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THE POLITICAL DETERMINANTS OF FERTILITY CONTROL
POLICY IN SOUTH ASIA

by

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B.A., The University of British Columbia, 1978

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
(Department of Political Science)

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

June 1982

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ABSTRACT

This thesis presents a comparison over time of the fertility control policies of India, Pakistan, Bangladesh, and Sri Lanka. It is a search for commonalities and idiosyncracies among the determinants of the three major elements of fertility policy, namely: (i) the fertility policy fact, (ii) shifts up or down in the vigour or coerciveness of fertility policy, and (iii) specific measures taken to control population growth on the subcontinent.

The development of these policies is divisible into three distinct phases. In the first phase the appearance of fertility control on the public policy agenda is explained. The shift into the second phase -- in which government activity in these countries took a dramatic upturn -- is then accounted for. This shift occurred when it became apparent that motivation of fertile couples was at least as important as providing them with the means to prevent conception, and was, accordingly, marked by a succession of "crash programmes" to attain both these objectives. In the third phase -- characterized by experimentation with policy concepts which go beyond the traditional practices of family planning -- India's experience with compulsion in fertility control policy is described and explained in contrast to her own and other countries' past policies.

The whole range of determinants of these shifts and choices is divided into five categories of analysis: environment, power, ideas, institutions, and process. The most important of these is highlighted for each

successive shift in policy direction. The thesis argues that the overall pattern of fertility control policy-making reveals that shifts in commitment occurred largely as a result of choices by individual leaders who responded to changes in the demographic and economic environments and, -- in accordance with what they perceived to be politically feasible -- attempted to affect that environment.

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CHAPTER I

INTRODUCTION

This thesis presents a comparative account of the evolution of the population control policies of India, Pakistan, Bangladesh, and Sri Lanka (Ceylon).¹ From this comparative account I hope to draw some conclusions about the relative importance of the various factors which work together to determine the existence of policies, shifts in these policies, and types of programmes in these countries. This analysis should answer the questions: What is the role of politics in the determination of these policies? Are the determinants the same for all countries at all times, or are the origins and shifts in these policies the outcomes of idiosyncracies of local environment and history? I will argue that politics infuses and will continue to infuse any attempt by governments in this region to affect the demographic picture.

By "population policy", conventionally, is meant "official measures affecting, intended to affect, or responsive to change in numbers, composition, or movements of the members of any group".² Such a definition is too broad for the purposes of this study, embracing as it does, not only a government's intentions to affect population size, but also any action which might inadvertently have a demographic impact or which might have been influenced by demographic change. In practice, population policy on the subcontinent has always meant fertility control policy. The demographer defines fertility as "a measure of the number of live children born to individuals, couples, or populations".³ Fertility control policy, then, means

indirect or direct intentional measures taken by governments to reduce the birth rate.

Why have India, Pakistan, Bangladesh and Sri Lanka been chosen for a study of fertility control policies? The countries of the Asian subcontinent share 26.8 percent of the developing countries' total population. The annual rates of natural increase for India, Pakistan, Bangladesh and Sri Lanka range from 2.5 percent or 3.0 percent in Pakistan and Bangladesh to 1.8 percent in Sri Lanka. India, which contains 60 percent of the total subcontinental population, lies between these extremes, with a rate of 1.9 to 2.2 percent.⁴ These countries have all experienced a dramatic decline in mortality rates over the last forty years, and it is to this that their rapid population growth is attributable. Possessing only finite resources of land, water and energy, these countries face a catastrophic return to high mortality levels if population growth is not brought into equilibrium through the intervention of national governments to limit fertility. Fortunately, the governments of South Asia have been among the first in the world to recognize and respond to this problem. The fate of a substantial proportion of the developing world, about one quarter, depends on the fertility control decisions made by these governments.

There are several kinds of case study. It has been said that the study of single cases has not led to an accumulation of theoretical propositions.⁵ Policy analysts such as Heclo recommend the comparison of different cases in order to capture the highlights of a particular policy phenomenon.⁶ Richard Simeon has suggested that, if, in addition to static comparisons "over space", one can present the unfolding of process over a selected

period of time, one is even more likely to advance the cause of public policy analysis in the right direction.⁷ It has been necessary to set chronological limits on the accounts of fertility policy events under study here both in the interest of brevity and for reasons of data availability. Policy does not stop after, say, 1972 in Sri Lanka or 1977 in India, but little has been written on fertility policy since 1972 in the former, nor has it altered its essential direction since 1977 in the latter. Figure 1 shows the periods under study here. I have arbitrarily set the official beginning of fertility control policy in a country as that time when the subject first began to be discussed as a matter of public policy.

Figure 1

Approximate Time Boundaries of Fertility Control Policies
in India, Pakistan, Bangladesh and Sri Lanka

| Country | Time |
|------------|----------------------|
| India | 1943 1977 |
| Pakistan | 1955 1978 |
| Bangladesh | 1972 . . . 1976 |
| Sri Lanka | 1954 1972 |

Comparative analysis entails the search for and explanation of both similarities and differences. If the differences between cases are fundamental and overwhelming, as, say, between India and Iceland, it is difficult to make a useful comparison. But the four South Asian states have much in common. They are all located in what is conventionally regarded as the same geographic region, the South Asian subcontinent. They have all

emerged from over a century of British colonial rule. Although the variety of cultures in the subcontinent is dazzling, nearly all have Dravidian or Aryan roots. Economically, they are all predominantly agricultural, and share the intertwined problems of high unemployment, low capital accumulation, and that pervasive and intransigent complex of scarcity often put under the rubric "poverty".

Timberg has recently described three typical paths to development in South Asia.⁸ These are exemplified by regions which transcend national boundaries, sharing features with counterparts in neighbouring countries. It is true that for the purposes of comparing the local developmental ecologies of South Asia, Timberg's subdivisions make more sense than does using national political boundaries. Since the focus here however, is on the actions of national governments, the unit of analysis will be the state itself, notwithstanding internal diversity. Comparative analysis of what national governments have done and are doing should provide a better understanding of fertility control policy determinants.

Although a great deal has been written on the many aspects of fertility and its control in the subcontinent, the bulk of the literature consists of single-country analyses which tend to focus on the unique demographic or policy features of each. No study has attempted a cross-country comparison of fertility policies in this region. Despite the difficulties in marshalling the evidence into comparable and analysable categories, this attempt to do so will, I feel, make some contribution to the search for universal determinants of fertility control policy.

At the outset, one ought to ask whether governmental policies in South

Asia have had any effect at all on fertility. When one looks at the difference in fertility declines between the four countries, it is particularly tempting to ask of the data whether or not their respective policies can account for this difference. Table 1 shows that crude birth rates are lower in India than in Pakistan and Bangladesh, and that they are still lower in Sri Lanka. Moreover, Sri Lanka has consistently led the others by a wide margin in her rate of decline in birth rates. Many minds have pondered the question of differential fertility rates as between countries, provinces, or districts, but have been unable to establish conclusively that a given decline in birth rate is the outcome of fertility control measures, the unintended consequences of some other policy, or whether the decline would have occurred in the absence of any policy or programme.⁹

TABLE 1

Quinquennial Averages of Births per Thousand Population
and Percent Change, 1950-55 to 1975-80, by Country

| Country | 1950-55 | 1955-60 | % Change | 1960-65 | % Change | 1965-70 |
|------------|----------|---------|----------|---------|----------|---------|
| Bangladesh | 49.1 | 49.9 | +1.63 | 48.7 | -2.4 | 48 |
| India | 40.5 | 42.7 | +5.4 | 42.7 | 0.0 | 40.9 |
| Pakistan | 49.6 | 48.8 | -1.6 | 48.1 | -1.4 | 47.1 |
| Sri Lanka | 38.5 | 36.6 | -4.9 | 34.7 | -5.2 | 31.5 |
| | % Change | 1970-75 | % Change | 1975-80 | % Change | |
| Bangladesh | -1.4 | 47.4 | -1.3 | 47 | -0.84 | |
| India | -3.6 | 38.6 | -5.6 | 36.9 | -4.4 | |
| Pakistan | -2.0 | 47.4 | -0.64 | 46.6 | -1.7 | |
| Sri Lanka | -9.2 | 28.6 | -9.2 | 25.9 | -9.4 | |

Source: U.N. Department of International and Economic Affairs, Selected Demographic Indicators by Country, 1950-2000: Projections As Assessed in 1978, (New York: U.N., 1980), pp. 131-137.

However, it is generally agreed that fertility control programmes have been well worth the money invested in terms of averted births compared with average returns on investments elsewhere in the economy.¹⁰

The demographic effectiveness, that is, the real success or failure of fertility control policies in the countries under study here must remain a matter of speculation. On the other hand, their perceived effectiveness in terms of acceptors, birth rates, and estimated births averted will be highly relevant to the explanation of subsequent policies.

There are no theories which claim a definitive explanation of any public policies, but there are students of the subject who have compiled useful categories under which they can be analysed. One such, Richard Simeon, has suggested five categories which embrace the fullest possible range of potential policy determinants. These are: environment, power, ideas, institutions, and process. The value of each category depends upon just which policy phenomenon one is trying to explain and on how close to actual events one wishes the explanation to be. A cursory check of the fertility control policy story in South Asia indicates that important explanatory variables are distributed throughout these categories.

As Simeon points out, "environment" encompasses a broad range of variables.¹¹ In the cases before us, some aspects of the environment may be more immediate than others to the fertility policy events in question. For example, the technological environment in which policy is made could be an immediate determinant if the discovery of an "ideal" contraceptive precipitates renewed enthusiasm for fertility control. On the other hand, the manner in which a contraceptive device must be distributed will determine

whether or not it is chosen for promotion. The non-existence of the tools needed to implement a fertility control policy will be a major constraint. The background economic/demographic environment, on the other hand, may be sufficient to explain the existence of fertility control policy itself.

What Simeon calls "power", we might simply call "politics". Politics, the contest for "who gets what, when, and how", has pervaded the issues of population control in South Asia in recent years.¹² Family planning programmes belong under the category of public policies which are not demanded by those most affected by them, but, rather, are imposed by governments from above. While it is true that the intended "acceptors" of contraceptive services and supplies seldom demanded them, it is not true that fertility control policy has been formulated in a political vacuum. The personalities of individual leaders and the interaction of birth control advocacy groups and professional medical associations with government have been decisive both in putting fertility control policy on the agenda, and in determining the direction it would take. On the other hand, the apparent threat to communal groups of policies which have the potential to alter the numerical balance has led to their temporary removal from the public policy agenda.

In the realm of ideas, the principal determinants of policy will be found along the left/right dimension and among the trends in thinking within the international family planning movement. Do leaders believe it is the business of government to influence private behavior, and if so do they feel the private or the public sector is best suited for the job?

Institutional differences among the countries under study may prove to be important in explaining the differences in fertility control policies.

The most readily apparent institutional differences in the region are India's federal and Pakistan's and Sri Lanka's unitary structures of government. Equally important in determining what a government decides to do might be the differences in levels of development of the bureaucratic or clinical infrastructure of a given country, as, for example, between Bangladesh and Sri Lanka. Finally, one would expect the policy of a government which must return to the electorate periodically for a fresh mandate to differ from the policy of a government which does not have to do so.

In Simeon's sense, the focus on policy process is closely related to the study of power and institutions. It is the sum of the influence of environmental and ideational factors through groups, politicians and bureaucrats on given policies. In another sense, process can be examined for its importance as a determinant. In this narrower sense, policy can be explained by previous policy.¹³ In both senses, this thesis is very much about process. It will attempt to capture the interplay and causal direction between environment, ideas, institutions and politics, as well as to assess the importance of policies to subsequent policies.

At the nexus of both power and process in fertility policy-making in South Asia has been the observable increase in the element of coercion in its formulation and implementation.¹⁴ A fertility control policy, to be effective, must be able to both deliver services and supplies and motivate millions of couples to alter their behavior. Of these two aspects of fertility control, the latter has led to a rise in the politicization of the process. As demand for services and supplies was met and policy-makers began to believe that what was being done was having an insufficient impact

on demographic or acceptor targets, it became necessary to include as clients those who would rather not be; that is, the vast majority of the fertile couples in the population. This has, on the subcontinent, first been attempted through propaganda, then incentive payments, and finally, compulsion.

Some countries, notably India, have gone farther than others in this process. It will be argued here that what stands out in the determination of these countries' fertility policies, among the whole concatenation of environmental factors, ideas, and institutions, has been the occupation of a commanding position in the policy of an individual with a strong conviction that greater fertility control effort was both necessary and politically feasible. The presence of such an individual became an increasingly necessary condition at the later stages of the process when fertility control policy was becoming more coercive and hence more unpopular.

The process whereby fertility control policy-making in South Asia experienced a continual expansion of its scope and therefore its politicization can be divided into three basic phases. There was the initial pioneering phase, during which India stood out as the main experimenter in policy options. This was, however, little more than an intelligence gathering phase during which governments pondered the propriety of getting into the family planning business. This phase will form the subject of the second chapter.

The second phase, of crash programmes, which is the topic of Chapter Three, was marked by a realization that whether or not fertility control policy evoked strong objections by some of the government's opponents, it

was a matter of greater urgency than had hitherto been thought. During this period, all four countries' governments launched unprecedented efforts to influence the birth rate.

The third phase, dealt with in the fourth chapter, was marked by a realization by thinkers in the field that the scope of policy had been altogether too narrow and henceforth government programmes must go "beyond family planning" if there was to be any hope of bringing down the birth rate enough to make any difference to the success or failure of national economic development efforts.¹⁵ This phase encompasses a great many disparate policy concepts, from intervention into the correlates of high fertility on the voluntaristic end of the range of options, to compulsory sterilization at the involuntary end. All governments have paid lip-service to the former category of measures, but only India has experimented with the latter. India's move from the concept of "beyond family planning" into action will be contrasted with the non-occurrence of such an event in the other three countries in Chapter Four. In Chapter Five, finally, I will present a country-by-country and phase-by-phase analysis to show how the actions and will of individual national leaders stood out among other less important determinants.

