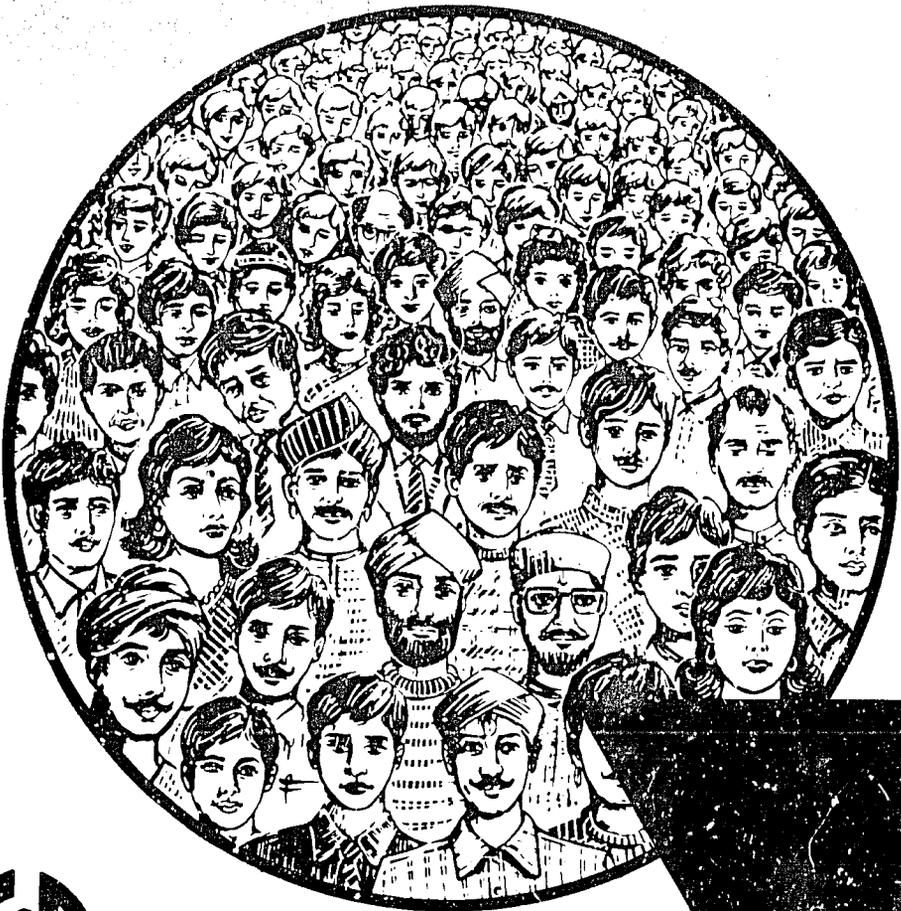


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**INDIAN FACTOR
IN
FAMILY WELFARE
IN INDIA**

VOLUME - I

OVERVIEWS OF PROBLEMS



**COUNCIL OF INDIAN EMPLOYERS
NEW DELHI**

Corporate Sector and Family Welfare Programme In India

VOL. I



**Council of Indian
Employers, New Delhi**

Corporate Sector and Family Welfare Programme In India

VOL. I

**Edited by – Dr Bhabani Sengupta, Ph.D
Anil Guha, B.A. (Hons.)
Dr P P Talwar, M.P.H., Ph.D**

PREFACE

The Council of Indian Employers (CIE, constituted by the All India Organisation of Employers (AIOE), the Employers' Federation of India (EFI) and the Standing Conference of Public Enterprises (SCOPE), in collaboration with the Enterprise Program (USAID) and with technical assistance from the Labour and Population Team for Asia and the Pacific (LAPTAP), International Labour Organisation (ILO), is organising a National Convention on Corporate Sector and Family Welfare Programme in India in a couple of months' time.

Today the population problem is the most baffling one that faces not only India, but the world at large. As early as the early 1960's, Dr. B. R. Sen, then Director General of F. A. O. had warned that there would be no lasting peace or security in the world until hunger and want were eliminated. That warning is even more valid today. In fact, what is in danger is not merely the health and happiness of individuals but the very basis of the human condition, especially in the developing nations. Indeed, the demographic overload has reached a most critical point in human history. Either we take the fullest measures to raise productivity and to stabilize population growth, or we face disaster, not only for individual nations but for the world as a whole.

Since independence, India has no doubt made great strides in many developmental fronts. Consequently the cultural landscape has undergone visible change across the country. At the same time, however, it is to be admitted that fruits of development have not reached out to the people at large either in equal or desired measures. One of the main reasons is that population growth has constantly outstripped developmental growth. We have not really grappled with the multiplying problems of multiplying population.

