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GSA-14
India: Family Planning I

25A Nizamuddin West
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Mr. Richard H. Nolte
Executive Director
Institute of Current World Affairs
366 Madison Avenue
New York, New York

Dear Dick,

Having sent my own baby off to Oxford Press (a slightly abashed plug for a volume on the framing of the Indian Constitution), I have been taking a look at India's population problem and at attempts to solve it.

Population and its partner, agricultural production, are India's most basic problems. They both appear to be nearly intractable, and to make matters worse they must be effectively solved in the immediate future. The situation boils down to this: the population is increasing rapidly and food production is not keeping up with it. Additionally, industry is not expanding fast enough to absorb the growing labor force. According to the 1961 census, the population of India was 439 million. It was predicted by the Central Statistical Organization of the Government of India that by mid-1963 the figure would be about 464 millions. It is now the end of 1964 and this year alone, according to the latest figures, there are 10.8 million new mouths to feed. So as this is written the population is nearing 480 million. This is a growth rate of about 2.2%. The growth rate for the decade ending 1951 was approximately 1.3%

India's overall population growth rate in 1961 was about that of the United States. Yet India is considered to be in the early stages of a 'population explosion'. There are several reasons for this. The U. S. growth rate is fairly steady but the Indian has almost doubled in two decades. India also is starting her 'explosion' with a base of 480 millions, whereas the U.S. population is 200 millions: More people produce more children who produce more children. The Indian birthrate is not increasing markedly, in fact it has been declining until the last decade, but the deathrate is dropping rapidly. Between 1881 and 1891 the birthrate was 48.9 per thousand individuals and the deathrate was 41.3 per thousand. From 1891 to 1901--years of two bad famines--the birthrate was 45.8 and the deathrate 44.4. Between 1941 and 1951 the birthrate was 39.9 and the deathrate 27.4. And in the last ten years only 22.8 persons died for every 41.7 per thousand who were born. (These figures come from the Economic Weekly published in Bombay, which notes that birth and death registration here is "seriously incomplete".) This drop in the deathrate has been due to the curbing of the great killers, famine and cholera, to the increasing control of other diseases like smallpox and malaria, and to great improvements in sanitation and public health generally. Life expectancy has, therefore, gone up remarkably fast. The census calculated that 41.2 years was the average life expectancy in the period 1951-1960, whereas it had been 32.1 years during the previous nine years. Computed for the year 1961 by the

Economic Weekly, life expectancy in 1961 was 45.8 years and was expected to increase about one year per year. The Third Five Year Plan, 1961-1966, has been using the figure of 47.5 years. All these factors point toward an increasing growth rate of the population in the near future, despite the not-too-high percentage of the birthrate itself. India seems to be far from the point where improved social and economic conditions and a much higher educational level might cause the growth rate to level off of itself.

The more than 22% increase in population that India experienced between 1951 and 1961 in large measure vitiated the quite respectable accomplishments of the first and second Five Year Plans, and there is no reason to believe that the Third Plan will be any less affected. Moreover, agriculture has responded less than other sections of the economy. India cannot feed itself, nor can it yet provide the increasing manpower with gainful occupation. The Planning Commission, according to Professor M. S. Thacker, a scientist and commission member, assumes a growth rate in the GNP of about 5.5%, but, he says, a population growth rate of 2.2% or perhaps 2.5% reduces the GNP rate to only 3%. This is 2.75% lower, according to Professor Thacker, than the nation needs for its economic survival. The planned increase in national income from 1951 to 1964 was 60%. Actual growth has been 52%, according to Professor K. N. Raj, one of the country's most respected economists, Manufacturing has grown 5% to 7% annually, but agricultural production during the period did not grow in a sustained and adequate manner, which has been due in part, says Raj, to the increased demand for food resulting from the rise in manufacturing. In some years food production grew by 2.5%, but in the last three years there has been almost no increase. In 1962 India produced 78.5 million tons of food grains, the staple diet, nearly 21 million tons more than in 1951. Yet because of the rise in population, this put only 2½ ounces per day more of chapatties or other flour-based foods and rice in the mouth of the average Indian, who has long lived on a subsistance diet. The last five months have seen the worst food shortages in India since independence, shortages of both wheat and rice but primarily of wheat. The effect of the scarcity has been heightened by the rise in prices--which has been in part due, according to K. N. Raj, to the "lagged" effect of the sudden jump in defence expenditure since the Chinese attack two years ago. The price of wheat on a national average has risen 50% during the past six months, according to the Hindustan Times. This year India is importing six million tons of American wheat to prevent famine.