CHAPTER I

FOOTNOTES

1. I will refer to this country as Ceylon in the text when events being recounted occurred before the 1971 name change, and as Sri Lanka when they occurred, after.
2. Harold D. Lasswell, "Population Change and Policy Sciences: Proposed Workshops on Reciprocal Impact Analysis," in Policy Sciences and Population, eds., Warren F. Ilchman, Harold D. Lasswell, John D. Montgomery (Lexington: Lexington Books, 1975), p. 117.
3. Robert H. Cassen, India: Population, Economy, Society (London: MacMillan Press, 1978), p. 341.
4. Dorothy L. Nortman, Ellen Hofstadter, Population and Family Planning Programs, Ninth Edition, (New York: Population Council, 1978), p. 11
5. Hugh Heclo, "Review Article: Policy Analysis," British Journal of Political Science 2 (January, 1972): 90 and Richard Simeon, "Studying Public Policy," Canadian Journal of Political Science 9 (December 1976: 551.
6. Hugh Heclo, op. cit., p. 88.
7. Richard Simeon, op. cit., p. 550.
8. Thomas Timberg, "Regions in India Development," Pacific Affairs 53 (Autumn, 1980): 643-50.
9. See, for example, Bernard Berelson, "An Evaluation of the Effects of Population Control Programmes," in Population and its Problems: A Plain Man's Guide, ed. H.B. Parry (Oxford: Clarendon Press, 1974): 133-68; Dorothy L. Nortman, "Status of Family Planning Programmes in Developing Countries in Relation to Demographic Targets," Population Studies 26 (March, 1972): 5-18; R.J. Lapham and W.P. Maudlin, "National Family Planning Programmes: Review and Evaluation," Studies in Family Planning 3 (March, 1972) pp. 30-50; and John Ratcliffe, "Social Justice and the Demographic Transition: Lessons from India's Kerala State," International Journal of Health Services, 8 (No. 1, 1978): 123-43.
10. There is a large literature on the money-effectiveness aspects of fertility control. See for example, L.G. Bower, "The Returns from Investment in Population Control in Less Developed Countries," Demography 5 (No. 1, 1968): 422-32. P. Demeny, "Investment Allocation and Population Growth," Demography 2 (1965): 203-32. Stephen Enke, "Birth Control for Economic Development," Science 164 (May 16, 1969): 798-802. J.W. Leasure, "Some Economic Benefits of Birth Prevention," Milbank Memorial Fund Quarterly 45 (October, 1967): 417-25 and J.L. Simon, "The Value of Avoided Births to Underdeveloped Countries," Population Studies 23 (March, 1969): 61-68.

11. Richard Simeon, op. cit., p. 567.
12. Nazli Choucri, "The Pervasiveness of Politics," Populi 5 (No. 3): 30-44.
13. Richard Simeon; op. cit., p. 578.
14. Theodore Lowi, "Population Policies and the American Political System," in Political Science in Population Studies, eds. Richard L. Clinton and Kenneth R. Godwin (Lexington: Lexington Books, 1972), pp. 25-42.
15. Bernard Berelson, "Beyond Family Planning," Studies in Family Planning 38 (February, 1969): 1-15.

CHAPTER II

THE PIONEERING PHASE

The Government of India was truly a pioneer in the development of national fertility control policy. The first signs of serious intent on the part of the central government to intervene in fertility behaviour came with the establishment of the Planning Commission after Independence. Nehru, who had been chairman of the Congress National Planning Committee, became its chairman. The 1951 Census Report pointed out that the population had expanded 13.2% over the previous decade. Although money was allocated for the purpose of family planning, the economic, political, international and technological environments of the early part of the pioneering phase were generally conducive to a relaxed attitude toward fertility control. The economic outlook, for example, was buoyant, and the Food and Agriculture Minister was able to predict, in 1953, that,

We shall not only be able to meet our own requirements, but in the near future, we may have a surplus.¹

In the first plan period, even those primitive contraceptive devices which were available were eschewed by the government in favour of experiments with the rhythm method. During the second plan period, barrier devices were gaining acceptability in government circles, but many pilot projects found that these were ill-suited to Indian conditions. The lack of an effective birth control technique was a major impediment to the launching of mass-scale programmes in this period.

Sterilization, especially vasectomy, began to look like the answer in the late 1950s. Due to the controversial nature of sterilization programmes, it was left up to the states to implement them. Madras did so, setting up

a clinic and even offering incentives to state employees to undergo surgery in 1958.² In 1959, Maharashtra pioneered the camp approach, in which high concentrations of medical manpower and equipment were brought into the target area. The success of mass sterilization camps eventually influenced central government thinking and the Central Family Planning Board endorsed the idea in 1957. The Health Minister summed up the change in attitude to this technique in 1960:

We were rather diffident about sterilization and vasectomy two years back, but the figures given are already out of date....My hon. colleague Shri Dey is holding camps, taking members of parliament, MLAs and everybody to seminars. Without our help people are holding seminars on vasectomy, 30 or 40 at a time, and when they come back, they are not the same as when they went in.³

Sterilization had a number of administrative advantages, given the technological alternatives of the time. It was the most effective method known, with a failure rate next to zero. Male sterilization is a simple operation requiring minimal equipment and facilities. Unlike all other methods, it is irreversible and therefore does not require continuous motivation. This relieves the bureaucracy of the need to exert constant pressure on clients. Follow-up care, not normally exceeding two weeks, imposes a lighter burden on health care facilities than female sterilization and some other methods. On the other hand, its terminal and male-centred characteristics are a disadvantage in a culture which values fecundity and virility.⁴

In India, as, indeed, in Pakistan and Ceylon, it was the private family planning movement which furnished many of the ideas which governments were to transform into policy. In 1923, a group of medical doctors, social workers, jurists, and reformers set up the Birth Control League. The League

both propagated the movement's ideas and distributed contraceptives.⁵ In 1935, the All-India Medical Conference also passed a resolution in support of the birth control movement, as did the All-India Women's Conference.⁶ Its most important source of support, however, lay in the fact that neither of the two dominant personalities of the independence struggle was opposed to fertility control, but differed only philosophically. Jawaharlal Nehru believed that parenthood ought to be planned, although the idea of "artificial" techniques repelled him. Gandhi believed that birth control was an excellent opportunity for self control.⁷

In 1938 a National Planning Committee of the Indian National Congress, with Nehru as president, recommended that contraception be taught in medical colleges, that there be more women doctors, nurses, health visitors, and government-supported health clinics offering birth control, that supplies be produced domestically, that family planning be propagated by mass communication, and that eugenic sterilization be permitted.

Another committee, called the Bhole Committee, also endorsed birth control in 1946. It was somewhat more cautious than the Indian National Congress had been, allowing that contraception should not be promoted by the state unless there was "substantial support" for it from the public. It feared mass resistance to birth control promoted purely on macro-economic grounds, and therefore stressed a family welfare rationale for government involvement.⁸

After independence, the fertility control brief continued to be carried by the Planning Commission, with Nehru at its head. The first plan, from 1951 to 1956, allocated about 6.5 million rupees to family planning.

This was 6.5% of the whole health budget. About 1.4 million rupees were actually spent. Basic research was carried out, and the staple intelligence-gathering tool, the Knowledge Attitude Practice (KAP) survey was instituted. The main finding of the Final Report on Pilot Studies on the Rhythm was that three quarters of the couples under a study in two experiments wanted to learn how to prevent conception. However, only 13.6% of these could or would learn the rhythm method. It was decided therefore that for the second plan, there would be a more active programme featuring non-rhythm methods.

Despite this Report's call for a more active role for the central government in the second plan, it continued to see itself as a coordinator and advisor, with the more progressive initiatives coming from the states.⁹ Budget appropriations indicated the passivity of the government's attitudes during the first two plans:

TABLE 2

Allocation by Plan for Various Subjects: Millions of Rupees

| Subject | First Plan | Second Plan | Third Plan | Fourth Plan | Fifth Plan |
|-----------------------|------------|-------------|------------|-------------|------------|
| 1. Family Planning | 6.5 | 50 | 270 | 950 | 520 |
| 2. Health | 1400 | 2240 | 3410 | 10009 | |
| 3. 1 as % of 2 | .5% | 2.22% | 7.9% | 8.71% | 12.72% |
| 4. Actual Expenditure | 1.6 | 22.9 | 70.1 | | |
| 5. % of Allocation | 25% | 46% | 43% | | |

Source: T.J. Samuel, "Allocation and Utilization of Resources for Population Control in India," Indian Journal of Economics, 46 (No. 182): 245. Fifth Plan figures from Alaka Malwade Basu, "Family Planning: Numbers Game Goes On," Economic and Political Weekly, 16 (No. 14): 630.

Not only did Family Planning get an extremely low allocation of funds, but the rate of utilization itself was quite low. This was not the case with all policy areas, as Table 3 indicates.

TABLE 3

Rate of Utilization in First and Second Plans

| Items of Expenditure | Rate of Expenditure | |
|----------------------|---------------------|--------------------|
| | <u>First Plan</u> | <u>Second Plan</u> |
| Family Planning | 25% | 46% |
| Agriculture | 81% | 93% |
| Irrigation and Power | 101% | 95% |
| Industries | 68% | 120% |
| Transport | 105% | 94% |
| Social Services | 135% | 96% |

Source: Samuel, *ibid.*, 260

This underutilization has been attributed in large part to the lack of initiative at the state level in organizing family planning programmes, to the red tape which rendered it practically impossible for private organizations to obtain grants, and to the severe shortage of doctors.¹⁰

In the central cabinet there was considerable disagreement about what priority ought to be given to family planning. There was, in addition to the "natural" vs. "mechanical device" controversy, a lack of appreciation of the gravity of the population problem.

The Indian Medical Association (IMA) had, from the beginning, an important, usually obstructive, role to play in fertility policy formulation. When, for example, it was suggested during the periodic review of the medical termination of pregnancy law, that abortion could be made an instrument of

fertility control policy by broadening its availability, the Association's position was always that it must be restricted to fully equipped hospitals. It argued that it was not a suitable method of fertility control because of the inadequacy of health facilities.¹¹ The main issue, however, was the question of quality versus quantity of health manpower. The IMA advocated the expansion of high level medical education and was opposed by those who believed in giving limited training to large numbers of paraprofessionals. The IMA's members' models were western, and it regarded any attempt at introducing paramedics as an attempt to bring "second class medicine" to India.¹²

The contention that health facilities were inadequate was, of course, correct. Health manpower policy, however, contributed to this inadequacy. At the time of independence, the ratio of doctors to population was 1: 6,300, with three-quarters of these doctors located in the cities. The ratio of health visitors to population was 1: 400,000.¹³ If sufficient numbers of clients were to be reached, sub-professional medical workers would have to be given some training in large numbers. Indeed, in 1949 India had about 30,000 licenciate physicians. This level had been abolished on the recommendation of the Health Survey and Development Committee in 1946. This recommendation was supported by Amrit Kaur (the minister of health), the IMA, and the Central Health Council. Proposals to train paramedics have cropped up repeatedly in subsequent decades, but have always been quashed in India by the medical professionals who have dominated the Medical Council of India.

Another potential source of support, opposition, or influence in the formulation of fertility policy was the international aid donor agencies.

The international environment, however, did not support India's attempts in the early 1950s. WHO was internally divided on the matter. However, in the second plan period, the Ford and Rockefeller Foundations offered funds for research in demography, communication, and medicine.

What efforts in the field of fertility control the government of India made during the first two plans could not have been made without the perception on the part of her national leaders, Nehru in particular, that there was a population problem, that not only economic development but also fertility control were legitimate areas of concern for government, and that the instrument for achievement of lower birth rates lay in the ideas furnished by the voluntary birth control movement. The rapid diminution of ideological inhibitions regarding the latest methods of contraception is illustrated by these remarks in the Draft Second Plan:

The logic of facts is unmistakable and there is no doubt that under the conditions prevailing in countries like India, a high rate of population growth is bound to affect adversely the rate of economic advance and living standards per capita. Given the overall shortage of land and of capital equipment relative to population as in India, the conclusion is inescapable that an effective curb on population growth is an important condition for rapid improvement in incomes and in levels of living.¹⁴

The belief that rapid population growth had a deleterious effect on economic development was reinforced in the minds of Indian planners by the publication of Coale and Hoover's Population Growth and Economic Development in Low Income Countries (1958).¹⁵ This book, which used India as its test case, had a telling impact on Indian policy-making, and completed the shift in the underlying philosophy of fertility policy from family welfare to national welfare. At this time too, those who held the beliefs of Gandhi,

such as in the benefits of abstinence or in the anti-carcinogenic properties of semen, were completely eclipsed by those who favoured the rational planning approach.¹⁶

There were two aspects of the institutional context which were relevant to policy-making in India during the pioneering phase. These were the country's federal structure and its democratic system. For reasons outlined earlier, population control was considered a health matter, and was therefore on the concurrent (centre-state) list. This meant that either the centre or the states were free to initiate fertility control programmes. However, because most of the states were reluctant to implement schemes quickly if at all, the centre, which had financial control, dubbed family planning a "centrally sponsored scheme". Most states tended to implement schemes which were designed by the centre.¹⁷ One may speak, then, of India's "family planning programme" with a fair degree of confidence that there was some uniformity throughout the states.

In India, an important institution, and one which, for most of the history of the subcontinent, sets that country off from Pakistan and Bangladesh, (though not from Sri Lanka) has been that of fair elections. Although the country, especially in the early period, was dominated by the Congress Party, Indian leaders have found their ability to impose unpopular policies more limited than those in countries where they have not had, periodically, to obtain fresh mandates from the people. There is no evidence, however, that policy-makers during the initial phase of fertility policy-making in India considered electoral implications of their decisions.

* * * * *

Pakistan emerged from the turmoil of the British withdrawal from India. Its *raison d'être* was that it should become a homeland for the Muslims of the subcontinent. Pakistan's energies were taken up from 1947 to 1957 in a search for a workable constitution, and political instability up to this latter date precluded concentration on fertility control. There were constant changes of cabinets, prime ministers, and a multiplicity of parties. Proponents of a state founded on Islamic theology were pushed to the background by the secular and modernist stream of influence during this period, but conservative parties such as the Jamaat-i-Islami continued to be vocal. There were ministries and agencies set up whose nominal role was planning and economic development, but these did not have the political or financial resources to accomplish much. The aspect of the population issue which was salient to the Government of Pakistan during the early 1950s was the problem of post-partition migration. Pakistan had ended up with a surplus of two million persons, or six percent of the west wing, and by 1951 one quarter of Pakistan consisted of refugees.¹⁸

The salience of the problem of natural population increase was further reduced by the apparently modest growth found by the 1951 census, which showed a growth rate of only 1.4%.¹⁹

No prime minister or president in Pakistan came out in favour of fertility control during the 1950s. There were, however, groups both in favour of fertility control, and against government intervention in this area. In 1953 the Family Planning Association of Pakistan was officially inaugurated. Its main source of propulsion was the group of upper class women who had aided in refugee relief following partition. In 1955 at the

beginning of the first five year plan, these women exerted sufficient pressure on their kinsmen in government to have included in that plan an allocation of a Rs. 500,000 subsidy for the Association.²⁰ Negative forces included certain ulema, who preached against family planning as a violation of Allah's will and there was some organized opposition from the religious parties.²¹

The institutional context in Pakistan differed from that of India in two respects. Pakistan was a two-province unitary state. Family planning was a subject of the Ministry of Health, Labour, and Social Welfare and was administered by the central government. There was a Central Family Planning Council which was intended to formulate policy recommendations for the minister.²² All branches of the administrative machinery, including the Health structure, were severely attenuated as a result of the migration following partition.

At the end of this pioneering phase in India and Pakistan, then, little had been done to actively influence the birth rate. Progress had been made in acquiring "policy knowledge", that is, governing elites in both countries had been shown by the efforts and lobbying of private family planning groups and by pilot projects and attitude surveys that there was less hostility to family planning than they might have thought, and that there was a latent demand for some family planning services.²³

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Ceylon, as it was then called, appeared to have one of the highest rates of natural increase in the region in 1958. The most apparent difference between Ceylon and Pakistan and India is the relative size of Ceylon. In

1958 it had ten million people, as compared with India's population of four hundred million, and Pakistan's population of 85 million. Ceylon's population was, however, packed into an island the size of Ireland.²⁴ Moreover, Ceylon's ethnic composition was and is a more fertility policy-relevant factor than it has been in India or even Pakistan. About seventy percent of the population is Sinhalese, twelve percent is Ceylon Tamil, and ten percent is Indian Tamil. The Sinhalese are Buddhist, while the Tamils are Hindu.

