FAMILY PLANNING

OUTLOOK FOR GOVERNMENT ACTION IN INDIA

STATEMENT
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ON
FAMILY PLANNING RESEARCH
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BY

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I. Preliminary Remarks.

I have been asked to present a paper on the "Outlook for Government Action in India" in relation to Family Planning. It is necessary to begin with a brief explanation of how I come into this picture. I am not a medical doctor or scientist or economist or statistician. I have no claim to scientific expertise or scholarship. I am only an administrative Civil Servant in the joint employ of the Government of Madras and the Government of India for the last thirty-three years.

2. During the last four years, my official duties have included the Chairmanship of the Programme Committee of the Family Planning Board of Madras State. In that capacity, I have helped the Government of Madras to take the decisions necessary for propagation of the practice of Family Planning among the people of Madras State; and I have watched the progress recorded by workers in the field. Earlier, about ten years ago, my official duties under the Government of India included the organisation and direction of the 1951 Census of India and the preparation of an All-India report thereon. In that context, I had occasion to participate in the discussions, which preceded the formulation of official All-India policy relating to control of the growth of population.

3. Last year, I was invited to present a paper to the International Conference on Planned Parenthood which met at New Delhi. I did so. Copies of that paper entitled "Administrative Implementation of Family Planning Policy" have been circulated. That paper contains an account of my appreciation of the situation in India up to the end of 1958. Full description is given of the manner in which policy was evolved, how the organization necessary for implementing the policy has developed, the nature of the problems encountered, and the solutions which were being discovered. This paper may be regarded as a Supplement to the earlier paper. The story is brought up-to-date so as to cover another eighteen months.

Though the facts presented in this Paper are derived from official sources, the appreciation of the developing situation is only a personal opinion. It is necessary that this should be mentioned at the outset in order to make it clear that nothing contained in this paper should be regarded as in any way committing the Government of Madras; much less the Government of India.

II. Slow progress of Government action and the Explanation therefor.

4. "Government" in the context of this paper, means not only the Government of India, but also each of the fifteen State Governments in India. What is the objective of Government action? The immediate objective of every State Government is to propagate the practice of Family Planning among all the married couples living in that State. The role of the Government of India is to provide financial assistance and co-ordination of the activities of all State Governments, within the framework of the Five-Year Plan of National Development. The ultimate objective, to be secured thereby, is to bring about a reduction of the birth rate in every State, and thereby for the Nation as a whole. No particular target has been specified for the amount of reduction to be effected in the birth rate, nor of the time within which this reduction is to be secured.

5. In terms of long-term objective it can be stated at once that India has not achieved any reduction of its birth rate. A definite statement to this effect cannot be proved or disproved because our vital statistics continue to be incomplete and defective. There is, as yet, no satisfactory means of determining from year to year what the actual birth rate is. There is nevertheless, no real reason for doubt on the point. All the indications are that no down-turn in the birth rate has actually occurred and there is no sign that a down-turn will occur in the next few years.

6. This should not, of course, cause much surprise. It is easy enough to see that it is too soon to secure a visible reduction of the birth rate of a Nation numbering one-seventh of the entire human race. The progress of Government action has to be judged immediately, and in the first instance, by the numbers of people who have received advice on family planning and assistance to practice it. The next test would be the actual number of people, in so far as this can be ascertained, who have started making serious effort actually to practise family planning and the success attending such effort. These are, at present, the only valid criteria by which to assess progress.

7. According to the latest returns compiled by the Government of India, the total number of family-planning clinics in India had increased during four years from 147 (in July 1956) to 1349 (July 1960). Three thousand and one hundred persons had been trained in sixty centres and made available for providing contraceptive advice. They had contacted 7.0 million persons and given contraceptive advice to 1.4 million persons.