The food shortage and the extent to which population growth has cut into the achievements of the Plans has caused the Government, somewhat belatedly, to talk in terms of a large-scale effort to control the population by cutting the birthrate. Ashoke Mehta, the deputy chairman of the Planning Commission, has spoken of allocating one billion rupees, about $200 million, for family planning in the Fourth Plan. He has been quoted in the press as saying that unless the nation wars against the population explosion, it "cannot escape social explosions and political upheavals". Mehta and others have also said that it is essential to halve the birthrate in ten years. Dr. Hugh Leavell, formerly a professor at the Harvard School of Public Health and presently a Ford Foundation consultant here with the National Institute of Health Education and Administration, thinks that this goal, although ideal, is higher than will be achieved. Colonel B.L. Raina, the Director of Family Planning in the Ministry of Health has set his sights a little lower. He aims at a goal of 25 births per thousand population by 1973, a drop of 40% from the present birthrate. The statistically-average family in India today has more

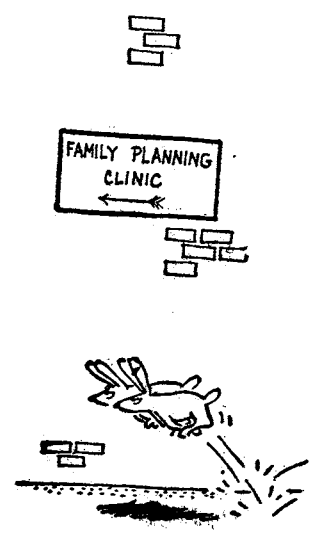
than six children. The family planning program is appealing to parents to limit their children to three.

The family planning organization as it now exists is not up to this task. It will have to be greatly expanded and perhaps partly redesigned. Plans for expansion already exist and to some extent are being realized. Additionally, an effective contraceptive method for mass use in a primarily peasant population will have to be found. The family planning program is now headed by a Director for Family Planning in the Ministry of Health, Col. Raina. Above him is the Director General of Health, the Secretary of the Ministry, and then the Health Minister, Dr. (Mrs.) Sushila Nayar. Under Col. Raina in the hierarchy come the directors and ministers of health in the state governments and under them the state family planning directors. Below them, when they are appointed, will be the district family planning officers of the more than 300 districts into which India is divided for administrative purposes, and at the bottom of the ladder are the family planning service centers, the primary health centers, the municipal government organizations, and the voluntary organizations that are working directly with the people. At present all the states have family planning directors, but only about five, a senior official told me, are thoroughly acquainted with the program and are energetically furthering it. Several state directors are burdened with other work, and several seem not to have grasped the necessity or the principles of the program. At the district level only about 50 family planning officers have been appointed. At the mass level, there are 9200 rural and 1700 urban service centers, according to Col. Raina. The rural figure includes the 5300 primary health centers, which deal with other medical and public health programs and activities. At all of these places, advice on family planning and contraceptives are available, I am told.

Parallel to the administrative structure will be a hierarchy of advisors. At the top is the Central Family Planning Advisory Board, formed in 1956, which is meshed with the Planning Commission and the Cabinet. The Union Health Minister heads the Central Advisory Board and Col. Raina is its secretary. Among its members are the state health ministers and the directors of the national volunteer organizations like the Red Cross and the Bharat Sevak Samaj that are aiding the family planning program. Attached to the Central Advisory Board are advisory committees on demography, communications (how to gain the masses' acceptance of birth control), and the scientific and technical aspects of birth control. Extending downward from the Central Board will be advisory boards at the state, district, community development block, and village levels. As yet these advisory boards are not much in evidence.