The economy of Ceylon was buoyant in the period following the Korean war due to high commodities prices, and this may in part explain the government's inactivity in the fertility control area. Ceylon did not adopt a public national fertility control policy until 1965. Prior to that time, however, the government of Ceylon had made policy by default, by permitting a great deal of freedom of action to private groups and population activists. A Canadian gynecologist, Dr. Mary Irwin, devoted her life to the promotion of maternal and child welfare and to a host of other welfare organizations, including the Family Planning Association. This became the Family Planning Association of Ceylon (FPAC) in 1953.

The World Bank (then International Bank for Reconstruction and Development) reported that a demographic/economic crisis was inevitable in Ceylon unless the birth rate diminished. It recommended in 1953 that government health centres be used to provide family planning services and that voluntary organizations be given subsidies.²⁵ This found favour with the then Prime Minister, Dudley Senanayake, but nothing was done, as he lost office in 1953 for having reduced the rice subsidy.

The FPAC was given a negligible grant of Rs. 2000 in 1954. Subsequent

Prime Ministers supported the family planning movement with modest subsidies and minimal publicity. The FPAC was also supported by the International Planned Parenthood Federation, Oxfam, the Population Council and U.S. AID. In 1958 the Sweden/Ceylon pilot project was inaugurated at the request of the FPAC and the Government of Ceylon. In its early years it proved ineffective both in deriving scientifically valid findings and in reducing fertility. It did, however, provide a nucleus from which the government could build its own programme, should it decide to do so in subsequent years.

What is of interest in the politics of population in the first phase of fertility policy in Ceylon is not so much the effectiveness of techniques, which were as primitive there as elsewhere, but the role which the government permitted volunteer organizations and foreign agencies to play. This was undoubtedly due to the sensitivity of the government to potential criticism mounted by spokesmen for the two main ethnic groups. In Ceylon, the danger was that fertility control could blow up into a communal political issue.

That there was a perception of a population problem which could not be resolved by economic development alone and a partiality on the part of governing elites to family planning as the solution despite their political inhibitions is shown by remarks found in all three planning documents of the period. In the Short-Term Implementation Programme of 1962, drafted for Sirimavo Bandaranaike, two schools of thought were mentioned. One was sanguine about the prospect of population and the other regarded the implications of rapid population growth as serious.²⁶ The draft concluded that the latter was the correct view. In 1962 Mrs. Bandaranaike ruled that family planning should be integrated with maternal and child health programmes.

She ordered "more educational work" for the Department of Health Services. The Interim Report of the Planning Council (1957), and the Ten Year Plan of 1959 had also stressed the importance of the population problem.²⁷ Population's most obvious manifestation as a problem was in the workforce projections, which showed up an enormous need for new jobs -- about one hundred thousand per year from 1961 to 1981 -- if current trends were to continue. Allocations however, were not made for fertility control of any kind.

Ceylon, like India, differed from Pakistan in having the institutions of periodic elections, a relatively experienced bureaucracy, and generally more political stability. It shared with India and Pakistan the mandate for economic development through planning. Due to the commodities price-recession, however, government by economic plan had given way almost completely to government by crisis management.²⁸ Health, under which active fertility policy would have fallen, had there been any, was controlled by the central government in Ceylon.

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The post-independence context of fertility policy-making in Bangladesh resembled that of Pakistan and India in many respects. The pre-existing fertility control programmes had been wiped out or discredited, so that the government had, virtually, to build from a zero base. As with the other countries, the roots of the historical context went back before the achievement of independence. However, the international, technological, and ideational environments from which the first phase emerged were those which prevailed in the 1960s, not, as for the others, those which had prevailed in

the British colonial period.

The first phase, from 1972 to 1975, was marked by what has been called by an observer of South Asian affairs, a "mouse of a population policy".²⁹ The government regarded the population issue as extremely politically sensitive: no vigour could be shown lest it appear to resemble the completely discredited Pakistani programme of the previous decade.³⁰ Although the Planning Commission in its first five year plan recognized the gravity of the population problem, and this was reiterated by Mujib in a speech given in June 1972, this was the only reference he is known to have made to the issue, and he was known to be indifferent to the problem at best.

His minister for Family Planning was opposed to family planning in principle. After liberation, he instructed his workers to cease population control activities altogether, arguing that, "We have had enough killing, enough of slaughter".³¹

The family planning brief in this phase had to be carried by the Planning Commission and individual family planning enthusiasts and associations. Both were extremely reluctant to take a forceful stand. The First Annual Plan (1972-1973) projected an expenditure which represented about 1.06 percent of all expenditures for that year. It stated that population control should be the number two priority after agricultural development. This was, however, to be a "serial" priority. One member put it this way:

When we say that population control should be our second priority, what we mean is that we will spend the next four or five years concentrating on agriculture and then we will take up population control in a big way. For the present, we really haven't had time to think about it -- besides it is probably a subject that is best left in the background until our people are ready for it."³²

There were a number of family planning enthusiasts outside government in Bangladesh, some experienced in population work done as early as the 1950s. The FPAP of East Pakistan became the Family Welfare Association of Bangladesh. Its members were eager to see Bangladesh adopt a more comprehensive population control policy, but there was a consensus that the issue was enormously politically sensitive, and that any attempt to use even persuasion and propaganda or incentives would set back their cause.³³

The political atmosphere of the 1972-1975 period was characterized by rampant corruption, factionalism within the many political parties, including the dominant Awami League, and chronic breakdown in law and order. The Family Welfare Association of Bangladesh was obliged to turn down an offer from Australia to fund an expansion because its executives knew the money would corrupt its own workers, and thereby render the Association no more effective.³⁴

There was no particularly strong ideological orientation in government: It was moderate, secular, believed in the mixed economy, and was allegedly guided by the essentially personalistic credo of "Mujibbism".

The institutional issue which pre-occupied the personnel of the Department of Family Planning was their integration with the Health Ministry -- a reorganization which made them mere adjuncts and occasioned a loss of status and pay.

* * * * *

There does not, up to this point, appear to be any dynamic in India, Pakistan, Ceylon or Bangladesh pointing inevitably to an increased coerciveness in fertility control policy. There was progress in India, Pakistan and

Ceylon in the negative sense that objections to the idea of fertility control policy were rapidly being dispelled among elites. In all four countries, however, governments were committed on paper at least to the alleviation of poverty through economic development. They believed that population growth would retard this.

Pilot projects and surveys continued to be done. Because they tended to be conducted in urban or otherwise well-favoured locations, findings were optimistic, and governments thereby received an exaggerated notion of the ease with which programmes might attain their goals.³⁵

It is possible to speak in general terms of India, Pakistan, and Ceylon in the first half of the 1960s and Bangladesh in the first half of the 1970s as being in roughly the same place in this process. Taboos about the public discussion of population issues were slowly disappearing in all four countries. Nehru and Ayub were addressing population conferences. However, in Ceylon and Bangladesh, while planners recognized the implications of rapid population growth, Mrs. Bandaranaike kept a low profile on the issue, and Mujib apparently assigned a low priority to fertility control. Policy went farthest in India both because of her head start and because a national leader was able to override the plethora of conflicting opinions within ^{her} his government. There is little evidence that there was very strong opposition from communal groups, possibly because at the pioneering level of activity in India, family planning programmes had not demonstrated any potential for reducing their numbers. The diffidence shown by Ceylon and Bangladesh during the first phase seems unwarranted and one can only surmise that it arose from "anticipated opposition" from communal

groups in the former and from post-war loathing for all things redolent of Pakistan in the latter.

The evidence coming out of the pioneering phase as a whole shows the importance of having both a stable political environment and a national leader who is favourably disposed to fertility control. It was these elements which were lacking in Pakistan, Ceylon and Bangladesh. By the end of the period, governments were discovering that opposition was either not as great as they had anticipated or were coming to the conclusion that the solution to economic and overpopulation problems was more important than such opposition. By 1965, India, Pakistan, and Ceylon, and by 1975, Bangladesh, were ready to take action.

CHAPTER II

FOOTNOTES

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CHAPTER III

THE CRASH PROGRAMME PHASE

The point in its history when a country entered its crash programme phase is not measurable in a scientifically precise way. Since one of the purposes of this thesis is to explain the transition from one phase to another, certain convenient earmarks for identifying the initiation of the crash programme phase are set out here:

- i) The issue of public statements to the effect that government is firmly committed to fertility reduction, usually by setting crude birth rate targets and,
- ii) The allocation of substantially more money and other resources to the pursuit of these goals.

Although India, Pakistan and Ceylon embarked on their initial phases at different times, largely as a result of the different circumstances surrounding their attainment of independence, all began the second phase in 1965. It is true that India gained world renown for its family planning experiments as early as 1953, but, although these were unprecedented, the degree of effort even remotely necessary to affect birth rates was not reached until the launching of the IUD programme in 1965.

Likewise, Pakistan gave only token support to family planning in its first plan (1955-1960). There was a pickup in momentum in 1964 when Ayub Khan's interest was stimulated, and this interest led to the announcement of the National Population Policy in 1965, when Ayub included family planning in his election campaign.¹

The intensified Pakistani fertility control policy, as it was practiced in East Pakistan, shattered during the 1971 civil war, lay moribund in

Bangladesh until the changes in government in 1975 put an Ayub-style military man into office.²

The SLFP government of Ceylon indicated an increasing interest in controlling fertility, but did not consider it politic to translate this into action. Not until the advent of the UNP government in 1965 did Ceylon have an official fertility control policy.

By 1965, conditions were "ripening" for a pronounced shift of both intensity and direction of national fertility control policy in India, Pakistan, and Ceylon. Changes in the technological, international, demographic and economic circumstances surrounding fertility policy were occurring. In Bangladesh during the Mujib period from 1972 to 1975, it is difficult to discern, except for the frightening population growth rate, any environmental determinants favourable to a strong shift. What was needed was a precipitant. This was to come in Pakistan, Ceylon and Bangladesh in the intervention of national leaders, and in India seemed to emerge from the 'discovery' of the IUD.

The actual measures chosen were the outcomes of institutional and technological constraints prevailing during the phase. No statistics are available which are easily comparable for the periods in question and which give an idea of these governments' capacities to reach the masses of rural clients through clinically oriented crash programmes. The following table, however, does show that Sri Lanka stands several orders of magnitude above, and Bangladesh several orders below the average ability of these countries' governments to reach their citizens, if one assumes that the "urban bias" is uniform in all cases.

TABLE 4

Medical Personnel in Bangladesh, India, Pakistan and Sri Lanka

| Country | <u>Population</u> Hospital Beds | <u>Population</u> Physicians | <u>Population</u> Nurses |
|----------------------|------------------------------------|---------------------------------|-----------------------------|
| Bangladesh (1976) | 4,868 | 14,178 | 51,679 |
| India (1974) | 1,465 | 3,961 | 6,735 |
| Pakistan (1977) | 1,903 | 3,600(est) | 8,002 |
| Sri Lanka | 334 | 4,007 | 2,013 |
| AVERAGE | 2,142 | 6,436 | 17,107 |

Source: WHO World Health Statistics, Geneva, 1979, v. III, 1978.
Health Personnel and Hospital Establishments, pp. 61, 74, 83.

Real governmental commitment to fertility control did not begin in India until the Third Plan (1961-1966).. Policy-makers realized that clinics were too sparse and too passive to reach enough clients. This led to the "extension education" approach. More field staff, more supplies, better statistics and better management were necessary for this strategy. Local "grassroots" organizations at the district and sub-block levels were created to implement the plan. It was at this time that crude birth rate figures as targets began to be mentioned in plans. The target for the programmes accompanying the third plan was a rate of 25 by 1973, down from a current (in 1961) 40 births per thousands.³

In 1965 a Cabinet Committee on Family Planning was formed. This called

for raising the priority of the family planning programme. As shown on Table 2, the budgetary allocation for family planning jumped from 2.22 percent to 7.9 percent of overall health allocation, and the rate of utilization also rose.

In the ten years between 1965 and 1975, the government of India launched a succession of "crash programmes", each based on high confidence in and stress on a single technique. In 1965, the IUD was tried and believed to have failed. Then sterilization (mostly vasectomy) drives were mounted. These sterilization drives usually involved the one-time concentration of doctors and clinical equipment in a single site, called a "camp". By going out to the villagers, rather than waiting for the villagers to come to the facilities, many more clients were reached. The number of acceptors of sterilization began to decline around 1970, but the technique was given a new lease on life with a modified camp approach in which relatively large sums (Rs. 100) were paid to acceptors, agents, and doctors. At this time also, the condom was promoted with some success through a high pressure sales campaign.

In the mid-1960s some changes occurred in India's economic and demographic environments. A sense of urgency began to pervade the Planning Commission and ministries concerned with the economy in New Delhi. This was partly the result of the 1961 Census Report, which indicated that net population growth for the previous decade had been 21.6 percent.⁴ There was a nearly calamitous famine in Bihar in 1965, and a crop failure the following season as well. There was less confidence than there had been in the previous decade in India's ability to develop her economy without

first, or simultaneously, controlling her population growth.

The international environment had also changed by this time, becoming highly favourable to fertility control. Meanwhile the technological environment seemed to be changing. The IUD, as previously mentioned, looked like a major breakthrough, and there were others in the offing.

Leaders in many countries were beginning to realize that population growth could not be left to take its own course. In 1963, Nehru indicated a shift in his thinking on the subject, telling the First Asian Population Conference (December 10, 1963) that population policy had been inadequate:

I confess that we (in India) have not succeeded remarkably and the growth of population in this great country is rather alarming.⁵

At the same time, leaders were less apprehensive, due to the absence of any negative mass response to family planning programmes.

The programmes acquired greater prestige and therefore priority in 1965 by receiving the active interest of two outstanding members of the government. These were C. Subramaniam, Minister of Food and Agriculture, and Asoka Mehta, Deputy Chairman of the Planning Commission and later Minister of Planning. It was these men who had formed the Cabinet Committee on Family Planning.⁶ Sushila Nayar, Minister of Health, who had a negative attitude towards fertility control, was replaced in 1966 by Dr. S. Chandra-sekhar, a demographer and birth control enthusiast.

The IUD episode illustrates the manner in which the interaction between foreign donor agencies, Indian medical and bureaucratic elites, and their clientele determined what was to become a typical pattern. In 1964 a delegation of Indian gynecologists and family planning experts attended an

international conference in New York featuring the IUD.⁷ They returned convinced that this was the breakthrough that would make mass birth control possible at last. At the same time, a U.N. advisory mission visited India and strongly advocated the promotion of the IUD. It was given top priority by the Central Health Ministry to the exclusion of other methods. The IUD programme reached a maximum of acceptors in 1966-67 and then experienced a decline to less than half that level by 1973-1974. Of those women who accepted the loop, a rather low percentage retained them compared with retention rates found in developed countries. Word of cramps and bleeding, which had serious overtones of contamination and impurity in Indian culture, quickly nullified the initially neutral attitude of the client public to the IUD. The low retention rate had been predicted by Indian, Korean, and Taiwanese field tests, yet the programme was considered a failure. Some scholars have argued that the strategy was adopted and then dropped too quickly, before inevitable kinks in the delivery and follow-up system could be remedied.⁸ When it became evident that the IUD was losing ground, a second U.N. advisory mission in 1969 reviewed its progress and called for a redesign of the programme with better planning and implementation.⁹ The government, however, was dispirited and the IUD's reputation had been damaged.