8. How is one to assess this progress? The total number of families in India at the present moment must be somewhere between 75 and 80 millions. If, after three years' effort, only seven millions were contacted, and among them only 1½ millions were

advised, how long would it take before all the families get contacted and advised? And, it should be remembered that even when every family has been advised, the work would not end; it would only have just begun. For, we do not know what proportion of those to whom advice is given would take it seriously, choose one method or another and practise it with care. And then again, we do not know what proportion out of those who begin to practise family planning would keep on at it throughout their child-bearing life. It is evident that the pace of progress is slow.

9. Why should this be so? Why has it not been possible to develop our organisation more rapidly so as at least to establish complete advisory coverage within a relatively short period? One plausible reason is easy to suggest. Actual expenditure over a period of three years was only of the order of six hundred thousand dollars. This is certainly a small amount; and some eminent observers have already referred to it as evidence that the allocation of funds does not match the serious spirit in which policy has been framed. I may say at once that this is an erroneous line of comment. Though it is true that the amount of allocation was small, and the amount of actual expenditure still smaller, there was and is no real difficulty about money. The State Governments and the Central Government were at all times ready to provide more money, if it could have been usefully spent. The fact is that more money could not have been usefully spent.

10. What was, then, the difficulty? Shortage of trained personnel? Yes. That was a difficulty to some extent. When we started the programme of opening clinics, the idea was that there should be one qualified woman doctor assisted by a nurse, both in whole-time charge: and, in addition, it was stipulated that the part-time services of a male doctor should also be made available. A clinic, staffed on this basis, was supposed to serve a local community of between 10 and 12 thousand families. It was found soon that it would be impossible to establish complete coverage on that basis in a country where doctors and nurses are extremely scarce; and where among the few who were available, most of them had a pronounced tendency to cluster in the cities and avoid working in villages. The general problem presented by this state of affairs affects the entire Health Development Programme, of which the opening of Family-Planning clinics is only a part. This general problem is being tackled; but progress can be expected to come about only gradually. If the development of organisation needed for provision of instruction in family-planning methods really depended on the provision of whole-time doctors and nurses on the scale originally contemplated, even such progress as did take place would have been impracticable. Actually, it was found that doctors and nurses on the scale proposed were really not needed. Separate and self-contained clinics could not function because they did not have enough work to do. This was so because people would not come to them in sufficient numbers and at a steady rate. The doctors in

charge of the first few clinics became thoroughly discontended, as they were forced to remain idle and denied the opportunity to exercise their professional skill. The organisation of clinics had to be changed; they had to function as integral parts of the organisation of hospitals and child-welfare centres. Once this decision was taken, it was found that the requirements of doctor-time could be greatly reduced. It was also found that the services of nurses in short supply could be supplemented by social workers recruited and trained on an *ad hoc* basis. In the result the problem of trained personnel could be and was reduced to readily manageable dimensions.

11. The true explanation for slow progress must be found, not in money (of which there was no shortage); nor in trained personnel (of which the shortage could be managed). It is to be found in the fact that the work which we had undertaken was unprecedented. We had to find out by trial and error exactly what was the right thing to do and what was the right way of doing it. We had, therefore, to limit the number of places at which active work was started, allow time for trying out our provisional ideas regarding the organisational set-up and methods of work. We had to keep a close watch on the responses; and learn the lessons therefrom, before attempting to extend the coverage. The correct explanation of the slow progress recorded so far is that we have been engaged only on what must be regarded as Pilot Experimentation.

III. Questions to be answered.

12. The validity of the explanation for slow progress which I have just now given will be disputed even in Indla. It will be disputed by persons whom I shall refer to hereafter as the " Orthodox School " of family planners. They include emient social workers whose mind has been moulded by participation in the International Family-Planning movement of the nineteen thirties. To them, it is obvious that the use of contraceptive appliances is the only possible way of practising family-planning. They recognize no other method. They know how the use of contraceptive appliances has been propagated in England and the United States. They see no reason why the Governments in India should find any difficulty in doing the same.

