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PHYSICIAN AND THE FAMILY WELFARE CONCEPT

By

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PHYSICIAN AND THE FAMILY WELFARE CONCEPT

Population Problem in India

Population problem worldwide has been assuming menacing proportions and the situation for a country like India is more acute than at any time before. Two major factors which contributed to bringing about this state of affairs are the following:

i. a belated recognition of the problem, and

ii. an inadequate commitment to the formulation of programmes and their implementation.

It is pertinent to note that some of the earliest family planning clinics in the country were opened almost 50 years ago, such as those in Bangalore and Bombay.

The interim government of a representative type was formed in 1945 and the nation assumed full control of its destiny in 1947. The First Five Year Plan became operative in 1951. For the purpose of planning, the resource position vis-a-vis the corresponding commitment was assessed. The planning effort was concentrated largely on resource augmentation and generation of new resources. May be it was this pre-occupation with resource mobilisation which led to a poor priority being assigned to population. Surely it could not have been a lack of population projections which led to the delay in adequate attention being given to the population problem.

Comments received from Professor R M Maru on an earlier draft of this paper proved most helpful in bringing about several improvements.

Early Years of Family Planning

The number of recorded family planning acceptors in 1956 was a mere 7,153. Gradually this number rose to about 160,000 in 1962. This data refers only to cases of sterilisation. It was only in 1963 that the first set of figures for conventional contraceptive users were collected. Their number was estimated at about 300,000. The total number of acceptors thus approached about half a million. The 1961 census, meanwhile, revealed the population of India as 439 million and the rate of increase was close to 2% per annum, the highest since authentic population data became available for the country, i.e., during the current century.

Conceptual Fallacies

It was not only that in respect of the numbers the mammoth figure had been reached and a huge growth rate had been recorded. The root of the problem in fact may be traced to the view which got widely accepted among policy makers and others namely that the population problem was primarily a problem of large and unmanageable numbers. A basic tenant almost overlooked was that we were dealing with a population of human beings. Another mistake had been committed. The origin of family planning in the country has been strongly associated in the minds of the masses with sterilisation. Family Planning had been equated with birth control. The recognition of the welfare concept was to await another decade and a half. This

appears paradoxical considering that the objective of the planning era, as indeed the guiding principles of the Constitution of India, emphasised economic upliftment of masses, social justice and so forth. This paper focusses on the role of physicians in creating motivation for family planning, and particularly the contribution they can make in giving a form to the concept of family welfare. The purely professional aspect of involvement of physicians as dispensers of advice and devices or modes of family planning is also equally important. That aspect is not intended to be covered in this paper. The focus of this paper is primarily on the physician in the social context.

Role of Physicians

In recent years a series of conferences have been held on the role of the physician in the context of 'Population Problem and Family Planning Effort'. This started with the Stockholm Conference of 1974. This was followed by the Bangkok Seminar in 1977 which focussed on the goals which physicians in South East Asia and Western Pacific could set for themselves and on the formulation of relevant programmes. India took the lead in organising a country level seminar on Physician and Population Change at Jaipur in March 1979. The first regional conference on the same theme was convened at Ahmedabad in November 1980.

Definition of a Physician

It will be best to start with the definition of a physician in the context of a country like India. The series of international bi-regional and national conferences and seminars seem to have equated a physician with a medical practitioner trained in the Allopathic system. This is indicated by the participation and certainly by the papers presented at these gatherings and the ensuing deliberations.[1,2]

It will be appropriate to define a physician as one to whom people go for medical consultation and advice regardless of the mode of treatment and systems used. This definition is particularly important in India when we consider the following estimates which refer to late 1970's.

System of Medicine	No. of Practitioners
Allopathic	1,71,000
Ayurvedic	2,22,000
Unani	40,000

In addition there are practitioners of Homeopathy. The nursing and para medical staff too should be taken into account.

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1. Indian Journal of Medical Education, Vol.XVIII, No.1, January-June 1977, Special Issue on the National Seminar on Physician and Population Change.

2. An occasional reference or two may have come up regarding the role of practitioners of the other systems. At the Ahmedabad Conference, for instance, Dr C L Jhaveri, in his presentation on 'Present Position and Strategy for Involving Physician in Population Change', referred to the large number of Ayurvedic and Unani Physicians and the contribution they can make in the family planning effort.