Apprehension that a given technique, such as the IUD, was not gaining the expected number of acceptors, and that consequently there was little hope of a significant impact on the birth rate, led some officials to conclude that a new method must be found. Others thought, meanwhile, that this new method must be combined with more forceful methods of motivation. A

number of states experimented with mild coercion as early as 1966. Uttar Pradesh launched a "multi-agency fortnight" in which employees from all government agencies were required to "motivate" a quota of vasectomy clients on pain of pay dockage or outright dismissal. Dalal ("brokers"), who brought in clients in return for payment from harried officials, contributed to the low demographic appropriateness of the sterilization cases. The too young and the too old were brought in, and their age records were falsified where possible.¹⁰ In 1967 a proposal that involuntary population control be introduced through the use of one hundred rupee payments was withdrawn under a "storm of questions".¹¹ This proposal was so unacceptable politically, that some high-level personnel were transferred within the Department of Family Planning.

Nevertheless, a one hundred rupee incentive payment was used in 1972 in the Ernakulum vasectomy festival, and it was hailed as an outstanding success. This indicates the shift in thinking both by politicians and economic and health planners, which had taken place as a result of the exhaustion of ideas and paucity of results in the intervening five years. The condom campaign's results had declined, IUDs were widely regarded as unsuitable in Indian conditions, and the one method which had not become the centre of a crash programme, the 'oral' pill, was thought to be too complex for self-administration by the Indian woman.¹²

In the crash programme phase, voluntary organizations, although still active, were eclipsed by the multi- and bi-lateral international donor agencies. These agencies do not seem to have had much influence on whether or not major shifts in the vigour of policy took place, but they did have

some impact on particular measures chosen. It was the Ford Foundation (from 1963 to 1967) and U.S. AID (from 1966 to 1972) which were most important to these choices in the second phase. Ford had been in India since 1951, but its involvement in family planning work culminated in 1966. Due to the opulent life-styles of the Ford consultants, and to the inevitable mismatch which occurred due to differing bureaucratic cultures, distrust and animosity for the Americans grew to the point in 1966 where some intellectuals and Indian politicians, including one cabinet minister, denounced the Foundation in Parliament. The Ford Foundation grants had exceeded one million dollars, of which a quarter had gone to family planning. However, this was never more than ten percent of the entire family planning budget for one year.¹³

The stamp of American aid was found on the ad campaign featuring the red triangle, and on the contraceptive marketing programme for distribution of Nirodh condoms through five large marketing firms. The condom campaign was the only one to be conducted largely outside the public sector. The condom also had several advantages over other methods. It is cheap, harmless, largely confidential, male-oriented where males make the important decisions in the household, and its reach is not restricted to that of the government health network. Furthermore, it does not lead to permanent infertility. and therefore appeals to younger couples. Sales were kept high by a high powered ad campaign, the informal leader of which was a marketing specialist from M.I.T. by the name of Peter S. King.¹⁴ Sales rose up to 1973, when the Nirodh's popularity plummeted. This was due to the discontinuation of the sales campaign and the reduction of the price-subsidy.

As in the first phase of India's fertility policy process, the personal preferences or aversions of India's Prime Minister played an important role in determining shifts in direction. Nehru had given some support to fertility control prior to his death. Neither Prime Minister Shastri, nor Mrs. Gandhi were at all vocal in their support, however. By the early 1970s several groups had been formed to oppose family planning, and Mrs. Gandhi's awareness of these, in combination with a possible reaction against the American agencies' excessive zeal for fertility control, may explain her reticence.¹⁵

The succession of crash programmes continued despite a lack of out-front support from Mrs. Gandhi. Then, although she had reason to remain silent on this issue, she underwent a turnabout in 1973. It is thought that she and her advisors were shaken by the 1971 Census Report, which was published at the same time that food, petroleum, and other resource shortages appeared imminent.¹⁶ Mrs. Gandhi's appointment of Dr. Karan Singh, a man generally considered effective as well as popular, marked a shift to more vigorous and sophisticated, if not more active, fertility control policy.¹⁷

At the Bucharest World Population Conference, Singh advanced, on behalf of India, a "balanced and realistic" position.¹⁸ He pointed out the deleterious effect of rapid population growth, and emphasized the necessity for integration of development and population control. The Draft Fifth Plan (1974-1979), bearing his stamp, called for a gradualist approach. There was a recognition that the programmes of previous years had been rushed and that a slower build-up with less visible results would be more effective in

the long run.¹⁹ The Plan envisioned three "crash programmes", even though the term had lost most of its connotation of force or urgency by this time. The first programme was to launch the development of a birth control method uniquely suited to Indian conditions. Such a method would have to be non-terminal, require no medical follow-up or meticulous attention of the user, nor require bathroom facilities or privacy. It was realized that no method, no matter how effective, would be adopted so long as the large family remained an institution. The government proposed therefore to promote the "small-family norm" with renewed energy, using all propaganda media, professional organizations, and so on. The third "programme" was the reorganization of the structure of the Health and Family Planning service network.

Ideas may exist long before they are transformed into policy. The World Population Conference lent political legitimacy to ideas which the social sciences had been developing since at least the previous decade. There were two streams of thought on fertility control. The "soft option", exemplified by the Indian stand at the World Population Conference in 1974, involved inducing fertility decline by manipulating the known correlates of low fertility. The "hard" stream went beyond the conventional voluntaristic family planning by directly applying incentives and disincentives. Dr. Singh chose the former approach when he proclaimed that "Development (was) the best contraceptive". Stated as vaguely as this, it was no better than the hope expressed during the 1950s that development must precede fertility decline. This time, however, it was known that education levels and family size correlated highly and that where fertility is low, infant mortality is also low, and the status of women is high.²⁰

The "hard" stream had also been considered as early as the pioneering phase in India. The high-level Health Survey and Planning Committee (Mudliar Committee) had recommended an expansion of conventional approaches to fertility policy through family planning. However, a minority went on to urge steps which were a significant departure from convention. These were: (i) graded tax penalties beginning with the fourth birth; (ii) removal of income tax disadvantages for single persons; (iii) no maternity benefits for those who refused to limit their progeny; (iv) limiting government services, like free education to no more than three children per family; (v) enlisting help of all government employees in promoting family planning and (iv) permitting abortion for socio-economic reasons. These recommendations were made in 1961.²¹

The most significant institutional change during India's second phase was the upgrading of the status of Family Planning. Experts in the Planning Commission's evaluation of 1965 had recommended that much more administrative and financial authority was needed. They called for a Central Family Planning Organization to be given semi-autonomous status within the Health Ministry. In the event, it was not given semi-autonomy, but it was made a Directorate and its chief technical officer was given the title of Commissioner of Family Planning.²² Family Planning was given department status and symbolic full partnership with health. When Mrs. Gandhi took office in January 1966, the ministry was renamed "Ministry of Health and Family Planning". Within the government of India as a whole, however, this policy area, as a "social policy" had rather low priority in comparison with areas such as industry.²³

One must, moreover, be cautious about attributing any significance to changes made in organizational arrangements. In the heyday of Ford and AID, "institution building" was a prime desideratum. An American public administration expert designed two Indian institutions. One, the National Family Planning Institute (NFPI) was to do research and training in family planning, while the National Institute of Health Administration (NAHA) was to deal with public health. These nascent institutions each had their behind-the-scenes American public health administrators. Neither the NFPI nor the NAHA has since appeared in the fertility policy literature.²⁴

Fondness of form, a quality observed in Indian bureaucracy, may well also be common to those in other countries of the region. When speaking of a vigorous as opposed to weak policy, it is wise to bear in mind that the vigour may only be verbal despite appearances to the contrary. The gap between action and implementation has been attributed to a paucity of institutional levers, chronic in any poor country, but many observers have commented on the penchant in India to regard ritual as an end. John Kenneth Galbraith, when he was U.S. Ambassador to India, remarked:

I had long been in Delhi before I realized how urgent would be the discussion of Family Planning...and how slight would be the consequences. The discussion was an art form. The reality was the absence of any levers for moving the great village mass...the absence, on occasion, even of the means of communication with the India of the millions.²⁵

This penchant for form results in a plethora of plans, paper, meetings, and seminars. The law passed or the funds allocated become an end and a solution rather than a means.²⁶

* * * * *

The 1960s was a decade during which Pakistan undertook many ambitious development plans. Although Ayub Khan was strongly development-oriented from the time he came to power in 1958, fertility policy cannot be said to have reached the second phase until 1965, when he made family planning a part of his election platform. Prior to this, the Ministry of Health, under its budget allocation of Rs. 30.5 million, had made contraceptives available through its maternal and child health centres. These, however, were spread extremely thinly, and reached very few Pakistani villagers. For 1965-1970, however, the Ministry received 394.2 million rupees, of which 37 percent was meant for family planning.²⁷ In short, resource commitments jumped significantly.

A long-range Perspective Plan (1965-1985) was drawn up in which the government assumed it possible to lower the birth from 50 to 25 in 20 years. A rate of 40 was therefore considered an appropriate target for 1970. During the Third Five Year Plan (1965-1970), however, only 18.2 percent of the Family planning allocation was spent.²⁸

The IUD, as in India, was hailed as the ideal contraceptive. A new field organization was set up to reach and motivate the villagers of Pakistan. Unlike India, the traditional birth attendant, or dai was deemed the front line motivator. Her duties were to motivate couples, distribute conventional devices, and to bring in IUD acceptors to the clinics. She was to receive a monthly salary of Rs. 15 plus a two-and-a-half rupee bonus for each IUD acceptor. Of the maximum strength of fifty thousand hoped for, only 36,000 were hired because of poor performance and constant quitting. Subsequently 1,400 male workers were hired part-time to approach

male villagers. They received quadruple the salary of the dais. There were also about 1,200 family planning officers, clerks, dispensers, and so on, to contact village leaders and promote family planning through publicity. This was quite reminiscent of the Indian extension education programme, which had been tried in 1964 and then abandoned. An Impact Survey was conducted in 1968-1969. It found that although eighty percent of the women interviewed were in favour of family planning, only four percent were practicing it. Since 64 percent did not know anyone in the locality to whom they could go for advice and devices, the inference was reached that the motivational programme had failed to reach most potential clients. Nevertheless, planning for the Fourth Five Year Plan (1970-1975) was predicated on the assumption that the programme must have reduced the birth rate by 1.8 points.²⁹

By the end of the Third Five Year Plan, disillusionment had set in both with the dai system and the IUD. The government concluded that the dai programme had failed because it was contrary to the dais' interests to prevent births so long as their compensation from their traditional patrons exceeded that offered by the programme to prevent births. Although these women seemed naturally superior to city people in a role in which they had to win the trust of the villagers, their low social status was a major disadvantage, as was also the fact that, as women, they would find it impossible to convince or even speak to men in the patriarchal household.

The IUD programme, in which had been invested so much hope and money, as in India, enjoyed a widespread jump in acceptors, and then soon suffered massive discontinuation due to a lack of follow-up services. Pakistan's

crash programme phase, then, appeared to replicate that of India.

During the period 1969 to 1972, family planning and population issues were virtually ignored in Pakistan by all levels of government, due to political turmoil. In 1972, a Two Year Scheme was prepared with a budget of Rs. 204 million. The government hoped to introduce a "population bias" into all areas of policy, and in keeping with this more universal approach, the Family Planning Division of the Department of Health was renamed the Population Planning Division. A commercial distribution system was set up to pursue the policy of "inundation".³⁰ Condoms were the centre-piece, and pills were also dispensed with out prescription. Prices were nominal, and supplies were furnished by U.S. AID.

The problems of couple-motivation and government shortness of outreach were dealt with by a programme called the Continuous Motivation Scheme (CMS). First piloted in Sialkot in 1969, the government hoped that this scheme would overcome some of the major deficiencies of the third plan. It would use male/female teams of "motivators" one member for access to each parent. Each team was to cover a "circle" of ten to sixteen thousand (!) persons during a three-month-long circuit. It was finally possible to try to implement the scheme in 1972 after the secession of Bangladesh and the upheavals of the Indo-Pak war had subsided. It is worthwhile recounting the CMS episode for the serious gaps it reveals between stated intentions and actual field behaviour. A study by a German scholar, Dietrich Brüning, was precipitated by the apparent waste of condoms and pills.³¹ According to the Pakistan Fertility Survey, one percent or 11.8 million men used condoms, whereas the "off-take" figures supplied by the Population Planning distribution

division indicated that if all condoms which were being given out were being used, 10.5 percent of eligible males must be using them. The implications were that 90 percent of the condoms distributed in Pakistan in 1975 were not being used for contraception. The survey found that workers were concentrated in the cities and that the majority were absent from villages when their tour schedules indicated they should have been there. Nine percent of motivators were present where they ought to have been. Only eight percent of the villages surveyed had been visited on schedule, 46 percent had been visited by population planning personnel of some kind in the previous year, 21 percent had been visited between one and eleven years previously, and 25 percent of the villages had never been visited! Bruning's conclusion was that:

Frequency of visits to particular villages and clients seems to be determined by the personal life of the motivator more than by goals of the programmes.³²

At the beginning of the crash programme phase in Pakistan, that is, the mid-1960s, perceptions of economic strength were more optimistic than they were in India. It was thought that Pakistan's "Decade of Development" under the direction of Ayub, then half over, was chalking up a more "impressive record" than India's was.³³ The returns from the 1961 census, however, had indicated a disturbingly high rate of natural increase. The returns from the third census, not available until 1972, indicated that there had been no drop in the crude birth rate, which persisted at the level of fifty per thousand despite the crash programmes of the 1960s.

As in India, the patronage and unequivocal support -- or its absence -- of a national leader proved of paramount importance in determining the

launching of Pakistan's second phase of fertility policy. At a seminar organized by the Family Planning Association of Pakistan called Pakistan's Population Quake (1964), Ayub Khan expounded his view:

If nothing is done to check the rate of population growth, I shudder to think what will happen after a few decades. My only consolation is that I shall not be there to face that situation. But my country and my people would be faced with it. And the coming generations would not forgive us for landing them in such a bad mess.³⁴

Because Pakistan was a "constitutional autocracy", Ayub was able to take a more forthright stand on fertility policy and to implement programmes which were less sensitive to opposition than could Mrs. Gandhi.³⁵ For example, in Pakistan, due to the weakness of the Pakistan Medical Association, paramedics were permitted to do IUD insertions. The disregard for the views of the medical profession had repercussions many years later, when the Bhutto government tried to re-integrate health services and family planning. The doctors remained cold to the idea.³⁶ That greater political sensitivity was desirable even in the absence of democratic checks to presidential power was shown in the anti-Ayub agitations of 1968-1969, when family planning centres were made targets of stone-throwing mobs.