13. The difficulty, nevertheless, exists and is very real, because India is not England or the United States. Is it likely that we shall succeed in persuading our people systematically to buy and use contraceptive appliances with that degree of persistence and care which is necessary for success in each individual case and which is necessary, collectively, for bringing about the needed reduction of the birth-rate? First, there is the question of cost which may prove prohibitive for a majority of the population. Then, there is the question of availability of adequate privacy and running water facilities. In the homes of a majority of the population, they do not exist. These are very strong a priori grounds for believing that

a nationwide drive to instruct people exclusively in the use of appliance methods may peter out as a futility; and thereby cause a grave set-back to the implementation of National policy. No Government can afford to court a spectacular failure.

14. The answer of the orthodox school to this contention is that Government should supply contraceptive appliances free of charge to poor people. It is, perhaps, a logical demand to make, given the position that the reduction of the birth-rate is accepted as a National necessity. But the proposal is, prima facie, too costly for a poor country. Even assuming that Government are prepared to accept an expenditure commitment of this order, is it certain that free supplies will be used with such persistence and care as to secure the result intended? Is it also certain that there are no other methods by which effective results can be secured with greater certainty at less cost? These are the questions to which definite answers had to be found by Pilot Experimentation.

15. Though the orthodox school declines to recognise anything except the use of contraceptive appliances as a family-planning method, it is well known that even in Western countries a great many people succeeded in limiting their families through the ancient practice of " Coitus interruptus ". Is there a chance that large sections of our people can be induced to practise it? If there was a possibility, it was the duty of the Government to explore it, for then there would be no expenditure at all. The fact that, in this case, one man's food is another man's prison cannot count for much. Similarly it was known that there was such a thing as the " Safe Period " and even His Holiness the Pope approved of it. Did it work? If so, could it be made to work in India? Even if it was not completely reliable, it might be of some use; and, in that case, in view of its costlessness, effort must be spent on it.

16. In addition to appliance methods and natural methods, there are the " surgical " methods—the operations known as ' Vasectomy and Salpingectomy '. True, the orthodox school protested vehemently that sterilization was a thing to be thought of only in relation to the " unfit "; and made no secret of its aversion to the mere thought of the possibility of normal healthy mothers and fathers being asked to get themselves sterilized. But the Government could not afford to thing in those terms. Were the operations harmless? And were they effective for the purpose of limiting the size of the family? All the experts including the Indian Medical Association, assured the Government that they were. In that case, the only remaining question was whether the people would take to them The possibilities must be explored.

17. These, briefly, are the reasons why it was unavoidably necessary that State propagation of Family Planning should be carried on, during the first few years, as Pilot Experimentation. In selected areas, we set up as good an organisation as we could assemble in

order to provide instruction in all three categroies of Family Planing methods, appliance methods, natural methods and surgical methods. Our aim was to ascertain whether any and if so which of these methods would " catch "; in the sense that a favourable response can be relied upon from sufficiently large sections of the people, when we passed beyond the stage of pilot experiment and undertook a large-scale campaign. In that same process of experimentation we sought to ascertain how best instruction could be organised and needed services provided.

18. In organising the work as a pilot experiment, we suffered from a handicap which should be mentioned here. We were precluded from employing anything in the nature of aggressive publicity. In particular, the powerful aid of cinematograph pictures could not be invoked. The climate of public opinion (though increasingly favourable) could at any time be disturbed by any offence given to the public sense of propriety. The possibility of a chance mishap in sterilization operations had to be jealously guarded against. This was all the more necessary because the orthodox school was opposed to the experiment; and, in deference to that sentiment, the Government of India remained neutral. They allowed the State Governments freedom to experiment, but withheld their official sponsorship of sterilization as a recognised method of family limitation. In the result, it has been uphill work all the time during the last few years.

