Committee, Vanitha Samaj, Amravati.
Gonapathy, K.T. ..	..	..	Medical Specialist, Gandhi Memorial Hosp., Rewa.
Gonukutty, K. ..	..	..	S. N. V. Women's Association, Trivandrum.
Gopalan, A.R. ..	..	..	Deputy Secretary to the Government of Andhra Pradesh, Health and Local Administration Deptt., Hyderabad.
Gopalan, C. ..	..	..	National Research Laboratory, Tarnaka, Hyderabad.
Gore, Sushila ..	..	..	Officer-in-charge, F. P. Training Research Centre, Bombay.
Govindarajan, S. ..	..	..	Director, King Institute, Guindy.
Goswami, Sumitra ..	..	..	F. P. Clinic, Ariadah.
Gowda, Savithramma Anne ..	..	..	Jail Road, Chikmagalur.
Gulati, I.S. ..	..	..	Faculty of Arts, Baroda.
Guha, G.S. ..	..	..	President, I. M. A., Shillong.
Gupta, B.M. ..	..	..	Hony. Secy., Indian Red Cross Society, Lucknow.
Gupta, G.L. ..	..	..	D.G.S. & D., New Delhi.
Gupta, M.C. ..	..	..	I.M.A., Delhi Branch.
Gupta, R.L. ..	..	..	Under Secretary to Government of India.
Gupta, S.M. ..	..	..	Hony. Secretary, Indian Red Cross Society, Shillong.
Gupta, Suraj Prakash ..	..	..	Medical Officer, Parkash Eye Hospital, Deoband.
Gupta, Shanti ..	..	..	F. P. Association of India, Delhi-8.
Gupta, U.P. ..	..	..	Assam Medical College, Dibrugarh.
Gyan Chand ..	..	..	'Ryara', 5/4, Roop Nagar, Delhi.
Haldane, J.B.S. ..	..	..	Indian Statistical Institute, Calcutta.
Hall Marian B. ..	..	..	F. P. Association, The Domes, Ajmer.
Har Bhajan Singh ..	..	..	Tarn Taran.
Haran, M.P. ..	..	..	73-A, Butterworth Road, Teppakulam, Trichirapalli.
Haran Singh, Suri ..	..	..	Fellow of Royal Economic Society.
Hem, Sanwal ..	..	..	President, F. P. Association, Agra.
Holmes, E.M. ..	..	..	All India Institute of Medical Science, New Delhi.
Indra, H.K. ..	..	..	R. G. Kar Medical College, Calcutta.
Israel, S. ..	..	..	Indian Cancer Research Centre, Bombay.
Iyer, C.V.N. ..	..	..	I.M.A., Kerala Branch, Calicut.
Jadav Darshan ..	..	..	F. P. Clinic, Rajkot.
Jagdish Singh ..	..	..	Director of Health Services Punjab, Patiala.
Jaiswal, K.G. ..	..	..	Shri Gurudev Hospital, Gurukunj Ashram, Mozri, Amravati.
Jatti, B.D. ..	..	..	Chief Minister, Government of Mysore.
Jayalakshmi, S. ..	..	..	President, F.P.A., Mysore.
Jha, D. ..	..	..	Head of Department of Economics, Patna University.

John, A.J.	Commissioner, Coimbatore Municipality.
Joseph, A.K.	Medical College, Madurai.
Joshi, Indumati	I.M.A., Nasik Branch.
Joshi, Kamla S.	College Hostel Bungalow, Junagadh, Bombay.
Kabir, Hamayun	Minister, Scientific Research & Cultural Affairs.
Kalra, S.L.	Armed Forces Medical College, Poona.
Kalidas, N.N.	S. K. Patil, Arogya Dham F.P. Centre, Bombay 46.
Kamaladevi, C.	Doctor-in-charge, Andhra Mahila Sabha Nursing Home Madras.
Kapil, K. Krishan	F.P. Association of Delhi.
Kapur, Y.D.	I.M.A., Faizabad Branch.
Kar, A.B.	Central Drugs Research Institute, Lucknow.
Karmarkar, D.P.	Union Minister for Health.
Karamchandani, C.J.	Medical Officer, P.H.C., Khadsupa.
Karani, N.D.P.	Armed Forces Medical College, Poona.
Karnik, D.B.	58, Pandara Road, New Delhi.
Karunakaran, C.O.	Ex-president, Indian Medical Association.
Karve, B.D.	Hingne Badruk, Poona-4.
Katju, J.	Officer-in-charge, Family Planning Training Centre, Delhi.
Kaur, S.	S.O. Ministry of Home Affairs.
Khader, A.T.M. Abdul	Director of Medical Services, Andhra Pradesh.
Khambatta, P.B.	Director (Medical and Health, Railway Board.
Khanolkar, V.R...	Director, India, Cancer Research Centre, Bombay.
Kharaiti Ram	Section Officer, Ministry of S.R. & C.A.
Kos, T.A.	Library House, Kanpur Road, Lucknow.
Kolet, S.R.	Zenana Hospital, Junagadh.
Koshy, H.	F. P. Clinic, Varkala, P.O. Trivandrum.
Kothandaraman	Planning Commission, New Delhi.
Krishnaswami, K.G.	Dean, Stanley Medical College, Madras.
Krishna Swamy, S.	Under Secretary to Government of India.
Krishnamoorthy Ch.	Soil Conservation Officer, Bellary.
Krishnappa, Lakshmi P.	General Secy., Indian Red Cross Society, Mysore, Bangalore.
Krishna Verma, B.	Member, Andhra Mahila Sabha, Madras 28.
K. Devki Amma	Member, Skipoo Committee, Malabar.
Kulkarni, Maltibai	Chairman, Project Implementing Committee, Sangli.
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