This insensitivity to the human impact of fertility control policy was evident from the beginning of the second phase in Pakistan. The fundamental conceptual orientation of the policy was expressed by Mr. Enver Adil, the new Commissioner of Family Planning, 1965, when he said that "Family planning is essentially an administrative matter."³⁷ Immense sums went into the periodic re-organization of programmes with the assumption that if one kind of organization did not work, another would.³⁸ When attempts to influence

the demand side of contraception, such as the Continuous Motivation Scheme, failed, ways were sought to effect improvements on the supply side through such programmes as "inundation", in which vast shipments of supplies were brought into the country, or the computer-based Information Systems on Contraceptive Movement (ISCM), which attempted to monitor the flow of supplies.³⁹

Pakistan's fertility control policy in the 1970s appeared to drift from one programme to another without any particularly dramatic or urgent shifts in strength or philosophy. The government was aware of the intellectual currents subsumed under the "development is the best contraceptive" slogan, but this led not to implementation of programmes which would affect people, but to the setting up in 1973 of the Democratic Policy Action Research Centre (DPARC).⁴⁰ The frequent modification of institutional arrangements was a vestige of U.S. AID's "institution building" in India in the previous decade.

* * * * *

Ceylonese fertility control policy also entered its second phase in 1965. This was largely due to the pro-family planning views of Dudley Senanayake, who came to power in that year. Previously, governments had been increasingly sympathetic to the idea of family planning for the purpose of health, but had not yet had the courage to take an unconditional stand in favour of family planning for the purpose of furthering demographic goals. By 1963, economic indicators had become quite discouraging, and there was, in fact, a per capita decline in real gross national product in that year.⁴¹

The Sweden/Ceylon project demonstrated (whether fallaciously or not) what could be done. The cabinet decided to disseminate family planning

services through the already existing maternal/child health network, which was quite well developed.⁴² A target of reducing the birth rate from 33 to 25 in ten years was set. All private clinics, including the Sweden/Ceylon office in Colombo were converted to government outlets.

By 1970, the government, which had been assertively providing contraceptive services, and, as well, mounting various communication programmes to propagate their use, began to back-pedal and, in fact, even reduced its financial support for family planning. The reason, of course, was the imminent election, prior to which the government wished to reduce its visibility as a target of the ethnic politicians in the opposition. In keeping with this desire, the Family Planning Bureau was changed to "Maternal and Child Health Bureau".

Ceylon also had its IUD programme, but there is some evidence that its results were quite different from those in India and Pakistan. A survey carried out between May 1967 and November 1968 of IUD acceptors showed a discontinuation rate of 0.7 percent.⁴³ This was in marked contrast to the discontinuation rates found in India, which reached the fifty percent level. The Preethi (condom) and Mithi (pill) commercial distribution scheme, begun in 1973, enjoyed a rapid rise in sales comparable to that in India's Nirodh marketing scheme.⁴⁴

Although Sri Lanka's rate of natural increase as well as crude birth rate were the lowest in the region, there were and are features of the political environment which have made its government more sensitive to the spectre of rapid population growth and anti-fertility policy backlash. Sri Lanka's government has had a stronger commitment to providing a wider range

of goods and services to its citizens than have the other countries.⁴⁵ Although there has been oscillation in this commitment according to which party was in power, the government of the day has always been expected to provide certain minimum levels of health care, transportation, education, and so on. The impact of projected rates of population increase on the Rice Subsidy Scheme alone, for example, estimated according to a "high growth" projection, was to raise costs by 108 percent over seventeen years beginning in 1971. According to the "low growth" projection, by contrast, the cost of the Scheme was expected to increase by only 60 percent.⁴⁶

While Sri Lanka planners have been sensitive to the harmful effects of population growth on the economy, politicians have been, in pre-election years, very sensitive to the damage that fertility policy could do to their prospects. This has been due to the electoral significance which the main communal division in Ceylonese society between Sinhalese Buddhists and Tamil Hindus has traditionally had. C.C. DeSilva, in his history of Family Planning in Sri Lanka, remarks that:

It is a curious fact that practically at every election since 1960 or so, one of the main planks of the opposition attack on the government misdeeds was the latter's encouragement of Family Planning: whichever side was out, attacked the one that was in;...as soon as they (the victors) have settled down to the business of governing they realize that Family Planning is an in-eluctible pre-option.⁴⁷

In India, there were groups who spoke out against family planning, but the government's response to these was the silence properly accorded to cranks. Moreover, the electorate there has traditionally been divided along many more lines than those of religious community. In Ceylon, ethnic/religious spokesmen were taken seriously. Prior to the May 1970 election,

for example, the minister of health declared:

Sinhalese and Tamils must keep their races growing
....To fulfill this noble task, their women should
be provided with all facilities to propagate the
races.⁴⁸

These remarks, and other like them, so contradictory to the avowed aims of the National Population Policy of 1965, were uttered to reassure those who believed the claims of prominent Sinhalese clergymen such as Mahanayake Theras and the Reverend Madihe Pannasiha. The attack on family planning in Ceylon was more vehement, sustained, and organized than in India or Pakistan. As in India, the most vocal opponents came from the religion of the dominant majority, and not from minorities, as one might expect. One Sinhalese clergyman declared that family planning was going to undermine the ethnic composition of the country due to differential rates of acceptance:

Owing to the methods of birth control now being practised, in another hundred years time the majority community would be non-Sinhala and the Sinhala race would be reduced to third place.⁴⁹

These preposterous views probably had less influence on policy than they did on the election statements of politicians, however. After the victory of Mrs. Bandaranaike in 1970 the government resumed its interest in promoting family planning, this time under the cachet of maternal and child welfare. It stressed in its statements that it would be even-handed, that is, it would work also in Tamil areas, and urged that the Family Planning Association of Sri Lanka do the same.

Opposition from ethnic/religious spokesmen lost what salience it had when a truly serious challenge arose to the government's existence in 1971. The JVP insurrection of April of that year was believed to have been largely

economic in its well-springs. The participants in that rebellion had been largely young men and women under the age of 25, and the relationship between growing unemployment and bottom-heavy age structure in Sri Lankan society precipitated renewed efforts on the part of the government to develop the economy and dampen the birth rate.

The five year plan of 1972-1976, drafted during the aftermath of the insurrection, sketched in general terms the government's renewed interest in expanding services and integrating them with Maternal/Child Health. There was no mention of motivating new clients, however.⁵⁰ Mrs. Siva Obeyesekere, the Deputy Minister of Health, stated unequivocally that fertility must be reduced, and done for demographic/economic reasons:

There is no dillydallying on this question. Either we practise family planning now and arrest the present rate of 370,000 births per year or face the prospect of more difficult times ahead.⁵¹

Mrs. Bandaranaike did not, however, speak out on the subject.

The influence of the foreign aid agencies after 1965 seemed to follow the pattern elsewhere in the region. The Ford Foundation gave grants to the Population Council of New York, which in turn aided the Family Planning Association of Ceylon. In the late 1960s, U.S. AID would have been the predominant donor, had its help not been declined by the Sri Lankan government for the same political reasons which prompted its caution in promoting family planning in pre-election years. There is no evidence of the effect, despite substantial sums given, of foreign donors on either the thrust of fertility policy or measures chosen.

Of the three institutional determinants which we are examining, namely, parliamentary democracy, federal structures, and bureaucratic capacity, the

first has already been considered. Sri Lanka's health policy, like Pakistan's, was formulated and implemented through the centre. Family planning programmes were not subjected to frequent organizational experimentation as they have in India and Pakistan, but remained a part of the existing health network. Following the 1970 election, the coalition government of Mrs. Bandaranaike made it clear that family planning facilities should continue to be an integral component of the family health service. Sri Lankan governments have generally desired to maintain a low profile. In any case, they have not had to build a separate family planning organization because the health network, as adumbrated in Table 4, was already capable of reaching far more clients than that in Pakistan, India, or Bangladesh. Health has had a higher status among ministries in Sri Lanka, according to some accounts, than it has had in India, Pakistan, or Bangladesh.⁵² However, the allocation for family planning, as a percentage of the health budget, has been about two percent (1968-1969).⁵³ This puts Sri Lanka lower than India and Pakistan for this indicator. Comparison of allocation, in any case, only indicates intended priority, and not the effectiveness or will with which money is spent.

* * * * *

Bangladesh entered a phase of assertive fertility policy for the second time (the first time having occurred when it was East Pakistan) in 1975. Penetration of the countryside by any kind of fertility control programme did not reach pre-independence levels until this time, when changes in leadership led to a renewed support for fertility limitation. By 1975, the Bangladesh economy was deteriorating rapidly due to floods and the breakdown of administrative authority. On January 25, 1975, Parliament amended

the 1972 constitution, making Prime Minister Mujib President of the country. On June 7, Parliament was compelled to make Bangladesh effectively a one-party state. The entire government was to be subordinated to this party, called BAKSAL, the executive of which consisted largely of Mujib's family. Mujib subsequently abolished all opposition parties, and altered other institutions such as the courts and the press so that they would be subservient to him.⁵⁴

In May 1975, a Bangladesh National Population Policy Seminar was held in which representatives from the foreign aid donor agencies attended. The government resolved to make a "still greater" effort at that time. To this end, the budgetary allocation for population planning was raised from 1½ percent of all expenditures for the Annual Development Programme for 1975 to 2.4% for 1976.

Beginning in September 1975, there was a series of military coups and counter-coups which put Ziaur Rahman in effective command of Bangladesh. Although the Bangladesh Population Project, begun under the Mujib government at the prodding of the donor agencies, had been initiated in 1974, it began to pick up momentum in late 1975 under the Zia government. Population was given a priority equal to that of food self-sufficiency. In January 1976, there was a nation-wide "Intensive Family Planning Week" to inform, motivate, and deliver contraceptives. Teachers, government extension workers, and model farmers joined with family welfare workers in an attempt to reach every household.

There was also, in 1976, an attempt to improve and expand maternal and child health-based family planning distribution, and large numbers of

men and women were hired for this purpose. Distribution of condoms, pills, and IUDs increased by 100 percent. This increase has been attributed largely, however, to the very low levels prevailing in previous years.⁵⁵

There is no doubt that Zia's enthusiasm for fertility control was a crucial factor in this upsurge in activity. He exhibited, however, the same naivete that Ayub had about the ease of motivating clients. In 1980, for example, he spoke of plans to increase the number of sterilizations from the then current 25,000 per month to levels of 100,000 or 200,000. He avowed that "our people want to do it, but we don't have the capacity to sterilize". On another occasion he described the reaction to his exhortations at a public meeting:

I told them that you have got to do family planning -- two children -- and I told them, raise your hands. And all the men, women, and children raised their hands. Now, many people necessarily did not understand what I said. But they raised their hands. When they go back, they will ask their friends, 'why did I raise my hand?...and they will want to do it.... You see, now we have motivated the people.'⁵⁶

Ideologically, Zia's victory over his rivals in 1975 represented ascendancy of development through aid over Mao-style autarchy; a path favoured by his rival Abu Taher.⁵⁷ Although the trauma of liberation and subsequent calamities had left little choice as to which road could be taken, Zia's open espousal of aid dependency probably gave the donor agencies greater leeway than they need have been given in determination of the organizational aspects of fertility policy and programmes.⁵⁸ The International Development Association (IDA), the development arm of the World Bank, negotiated a population project costing \$45 million. Bilateral population agencies could not agree with the approach of the IDA, which

featured a complex mix of programmes involving five different ministries. The IDA was willing to direct bilateral projects, but the other major donor, the United Nations Fund for Population Activities, would not surrender the autonomy necessary for coordinated activities, and ultimately they mounted separate projects.

The World Bank, chairman of the Aid Bangladesh Consortium, was particularly dissatisfied with the arrangement whereby the Population Planning Division would be placed within the Ministry of Health, on the grounds that the health bias would exclude other ministries which ought to be included if an all-out effort were to be mounted. The IDA, therefore, dictated high-level appointments -- usually preferring to de-emphasise the health bias -- and attempted to stipulate which functions would be performed by which ministries. The Bangladesh Government was compelled to agree that the part of the project financed by IDA soft loans should be subject to frequent searching reviews, prescriptions from which would be binding.⁵⁹

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In all four of these countries, the adoption of stronger national fertility control policies followed the intervention by strong leaders in what they perceived to be a worsening demographic and economic situation. The measures chosen, both technical and organizational, were determined by what looked bureaucratically and politically feasible, and by outcomes of the trial and error of previous programmes.

Upon a closer examination of the period just preceding the actual launching of more vigorous programmes there appears to have been a period of "thought" on the part of key leaders. Ayub's concern about population and

his interest in its control was evident as early as 1959, while Nehru, in his address at the Asian Population Conference is a true reflection of his thinking, showed his heightened interest. In Ceylon, the question of population began to appear in planning documents in 1962 and 1963, and in Bangladesh, there was some discussion of fertility control policy issues in early 1975 under Mujib's new one-party state.

The Sri Lankan case illustrates that no matter how daunting fears of political opposition to fertility control policy may be, they will be overcome where overpopulation or overly rapid population growth appear sufficiently formidable. Although both major political parties were attuned to the political implications of excessive forthrightness on the question of fertility control, once in office, they were willing to take a stand. Dudley Senanayake, who showed his interest in fertility control as early as 1953, was the first to initiate a National Population Policy when he returned to office in 1965. Under the military governments of post-1975 Bangladesh, fertility control policy rose from its moribund state under the Awami/BAKSAL government to at least the level of effort which had been achieved under the Pakistani regime.

Once the institutions of fertility control policy are in place, for example, the Department of Family Planning in India, or the Population Planning Division in Pakistan and Bangladesh, it does not appear to have required a dynamic leader to keep them there, and only a direct political upheaval to dislodge them. For example, the population policy of the UNP government in Sri Lanka was continued by its successor after 1970, even though Mrs. Bandaranaike herself did not take a vocal role in its perpetuation.

India's heightened fertility control policy after 1965 seemed to continue independently of Mrs. Gandhi, who was passive in regard to the issue until 1973. Except for the hiatus of war, the government of Pakistan also continued to devote the same approximate order of resources to its fertility control programmes.

Just as the attendance of a prominent leader at population conferences, the public manifestation of "thought", preceded shifts in fertility control policy action in Pakistan (1964), India (1963), Ceylon (early 1960s) and Bangladesh (early 1975), the Bucharest Conference of August 1974 was a harbinger of a new plateau in this policy area. Without denying the value of conventional family planning approaches, the Conference registered some "new" conceptions about the preconditions necessary for mass acceptance of small family norms. The consensus was that the "soft" path to motivation through improvement in quality of life and hence modification of fertility decision calculations of couples was the answer.⁶⁰

As India, Pakistan and Ceylon translated the ideas of the international birth control movement into policies in the early 1960s, a government of the 1970s would be likely to draw from the ideas prevailing at the time if it felt that a change in policy were necessary. Such a "necessity" would be perceived by a leader who believed that demographic and economic trends constituted a sufficiently urgent crisis to warrant more radical intervention. If his government had already given the conventional fertility policy motivational approaches of advertising, incentive payments and canvassing a thorough try, he would be likely to conclude that only these new approaches held hope for further reduction in the birth rate and render his conclusions

into active programmes. India qualified according to these criteria. Mrs. Gandhi experienced a change in thinking and appointed a very able minister. This man, Karan Singh, proceeded to change the emphasis of India's fertility control policy to one more in line with the intellectual currents of the time.