IV. The answers to our questions.

19. We had expected that it would be easy to get Family Planning accept in principle; and that the real difficulties would arise in getting any very sizable proportion to practice it. The pilot experiment has confirmed that this is sober truth. This may be illustrated by an analysis of detailed data relating to the City of Madras for the first seven months of 1959. During this period, intensive instruction was provided for women who came to anyone of three large maternity hospitals maintained by the State Government or anyone of 44 Mothers' Information Centres located in Child Welfare Centres maintained by the Madras City Corporation. Altogether, 38,829 mothers were given instruction during the seven-month period. Out of this number, only 2,888 mothers (or 8 out-of 100) disclaimed interest in family planning. All others (that is 92 out of 100) were interested. They indicated their desire to do something to limit their families, and received instruction willingly. Subsequently, when a follow-up was made. it was found that only 1,578 women (or only 4 out of 100) had acted on the advice. Four hundred and seven women got themselves sterilized. Eight hundred and ninety-eight had started using foam tablets. One hundred and thirty-two had started using jelly. Fifty-one had started trying the Diaphragm and jelly. Eighty had succeeded in influencing their husband—74 to be careful, and six to use sheaths.

20. It is somewhat depressing, but not exactly surprising, to find that though 92 out of 100 women were definitely desirous of limiting their families, 88 out of the 92 did nothing about it. The desire to limit families is there. But it is not keen enough to move the people to change their accustomed conjugal habits. We are not, of course, giving up the instructional effort for this reason. Arrangements for providing instruction in family planning will hereafter remain a normal feature of the routine working of hospitals and child-welfare centres. The pressure will be kept up month after month and year after year. Publicity and propaganda will be intensified. Under these conditions the percentage of active practitioners is bound to increase. But it is obviously going to be a slow process of gradual change in the conjugal habits of the people.

21. It has been found very difficult to organise systematic instruction for fathers. Mothers assemble in large numbers in institutions where conditions are especially suitable for their instruction. Fathers, on the other hand, assemble only in work places, where instruction is not possible. The only satisfactory way of reaching large numbers seems to be through documentary pictures; which, however, we have intentionally refrained from attempting, at the present stage of pilot experimentation. In the absence of something better, 32 Fathers' Information Centres are being run in the premises used for registration of births and deaths. Instruction is provided by part-time social workers in evening classes. Altogether 18,031 fathers were instructed during the same seven-month period in which 38,829 mothers received instruction. It is known that, among those instructed, 240 fathers got themselves sterilized. What the others do at home is not known, for there has been no follow-up.

22. When we started work, it was hoped that the " natural methods " which cost nothing and required no assistance (apart from instruction) would " catch ". The results are not very encouraging. Though there are no figures to go upon, the impression so far gained is that " natural methods " are already being practised in very limited numbers among a section of the intelligentsia, and are now spreading to larger numbers among them. But their appeal seems to be limited by social class. The practice of natural methods demands the same degree of sustained determination and care, as the practice of appliance methods. Therefore, it does not seem likely that they will ever become as widespread as they are believed to have been in England about thirty years ago.

23. The only encouraging conclusion which has emerged from the experience gained so far is that surgical methods are likely to " catch ". While the orthodox school was opposing and the Government of India remained neutral, the State Governments went ahead. As a result, the idea that sterilization can be resorted to as a method of family limitation has become known and has begun to gain ground in almost every State. According to returns collected by the Government of India, the number of sterilisation operations performed dur-

ing the two years 1956 and 1957 was twenty thousand. In the year 1958, the number rose to twenty-four thousand. Incomplete figures available for the year 1959 added up to 31 thousand. These figures are limited to reporting institutions. A considerable number of operations are being performed without being reported. It is unlikely, however, that, in the country as a whole, the 1959 output of sterilisation reached as much as 60 thousand.

24. The population of Madras State is roughly one-twelfth of that of India. The number of operations in this State was 695 in 1956, 1,804 in 1957, 2,850 in 1958 and 3,343 in 1959. During the first six months of the current year 1960, the number has risen to 2,145, indicating that the figures for 1960 would exceed 4,000 substantially. These figures are limited to Government hospitals. They do not include operations performed by private medical practitioners. It is unlikely, however, even taking them into account that the annual output of sterilisation in Madras State has reached as much as ten thousand. There are at least two other States in India, where sterilization is making quicker progress than in Madras; and many other States which are not far behind.