Accessibility to Physicians

The above data indicates the limitation imposed by treating only Allopathic medical practitioner as physician in the context of their role in influencing the pattern of population change. The question of accessibility of a physician to the people, particularly those located in rural areas as well as the under-privileged sections of the society in both rural and urban areas, is extremely important for a country like India. The availability of health services in India compares poorly with several other countries particularly when we consider the requirements of such services for a large and rapidly expanding population. It is particularly relevant in the context of this paper where we shall be primarily concerned with the motivational aspects of a physician's role rather than organisational features such as actual provision of contraceptive services e.g. IUD insertions, sterilisations of various types, or for that matter distribution and advice for oral pills. At the same time it must be clarified that it is not intended to consider any method of contraception which is not accepted as a standard method by the allopathic profession. Medical research which provides reassurance of the soundness of the method and also reveals any undesirable side effects, as in the case of oral pills, is available mainly in this system of medicine.

A physician, according to our broad based definition as given above, performs two major roles. The first is that of diagnosis and

treatment of ailments and the second is that of an advisor with regard to overall health problems. The second role is more relevant in the of family physicians (general practitioners) and possibly a large number of specialists and consultants as well. The observations and comments in this paper may primarily refer to the family physician or its equivalent. However, these may also be equally relevant to specialists and consultants in fields like internal medicine, gynaecology, obstretics and a variety of specialities closely related to internal medicines such as abdominal and chest diseases and Sexual Transmitted Diseases. We shall be concerned with the second role of the physicians and seek an extension of this role in the context of a comprehensive perspective of the population problem. The role has of course been emphasised by the persons from the profession.[3]

Process of Communication

It will be useful to have an analytical framework outlining the various dimensions of the problems, particularly those which are most relevant to the role of the physician. These parameters will have a bearing on the basic process of communication and acceptance of the concept by a potential acceptor. The basic steps in communication

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3. Sharma, Rameshwar, 'Role of Physicians for Promoting Participation of Other Members of the Community', the Indian Journal of Medical Education, Vol.XVIII, No.2, January-June 1979, p.39.

are the following:[4]

Unawareness

Awareness

Comprehension

Conviction

Action

The above stages may of course be broken into further sub-steps if one wants to go into the details of the communication process. However, the above framework will be adequate for our purpose. The creation of awareness is to a large extent the responsibility of the educative and mass media channels as well as political and social leadership. The importance of the physician at the individual level increases quite substantially in the next two stages, namely that of comprehension and conviction. At the action stage the organizations and systems assume dominance.

Stage of Communication	Message and Media
Creating Awareness	Educative approach through Mass Media
Correct Comprehension of the message	Mass Media supplemented by word of mouth, especially by opinion leaders and professionals, e.g. physicians.

4. Colley, Russel H., 'Defining Advertising Goals for Measured Advertising Results, Association of National Advertisers, Inc., 1961, Chapter 22, p.55.

Conviction

Stage 1: Acceptance of the concept of planning one's family.	Mass Media supplemented by word of mouth, especially by opinion leaders and professionals e.g. physicians.
Stage 2: Choice of appropriate method.	Access to information from reliable sources including physicians, para-medical personnel health centres and the like .
Action	Delivery systems.

Effectiveness of Communication

The effectiveness of communication, especially at the stages leading to action, can be increased only if message appears relevant to the receiver, whether an individual, a couple or a family. Mass media programmes often suffer from the drawback of not being able to achieve this particular effect. This applies to mass communication of social objectives as well as to a great extent in the case of commercial advertising. In India we have a further handicap owing to diversities of social and economic strata as well as regional variations and also a large number of special sections of community and tribes. It is not surprising, therefore, that the effectiveness of mass communication media is seriously hampered. Opinion leadership and word of mouth communication is certainly helpful in this type of environment.

In India professionals, particularly physicians, command great deal of respect and this is more so in non-urban communities. Therefore, a physician can play a vital role in putting across the concept of welfare of the family at the level of the decisionmaking

unit. It may be added that the family unit in the Indian context should be considered not as a nuclear family but also other relations, characteristic of a joint family system. It should also be borne in mind that decisions concerning conception and bringing up a family may be influenced implicitly or explicitly by several relations in the family circle whether they are a part of the same household or not. Moreover, social and communitarian considerations also have an important role.