CHAPTER III

FOOTNOTES

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CHAPTER IV

BEYOND FAMILY PLANNING

In 1969, Bernard Berelson, Director of the Population Council of New York, coined a phrase which was to demarcate nicely the conceptual boundary in the fertility control field: "beyond family planning". In the article bearing this phrase as its title, he recorded the conviction that the traditional voluntary family planning approach had not been effective in limiting population growth.¹ He then proceeded to review all of the fertility control measures which had been proposed over the years, some of which had been tried in the countries under study here, and some which had not. His article is useful because of the exhaustiveness of his list. We can use this list, then, to ascertain for a given time, which alternatives were left to the South Asian countries. The list lumps together what I have called "soft" and "hard" types of measures of fertility control, and ranks them according to such criteria as scientific readiness, political viability, and administrative feasibility. His tabulation of these measures and their likely criteria, reproduced overleaf, provides for the student of the subject a useful map of the fertility policy universe.

By 1975, India, Pakistan, Sri Lanka, and Bangladesh had either considered or tried many of these proposals. None had, however, tried to impose involuntary fertility control (category B). Measures under category E, that is, tax and welfare incentives and penalties, would not apply to South Asian countries where the majority of citizens do not pay income taxes.

TABLE 5

Fertility Policy Proposals By Criteria

| <u>Measure</u> | <u>Scientific Readiness</u> | <u>Political Viability</u> | <u>Administrative Feasibility</u> | <u>Economic Capability</u> | <u>Ethical Acceptability</u> | <u>Presumed Effectiveness</u> |
|---|--|--|---------------------------------------|---|--|-----------------------------------|
| A: Extension of voluntary fertility control | high | high on maternal care, moderate to low on abortion | uncertain in near future | maternal care too costly; for local budget; abortion feasible | high for maternal care: low for abortion | moderately high |
| B: Establishment of involuntary fertility control | low | low | low | high | low | high |
| C: Intensified Educational Campaigns | high | moderate to high | high | probably high | generally high | moderate |
| D: Incentive Programmes | high | moderately low | low | low to moderate | low to high | uncertain |
| E: Tax and Welfare Benefits and Penalties | high | moderately low | low to moderate | low to moderate | low to moderate | uncertain |
| F: Shifts in Social and Economic Institutions | high | generally high, but low on some specifics | low | generally low | generally high, but uneven | high, over long run |
| G: Political Channels and organizations | high | low | low | moderate | moderately low | uncertain |
| H: Augmented research efforts | high | moderate to high | high | high | high | uncertain |
| I: Family Planning Programs | generally high but could use improved technology | moderate to high | moderate to high | high | high | uncertain |

SOURCE: Bernard Berelson, "Beyond Family Planning", Studies in Family Planning, No. 38, Feb. 1969, p. 11

TABLE 6

Fertility Policy Proposals as Considered and Tried, and
Their Perceived Effectiveness c 1974

| | <u>Proposal</u> | <u>Considered</u> | <u>Tried</u> | <u>Tried and Thought Ineffective</u> | <u>Predicted Political Viability</u> |
|--------|--|-----------------------------------|---------------------|--|--|
| ↑ soft | I: Family Plan- ning Programmes | all | all | India | high |
| | A&F: Maternal care, status of Women, other social/ economic Insts. Changed | India Pakistan (Sri Lanka)* | no no (S.L.)* | none | high |
| | D&E: Tax Benefits, Penalties, Incentives | India Pakistan | India Pakistan | India | moderately low |
| ↓ hard | B: Involuntary Infertility Control | none | none | none | low |

*Sri Lanka had already arrived at a point where such measures had been taken. Because they were not necessarily intended to induce lower fertility, they were not, by definition, fertility policy.

As Table 6 illustrates, all countries had implemented programmes of conventional family planning but only India had arrived at the conclusion that there were no more technique-centred crash programmes to try. All countries had considered "soft" measures, and Sri Lanka had already arrived at a point where such measures, whether or not specifically implemented in order to induce decisions to have fewer children, had been taken. Moreover, Sri Lanka's birth rate by 1975 was very near the target set in 1965 under her National Population Policy (Table 1). Speaking strictly from the standpoint of ideas, then, and assuming they were politically and economically costless, India, Bangladesh and Pakistan had the alternative of introducing soft options and Sri Lanka had the choice of improving on its quality of life still further if it wished to accelerate its birth rate decline. However, Bangladesh and Pakistan, again, disregarding the political viability of such actions, had either not tried incentives or had not found them ineffective, and could therefore try them or keep on using them.

On the other hand, India had tried category D in its several permutations, and found it insufficiently effective. Although Pakistan, Bangladesh and Sri Lanka were not known to have considered compulsion, some Indian states were known to have attempted marginally coercive tactics in 1966.² If the governments in these countries were resolved to take further, more vigorous action in the fertility control area, then it would appear that any of them might pursue the latest indirect social/economic inducements, but only India would be likely to try both these and/or involuntary fertility control.

That there was a commitment on the part of the government in India,

in the persons of Mrs. Gandhi and Dr. Karan Singh, to take the soft option of fertility control was evident as early as the Bucharest Conference, when Dr. Singh made his famous declaration. In the same month as that conference, Mrs. Gandhi sent a letter to every sarpanch, or head man, in each of India's 570,000 villages, urging lower birth rates. She appeared to share her health minister's gradualist view of fertility control, as is shown by her explanation for reduced allocations for conventional family planning:

All workers of the family planning movement do not always fully appreciate the integral relationship between general development and family planning. When we reapportioned some funds to strengthen our rural health services, and there was a reduction in the percentage of the funds allocated under the separate head of family planning, there was an outcry. This was misrepresented by the international press to suggest that we were giving up our family planning programmes.³

Her imposition of an Emergency on June 26, 1975 gave no hint of the direction subsequent fertility policy, if any, would take. Initially, she showed no interest in population issues. Population was not mentioned among the 'Twenty Points', a list of priorities published shortly after her declaration. In fact, the Population Council of India was forced to shut down in 1975 for want of public or private support.⁴

Fertility control became a matter of interest to the government in February 1976, after it was included by Mrs. Gandhi's son Sanjay as one component of his unofficial 'Four Point Programme'.⁵ Then, in April 1976, Karan Singh announced a new National Population Policy which appeared to be a blend of both soft and hard types of fertility control. It quickly became apparent, however, that it was the latter type which would be put into practice. The policy statement spoke of the national imperative of curbing

population growth:

To wait for education and economic development to bring about a drop in fertility is not a practical solution. The very increase in population makes economic development slow and more difficult of achievement. The time factor is so pressing, and the population growth so formidable, that we have to get out of this vicious circle through a direct assault upon this problem as a national commitment.⁶

Most of the measures outlined in the statement reflected the latest thinking in population policy-making, and could have been used as a model in any country of the subcontinent. State allocations of finance, formerly based on population of the states, were frozen at 1971 levels and family planning performance was to be one consideration in the allocation of resources from the centre to the states. Female education, nutrition, and basic health services were given some importance. Nuptiality patterns were to be influenced by raising the minimum age at marriage to eighteen for females and twenty-one for males; there was to be a "population education" component in school curricula; all government departments were to be involved in the family planning drive; larger monetary incentives were to be made available to acceptors of sterilization; Zilla and Panchayat Samitis, teachers, cooperatives, organized labour, private population groups were all to be brought into the fertility control drive.

These ideas had been expressed before. Where the new policy departed from previous ones was in two compulsory measures. The first was the permission given to the states to make sterilization compulsory. The second was the compulsory sterilization imposed on those employees of the central government who had a specified number of children, and the permission given state governments to impose their own small family norms on their employees.

It was these latter compulsory measures which became the predominant features of the new policy. Although Maharashtra was the only state to initiate passage of a compulsory sterilization bill, many states now had the authority to pursue the vasectomy targets which had been assigned them through the whole state bureaucracy, and without their having to stir the inner motivation of potential clients. The public in many parts of India were required to produce a sterilization certificate before permits, licenses, and so on would be given. Teachers' salaries were withheld for inadequate recruitment of acceptors.

The Centre fixed a national target of 4.3 million. Statewise allocation of targets was worked out by the Central Family Planning Council. These were "scientifically" determined and were thought to require stupendous efforts to achieve. Nevertheless, under the pressures mentioned above, these targets were subsequently raised by a number of state governments. Table 7 shows how various states raised targets assigned them:

TABLE 7

Statewise Sterilization Targets, National Population Policy, 1976, in Lakhs (1 lakh = 100,000)

| <u>State</u> | <u>Assigned</u> | <u>Raised To</u> | <u>Achieved April-October 1976</u> |
|------------------|-----------------|------------------|--|
| Bihar | 3 | 6 | 2.04 |
| Haryana | .52 | 2 | .79 |
| Maharashtra | 5.62 | 12 | 5.16 |
| Himachal Pradesh | .315 | 1 | .5 |
| Madhya Pradesh | 2.675 | 7 | 7.43 |
| Rajasthan | 1.75 | 3.5 | 2.92 |
| Punjab | .465 | 2.5 | .66 |
| Uttar Pradesh | 4. | 15 | 5.55 |
| West Bengal | 3.92 | 11 | 7.312 |
| Delhi | .29 | 1 | - |

Source: Columns 1 and 2, Government of India, Commission of Inquiry into Misuse of Power During Emergency (Shah Commission), 1977, vol. III (final), p. 154. Achievement figures from B. Ghosh, "India's Population Policy: An Appraisal," Demography India, 7 (1, 2, 1978), p. 45.

Despite the inability of most states to achieve their revised targets, there was an unprecedented rise in numbers of vasectomies performed throughout India. The target set by the Ministry of Health of 4.3 million for 1976-1977 was exceeded by September 1976, and most states overfulfilled their original quotas.⁷ During the 1976-1977 period 8.25 million people were sterilized, most of them between July and December 1976. Couples estimated to be "protected" rose from 14% to 21% for India as a whole.⁸

This accomplishment was the outcome of the personal pressure exerted by Sanjay Gandhi, through the alteration or bypassing of the formal channels of public policy formulation and implementation. The development-oriented measures of the National Population Policy were ignored in practice, and the entire array of health, police, and other government machinery was put at his disposal. The Lok Sabha, which had reacted to proposals of semi-coercive measures in 1966 with a "storm of questions" had been reduced to rubber stamp status. Policy directives were issued from the Prime Minister's Office, wherein resided Mrs. Gandhi's "kitchen cabinet" or inner circle of close associates. Closest to her was Sanjay, to whom she often referred visiting state Chief Ministers. He enjoyed informal domination of the Congress Party, and formal control of the Youth Congress.⁹

The revised targets were received by the Chief Ministers, who passed them on to each department down the chain of command to the District Collectors, or District Magistrates at the lowest level.¹⁰ Orders transmitted to the states left no room for equivocation, as they had done under all of the previous regimes.¹¹ Sanjay's crucial role at the top of this column of pressure is illustrated by memos such as this one from the

Joint Director of Family Planning to various District Officers:

I wish to inform you that Shri Sanjay Gandhi is visiting Maharashtra State about October 28, 1976 and the Chief Minister desires that before the visit of Shri Sanjay Gandhi, Maharashtra State must have completed 5 lakhs sterilizations. You will appreciate the seriousness with which the C.M. has issued instructions; and, therefore, though the task is stupendous, we shall achieve this objective.¹²

Where Sanjay's writ ran strong, then, revised targets and the zeal with which they were pursued were highest. Where state governments enjoyed independent bases of power, such as in Kerala, Kashmir, and Tamil Nadu, they were able to moderate or resist the pressure for performance. The strength of the Gandhis appeared to depend very much on linear and cultural distance from Delhi. "Family planning" performance was most dramatic (and repressive) in the Hindi heartland of Haryana, Uttar Pradesh, and Madhya Pradesh. Its intensity dropped off beyond this region.¹³

Evidence of the repressiveness of the sterilization drive is largely anecdotal, but does add up to more than the isolated incidents claimed for it by Mrs. Gandhi on British television.¹⁴ There is evidence that the Haryana authorities, for example, used police systematically to round up villagers. The Chief Minister, Bansi Lal (a member of the inner circle) chose to apologize, rather than deny the high handedness of his state government's sterilization campaign in the January 1977 election campaign. There were incidents of violent resistance in New Delhi in which an undetermined number of people died, and in Muzaffarnagar, U.P., where 20 to 25 people were killed. Most of the deaths were the result of "police firings", but several were those of officials at the hands of irate villagers.¹⁵

There were, as well, a number of deaths due to post-operative sepsis.

In September 1976, the government offered Rs. 5000 (per capita annual income for India is about Rs. 1000) to the families of those who died within ten days of sterilization. Of the 900 claims, 700 were, by 1979, paid out by the Janata government. It is difficult to tell how many deaths actually occurred as a consequence of the sterilization operations, but it is in the order of three figures.¹⁶

The policies promulgated by the Ministry of Health and Family Planning had very little to do with what became the major features of fertility control policy under the Emergency. Its impotence also meant that it could not moderate the aggressiveness of the informal centre of power. Whether or not there was a will to do so is questionable. On the one hand the Ministry on many occasions sent circulars and memos to the state governments urging them not to overstrain themselves or use coercion of any type. On the other hand, it never published a code of acceptable behaviour.¹⁷ An agency of the Centre, called the Intelligence Bureau, in its Family Planning Programmes: An Assessment (September 24, 1976), brought up the problem of excessive zeal on the part of the state governments in raising targets. It also aired the matter of resistance from clients in some states. This circular was brought to the attention of Karan Singh by his Health Secretary, Gian Prakash, who suggested a meeting. There is, however, no record of any meeting. Indeed, throughout 1976, the Ministry congratulated those states which exceeded their original targets. In December, the government, in Centre Calling, an organ of the Ministry of Health and Family Planning, congratulated itself on the progress of the programme. Meanwhile, the Health Secretary addressed a meeting of senior officers of the Health Department of the Government of Bihar. It was described by a participant as

"the most unpleasant meeting held at the state level". The Secretary upbraided the Chief Medical Officers for inadequate performance, saying it "amounted to a criminal and anti-national act" to drag one's feet on the sterilization issue.¹⁸ Except for token disclaimers, then, the Ministry appears to have been subservient to the fertility control hawks within the Emergency government.

The final shift in fertility control policy under the Emergency was, of course, its termination. Despite press censorship and the sycophantic reluctance of the government's intelligence agencies to bear bad news, the above-mentioned incidents of backlash could not escape its attention. Naturally enough, because all government machinery was being used in the sterilization drive, neglected areas began to require attention. Malaria was returning, and the health system could not continue to disregard it indefinitely. Moreover, the increased fear and suspicion with which any sort of official who entered the countryside began to be viewed rendered other tasks unrelated to the sterilization campaign impossible to perform. It appeared, then, that the sterilization campaign was administratively infeasible, as well as politically so.¹⁹

The final blow to coerciveness in fertility control policy was dealt by the Indian electorate in the January 1977 election. It was a campaign issue, and is known to have been a major factor in the defeat of the Congress government. In those states where the sterilization drives had been strongest, the Congress party lost heavily.²⁰ The Janata government promised never to use coercion in family planning again.

Because it had capitulated on the Congress Party family planning

record, the Janata government was expected to be anti-family planning. In fact, it appeared that the programme might be reduced to the levels of the 1950s when Raj Narain, a champion of sexual abstinence, was appointed Minister of Health and Family Welfare (the name was changed by the Janata government).