Working along side government officials below the state level will be a number of honorary family planning education leaders--'rupee-a-year' men and women--who will help popularize family planning among both the rural and urban populations. Such persons may well do good work. So

Out Of My Mind
—BY SUDHIR DAR



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The Statesman

far, however, the more important role in bringing the message of family planning to the masses has been done by the volunteer organizations. There are those like the Red Cross and the Bharat Sevak Samaj, as has been said, and the many family planning associations throughout the country. The volunteer organizations have a parent body, the Family Planning Association of India, with headquarters in Bombay, and subsist largely on government grants. These groups do educational work and in many cases also establish channels for the distribution of contraceptives. Although the Bharat Sevak Samaj is active primarily in the countryside, the majority of family planning associations exist in urban areas. For this reason their impact, no matter how good their work, has been and must be marginal: only 18% of India's people live in towns; most are on the land. Some industries, for example the Tata steel mills in Bengal and the Delhi Cloth Mills in old Delhi, have begun family planning campaigns among their workers. Their efforts have not yet shown appreciable results, and if they do, helpful as any contribution will be, a reduction in urban population will but touch the fringes of the population problem. The volunteer organizations, if they receive adequate government aid, and if their efforts are closely coordinated with the government's program, can be immensely helpful in family planning work.

Before returning to the government's family planning efforts, we may look briefly at how three volunteer organizations are approaching the problem. The Delhi and the New Delhi Family Planning Associations, the former is ten years older than the latter, are both active in the rural areas of Delhi state as well as in the city. The Delhi FPA has one male social worker and three female health visitors--soon to be augmented--as full-time staff and the services of two doctors are available. There is a paid office staff and the executive positions are filled by upper middle class men and women who donate their time and effort. One of the association's two working groups operates in the rural areas, the other in the city among small shopkeepers and in the "slums"--which includes the areas where the bulk of the population lives. Each of the health visitors is assigned an area and visits the families in it to advise on general health matters and maternity welfare. If a couple has produced its third or fourth child, the worker suggests how to prevent more. She can issue free contraceptives if they are desired. The association also runs a clinic where it holds discussion groups, shows films, and so on--film showings, exhibitions, etc. are also held in various places in the city--and where men and women can come for family planning advice and contraceptives. The clinic will arrange for male and female sterilizations. The New Delhi FPA has similar programs. Neither group bothers with the economically advanced classes, who are sophisticated enough to plan their families and to seek out medical advice, or with the million or more government servants, who can make use of the family planning workers of the government's Contributory Health Scheme.

The New Delhi FPA recently completed a campaign in the village of Okhla, not far from where we live. In August the association's workers began to concentrate on the village. The first step was to gain the interest and cooperation of the officials, the schoolteacher, and the most respected elderly men and women. If any of these persons was especially interested, he was given training and a certificate as a family planning worker. The workers then organized film shows and distributed literature; they held individual and group talks with the village leaders present. In November there were mass meetings and the association brought as speakers a man and a woman who had been sterilized. This approach is most important because there is a common fear that

sterilization will result in physical damage or impotence. Generally speaking, however, sterilization, particularly male sterilization or vasectomy, has proved more acceptable in India then in Europe or America. During the period when this orientation and motivation is being carried on, the association established 'depots', that is, enlisted men and women who would keep contraceptives and distribute them on demand. Should a husband request to be sterilized, the association assures itself that the couple understands what it is doing and then obtains its consent in writing and immediately sets a date for the operation. If the man appears at the association's clinic in New Delhi--ten miles fron Okhla--at the appointed time, he is operated upon (a matter of ten minutes), given encouragement and a cup of tea, some cautionary advice, and the sum of thirty rupees to compensate him for transportation and the loss of wages during the three or four days away from work. He then goes home. Villagers trained by the association and its workers check to see that the man recovers properly. If four or more persons request sterilizations at the same time, the association will provide transport to the clinic. Next week the association is scheduled to perform several on-the-spot vasectomies--female sterilizations demand hospitalization--but prefers to use its clinic because it is more hygenic. If the demand for vasectomies increases greatly, the association will ask the government for a mobile clinic. In the meantime the successful vasectomies, the association's director hopes, will encourage a large number of other men to follow suit.