Age of Marriage

One of the first question which arises or should arise is when to start a family. Earlier, child marriages were not uncommon and even now marriages at relatively young age are a common feature in India. This is particularly true of a very large proportion of rural households and economically and socially backward sections of the community, even in urban areas. The average age of marriage in India for families is still estimated at about 16 years. The Child Marriage Restraint (Amendment) Act, 1978 has raised the minimum age of marriage from 15 years to 18 years for women and 18 years to 21 years for men and has also made its infringement a cognizable offence. This is certainly a progressive step. However, it will take a fair bit of time for this Act to become effective. It is extremely difficult in a country of the size of India to have adequate administrative structure to implement a measure of this nature. In a large number of cases persons may not even know their age as the system of recording of births and deaths has yet to become fully operative. It will, therefore, be desirable to rely on an educative approach.

Child Bearing Age

In the overall framework of the welfare concept one factor which is directly related to the concerned individuals, particularly females, is that of their own health and the well being of their offspring. There are specific indications regarding the ideal child bearing age. It is well-known that when a mother is under the age of 17, the infant mortability rate is quite high and yet 60% of first child births in India are estimated to be under this age. At the same time the fertility is relatively low and the overall demographic effect of wives bearing their first child below the age of 17 may not be that substantial. This however, should not be accepted with a feeling of relief. There are two factors which we should consider in this context. The first of these relates to the age composition of India's population and distribution between rural and urban sectors. The second concerns the relevance of postponement of births.

Age Composition of Indian Population

The breakdown for the estimated population by age and sex, as on 1 March 1978, shows that the population of India is heavily weighted in the favour of younger age groups. Out of 135 million females of reproductive age, 42% were in the age group of 15 to 24. The net annual addition to the reproductive age group is estimated to be over 4 million (Table 1). There is also cause for concern when we observe that for 14% of rural couples the age group of wife

was 15 to 19, and for 20% of them the age group of wife was 20 to 24, according to the 1971 census data. To what extent this has progressed in the favour of higher age group of wife will be revealed when detailed data becomes available from the 1981 census.

Young Rural Wives

It may be added that rural couples constituted 80% of the total for the country. It should be also noted that the Crude Birth Rate (CBR) for rural couples having wife in age group of 15-19 years was 24 compared with 16 in the case of urban couples. It is only in the higher age group for wife of 20 to 24 years and 25 to 29 years that the CBR increases to 35 both for urban and for rural couples. The figures in the higher age groups, 30-34 years, 35-39 years and 40-44 years were comparable between urban and rural wives. This clearly indicates the need for focussing much greater attention on the rural couples especially for couples where the wife is in the age bracket of 15 to 19 years (Table 2).

Postponement of Births

The second aspect is that of emphasis on postponement of births in addition to that of prevention of births. This is an important point considering the fact that the family planning programme has been focussed a great deal until recently on families having 2/3 children or more. In recent years some attention has been given to the theme of spacing through the mass media. The appeal

consists in making the couples think about having a second child when the first one goes to school. Only very recently, during the last year or two, the definition of target couples has gradually been enlarged to include families with one child and even the newly married couples who are yet to have a child. We are not concerned primarily here with the economic implications of the postponement of births although that is a factor which should not be ignored. Our basic concern is to substantiate an effective communication approach which will lead to the couples accepting the idea of planning their families in their own interest from the earliest stage.

The First Child

Another important aspect of the same problem is an implicit pressure which acts on most couples particularly in the rural communities and economically depressed sections of the urban communities. This pressure consists in their having the first child as early as possible after the wedding. The birth of a child is almost taken as an evidence of the child bearing capability of a couple. It is still considered to be almost a natural phenomenon. If this does not happen eyebrows are raised and in several instances, and even worse fate may befall the new wife. These pressures emanate from all directions, say the mother-in-law, or women of neighbourhood or even the community in general. One can almost visualise a situation when medical practitioners can give reassurance to the members of the family of newly married couples regarding their child bearing capability. Unless and until motivation is created to plan the first

birth we cannot expect to get a worthwhile solution to the population problem. It is in this context that the physician can play a dual role:

> The first consists of advising the newly married couples, or even those intending to get married, about the value of planning the family as a way of life. It is important for them to know that it is not an unnatural approach.
>
> The second aspect of providing information regarding contraception is important. Ideally such advice must be given to the females on their way to marriage as the burden of carrying the child and bringing it up falls mostly on the women in India.