However, India's fertility control policy machinery was not dismantled. The Janata government was silent on population issues for its first year in power, and the Draft Sixth Plan (1978-1983) did not view rapid population growth as a problem. It did, however, increase the Family Planning budget by 50 percent over levels earmarked by the previous plan. Implementation, however, was weak.

Following the Emergency vasectomy drives, acceptance of all types of contraception had been extremely low. Morarji Desai, who took over Raj Narain's portfolio in late 1978, issued statements emphasizing his personal belief in family planning, and during 1978-1979, there were family planning fortnights, "months", "quarters", and so on.

The Janata government disintegrated for reasons quite unrelated to fertility control policy, and Mrs. Gandhi swept to victory in January 1980. She resurrected the Twenty Points, none of which was concerned with population. Neither she nor her son Sanjay, before his death in June 1980, made very many references to family planning, although their views on the issue were strongly favourable.²¹

CHAPTER IV

FOOTNOTES

1. Bernard Berelson, "Beyond Family Planning," Studies in Family Planning, 38 (February, 1969): 1-15.
2. Robert E. Elder Jr., "Targets vs. Extension Education: The Family Planning Programme in U.P.," Population Studies, 28 (July, 1974): 252, 258.
3. Indira Gandhi's address to the National Population Conference, 1974; quoted in D. Banerji, "The Political Economy of Population Control in India," in Poverty and Population Control, eds. Lars Bondestam and Staffan Bergstrom (Toronto: Academic Press, 1980), p. 85.
4. Marcus Franda, "India's Double Emergency Democracy, Part II: Reactions and Adaptations," American Universities Field Staff Reports, 18 (December 1975): 11. For the government's attitude to voluntary organizations, see also, V.A. Pai Panandiker, R.N. Bishnoi, and O.P. Sharma, Family Planning Under the Emergency: Policy Implications of Incentives and Disincentives, (Delhi: Radiant, 1978), p. 77.
5. Davidson R. Gwatkin, "Political Will and Family Planning: The Implications of India's Emergency Experience," Population and Development Review, 5 (1, March, 1979): 35. The other points were adult literacy, dowry abolition, reforestation and equality among castes.
6. Robert Cassen, India: Population, Economy, Society, (London: MacMillan Press, 1978), p. 182.
7. Misreporting is not thought to have been a major problem. See Gwatkin, op. cit., note 38. Table 7 achievement figures are from Centre Calling 11 (1, 2), reproduced in B. Ghosh, "India's Population Policy: An Appraisal," Demography India, 7 (1, 2, 1978): 45.
8. Gwatkin, op. cit., p. 49.
9. James E. Kocher, "Population Policy in India: Recent Developments and Current Prospects," Population and Development Review, 6 (2, June 1980): 309, no. 19.
10. Gwatkin, op. cit., pp. 39, 40.
11. Ibid., p. 41.
12. Government of India, Commission of Inquiry into Misuse of Power During Emergency (Shah Commission), Volume III (final).

13. Gwatkin, op. cit., p. 55, no. 24.
14. cited in Cassen, op. cit., p. 181.
15. Gwatkin, op. cit., p. 181.
16. Ibid., p. 47.
17. Cassen, op. cit., p. 185.
18. Shah Commission, p. 157.
19. Cassen, op. cit., p. 187.
20. Myron Weiner, India at the Polls: The Parliamentary Elections of 1977, (Washington: American Enterprise Institute, 1978), Chapter 6.
21. Kocher, op. cit., p. 305.

CHAPTER V

ANALYSIS AND CONCLUSIONS

The purposes of this thesis are to discover the importance of each component of the mix of determinants of the fertility policy fact, of the particular fertility control measures chosen, and of shifts in policies. While the underlying reason for fertility control policy is simple, particular measures chosen are the outcomes of a multiplicity of determinants. The coerciveness of these policies, and the shifts in policy, will be shown in this chapter to arise from the actions of leaders. These leaders, I will show, do not act entirely out of personal predispositions, but in fact are themselves impelled or constrained by their political circumstances.

The fundamental determinant of fertility control policy throughout all phases has been overly rapid population growth. The perception that population growth has been excessive stemmed from the powerful urge among leaders to overcome the poverty which has gripped their countries from time immemorial. This urge was particularly strong on the part of people such as the Nehrus, Ayub, Ziaur Rahman, and Sri Lanka's leaders. They were influenced by planners, largely economists, who could see that gains in GNP of 3-5% were easily wiped out by population growth rate of 2.5-3.5% per year. Since population growth is the outcome, largely, of an excess of childbirths over deaths, and since death control has been a "moral imperative", and childbirth is the outcome of conception, the logical policies to initiate seemed to be those which facilitated contraception and persuaded couples to have smaller families.

In phase one, the tenets of the family planning movement already fitted the goals of government up to a point -- that is, the right of every couple to decide for themselves how many children to have. This concept was in keeping with the democratic ideals with which the South Asian governments began and was applicable as policy as long as one assumed that parents would elect to have fewer children once they had control of their own fertility. The realization that this assumption was wrong marked the passing of phase one.

One question posed in this thesis is, "what caused the governments in the subcontinent to act when they did?" The economic and demographic environments which India, Pakistan, and Ceylon inherited after independence were broadly similar, yet they adopted fertility control policies at different times. The outlook for food self-sufficiency in India was thought to be good and the commodities and terms-of-trade outlook in Ceylon were also bright. In Pakistan, due to undercounting, the rate of population growth was not as alarming as it was to some observers in India and Ceylon. There, leaders were aware that their populations were growing rapidly, but there was no unanimous recognition that this was a problem. Ceylon and Pakistan gave small grants to their respective family planning associations, but only India openly engaged in family planning work. The Indian lead in the 1950s can be attributed to the historical advantage she had in discussing fertility control as a matter of public policy under the Bhore committee and the Congress Planning Committee prior to independence.

During the pioneering phase, having a leader who was forthrightly favourable to fertility control was equally important as the duration of his

incumbency. In Ceylon, S.W.R.D. Bandaranaike and Dudley Senanayake were aware of the implications of population growth, and were partial to fertility control. Neither was in power long enough to translate this interest into public policy. It is possible that communal sensitivities would have precluded this anyway, but if so, there is no evidence that ethnic spokesmen were aroused by this issue at that time. In Pakistan, the question was far down on its list of preoccupations and similarly, in Bangladesh from 1971 to 1974 the situation was too turbulent for the government to consider fertility control policies. In India, fertility control policy had the chance of receiving consistent and concerted attention from the bureaucracy during the long period of Nehru rule throughout the pioneering phase.

The levels of activity of private family planning associations appear to parallel those of their governments. India had the oldest and most active movement beginning in the early 1930s and this activity continued after independence. Ceylon had a few population activists in the same period and the Ceylon government lent them token support, following their formation into the FPAC in 1954. Likewise, in Pakistan, where there was probably the weakest private family planning movement, the government began to support the Family Planning Association in 1955. In Bangladesh, the remnants of the erstwhile FPAP lay low during the pre-1975 (and post-1975) period. Nevertheless, Mujib (and of course Ziaur Rahman) made remarks favourable to fertility control, which suggests that by the 1970s, private associations had outlived their role as advocate, breaker of inhibitions, and politically safe surrogate dispenser of family planning services for governments. It is difficult then, to discern whether the activities of these groups are a

cause or a result of fertility policy adoption by governments or merely a concurrent event.

It was during the pioneering phase also, that population policy was firmly set in the direction of fertility control through medical clinics. This was due both to the adoption by governments of the family planning movement's ideas, and to the constraints of contemporary technology. The condom was the only extra-clinical method that was technically and organizationally feasible during the pioneering phase. Mass distribution of the condom did not occur until the late 1960s in India, Pakistan and Ceylon, which lends credence to the accusations of "clinical bias" during the early years.¹ The clinical approach was favoured by the family planning movement, whose stated goal was family welfare and not population control. This goal was shared by the governments of India, Pakistan and Sri Lanka during the first phase. That the motives for downplaying demographic objectives were political was shown by the conclusion of the Bhore Committee, which was that only family welfare was a politically safe goal. A political consensus around this goal among Indian elites was possible, whereas the goal of population growth rate reduction was too bald for some members in the early years. The pre- and post-independence governments therefore adopted the philosophy of the movement, as well as the clinical approach which accompanied it in India.

Generally, the particular types of measures taken to deal with the population problem in a given country were determined by methods available, the limits of organizational and infrastructural feasibility, and the personal sensibilities and predilections of particular leaders. India began

experimentation with the rhythm method after independence because mechanical methods were ruled out by the Prime Minister and his minister of health. Meanwhile, and subsequently, through pilot projects and attitude surveys, it was found that non-rhythm methods were not objectionable to the clientele public, and by 1959, in India, these experiments led the government to conclude that vasectomies were feasible, both surgically and administratively, and that, most importantly, there was a demand for them. Because India was the pioneer and the other countries lagged behind, they were able to learn from India's experience and thereby catch up to India on the technological front by 1965.

In the second phase, governments set national birth rate targets, and mounted a succession of technique-centred programmes. These were pushed with the most vigour in India and Pakistan and with the least in Ceylon. They amounted to little more than declarations by President Ziaur Rahman of Bangladesh. It is not a great discovery, then, to find crash programmes falling short of leaders' expectations in India and Pakistan, but not in Sri Lanka, where the gap between expectations and perceptions of failure was smallest. The major engine behind the renewed vigour for fertility control in Bangladesh, Ziaur Rahman, was assassinated in 1981, and subsequent developments there are an open question. In Sri Lanka there have also been fluctuations in fertility policy, but this has not been due to excessive ambitions and failures, but rather, has been an outcome of the electoral cycle.

Both Pakistan and Ceylon declared national population policies in 1965 while India committed a substantial rise in resources, up from 3.49% of the health budget (1956-1966) to 9.7% for the annual plan beginning in 1966, and

launched a major programme -- the IUD scheme -- the same year. The remarkable contemporaneity of these events lead us to look for environmental factors which all may have shared. All three had completed decennial censuses two to four years previously, the data of which may have required a few years to trickle up to policy-makers. It is known in India's case that population growth between 1951 and 1961 had alarmed planners. India also experienced a serious drought and crop failure in the mid-1960s. In Bangladesh, there was also crop failure and famine in 1974, just prior to the declaration of resolve to curb population growth. In all four countries, economic problems brought home to governments that the population/resource balance was not going to improve without much greater effort and more radical intervention.

There are two aspects of technology and organizational approach to consider. Birth control techniques themselves were determinants of both programmes and policies. Programmes centred on a particular method of birth control were chosen because, like Mount Everest, these techniques were "there". Moreover, one technique, the IUD in India in 1964 - 1965, was itself a catalyst for the renewal of a moribund fertility control policy. There is no evidence that new devices played this role to nearly this extent in the other countries. The IUD seems to have been chosen not just because of urgings by foreign experts, but also because of its novelty.

In Pakistan, there was an accent on improvement of management and logistics. This took the form of "inundation" of the distribution network of the Population Planning Division with condoms and later with pills. The search for a distribution system, first through dais, and then through male

family planning workers was not just the outcome of an American fixation with such ideas, although this was undoubtedly important, but was due also to the absence of an effective clinical network and, in the case of the pill, which was given without prescription, to an absence of a strong medical association. By the same token, Sri Lanka has not seen the need to build extra-clinical organizations because of the outreach capability of its existing health structure. In short, in the matter of measures taken, governments do what is feasible and keep on doing what they have been.

What differences do the variations found in these countries' institutions make during the second phase? India stands out as an institutional anomaly during the first two phases in respect of its federal structure. Health and Family Planning was effectively a concurrent subject. This gave the states greater autonomy in this policy area, yet since the centre controlled allocation of finances for programmes, it could keep the upper hand. However, federalism did give the states a greater freedom either to innovate or drag their feet in accordance with local preferences and conditions than did the corresponding provinces in Pakistan or districts in Ceylon.

More important to the assertiveness, or political will behind fertility policy than the federal/unitary distinction appears to be the differences found in democratic freedoms over time and space. Ayub and Zia, both military men, were less hesitant than Nehru and Mrs. Gandhi (before 1976) and the Bandaranaiques about initiating action policies which had within them strong motivational programmes. Both strongmen, despite efforts to build local support bases, were essentially top-down rulers isolated from the early-warning

signals of fair elections.

Left/right orientations or postures in governments did not appear to be reflected in types of fertility control policies chosen. Professedly socialist regimes such as Mrs. Gandhi's or Mrs. Bandaranaike's appeared to emphasize government solutions while initiating commercial distribution schemes as well. "Free enterprise" regimes such as Ayub's or Zia's and Senanayake's also gave a major role to government, while also promoting commercial distribution of supplies. On the other hand, Ayub, Ziaur Rahman, Senanayake, (and Sanjay, in phase three) were all more right-wing than their predecessors, and all were instrumental in pushing crash programmes.

Foreign aid donors did not influence the broad direction of fertility policy. However, they influenced the types of organizational approaches taken by governments. This imprint has been heaviest in Bangladesh, where over half of the government budget was externally funded, and the least in India, where little over ten percent of family planning activity was ever funded by foreign donors. In all cases, the "fertility policy fact" and the vigour or lassitude with which it was pursued originated from within.

One would expect communal sentiments to be important determinants of any policy which had the potential for affecting the composition of a population. In all four countries whose evolving policies have been described here, there were religious, ethnic, or regional elements who were opposed to fertility control because of this potential. In India, a very small number of Hindu extremists were militantly opposed to fertility control. In Pakistan, the only apparent opposition came from the Jamaat-i-Islami

on moral grounds. In Sri Lanka, Sinhalese Buddhist clergymen were quite vocal in their opposition, while in Bangladesh, the government feared to take any stand in its initial phase because of the association of fertility control with Pakistani fertility control policies and genocide.

Yet in only one of these countries, Sri Lanka, is there any substantial evidence that communal sentiments were an important determinant of fertility control policy. Why this was so will emerge from an examination of each case in turn. Firstly, in Sri Lanka, the religious and ethnic divisions were highly congruent. An absence of cross-cutting cleavages raised the salience of this single division to policy-makers. Although the Sinhalese Buddhist segment, which in fact did take to fertility control slightly more readily than the Tamil population, comprised 70% of all Sri Lankans, could not realistically expect to be outnumbered within any relevant historical time-frame, their perception of an overly numerous Hindu Tamil population may have been derived from the region-wide perspective, within which they correctly viewed themselves as a minority. In politics, perceptions, though false, have real consequences.

The question remains, however, as to why the backlash from the potential impact of fertility control policies on the ethnic, religious, or regional composition of populations in the other countries did not become a real consideration in the fertility policy-making process there. In India, although about 80% of the country was Hindu, the Hindus did accept family planning more readily than Muslims, and there was no dearth of Hindu/Muslim antipathy, this was seldom manifest in opposition to fertility control policy during the second phase. When there were some manifestations, as in Delhi during the

emergency, means whereby opposition (on the part of Muslims, who in this case were the ones who believed themselves the victims,) could affect policy had been suspended.