It has been realised by the planners that unless population growth is brought down to a manageable level within a stipulated time span the country cannot hope to progress meaningfully in any field - economic, cultural and social. The need of the hour is to transform the current national population control programme into a gigantic people's movement. In this great task, the Corporate Sector has to play a crucial role.

Though the picture appears to be not very encouraging at the moment, one redeeming feature is that some peers in the industrial sector in India have had the vision to see the danger signal much ahead of the time. They launched population control programmes in their spheres even before the Government stepped in with the official programme in 1951.

Currently, a number of large industrial houses have developed their own infrastructure to provide family welfare services to their employees as also to the

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communities around. Some are also offering services with the help and cooperation of government agencies and voluntary organisations devoted to the cause of population control.

The Council of Indian Employers has been actively involved in the family welfare activities in one form or the other for about two decades. A considerable fund of knowledge and experience has accumulated. It is, therefore, natural that the Council venture to prepare some kind of a futuristic plan of action, specifically in the context of the 90's and in the perspective of the present demographic trends. The proposed Convention has been conceived with a view to bringing into bold relief what the Corporate Sector can do in the light of past experiences and lessons and the challenge of the future.

To facilitate meaningful and effective deliberation on various problems of multiplying population, the publication entitled *Corporate Sector and Family Welfare Programme in India* in two volumes – Vol. I: 'Overview of Problems' and Vol. II: 'Case Studies' is brought out.

In this Vol. I, several renowned subject specialists have contributed thought-provoking papers covering important aspects of the programme. It is hoped that this publication will help the management and others involved in running the family welfare programme in the industrial sector to improve their performance.

It has indeed been an arduous task for Mr. Anil Guha, Consultant, to press a mass of varied material into two volumes of this publication. He has had the benefit in this effort of constant guidance and support of Mr. R. C. Pande, Secretary to the Council. The Council takes this opportunity to sincerely thank them and all others who have been directly and indirectly involved in the preparation and production of this publication.

January 15, 1990



COUNCIL OF INDIAN EMPLOYERS
NEW DELHI

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ACKNOWLEDGEMENTS

It is a rare privilege to be able to work as Consultant for the CIE/Enterprise Program/LAPTAP (ILO) Project – The National Convention on Corporate Sector and Family Welfare Programme in India. It has been a challenge to undertake a comprehensive survey of the current status of several industrial units located in different regions of the country in respect of their family welfare programme and to bring out this comprehensive publication in two volumes.

The first volume which presents several thought-provoking papers from a number of renowned specialists covering important and vital components of the family welfare programme – the task of the management, the role of workers and unions, the role of women's organisations and other NGOs, role of cooperatives, role of incentives and disincentives, and so on.

The second volume contains case studies of selected industrial units (public/private, large/medium/small/agglomerations) located in different regions of the country. It brings out the weaknesses, strengths and success factors.

In the present volume, some eminent demographers, social scientists, media specialists, economists, social workers, like Mrs. Avabai B. Wadia, Prof. N. N. Pillai, Dr. P. P. Talwar, Mr. K. L. Gaba, Dr. Y. P. Gupta, Dr. Chansarkar, Mr. H. R. Munjal, Mr. Jalaluddin Ahmed, Mr. P. S. Bhatia, Dr. Harold R Hunter, Mr. R. C. Pande, Dr. N. Hamsa, have contributed valuable papers. I am extremely grateful to all of them.

A great deal of work was involved in the collection of material, standardisation of format and sifting, sorting and editing of the manuscripts of the two volumes and getting them produced in the present handy form. I have been greatly helped in my endeavour by many colleagues and friends in the CIE and outside whose debts I gratefully acknowledge. I must offer special thanks to Dr. N. R. Parthasarathy, Dr. N. Hamsa and Mr. D. K. Pradhan for working with me in the Project. A special mention should be made of Dr. P. P. Talwar of N. I. H. F. W. who extended his helping hand ungrudgingly whenever called upon to do so.

Dr. Bhabani Sen Gupta, of the Centre for Policy Research, an academic scholar and journalist of international repute, took the responsibility of overall editing of the manuscripts.

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whom I have discussed this publication and who have contributed towards its thematic development.