25. There is one feature about the progress of sterilization to which attention should be drawn. To begin with, sterilization was confined almost entirely to women. But men are getting attracted increasingly. The number of vasectomy operations in Government hospitals of Madras State has increased from 25 in 1956 to 231 in 1957, 986 in 1958 and 1,330 in 1959. During the first six months of the current year 1960, the number has risen to 1,015. Vasectomy operation represents only 3 per cent of all operations performed in 1956; and 13 per cent in 1957. They have risen to 45 per cent during the latest half-year. Private medical practitioners are known to perform far more vasectomies than salpingectomies. This is a particularly encouraging development because the sterilization of fathers is a far more easy process than that of mothers.

26. Sterilizations effected in Government hospitals are governed by clear-cut rules. The operation (whether of vasectomy or salpingectomy) should be performed only after both the husband and the wife have jointly made a written statement in a prescribed form, declaring that they realize that the operation is irrevocable * and they are content to have no more children. The operation should not be performed unless the couple have at least two living children. Salpingectomy is not to be performed if the mother has not completed 25 years of age.

27. The question of giving a little monetary inducement for sterilization had been considered, from time to time. There were divided views to begin with, and a decision was postponed for sometime. Then a cautious beginning was made with the offer of a small

* [NOTE.—It is known that the operations are not entirely irrevocable. Nevertheless, it is considered expedient not to hold out hopes.]

cash payment limited to employees of Government and the Corporation. This did not seem to have much effect on them. At the same time, however, the news reached the poorer classes of people who were visiting the Information Centres. Requests were received for the extension of the scheme to the general public in Madras City. Last year, after a great deal of hesitation, it was decided that a cash grant of 30 rupees (about six dollars) should be paid to every poor person who got himself/herself sterilized in a Government hospital for Madras City. This grant was justified as necessary in order thereby to meet the cost of transport to the hospital and back and partly to cover loss of earnings. Whereas, the existence of two living children was sufficient for the performance of the operation, the existence of three living children was stipulated as a condition for payment of cash grant.

28. This offer of a small cash grant to cover transport expenses and loss of earnings turned out to be a good investment. Visitors to the hospitals in Madras City increased in number, rapidly enough to lead to the demand for new building accommodation and the setting up of whole-time surgeries. The news spread to other districts and created a demand for extension to rural areas. We were initially hesitant because of our anxiety to limit the work to highly skilled surgeons and to keep the pilot experiment under close observation. But the demand was insistent. The benefit of the scheme, with some slight modifications, was extended to 2,000 selected villages—out of a total of some 15,000. It was found that the demand could not be limited even to the selected villages. A few days ago, Government felt compelled to issue orders extending the schemes to all villages and towns in the State. This experience has led us to believe that sterilization, as a method of family limitation is beginning to " catch ".

V. THE LESSON FROM JAPAN.

29. Just as we were completing the third year of our Pilot Experiment, the news come through that Japan had halved her birth-rate in ten years. How was this done? This was explained in detail in a paper which Professor Kitaoka presented to the International Conference on Planned Parenthood held in New Delhi early last year. A close study of this document showed conclusively that we in India were on the right track in our pursuit of sterilization as a method of family limitation. Let me explain how this conclusion emerged from the facts of Japanese experience, as narrated by Professor Kitaoka.

30. The Japanese Birth Rate (number of births per thousand per annum) fell from 34 in 1947 to 33 in 1949, and then sharply to 25 in 1951, 22 in 1953, 19 in 1955 and 17 in 1957. This fall of the birth-rate by 17 points in 10 years has been accounted for as due to two causes, viz., the growing use of contraceptive appli-

ances and surgical abortions carried out in the public hospitals. Can the contribution made by each of these two causative factors be *separately* assessed and thus their relative importance in the process of halving the birth-rate be determined? It seems possible to do this first by computing the " Surgical-abortion—Rates " then adding it to the birth-rate to arrive at the " Pregnancy Rate ". When that is done it is found that 34 pregnancies occurred among every 1,000 people in Japan during the year 1949. In that year, only one out of the 34 pregnancies ended in surgical abortion; there were 33 child-births. During the year 1957, the number of pregnancies had fallen to 29, as aganst 34 in 1949. This drop of five points is clearly attributable to the growing use of contraceptive appliances. In the same year (1957) 12 out of the 29 pregnancies were terminated by surgical abortion—thereby reducing the number of child-births to 17. Thus a drop of 12 points had occurred as a result of surgical abortion.