The above approach is of considerable importance taking into account the fact that level of literacy is still very low in India, and even lower for the target audience we have in mind. It will not be possible to keep on waiting for the literacy levels to catch up with the increasing demands of the population problem. The present communication strategy may of course be directed towards the new target segment taking into various limitations. However, the amount of time required for developing this strategy is a major drawback. Moreover, the reach of media appropriate for effective communication of this nature is yet another formidable handicap. How would one approach a typical tean-age girl from a slum area who is going to get married at the age of 18 years, assuming that the new regulation is being followed by such families. It is possible that such a girl may be exposed to a media like radio or some form of outdoor communication. Will she be in a position to understand

the message? Furthermore, there is also the more important question of being able to understand how contraception is possible, what methods are available and how to make use of an appropriate method of contraception. This is a point to be given due consideration. An indication of the possible acceptance of the concept of having the first child, say, two years after marriage is available from a research study commissioned by the Department of Family Welfare, Government of India. It is pertinent to note that females showed preference for the first child birth at a date later than that mentioned by males. Further, this proportion was 75% in villages compared with 50% in urban areas (Table-3).

Family Size

Family planning campaign in India has been geared a great deal to the theme of family size. As mentioned above, the campaign theme has been gradually extended from large families of two or more children to smaller families with one child, or none. At the same time sterilization is recommended for families which have already completed, or supposed to have completed their family, namely, three or more children. During the period of "Emergency" it almost became mandatory for couples having three or more children to undergo sterilisation. It is not clear whether the programme at that juncture was actually intended to achieve that sort of effect or create that impression of urgency and apprehension in the minds of the couples falling under this category. However, this apparently did a lot of damage in the following year. The number of sterilisations fell from 8.3 million in 1976-77 to 0.95 million in the following

year. During the year 1978-79, the number of sterilisations reached 1.7 millions and the provisional estimates for 1979-80 are the same i.e. 1.7 million. This compares with 2.7 million in 1975-76 and 3.1 million in 1972-73. The number of equivalent conventional contraceptive users, however, was 3.0 million in 1979-80 compared with 3.2 million in 1977-78.

The question of family size is undoubtedly important from the demographic point of view. It is certainly desirable to put forth the norm of a two children family. At the same time we are assuming that the democratic processes operating in the country and have to be given due consideration. It is not merely the question of the principle of upholding the constitutional rights of an individual and trying to prove that democracy exists. The basic issue is that of the acceptance of the welfare concept in the first place. The consideration of the family size should follow. This is particularly important when we are taking into account a high level of infant mortality, inadequate provision of health services and generally a lower level of nourishment and hygiene in the country. Added to that is the sheer economic necessity for the low income segments of the society who are perhaps able to barely make the ends meet with the help of their children who can also contribute to the family income.

The decision regarding the family size should be made by the couple concerned. The decision may be influenced by the overall national considerations as well as the specific benefits they

themselves stand to gain from a small family. This makes all the difference to the basic process of acceptance. Otherwise, it may lead to a race for achieving the target of having two children or whatever and then perhaps go in for sterilisation. In recent years when the emphasis on family planning became noticeable a large number of uninitiated masses perhaps get the impression that they will be subjected to sterilisation. It would, therefore, be in their interest to have as many children as they can before the axe falls.

Choice of the Method

This leads us to the question of the choice of the method of contraception. As indicated above we would like to position contraception not as an end in itself but as a means to planning and phasing the conceptions. This is the application of the basic marketing concept which offers flexibility and discretion to a potential acceptor. In a study carried out at Dr N A Purandare Research Centre of KEM Hospital, Bombay, over a ten year period, from 1967 to 1977, one gets a clear indication of a shift in the favour of sterilisation in the case of voluntary acceptors.[5] In a large sample of 3,376 family planning acceptors, 2,116 opted for tubectomy. Of the tubectomy acceptors, 68% had three children and 31% had two children. On the other hand, in the case of users of oral pills, about 40% had one child and approximately the same proportion had two children. The number of oral pill users was 379. Amongst the 881 IUD acceptors, more than 50 per cent had one child and about a third had two children.