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ANIL GUHA
Consultant



CONTRIBUTORS

1. Dr. P. P. Talwar Professor and Head of the Department of Demography and Statistics, National Institute of Health & Family Welfare, New Delhi.
 2. Mr. K. L. Gaba Associate Professor, National Institute of Health & Family Welfare, New Delhi.
 3. Mr. R. C. Pande Secretary (labour), Federation of Indian Chambers of Commerce & Industry, New Delhi.
 4. Dr. Y. P. Gupta Associate Professor, National Institute of Health & Family Welfare, New Delhi.
 5. Dr. M. A. Chansarkar U. N. Chief Technical Advisor, ILO-UNFPA Project, National Instt. for Labour Studies, ILORIN, Nigeria; Ex-Director, Central Board of Workers' Education, Nagpur.
 6. Mr. P. S. Bhatia Associate Professor (Retd.), National Instt. of Health & Family Welfare, New Delhi.
 7. Mrs. Avabai B Wadia President, Family Planning Association of India, Bombay.
 8. Dr. N. Hamsa Senior Assistant Secretary, Federation of Indian Chambers of Commerce & Industry, New Delhi.
 9. Prof. N. N. Pillai Principal, Sardar Patel College of Communication and Management, Bharatiya Vidya Bhawan, New Delhi; Consultant (IEC) to the Govt. of Kerala; Former Professor (Communication) in the Indian Instt. of Mass Communication, New Delhi.
 10. Mr. H. R. Munjal Secretary, National Council for Cooperative Training, New Delhi.
 11. Mr. Jalaluddin Ahmed Advisor, Labour and Population Team for Asia and the Pacific (LAPTA?), ILO, New Delhi.
 12. Dr. Harold R. Hunter Professor and Director Health Care Administration Program, California State University, Long Beach.
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- *13. Dr. Richard V. Moore Vice-President, John Snow Inc. Project Director. Enterprise Program; Senior Associate, The Population Council, New York.
- *14. Dr. N. K. Parthasarathy Ex-Consultant WHO, New Guinea; For some time worked as Consultant with CIE for conducting case-studies; Ex-Statistical Officer, Min. of Health & Family Welfare, Govt of India.
15. Dr. Bhabani Sen Gupta Scholar and academican, a novelist and a journalist of great repute; currently with the Centre for Policy Research, New Delhi.
16. Mr. Anil Guha Consultant to the Council of Indian Employers, New Delhi. Former Publications Officer, Min. of Health & F. W., Govt. of India; EX-UNESCO Consultant to the Advisors (Communications) located at Nairobi (Kenya) for African region countries and at Cairo (Egypt) for the Arab Countries.

* Contributions appear in Volume II of the publication entitled "Corporate Sector and Family Welfare Programme in India - Case Studies".

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AS YOU TURN OVER THESE PAGES

You will not be reading a success story. You will have an idea how India's family planning effort, the longest and the most expensive in the developing world, can still be made a success story. You will also know about the factors that have *not* made family planning in India a success.

At the end of the decade, our population will cross the billion mark. We are still adding 15 million annually to our population, as much as the entire population of Australia. Why have we failed to bring population growth under control? Do we intend to make it a success? How can we make it a success? Even when we know how to, shall we do it the way it needs to be done? Do we have the will to tackle the population problem? These and many other like questions will make you to ponder, trouble your thoughts, as you read the pages that follow. Perhaps, this and its sister volume will catalyse your mind and body to get to doing something about the numbers that stand as major stumbling block on the road of our economic development. It is now acknowledged that in making family planning a truly national programme of ideas and action, each one of us can contribute his or her mite.

What's gone wrong with our family welfare programme is now fairly well known. In the words of Professor Ashish Bose, noted population expert of the Institute of Economic Growth, University of Delhi: "Far from being a people's movement, India's family planning programme is one hundred percent a bureaucratic programme, a vertical programme designed, financed, controlled and monitored from New Delhi. It is based upon wrong premises: the government should give financial incentives to the people to practise family planning. Over the years increasingly large demands have been made in the name of financial incentives. This has brought about an increasingly large element of corruption in the family planning programme – both individual corruption and collective bureaucratic corruption. This has damaged the credibility of both the health and the family welfare programme". (*From Population to People* Vol. 1, New Delhi, B. R. Publishing Corporation, 1988, p 135).