The relative importance on the one hand of the use of contraceptive appliances and on the other hand of surgical abortion may thus be expressed in the ratio of 5 *to* 12.

31. It is clear from the account given by Professor Kitaoka that great advances had been made in bringing contraceptive appliances to the very door of the people of Japan and instructing them in their use. It will take a long time before India can reach that stage. And yet it appears that for every five Japanese mothers who chose to avail themselves of these facilities, 12 did not; even though the latter disliked child-bearing to the point of resorting to surgical abortion. Here is conclusive corroboration of the lesson of Indian experience that the reluctance to change over from normal care-free conjugal habits is stronger than the desire to avoid unwanted pregnancy. Where this psychology prevails, the use of contraceptive appliances can be expected to spread only very slowly.

32. Ever since Japanese experience became known, voices have been raised in India from responsible medical quarters for similar provision of facilities for surgical abortion. It cannot be denied that there is a good deal of illegal abortion giving on in a crude and dangerous manner. If reliance is placed exclusively on contraceptive appliances, it is certain (having regard to the limited scope for the development of such use) that the evil of illegal abortion will increase. Legalized surgical abortion will be certainly preferable to such increase. But how much better would sterilization be as compared with surgical abortion? Induced abortions are unlikely to be desired by young mothers, except in cases of illegitimacy (which can be ignored). In other cases it should be possible to induce the mothers to complete their pregnancy and accept sterilization as preferable to abortion. The correct course, therefore, is seen to be the continuance of the existing law in respect of abortions; and the rapid expansion of facilities for sterilization on the lines already started.

33. The effect of every induced abortion, so far as the birth-rate is concerned, is only the diminution of the number of child-births by one. On the other hand, a sterilization effected after three children are born and before the fourth is conceived will diminish the total number of child-births by at least three. In other words, the result produced in Japan by a surgical abortion rate of 12 per thousand per annum can be produced in India if the sterilization rate is stepped up to 4 per thousand per annum. A sterilization rate of 5 per thousand per annum should be ample, even allowing for a less rapid growth in India than in Japan of the use of contraceptive appliances.

This indicates the rule by which a sterilization target may be set for every village, every Development Block, every Municipal Town as well as every district and every State in India. For India as a whole, an annual output of about 2 million sterilizations, is thus indicated.

That number, obviously, is very far away. Our present annual output is an exceedingly small fraction of the needed annual output. But then we are only in the stage of pilot experiment. If, as we believe the method has begun to " Catch ", the annual output can be stepped up rapidly.

34. That brings me to the important question of relative costs. The orthodox school of family planners in India maintain that the use of contraceptive appliances can be rapidly accelerated and made practically universal, if only the Government would supply them free of charge to the poor. Assuming (in the face of Japanese experience) that this is correct, we may try to ascertain what this proposal would cost and compare with it the cost involved in their provision of sterilization facilities at the rate of 5 per thousand per annum. On any fair test of poverty, it has been found that at least two-thirds of the population qualify. A fairly simple calculation shows that, at present prices, the free-supply of Diaphragms to all poor people will cost at least a dollar per head of the total population, every year. Free-supply of cheaper (and less effective) contraceptive appliances to all poor people will cost not less than 50 cents per head of the total population every year. On the other hand, the cost of maintaining one surgery for performing 2,000 vasectamies in the course of one year would be 4,000 dollars or 2 dollars for each operation. Even if we added 8 dollars as cash grant for covering transport expenses and loss of earnings in each case, the cost would be only 10 dollars for every operation. Every community of 1,000 people will need only five operations a year. The cost would be only 50 dollars per 1,000 people or 5 cents per head per annum. For the country as a whole, it may be estimated that Government expenditure needed for performing sterilization of the order of two million every year will be only 20 million dollars per annum. It will cost from 200 to 400 million dollars every year to provide a free supply of contraceptive appliances to all poor people.