A physician is in an excellent position to give reassurance about family planning and also give information regarding the methods available for contraception. A series of studies undertaken by the Institute for Research in Reproduction, Bombay reveal some pertinent facts regarding the interaction of the physician with the

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5. Divekar, S.A., et.al., "Acceptance of Family Planning, Journal of Family Welfare, Vol.XXV, No.2, December 1978.

potential family planning acceptors.[6] The sample consisted of 500 couples drawn from three states through random sampling. Data was collected for 450 couples. Of these the proportion of couples getting family planning advice from doctor was extremely low, hardly 4 per cent. Doctors tended to be equate family planning advice with sterilisation or DGF, if women were overdue. In this sample 108 women came to know of DGF and 142 of Medical Termination of Pregnancy through various sources including physicians. Another study carried out by this Institute in a maternity hospital on 100 patients showed that they had inadequate or no knowledge of contraceptive methods. This situation is of great concern in a country like ours where a large proportion of women owing to their illiteracy or ignorance could get this information from physicians and possibly from some knowledgeable women. The chances of their not getting any information, as revealed in the above study, or getting misleading information are quite high considering that even lower levels of literacy and awareness prevailed amongst the earlier generations of women in India.

Inherent Apprehension

One pertinent aspect in relation to the acceptance of contraception when it comes to the individual level has remained largely unexplored. There is certain amount of fear and apprehension lingering in the minds of a large number of potential acceptors,

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6. Joshi, Lata, "Assessment of the Role of Health Personnel in the Family Planning Programme", The Indian Journal on Medical Education, Vol.XVIII, No.1, January to June 1979, p.90.

both men and women, regarding the effect of contraceptive method on their health and physique. This is true not only in the case of terminal methods such as sterilisation, but also for the use of simple conventional contraceptive such as condoms. One should not lightly disregard this type of apprehension, which does come in the way of acceptance and implementation of the family planning programme. This fear may be as unfounded as the fear of travel by air or rail. It may be relevant to refer to the earliest motivational studies carried out in the United States regarding inhibition to travel by air. These studies revealed that a number of Americans, who could afford to travel by air in the early days of air travel were disinclined to do so for the fear of post-mortem ridicule. They were not entirely convinced of safety of air travel. The apprehension that people may mock their unworthy decision of travelling by air in the event of an accident put them off from travelling by air. It was, therefore, necessary for the airlines to launch a campaign emphasising the safety of air travel which gradually got rid of this fear. This factor has now receded into insignificance in respect of the decision to travel by air.

The possible risk in contraception to those people who do not have adequate information, or perhaps have misleading information, appears extremely high. In addition to mass media campaign for eliminating this fear, word-of-mouth communication can play a decisive role. This type of communication may be projected as coming from opinion leaders, the village elders, friends and persons from medical

and paramedical profession. An excellent film where a vegetable seller acts as the opinion leader to recommend Nirodh to a young man, has been made on this very theme. A great deal more of intensive campaigning and persuasion is required at the individual level. The human dimension of the problem can only ignored at the peril of defeating the objectives of the programme unless a resort is made to the coercive approach.

Support Services

It must be emphasised that the importance of mass media of communication and a number of other important agencies such as the community health centres, voluntary organisations and opinion leaders is not meant to be underemphasised in the above approach. One has to look at the programme in an integrated fashion. The other aspects of the programme are ante-natal and post-natal care, maternity services and health and nutritional care of infants and children in general. These services are important as the mortality rate is very high for children upto 5 years of age in India. The question of the availability of contraceptive methods and services is obviously of paramount importance. In this respect a reference may also be made to the increased availability of Nirodh condom through the Marketing Programme of the Government of India operated in collaboration with fourteen companies having extensive distribution work. This may all be put in the overall marketing framework where the distribution aspects, that is the accessibility of the target audience to the means

and methods, help increase the chances of acceptance. Data obtained from a Department of Family Welfare study on persons/organisations suggesting the use of Nirodh affords a comparison of the role of doctors vis-a-vis other agencies (Table-4).