The Bharat Sevak Samaj is one of the most distinguished of India's volunteer organizations. Formed in 1952 to enlist the people's cooperation in achieving the goals of the five year plans, it chose Nehru as the first president and G.L. Nanda as the first chairman. Nanda was then deputy chairman of the Planning Commission; today he is president of the Samaj and is a member of the Planning Commission and Home Minister. Because of its Gandhian background (Gandhi advocated abstinence as a means of limiting families and preached against contraception), the Samaj for some years refused to join in family planning work. Under the influence of certain leaders, notably Dr. D.R. Mehta, now secretary of the health and family planning sections, the Samaj reversed itself and in 1962 decided to take up the cause. Work began in the winter of 1963 when the Samaj held three camps for training its own labor and health workers in family planning and in how to organize family planning orientation camps. After being themselves trained, these workers set up 183 camps in the countryside where each camp could draw on the populations of a half dozen to a dozen villages. Nearly 11,000 persons attended the three-day camps, most of them village leaders and social workers. The purpose was to send these individuals back to their villages as advocates of family planning. Additionally, two or more of the most promising campers from each village were specially designated to carry on further family planning propaganda in the villages and to provide guidance for the families seeking it. During the cold weather of 1963-64 the Samaj held more than 500 such camps, and this winter it hopes to nearly double that number. The specially chosen workers, however, were not always given contraceptives to distribute on their return to the villages because the Samaj lacked the money to buy them. The reason for this lies in the financial relations between the volunteer organizations, a subject I'll take up later.

The susceptibility of the urban workers and the peasants to the efforts of the family planners, whether government or volunteer, generally speaking seems to have been favorable, although hesitant if not apathetic. The Health Minister has said that 70% of Indians want to limit their families, but Delhi officialdom's view of the masses is frequently a reflection of its

own desires. A study done in the Punjab several years ago, on the other hand, indicates that the percentage may not be far wrong. Yet a good deal of initial resistance will have to be overcome. There are varying reasons for the resistance to family planning. The bride who might want to put off having children for a few years may be under pressure from mother-in-law to become pregnant in the first year to prove that she is not barren. A woman who wants to stop having children may be prevented from using contraceptives by her husband, and some women use them secretly. A family with girl children will usually not stop having them until at least one son or even two are born. Sons are auspicious; there should be one to light the father's funeral pyre; and sons mean more help for father in the fields. Children are considered a "gift from God" and it is widely believed that to prevent them is a sin. But this belief seems in many cases to stem from a confusion between preventing conception and abortion, family planning workers have told me, and when it is explained that family planning means the prevention of creation rather than the killing of the created, much of the resistance to contraception disappears. Believing in reincarnation, many couples think that to prevent conception and birth is to prevent the rebirth of a soul. This belief can be successfully countered, according to several family planning workers, by arguing that a soul is reborn for fulfillment and that it is better for the soul to wait until it can be housed in a body that will be well-fed and healthy, else it might retrogress.

Men, it appears, are more against contraception then women. One reason is that the family planning program has so far concentrated on women. Another is that men often believe that women family planning workers are trying to turn their wives against them. Also men perhaps more than women distrust the new-fangled and the unknown. Villagers react favorably to frank physiological lectures, if delivered in a matter-of-fact manner, according to Dr. Mehta of the Bharat Sevak Samaj, and thus this husbandly suspicion can be overcome. Those family planning workers I've talked with disagree as to whether the husband or wife responds better to arguments concerning household costs and child welfare. But in any case these are the main points that family planning workers try to make: that if a couple has fewer children they can clothe, feed, and school them better for less money. Among the poor, however, and nearly everyone here is dirt poor, this argument often has little affect. The children wear rags, they don't go to school and even a five-year-old may earn a few rupees a month toward the cost of food. But if villagers can be shown that they and their children will be better off if the number of children can be limited to three or four, and there is good evidence that this can be done, then the family planning program should not founder on the rocks of public resistance and apathy.

The educating and motivating of the Indian masses so that they will not only accept family planning but eagerly cooperate with the government's program is primarily a matter of approach and organization. But the effectiveness of the family planning program, that is, the lowering of the birthrate, depends on the effectiveness of contraceptives. And to a large extent, too, the acceptance by the masses of the idea of family planning depends on the popularity or otherwise of the various contraceptive techniques. To date the program has been based on the use of condoms, foam tablets and jellies, and sterilization, particularly male sterilization or vasectomy. Diaphrams are used only among the upper classes--with whom the program is not greatly concerned. Oral pills have not been used at all, and interuterine devices are presently being used in intensive, small-scale research to test their

effectiveness and acceptance in mass society. In the mass program that the government contemplates, no contraceptive technique is to be ignored. It is hoped that condoms and foam tablets might be distributed, free or for a nominal price, through the same all-pervasive network as betel-nut, bidis (leaf cigarettes), and kerosene, the perennial staples of the common man's life. This so far has not been done for two reasons. One is that the government has not worked hard enough to utilize these distribution channels. The other is that condom production has been a failure. Licenced production capacity (the amount of rubber released by the government) for condoms in India is 81 million a year. Lack of interest among manufacturers, corrupt practices (for example, use of allocated rubber to make other products like nipples for baby bottles and fountain pens), and general inefficiency has kept the actual production to four million, and these of doubtful quality, according to a report written in 1963 by Col. Raina. Thirty million condoms are imported yearly. There are close to 50 million married men in the country. In contrast, India manufactures twice the number of foam tablets that are presently used.