What is to be done? We have 17 population research centres in different universities and research institutions. We also have two huge institutions devoted entirely to population research and study: The International Institute for Population Studies, in Bombay, and the National Institute of Health and Family Welfare, in New Delhi. Why have not

these research centres produced effective blueprints and methods for a successful family planning drive? We know why. "Unfortunately, all these institutions are under the purview of the non-professional bureaucracy at the Centre, which displays a tendency to treat the research institutions as servicing agencies of the Ministry", writes Prof. Bose (ibid p 94). This has gone on for such a long time that any attempt to question barren bureaucratic control of the research institutions leads inevitably to cutting off of funds or punishment of research personnel. No wonder, the research bodies have become part and parcel of bureaucracy.

In order to be a success story, family planning must be rebuilt as a people's movement. The programme has to be liberated from bureaucratic control. It has to be woven into our five year plans as an integral part of social and economic development. From 'population' the emphasis must shift to 'people'. Professor Amartya Sen, of Harvard University, has been pointing out that India's two main development problems are education and health. Attack these two problems with full vigour, not only will the back of mass poverty be broken, family planning will get wings and the birth rate will come down.

Women must be educated in order to understand the need for family planning and practise family planning as a health and development measure when they are young and reproductive, not when they have already given birth to four or five kids. If the health of the family gets better, infant mortality wanes, fewer children are born. If the age of marriage is raised to the desirable level, and boys and girls are given family planning lessons in schools, smaller families will be the norm of the human condition. The blunt reality is this : there will be no success of family planning as long as our women remain illiterate, our people suffer from poor health and poorer nutrition, population planning programmes will continue to produce poor results. Family Planning, then, must be made an integral part of human resource development.

It is in the context of this plain but stern reality that you must look for what the organised and informal sectors of industry can do in the field of family planning. The organised sector of industry has workforce of more than 25 million. A very large section of this big workforce is young, in the reproductive stage of life, and therefore the ideal target for family planning. The workers and their spouses are generally educated, have a better sense of health, are better fed and clothed than vast majority of our population. The corporate sector of industry therefore can/should play a

significant role in making family planning an integral part of the webs of life of its employees. And once this happens in the corporate sector, the ripple effect will be felt on the much larger cooperative and informal sectors of industry, and then roll on to the rural population which are intimately connected with both sectors.

India is a signatory to the Alma-Ata Declaration of 1978, which pledges Health for All by 2000 A. D. It is now a charter of health for all countries, especially the developing one. Is there a real possibility that all Indians, regardless of age and habitat, will be brought under a national health plan at the end of the century? To attain that objective, we have to reduce infant mortality to 60 per thousand from the current level of 120 and reduce the level of death to 9 per thousand from the current level of 15. The present scale of our health programmes is far too inadequate to achieve that target. There must be a massive expansion of health programme in India, built with the active cooperation and participation of the people. Not through big hospitals and medical doctors who are, in any case, unwilling to work in the villages. But with hundreds of thousands of networks of rural health centres and mobile dispensaries and a vast army of barefoot doctors and trained village nurses and midwives, enlisting the active cooperation of voluntary agencies and social workers, mobilising people's resources for a people's health plan run by the people for the people. Properly organised with grassroot leadership, money is no obstacle to a national health scheme. In Maharashtra, voluntary organisations run rural health services raising a mere ten rupees a year from each beneficiary family. Family Planning will have to be woven into a network of health service which in turn will have to be woven into a vaster network of national development. But 2000 A. D. is only ten years away.

New Delhi
January 15, 1990

BHABANI SEN GUPTA

POPULATION PROGRAMME

THE NATIONAL SCENE

ANIL GUHA*

I. BACKGROUND

With India's firm commitment to stride into the twenty first century as a country in an advanced stage of development by shaking off all weaknesses and clearing all backlogs, there is no need to make any fresh case for population planning. Many of the challenges of development are interlinked with those of population and the challenges on both fronts seem to grow, making the task of overcoming them harder everyday.

II. BASIC FACTS

The facts stare at our face. In 1981, the population stood at 685 million. In March, 1987 it was estimated at 776 million, increasing approximately at 15 million every year. Today it is expected to be anything around 800 million. At the turn of the century it could well be 1000 million. If we consider the 1971 population of 547 million, India will then have nearly doubled the population in a span of barely 30 years.

Figures, however colossal, have no significance unless put in a proper perspective. In case of population, particularly in welfare state, figures have to be seen in terms of quality of life. Every life born has a right to its food, cloth, shelter, health, education, proper environment of growth and full development as a human being. The social and economic activities of the state have to assure the citizens of the state's concern and efforts for their well-being. Do our resources and pace of development enable us to rise up to the challenge of meeting basic needs of this huge population?