A W.H.O. sponsored Seminar on Social Marketing of contraceptives was convened at Hyderabad in October 1979 by the Department of Family Welfare, Ministry of Health and Family Welfare, Government of India. This Seminar brought together the concerned government officials, the executives of the companies participating in the Nirodh Marketing Programme and representatives from their distribution channels. Persons from selected management institutions were invited to present the theme papers on the three areas covered by the seminar, namely Communication, Organisation and Distribution. The theme paper on Concept Selling and Communication dealt specifically with the question of creating conditions for the acceptance of voluntary contraception in the overall context of family welfare.[7] This paper emphasised the need for effectiveness of communication so that the theme may be fully appreciated at the individual level.. The questions of younger age groups in the population of the country and particularly a substantial proportion of females of reproductive age group in rural areas and amongst the under-privileged sections of the community in the urban areas were dealt with. The qualitative aspects of communication, namely, how to develop themes

7. Mohan, Manendra, "Concept Selling and Communication", Paper presented at the W.H.O. Seminar on "Social Marketing of Contraceptives," Hyderabad, October 1979.

which may be understood by a large proportion of target population, most of whom may be illiterate, was considered to be a crucial one. The question of communication was also considered important at the distribution level. When it comes to selling a product like Nirodh inhibitions also exist even in the minds of those dealers who may be stocking Nirodh. The Marketing Executive of Department of Family Welfare highlighted the importance of promotional methods such as display contests in order to motivate both the potential buyers and the dealers.

Social Obligations of Physicians

The present level of involvement of physicians appears to be somewhat limited both in terms of reach as well as the perception of their role in family planning. This is partly reflected in confining the deliberations the series of conferences and seminars mentioned above largely to allopathic systems. There seems to be an over-emphasis on the narrow professional role of the physician as indicated in the study by Lata Joshi.[8] It is encouraging to note that an extension of the role of physician has been sought by some of the practitioners by recommending that the physicians should consider themselves as social scientists.[9] This is certainly in line with the spirit

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8. Joshi, Lata, op.cit.

9. Mukhopadhaya, B, "Education of Physicians for Playing a More Effective Role in Bringing About Population Change Through Fertility Regulation and Other Aspects of Family Health", Indian Journal on Medical Education, Vol.XVIII, No.1, January-June 1979, p.68.

of effective communication which is sought to be achieved for the success of the programme. It will not be out of place to mention that patronage system still plays a dominent role in the medical profession. This perhaps comes in the way of taking a more broad based approach to the problems of the society. It will be necessary to chart out new paths where social obligation of professional should be accepted as a part of his overall responsibility. This social obligation indeed applies to other professions and occupations as well. In the case of medical profession it is even more relevant as medical education is extremely expensive and its cost is largely borne by the society. Moreover, medical education is directly dependent on the society for its experimental material.

The Time Dimension

Needless to add that the time dimension of the problem is crucial. It is not unusual to hear at conferences and seminars figures relating to the number of births per minute and per hour and so on. However, one clearly gets the impression on analysing the formulation of various programmes and their effectiveness that many such projections of doom outlive their utility in these gatherings. An effective use of this type of data has been made in films which emphasise the adverse effects of overcrowding i.e. shortage of resources, din and noise and tension arising from rapidly expanding population. That is certainly an effective use of the fear appeal. It is far more important to disaggregate the components of the overall family planning and welfare programme broken down by regions, locations and areas as well as sources of advice and information and delivery

systems. It is necessary to streamline systems for provision of services and impart a sense of urgency at all these levels. A physician, of all persons, is much more siezed of the importance of time. He is in a position to effectively convey that sense of urgency both to the patients, as well as other agencies and organisations participating in the effort.

The Welfare Concept

The concept of welfare is very comprehensive and is basically related to the question of quality of life. There are several facets to the quality of life, many of which appear to be somewhat far fetched considering that almost half the population in India continue to remain below the poverty line. Yet, it is in this segment of the country's population that the need for acceptance of family planning is the most acute. Quality of life is obviously understood by the middle and upper income groups as relating to the comforts, facilities and conditions for increasing the efficiency level, entertainment and enjoyment, providing for adequate means for the younger generations and so forth. However, for the masses of people things which matter most are obtaining the basic wherewithal namely food, shelter and clothing for themselves and their children. Even the provision of minimal educational facilities for children may not mean very much to them. Education at school level or higher does not itself indicate a secure future. Moreover, in a highly labour intensive economy availability of more hands holds immediate promise of a marginal increase in the earnings of the family.