Even if condoms and foam tablets were widely distributed, however, their effectiveness in materially lowering the birthrate is to be doubted. Both have to be in good condition when used, not always possible in a climate like India's. And both have to be handy at the moment when they are needed. This is a great drawback in a society generally lacking the privacy of toilets, cupboards for storing things, and where many persons sleep in the same room. In the villages, all the women may be in one room while the men sleep with the cattle, or the members of the joint family (the couple in question, their children, in-laws, a grandmother, and brothers and sisters) may occupy one small room. Added to these material, if you will, drawbacks, there is also the matter of 'not bothering' found everywhere but especially in a mass of people who anyway may not be highly motivated toward cutting down the size of the family. All this has been discovered by research in various areas. A few years ago a five-year study was made in the Ludhiana District, Punjab. Dr. Helen Gideon (an Indian) told me about it. Dr. Gideon and two workers were assigned villages totalling 4000 persons, which meant about 900 couples. One of the three visited each couple once a month. They found that 92% of the couples said they agreed with the idea of family planning--the Punjab peasant is relatively prosperous and sophisticated. About 60% said that they would use contraceptives and accepted them. Only about 25% actually did use them, however, and after two years this had dropped to about 12%; the couples had lost their enthusiasm and didn't bother to use contraceptives any more. The complaints, according to Dr. Gideon, were those mentioned above. Last of all, the research showed that the birthrate in the villages under study had not decreased.

The same arguments plus others are used by family planners here against oral contraceptive pills. "What peasant woman is going to take a pill 20 days in a month?," exclaimed Dr. Katherine Kuders of the Ford Foundation, who has been doing family planning research in India since 1952. And, as Dr. Kuders and others have said, what about the fast-days when women allow nothing to pass their lips? And what about women who forget to take pills for five days and then swallow five pills at once? And what about the woman who stops taking the pills because her husband has planned to be away for a week but suddenly returns home? The principal fear of Dr. Kuders and others, however, is of the bad side effects that these pills have on some women. A few such cases, they say, could seriously retard the program in a considerable area.

If these methods have to be rejected in India as unsuitable for a mass birth reduction program, what is left? The answer seems to be either sterilization or interuterine devices--and it must be reemphasized that no matter what method is concentrated on, all others must have their place. Sterilization has, on a small scale, been relatively successful. Up to March this year nearly 350,000 men had had vasectomies, and about 200,000 women had been sterilized. So far as a mass program is concerned, the Government has been talking in terms of vasectomy because it is more quickly and easily done and the man does not have to be hospitalized. Vasectomy camps have been held in some states with great success, according to Dr. Leavell, and their 'camp-meeting' atmosphere has produced a sense of pride in the men who were sterilized. Dr. Leavell thinks that a vasectomy campaign might yet catch on if properly handled. Dr. Gideon tends to believe, however, that although vasectomy must not be ignored as a method it will be too time consuming and demand too much equipment, organization, and trained staff to succeed in the five or ten years India has in which to sharply reduce its birthrate. Vasectomies should only be performed by a surgeon or a doctor with surgical training, and India at present doesn't have the doctors to do the work. Of the nearly 5000 primary health centers presently existing only about 80% have doctors and perhaps 20% of these know how to do vasectomies, although it would not take long to train them. But these doctors have from 50 to 500 patients to see a day at a primary health center and have little time for family planning work. Moreover, the 5000 primary health centers can reach only a tiny proportion of the population. According to the Health Minister, from six to nine sub-centers will be established under each primary health center, the goal being a sub-center for each 10,000 persons. But even when this has been achieved, the problem of doctors for these sub-centers will remain. The Government has claimed that 2.5 million sterilizations a year for ten years will halve the birthrate. Many demographers disagree; an estimate of five million yearly may be low, in their opinion. Thus the personnel problem for a vasectomy campaign is appalling.