35. From the point of view of relative costs, there can be no doubt, as to which is preferable; whether to provide free surgical services, and cash grant *once in their lifetime*, for every married couple seeking such services, or to provide a free supply of contraceptive appliances to every poor married couple, *throughout their child-bearing period*. Any responsible Government, especially of a poor country, is bound to prefer the former to the latter, if only for the reason that the latter is ten to twenty times more costly. It looks as if the preference of the poor people, will be also the same as that of the Government. Even if a free supply of contraceptive appliances can be drawn regularly from a Government clinic, there is the trouble of storing them and using them with care and persistance week after week, month after month and year after year during the entire child-bearing period. All the evidence points to the conclusion that such sustained determination is too much to expect, in respect of a large proportion of the population. How much simpler for them to have an operation once for all and live a care-free life thereafter!

VI. Likely Development during the next five years.

36. India's Third Five-Year Plan is now being made. It is likely to be settled during the next few months. It will be in operation during the five-year period from the next fiscal year 1961–62 to 1965–66. In every State, the experience of the last five years is being reviewed in every field of development and programmes are being resettled for intensification of effort during the next five years. This will naturally include intensification of the effort to propagate the practice of Family Planning.

37. In Madras (as in many other States) two important developments are scheduled to take place. The first involves the process of what has been described as " Democratic Decentralization ". A new type of local administration of rural areas by elected representatives of the village people is to be set up in every Development Block. The responsibility for planned development is to be devolved on them together with the necessary statutory authority and financial resources. It is expressly stipulated in the statute under which these new local authorities are to be incorporated; that they should exert themselves to secure two major national purposes. The first of these two purposes is to stimulate the production of food so that it may keep pace with the growing needs of the population as long as it continues to grow. The other major national purpose is set out expressly in the statute as the effort to bring the growth of population under control. The statute further specifies the provision of advice on Family Planning among the services for which provision should be made. As far as can be now foreseen, there is every indication that the leaders of the village people who will assume responsibility in the near future will take these duties seriously.

38. Steps have been taken during the Second Plan period for increasing the training facilities for Health Service personnel who will become available for service in the next few years. The programme by which a Primary Health Centre is set up in every Block is going forward and will be intensified during the Third Plan period. In the context of more active interest which is expected to be taken by the local leaders of the village people there is reason to belive that the activities of Primary Health Centres can be developed so as to achieve complete coverage in respect of the provision of instruction in Family Planning methods. Thus, knowledge about the use of contraceptive appliances can be imparted to every body, as also knowledge about other methods, surgical and non-surgical. Though it is not proposed to provide a free supply of contraceptive appliances to all poor people for all time more funds are being allocated for free supply of contraceptive appliances as a measure of initial popularisation not only of such appliances but of the entire Family Planning Programme.

39. Last year, the Government of India came out openly in favour of sterilization as one of the recognised methods of family limitation. As already explained, public opinion in the State has been gradually cultivated to the point at which it should be possible, in the near future, to undertake a fully publicised campaign throughout the State in favour not only of family planning in general, but specifically in favour of resort to sterilization as a method of family limitation. Provision of facilities for sterilization can be continually enlarged so as to keep pace with growing demand thus stimulated. The next few years should suffice to show whether or not the response of the people will be as gratifying as it is now believed it would be.

VII. Concluding Remarks.

40. To sum up: The visible results of Government action in India during the last few years are very small. But this should not cause discouragement, because we have been so far engaged on activities which had to be and were intentionally limited to the scale of pilot experimentation. The pilot experiments have served their purpose. Lessons have been learnt which are to be used as the basis for extending the coverage and intensifying the effort during the next few years. The success of Government action in the next few years will turn almost entirely on the rapidity with which the people can be persuaded to resort to sterilization as a method of family limitation. In this respect, the outlook for Government action in India is, at the moment promising.

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