There are certain features of welfare which are of immediate relevance to all sections of community, especially those who are not in a position to afford the cost of medical advice and treatment such as programmes concerning the health of mothers, at pre-natal and post-natal stages and that of children. The concept of Integrated Child Development Services (ICDS) is one which deserves consideration.[10]

The ICDS is considered as an important step towards human resources development. It has the following objectives:

i. improvement in the nutritional and health status of children below six years of age;

ii. laying the foundations for proper psychological, physical and social development of the child;

iii. reduction in the incidence of mortality, morbidity, malnutrition and school dropout;

iv. effective coordination of policy and implementation amongst the various departments to promote children's development; and

v. enhancement of the capability of the mother to look after the normal health and nutritional needs of the child.

To achieve these objectives, ICDS provides a package of services to children below six years of age, pregnant women and nursing mothers. It includes supplementary nutrition,

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10. Dayal, M.S., Integrated Child Development Services, Health and Population Perspectives and Issues, Vol.2, No.1, March 1979, pp.80-81.

The Expand Programme of Immunisation (EPI) is an important programme aimed at reducing the incidence of morbidity and mortality owing to childhood diseases.[11] The EPI presently covers diseases like diphtheria, whooping cough, tetanus, tuberculosis, polimyelitis, measle and smallpox.

Conception Guidance

The availability of improved maternity facilities, especially in small towns and rural areas is not known, or at times not accepted by women who need them most. The same applies to provision for pre-natal care of women. The overall impact of these programmes may be seen in ensuring proper nutrition to pregnant women, safe delivery and care of mothers and children. This would increase the chances of survival of children and their leading a healthy life. The emphasis will thus shift to quality of life. The present trend appears to be have more children almost as a means of insurance against low survival. Physicians are in a most suitable position to impress these aspects of couples and concerned families.

It is important to reiterate the oft pronounced motto, and yet so often ignored in the context of the programmes of family planning. The objective of family planning is not a mere reduction in numbers. This is a plain fact and yet so often ignored. It is equally important

to ensure that the existing population is also capable of moving towards the goals the society has set for itself. The qualitative aspects of the demographic profile are not less important than the numbers, age groups, rates of growth and regional disparities and the like. Therefore, it will be desirable to develop a concept of Conception Guidance to which contraception should be treated as a via-media and not the other way round. It is in this respect that a physician will be in an ideal position to put across some of the basic features of quality of life such as health and vigour and physical well being in a limited but extremely effective way.

Concluding Comments

At the time of completing this paper some recent statistics on two important aspects of the problem under consideration has become available. The 1981 Census data which has indicated that the population growth during the last decade has continued unabated. The urgency of the problem is quite obvious. No less important is the question of devising more imanative approach to solving the problem.

The other set of statistics is the provisional data for acceptance of family planning methods, classified in three broad categories, for the first half of 1980-81, i.e. April-September 1980. The data along-with the comparable figures for 1979-80 is reproduced below:

Period	Sterili-sations	IUD inser-tions	Equivalent conventional contracep-tive users	Total Accep-tors
			(million numbers)	
April 1979-March 1980	1.736	0.620	2.992	5.348
April-Sept. 1980	0.700	0.257	3.267	4.224

The half year data for the 1980-81 is encouraging as the total number of acceptors for the full year by simple extrapolation may exceed eight million which will be higher than the 'pre-Emergency' peak of 6.8 million. It is even more encouraging to note that the conventional contraceptive usage which clearly indicates greater acceptance of non-terminal methods of family planning has almost doubled compared with 1977-78, the 'post-Emergency' year.

The role of the physician at the present juncture is far more vital than perhaps at any time before. In our communication spectrum, as outlined on page 7, a physician can play a major role at the stages of comprehension and conviction. The level of awareness and receptivity is appreciably high and can be further augmented and supported by mass media. However, the breakthrough is yet to come in the following two stages which in turn lead to action. Opinion leaders drawn from all sections of community and the medical and para-medical professionals can achieve a great deal in encouraging the adoption of the concept of Family Welfare for which family planning, better still - Conception Guidance, as outlined above, should be treated as via media.

The conviction in respect of adopting family planning as a way of life for the bulk of the target population will come only when they accept it as a natural process and not something imposed on them. The physician supported by para-medical personnel and community health workers is ideally suited to drive home this message. This may be achieved in the course of usual professional advice to patirnts. They can bring to bear the onus on individual target units, couples and families, rather than make a general appeal.[11]

The social obligation of physicians requires them to go a step further. They should voluntarily offer to interact with the target groups in appropriate forums. The question of the choice of an appropriate method is vital. There is a great deal more attention required to be given to this aspect than has been done so far. If the physician in his socio-professional capacity can help remove the apprehension of potential acceptors and convince them that there exists a method which they can safely adopt, a lot of ground would have been covered and the way paved for the final stage of action.