For this reason, most of the persons I've interviewed place their hope if not their faith in interuterine devices (IUD). These devices, usually of plastic, are in the form of a coil, a figure eight, or a 'Z' and are easily introduced into the uterus. Why the IUD prevents conception is not known, but its effectiveness is well established. Their great value as a contraceptive, particularly in peasant societies, is that they are simply and easily inserted and remain in place almost indefinitely. An attached string allows the woman to check whether the device has been expelled. Research conducted with IUD's in South Korea and Taiwan, where conditions are similar to those here, has proved them very successful. And Pakistan has already begun a national family planning program based on IUD's, but it has encountered serious difficulties due to inadequate preparatory research. The Indian Government took an interest in IUD's in 1962 after reports of their successful use had been made at the first international symposium on their working. There are now more than 50 centers in India where they are being tested in sample populations. Dr. Kuders of the Ford Foundation has been given the job by the Government of overseeing these experiments and collating the results. The evaluation of the research is going on now, according to Dr. Kuders, and in January this coming year there will be a meeting of the Indian Council of Medical Research to discuss the results. Dr. Kuders is reserving her judgement until all the results are worked out, but she hopes that they will be favorable and that the meeting of the Council will be able to make a decision about their use and manufacture in India.

The value of the IUD, if the tests are successful, needs little elucidation. The device will have to be introduced by a doctor trained to do so and able to give pelvic examinations. But the time needed to do this is a great deal less than that needed for vasectomy. Moreover, research now being started by Dr. Gideon may demonstrate that highly trained personnel who are not doctors can safely introduce IUD's. And the cost of a program based on IUD's would be infinitely less expensive than one based on vasectomy. Also, a device that can be placed semi-permanently like the IUD is obviously not so haphazard as other contraceptives, and it also meets the request often heard by family planning workers for long-term protection. "Can't you give us a pill or an injection that will last for months or a year?," is a common demand, they say, particularly from women. But most important, the IUD can be placed at the moment the couple has made up its mind to limit its children. Had the IUD been available during the Ludhiana District Survey, the 60% of couples that accepted contraceptives could have been rendered non-reproductive, instead of the 25% who actually used the contraceptives (and then neither carefully nor for long) that they had been given. These devices can occasionally produce adverse reactions, like several copious menstruations, but such possibilities can be explained to a woman and should pose no major problems, according to Dr. Kuders. In this respect, as well as in others, IUD's are considered more appropriate for India than oral pills.

If the Indian Council of Medical Research at its meeting this coming January decides that interuterine devices are the thing for a mass family planning program in India, it seems doubtful that the Government is ready to go rapidly ahead with their manufacture or procurement from abroad. Col. Raina, according to the colonel himself, began negotiations in New York City several months ago for the Government to acquire the patent rights to 'Lippi's loop', a well-known interuterine device. He expects that modifications in the loop andin the simple mechanism for introducing it may have to be made. When they are--and if research has proved them successful here--the Government will decide whether to undertake their manufacture itself or licence it for private industry. The estimated cost of manufacture in the United States, according to one man here, is ten cents. It is hoped that this price can be duplicated here or even reduced to 12 paise or 2.5 cents. This is the plan. But as one American put it, "There is many a chit between the cup and the lip." And there is discouragingly good reason to doubt that action will be taken quickly. For example: The quantity and quality of condoms made here has been officially acknowledged to be bad. As a result, the Health Ministry proposed to the Cabinet that they should be mass produced in a public sector factory. But the files on the suggestion have been moving from ministry to ministry for from six to eight months, Dr. Nayar, the Health Minister, told me, and no decision is yet in sight. Other examples: The Union Government's Family Planning Training and Research Center in Bombay has been without a Director for a year. The Center's primary function is to train doctors and health visitors in family planning techniques. The high-powered committee on family planning, consisting among others of the ministers of agriculture and external affairs and the deputy chairman of the Planning Commission, that was appointed in August to give urgent consideration to the problem met first on 16 December.