Likewise, in Pakistan, although the fissure was regional and ethnic, and numbers were closely balanced between the east and west wings, there is no evidence that fertility control policy was affected by this cleavage, which otherwise infused Pakistani politics from the time of independence. One can infer, if the low visibility of the Continuous Motivation Scheme in West Pakistan in the 1970s is any indication of the general ability of the Government of Pakistan to reach politically significant numbers of clients, that this was due to the shortness of reach of the Pakistani programmes. In Bangladesh, there is no record of the dominant Muslim majority (88%) feeling threatened by the dwindling Hindu minority. Conversely, there is no evidence that Zia took into account the sentiments, if any, of the Hindus or other minorities in formulating his fertility control policy.

In India, Pakistan, and Sri Lanka, there were communal politicians who were willing to make political use of any policy which affected their followers, but only in Sri Lanka and India, where, naturally enough, numbers were more important because there were honestly conducted elections, did they exploit the issue of fertility control policy. In the event, only those in Sri Lanka succeeded in influencing their government's policies at all.

It would seem, then, that even where communal rivalries exist, fertility control policy does not necessarily become a target of communal spokesmen, nor does the government necessarily heed them. Whether this occurs depends upon the sensitivity of the government to feedback mechanisms such

as elections, upon whether or not communalism has in the past regularly been a major electoral factor, and on the visibility of fertility control programmes. The actual potential of fertility control programmes to affect the relative size of vying communal groups is less important than the pre-existence of politicized communal rivalries.

Outcomes, either in the form of successes or failures in reaching acceptors, or in the form of backlash or its absence from target public, have been important to the determination of subsequent policies. Voluntary sterilization and sterilization camps in India and condom distribution programmes everywhere were thought successful and have therefore been continued. The process during the crash programme phase has been one of "learning by doing".² Since a great deal was tried in India, as compared with Bangladesh and Sri Lanka, a great deal more was learned there. One of the most important things learned in India for the pursuit of subsequent programmes was that those techniques requiring continuous motivation did not work well. This led to the stress on sterilization in that country. Both India and Pakistan recognized and began attaching increasing importance to motivation once the inadequacy of the traditional ideals of voluntarism in family planning were realized. India mounted a special motivation campaign in 1964, with its ill-fated "extension education" scheme and Pakistan did so beginning in 1969, with its Continuous Motivation Scheme. The value of these unsuccessful schemes was in showing that different approaches and more effort were going to be necessary if the masses of the population were to be reached. India lost all inhibition about paying incentive money by the early 1970s. One does not read of crash programmes in Sri Lanka because

of the extreme political sensitivity of the issue. Yet another, process-related, reason, however, is that successful programmes such as its IUD scheme were not abandoned in the search for newer and more effective methods, but were rather, continued unobtrusively.

While the Sri Lankan government had good political reasons for not announcing grandiose and unattainable demographic targets (the birth rate target of 25 by 1975 was, for whatever reason, nearly attained), the Indian government was in the habit of setting impossible targets in all economic areas, including population planning. The arbitrary setting of unattainable targets was done out of a "political need designed to generate optimism and enthusiasm".³ Bangladesh's Zia, who launched his country into a phase where there was at least the possibility of more effective programmes, seemed, with his patently unrealistic overestimate of the latent demand for family planning services, to be duplicating the high target-setting habit which India suffered from.

If government capacity and popular demand for contraceptive services were so far short of carrying programmes towards these demographic targets, and the order of allocation for population control in Sri Lanka, Bangladesh and Pakistan has been around 1.5 to 3 percent of the health budget, and in India up to ten percent, one is compelled to ask why, if the setting of targets was not to be completely meaningless, governments did not spend a great deal more. There are two explanations for this. The first is that family planning had a very low priority and therefore that its proponents lacked, relative to those who could exert pressure for other expenditures, adequate political weight. Budgetary battles occur behind closed doors, but

the allocation and expenditure figures seem to speak eloquently. Another possible explanation, which does not entirely exclude the first, and one which is borne out by the substantial underexpenditure in both Pakistan and India in the early years, is that the government infrastructure was simply inadequate to absorb any more funds. This could apply to India, Pakistan and Bangladesh, where, for example, trained workers, especially female workers, who would be indispensable for administering female-specific contraceptives, or even educating and motivating wives, were in chronic short supply. In fact, the great rise in expenditures, as compared with previous years in India, occurred when crash programmes offering incentive payments were launched. The dispensing of cash incentive payments during vasectomy drives, naturally enough, produced the fewest bottlenecks to expenditure.

To this point, I have summarized what these countries have done during their second phases, and highlighted the roles of context (economic, demographic, and technological); institutions (federalism, infrastructural, and democratic), ideas (ideology) and process (success, failure and goals). I have shown how this mix of determinants has influenced measures chosen. The first category of analysis, environment, appears to be important in determining when a shift to stronger policy took place, while all the rest appear to have been important in explaining differences in measures chosen.

Notwithstanding the common experiences of scarcity crises coupled with frightening census reports, which point to the primacy of changing context as a determinant, the occurrences of specific policy shifts have had a political cause. Environments alone cannot induce policy changes, nor can leaders alone. The demographic/economic outlook was worse in Pakistan than

in India during the pioneering phase, yet India led Pakistan by about five years. Likewise, the economic/demographic environment in pre-1975 Bangladesh cried out for intervention, yet no one intervened. The fact that Sri Lanka's birth rate has always been much lower than that of her neighbours did not deter her leaders from formulating a National Population Policy when they finally perceived the risks of doing nothing as greater than the political risks of doing something. The population/resource balance or imbalance must be perceived as a crisis by a leader who is in command of the polity, or who is close to those who are. He (or she) will then initiate shifts in fertility policy which he will implement through existing institutions. This is supported by the evidence from four of five fertility policy events recounted here. In Ceylon (1965) and Bangladesh (1975), significant shifts in fertility policy followed the rise to power of new leaders. In Pakistan (1965) and in India, when Mrs. Gandhi had a change of views, shifts in policy were stimulated by leaders who had been in office for about six years. Whether change of regime or change of mind operated in these cases, the impetus originated from national leaders. In the anomalous case, (India, 1965), a substantial rise in commitment to fertility policy occurred at the end of Nehru's life and during Lal Bahadur Shastri's brief interlude. Neither was a family planning "hawk", although Nehru began making some strongly favourable statements in 1963. His appointment of two energetic and able officers indicates this resurgence of interest.

In the third phase, India was to assume, at any rate, the pattern which the other three countries followed in their second phases. The role of leadership in the general pattern of the fertility policy-making process

on the subcontinent is rendered clearer by examination of this third phase in India.

The critical point in the succession of the phases of fertility control policy was at the point in the crash programme phase, when all techniques were either introduced or ruled out of the question as impracticable (such as the pill in India) and all democratic methods of persuasion were essayed and judged inadequate to stem a rate of reproduction which was threatening to wreck "time-bound" targets or were going wrong due to maladministration or other complications associated with implementation. At the cut-off times set down on page 3, Sri Lanka's birth rate was at the 1975 target, Pakistan was still experimenting with logistical and administrative controls, and Bangladesh's policy-makers were still struggling with the challenge of reaching her ninety-million people with any fertility control programme at all.

India, however, again in the lead, had reached the above described juncture by 1973. The vasectomy camp method had lost its appeal because of its cost; fatalities had occurred in those areas where the government could least afford the fall of this method into disrepute; and the suspicion had arisen that demographic goals were being subverted to an unacceptable extent by misreporting and middlemen. At the same time, all other devices including IUDs and condoms, although still available, were not seen as the "solution" to the problem of target achievement. It was at this point, when the alarming 1971 census results came in, and the economy was believed to be quite sick, that Karan Singh introduced his "beyond family planning" proposals. The idea that development must precede birth rate declines had been

circulated before in India, as well as in Pakistan and Sri Lanka during the first phase when prospects were brighter. This philosophy differed from that of the 1950s, however, in the fervor with which the Indian government embraced it. This fervor was, perhaps, a measure of the dissatisfaction with methods tried by India to date. All four countries were exposed to the ideas which were the highlight of the Bucharest conference of 1974. India went farthest in stating its intentions to go beyond family planning by recording them in the Fifth Plan, the population provisions of which bore the stamp of Karan Singh. The provisions for female education, late marriage; more widespread maternal/child health, minimum needs, and so on, however, were not implemented, and so do not fall under the definition of fertility control policy given in Chapter 1. As an airing of ideas, however, it might have been a harbinger of real shifts in fertility policy.

The final stage of the process, and the latest thinking on fertility control, therefore, foretold of a major shift in fertility policy action both in strength and direction. As in most of the policy events recounted in earlier chapters, a key leader intervened in 1976 to shape the strength and nature of this shift. This occurred when Mrs. Gandhi altered the institutional structure of India so as to make her own office the exclusive centre of power, subordinated parliament, elevated to preeminence her son Sanjay, an unequivocal family planning "hawk", and suspended free elections and in other ways blocked opposition and criticism. Although democracy had been suspended under the Emergency, fertility control was not in Mrs. Gandhi's Twenty Point Programme. This suggests that population issues had been pushed back down to a position of low priority in her mind. If fertility control

control policy were to experience an upsurge, and the thesis that leadership is the key variable is correct, some one nearly equal in power to Mrs. Gandhi would have to precipitate it.

Sanjay fulfilled the leadership requirement, pushing the developmentalist measures of the National Population Policy promulgated by Karan Singh to the background. Sanjay's methods during the Emergency were attributable almost entirely to lessons which he and the subordinates in his chain of command had drawn from India's past experiments. These were the efficacy of sterilization delivered through camps and clinics, and motivated through cash payments. To this he added the tactic of compulsion.

The maintenance of such a policy, after evidence began to come in that it was encountering considerable resistance, may be explained by the scattered and atomistic natures of both information and opposition. The muzzling of the press and the sycophancy of the government's intelligence wings also contributed to its deafness. But as is shown by the quick backpedaling by some politicians when an election was called, the suspension of this ultimate feedback mechanism was the most important explanation of all for the continuation of compulsion in family planning.

Both Pakistan and Bangladesh experienced the rise of military men who abolished parliamentary institutions, yet neither resorted to compulsion in fertility control. Both recognized the need for popular approval, and sought it by forming their own parties and building local governments. The democratic history of India may have meant that the Emergency government had insufficient experience with dictatorship. The novelty of power without opposition in the parliamentary sense may have blinded the inner circle to

the existence of extra-parliamentary opposition.

The calling of fair elections, if not the Emergency fertility control policy, was therefore, a political "blunder" of major proportions for which Mrs. Gandhi and Sanjay were responsible. Hitherto, leaders, including Mrs. Gandhi, had been more wily in their calculations before launching vigorous crash programmes. Mrs. Gandhi had favoured the "soft" politically feasible path to fertility control before she suspended all democratic rights and expunged the opposition from the Lok Sabha. Afterwards, she (wrongly) believed that she was politically able to initiate more compulsive measures. Likewise, in Pakistan, it was not until Ayub had gone through the legitimizing ritual of a presidential election that he commenced the National Population Policy of 1965. Sri Lankan leaders renewed their stand on fertility control when they were least vulnerable to attack on the issue from opponents; namely, after they had attained office. From the beginning of his rule, Ziaur Rahman strove to suppress the Awami/BAKSAL opposition as well as dissident factions of the armed forces by suspending those checks which remained to unhindered exercise of presidential power. He thereupon initiated the types of fertility control policies which his predecessor, Mujib, had feared to do, either because of indifference or potential opposition.

There is, thus, a pattern to fertility control policy formulation and implementation in these four countries, one which follows the rise and fall of government perceptions of the demographic/economic environment. In all four countries, rises in policy assertiveness occurred in response to overly rapid population growth. Their catalysts, however, were the imposition of

the wills of individual actors to alter this environment.

We have looked at the inceptions of fertility control policy in four countries, major shifts in the same four, and another major shift of qualitatively different proportions in one of them. The first stirrings of fertility control policy seem to be less the outcomes of personal whims than of a combination of the urgings of interest groups, the post-independence urge to modernize, and the absence of opposition. Out of the total of five shifts (three in 1965 and two in 1975) as I have constructed them from the history of fertility control, it is unlikely that four of them would have occurred without the activities of their respective precipitants in the persons of Dudley Senanayake, Ayub Khan, Ziaur Rahman, and Sanjay Gandhi. The shift by India into a stronger policy in 1965 did not depend on the initiative of a single personality, but rather, on the catalyst of gadgetry and the atmosphere of urgency.

There were, for each of the major initiatives in fertility policy, also corresponding terminations in Sri Lanka, Pakistan, and India. These were due to the fall of governments in Pakistan (1969) and India (1977). In Sri Lanka the policy was temporarily terminated in anticipation of elections. The declines of the various crash programmes in India between 1969 and 1975 present again evidence contrary to the generalization that fertility control programmes decline for political reasons. The periodic demoralization of the Ministry of Health and Family Planning, which stemmed from perceptions of failure and led to the cessation of one method-oriented programme after another, appears to explain these terminations. The case of India prior to the Emergency suggests that in comparison with the other

countries, its fertility policy-making process was the least political and the most "mature" during those phases. This can, of course, also be explained by the stability of rule. In the other countries the frequent changes in government and other upheavals meant that it was impossible to carry many policies through to implementation and ultimate success or failure, as it was in India.

Idiosyncracies of history and locality are important, and they influenced the manner in which governments went about trying to limit population growth. The salient idiosyncrasy in Pakistan was the American influence (inundation and "management"), in Bangladesh, the influence of multilateral donor agencies (on the institutional structure), and in Sri Lanka the inflammable communal sentiments which kept family planning confined to maternal and child health clinics. In India one cannot so handily grasp any single predominant measures-related output, unless it was the tendency of the bureaucracy to become obsessed with some "quick fix" which was then just as compulsively abandoned. The outcome of India's head start, in combination with this penchant for one single-method programme after another, was that by 1977, she had accumulated such a depth and breadth of experience that her later experiments were more outcomes of process than in any other country.

The final experiment in this study, the salient feature of which was its coerciveness, was, above all, an outcome of the learning process in the minds of India's top leadership. Sanjay and his subordinates drew from the lessons of the past and came up with vasectomy camps, to which they added the component of police power. The lessons which future governments of India or those of her neighbours could draw from this experiment could be that

coercive fertility control is politically unfeasible, or, it could be that if one has control of the appropriate institutions, particularly the electoral process, that it is feasible. However, the pattern which has emerged from this study indicates that many other conditions would have to be fulfilled before coercion is attempted. These are the coincidence of a "family planning hawk" in a position of unassailable security along with a nation-threatening demographic/economic crisis and a belief that all other less coercive methods of persuasion have been tried and have not worked or will not work. Such a coincidence is possible, though improbable, if only because the backlash from India's misconceived experiment in coercion has shown all leaders that it does not work either.

CHAPTER V

FOOTNOTES

1. Uday C. Desai, "Professional Policy-Making: The Case of Indian Population Policy," Indian Journal of Public Administration, 22 (No. 4, Oct.-Dec., 1976): 697.
2. Nurul Islam, Development Strategy of Bangladesh, (Oxford: Queen Elizabeth House, 1978), p. 65. For a treatment of the evolution of policy as a learning process, see Hugh Heclo, Modern Social Politics in Britain and Sweden: From Relief to Income Maintenance, (New Haven: Yale, 1974), Chapter 8.
3. Robert Cassen, India: Population, Economy, Society, (London: MacMillan, 1978), p. 214.

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