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11. Basu, Alaka Malwade, makes a story case for viewing contraception as a matter of individual rights rather than duties. Vide Family Planning Numbers Game Goes On, Economic and Political Weekly, Vol. XVI, No.14, 4 April 1981, at p. 632.

Tva
Mar./Apr.81.

TABLE - 1.

PROJECTED POPULATION BY AGE AND SEX AS ON 1 MARCH 1978

In Thousands

Age Groups	Person	Male	Female
15 - 19	67,298	34,985	32,313
20 - 24	56,295	29,074	27,221
25 - 29	47,505	24,286	23,219
30 - 34	41,116	20,930	20,186
35 - 39	35,865	18,394	17,471
40 - 44	30,996	16,165	14,831

Source : Government of India, Ministry of Health & Family Welfare, (Department of Family Welfare), Family Welfare Programme in India Year Book 1977-78, New Delhi, p.28.

TABLE - 2

NUMBER OF MARRIED COUPLES - ALL INDIA

(in thousands)

Age Group of Wife	Number of married couples					
	Rural		Urban		Total	
	Number	Rate per 1000 popn.	Number	Rate per 1000 popn.	Number	Rate per 1000 popn.
15 - 19	10,533	24	1,790	16	12,323	23
20 - 24	15,353	35	3,768	35	19,120	35
25 - 29	15,579	35	3,869	35	19,447	35
30 - 34	13,599	31	3,203	29	16,802	31
35 - 39	11,517	26	2,794	26	14,310	26
40 - 44	9,092	21	2,046	19	11,138	20
Total (15-44)	75,673	172	17,470	160	93,140	170

Based on revised 1971 Census sample tabulations

Source: Government of India, Ministry of Health and Family Welfare, (Department of Family Welfare), Family Welfare Programme in India Year Book 1977-78, New Delhi, p.29

TABLE-3

NUMBER OF YEAR AFTER MARRIAGE
THE FIRST CHICD DESIRED

Family Planning Practice	Current		Lapsed		Never	
	M	F	M	F	M	F
Metro & Class I Cities						
1 Year	11	14	11	10	14	9
2 Years	39	50	40	46	35	30
3 Years	27	16	33	24	25	30
4 Years	8	12	6	18	9	12
Class II & Small Towns						
1 Year	16	-	11	8	12	11
2 Years	32	50	40	36	36	22
3 Years	32	33	26	36	28	26
4 Years	11	-	10	16	11	15
Villages						
1 Year	16	12	30	14	30	11
2 Years	60	75	45	71	32	67
3 Years	20	12	20	14	31	22
4 Years	7	-	4	14	10	11
Sample Size	Class I : 904		Class II: 589		Rural : 302	
Initial Sample	Class I : 4980		Class II: 4880		Rural : 1489	

Percentages

Source: Unpublished Research Reports of Department of Family Welfare, New Delhi, November 1980.

TABLE 4

SOURCE OF RECOMMENDATION FOR THE USE OF NIRODH

F P Practice / Suggested by	Current Users %						Lapsed Users %					
	Metro & Class I		Class II & Small Towns		Village		Metro & Class I		Class II & Small Towns		Village	
	M	F	M	F	M	F	M	F	M	F	M	F
1. Doctor	20	17	27	33	9	-	16	10	12	20	21	14
2. Health/ FP Centre	8	3	1	4	9	12	6	1	3	4	8	-
3. Social/ FP Worker	1	-	4	12	2	-	2	-	14	4	2	-
4. Friends/ Relatives	27	22	13	38	42	50	27	28	33	34	27	71
5. Advertising	4	6	5	-	7	-	4	5	2	-	-	-
6. No one/ No opinion	44	52	42	16	34	38	50	57	37	30	41	15
Total	100	100	100	100	100	100	100	100	100	100	100	100
Sample Base	237	65	156	41	80	21	234	63	153	43	81	20

Source: Unpublished Research Report of Department of Family Welfare, New Delhi, November 1980.