This lack of urgency, of dynamism, seems to characterize the Government's approach to family planning, although several members have taken a strong interest. "There is a lot of lip service given to the subject," Dr. Nayar told me; "there is loud talk, but they read their papers and it takes six months to get anything done." I am not sure how far Dr. Nayar herself is

willing to press her colleagues in the Cabinet and the health ministers in the states--on whom the success of a family planning program largely rests because health is a state subject under the Constitution. "There is no way of convincing the unconvinced," she says. Yet without steady, skillful Union Government pressure and supervision no large health program--or any national program--will succeed. The National Malaria Eradication Program (GSA-13) has proved that. Demonstrating this point equally are the attitude and the efforts of Dr. Nayudamma of the Central Leather Research Institute in Madras. (See CHGO-34). There seems to be some fear here of using authority. An eminent Kings Counsel is supposed to have said that to cross examine is not to examine crossly. Perhaps the implicit lesson for the Cabinet is that it can be authoritative without being authoritarian.

The organization to carry family planning to the villages that has been begun and whose expansion has been so carefully planned by Col. Raina will not only have to be created in full, someone will have to make it work. Nearly everyone with whom I've talked has emphasized that the family planning program must be the sole responsibility of one man and that decision-making, particularly in regard to financial matters, must be faster. At present Col. Raina has other work besides supervising the family planning program, and the Union Public Service Commission is only now advertising for four regional officers to act as his liason with the state governments. Moreover, Col. Raina seems to have to refer too many matters upstairs. Many files must go to the Director General of Health, thence to the Secretary of the Ministry, and to the Health Minister for decisions. To remedy this situation several persons have recommended that a Joint Secretary--who would be next to the Minister in authority--be appointed in the Health Ministry to run the family planning program. Dr. Nayar seems doubtful about this idea, and she rejects suggestions for a separate family planning ministry. She would even increase the scope of the program by making it part of a 'family welfare' program. There are some sound psychological, if not administrative reasons for this. Individuals sometimes shy away from the 'family planning' clinic or mobile unit because they are embarrassed about collecting contraceptives. If a woman or a couple should go to a 'family welfare' clinic, however, they could be consulting about Junior's worms or cut hand. Also, maternity workers and others could spread the word about family planning while calling on families for other reasons. But the danger in the scheme is that the energy that should be concentrated on family planning by the director and by all concerned might be diffused among the other goals.

The criticisms of the family planning program most frequently made to me were directed at financial procedures. From government servants to the heads of volunteer organizations, few had good things to say about the Finance Ministry--an attitude prevalent no doubt in many countries, but perhaps in part responsible here for the low expenditure on family planning; the provisional budget for the family planning program for 1963-64, the largest budget so far, was only 10% of the minumum amount allocated for the program under the Third Plan. The volunteer organizations were particularly critical. "We have to go to the Government and beg for funds," one director said. "Every account, even if it's only for a few rupees, and in the countryside accounting is bound to be a little shaky, must be certified by a chartered accountant," said another. "We have submitted accounts for 95% of our training camps held last year," said a third director, "but we can't get our grant until we have submitted all the accounts." Many of the village workers of one volunteer organization have no contraceptives to distribute because the organization

lacks the money to buy them; the Government pays 100% of recurring expenditures of voluntary organizations, but only in the form of repayment, not in the form of grants against possible costs.+ One man said to me, "I've told Sushila Nayar that the Government must come to the volunteer organizations. But she says they must come to the Government." A senior official of the Central Family Planning Institute strongly believes that grants to voluntary organizations should be made in anticipation of costs, but this is not yet the Government's attitude. Many of the absurdities in accounting procedures have been acknowledged in Col. Raina's extremely frank and self-critical report of the family planning program published in 1963, and the word has gone out that they must be stopped. But the minor officials in the countryside and in the Finance Ministry, an American involved told me, have not yet heeded the suggestion.

The Government of India is fast reaching a moment for decision. If the evaluation of the research on interuterine devices shows them to be suitable to Indian conditions, the tool for a mass birth control program will be available. Then it will be up to the Government. I am by nature an optimist, but I can't forget the near dispair of a doctor who has worked in demography and family planning in India since the late thirties. "The Government is fiddling while Rome burns," he said. And I would add that this time we all may feel the fire.

Yours sincerely,

Red Austin

Granville Austin

+ The Government does make grants to volunteer organizations and to the states on the basis of budgets submitted for the forthcoming year. But it seems to do this in a hypercautious fashion and will not grant funds named in the following year's budget until detailed accounts of the current year have been rendered. And if an organization exceeds its budget, it cannot get more money until the next year.

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