The sheer magnitude of the task is unnerving. India has only 2.4 per cent of world's land area, while it holds more than 15 per cent of the world population. There is no scope of expansion of land area nor can there be a large scale migration to virgin lands. This basic imbalance between population and land mass, which grows adversely with passing year, can never be rectified. We have to accept this and still achieve our socio-economic goals. The course is well charted; optimum utilisation of our limited resources, faster economic growth and a quick drop in the rate of population growth. Since death rate should expectedly go down as a result of improved health measures, the only way to bring down the growth in population is to achieve a low birth rate.

* Consultant, Council of Indian Employers

III. THE GOAL

The twin objectives of the National Health Policy is to achieve "Health for All" and a "Net Reproduction Rate of Unity" by the year 2000 A.D. The 1987 birth and death rates are around 32.0 and 11.0 per thousand respectively, giving a growth rate of about 2.1%. The goal by 2000 A.D. of a replacement level of fertility (NRR = 1) requires reduction in birth rate to the level of 21 and death rate to 9 by the turn of the century. On way to this, as midterm goals, we have to achieve a crude birth rate of 29.1 and a crude death rate of 10.4 by 1990. This necessitates comprehensive health care services for all, a steady drop in infant mortality rates and wider programme to induce couples in reproductive age groups to have small families.

IV. THE PROGRAMME

It is not that India woke up suddenly to realise the importance of population planning. It was the first country in the world to take up an official family planning programme as part of its socio-economic plans introduced shortly after independence. Much before that, the Mysore State Government in British-ruled India was credited with opening family planning centres as a welfare measure.

The official family planning programme included in the very first Five-Year Plan (1951-56) has grown in size and importance over the successive five year plan periods, population planning having been placed in the core of the entire planning system. The first plan had an outlay of a modest Rs. 65 lakhs (Rs 6.5 million), but it denoted a sound basic thinking at the right time. The increase in outlay over the next plans and the consequent expansion of the programme are an evidence of the growing awareness and the will to act. Table 1 makes an impressive reading :

Table 1
Outlay and Expenditure on F.W. Programme
over Different Plan Periods in India
(In crores of Rupees)

Period	Outlay	Expenditure
First Plan 1951-56	65.0 (In lakhs)	14.5 (In lakhs)
Second Plan 1956-61	5.0	2.2
Third Plan 1961-66	27.0	24.9
Annual Plans (Inter Plan Period)		
1966-67	14.9	13.4
1967-68	31.0	26.5
1968-69	37.0	30.5

Contd.

Table 1 (Concl.)

<i>Period</i>	<i>Outlay</i>	<i>Expenditure</i>	
Fourth Plan 69-74 (Outlay)			
	330.0		
1969-70	42.0		36.2
1970-71	52.0		48.9
1971-72	60.6	285.8 @	61.8
1972-73	76.3		79.7
1973-74	54.9		57.8
Fifth Plan 74-79 (Outlay)			
	497.4		
1974-75	54.1		62.1
1975-76	63.2		80.6
1976-77	70.1	285.6 @	173.0
1977-78	98.2		93.3
Sixth Plan 1978-83 (Outlay)			
	765.0		
1978-79	111.8		107.6
1979-80	116.2	228.0 @	118.5
Sixth Plan 1980-85 (Outlay)			
<i>(Revised)</i>	1010.0**		
1980-81	140.0 @		140.9
1981-82	156.0 @		193.02
1982-83	245.0 @		288.32
1983-84	330.0 @		382.98
1984-85	438.0 @		424.07
Seventh Plan 1985-90 (Outlay)			
	3256.0		
1985-86	500.0 @		479.81
1986-87	530.0 @		569.18
1987-88	585.0 @		607.39*

@ Budget provision

* Provisional

** Additionally Rs. 68.00 crores had been transferred for Village Health Guide Scheme under Family Welfare Programme.

V. STRATEGIES

The nature, scope and direction of the programme over the years went through various phases following change in strategies in a dynamic situation. In the beginning, it was a clinical approach, the programme consisting of opening of service

centres with the hope that people would come forward to make use of the services. It was soon realised that in a vast country where the states, regions, peoples, communities were at varying stages of development with the majority being at below subsistence level, a come-take-it approach would not touch even the fringe of the problem. The natural shift was to "Extension Approach", much in the style adopted for agricultural development. The necessary infrastructure was built up so that the message of family planning and the services could be taken almost to the doorsteps of people even in interior areas of the country. Adoption of family planning would require motivation, which in turn depends on an individual's own judgement based on one's education and level of information on the subject and felt-need. Provision of services all over the country, backed by an effective communication formed the core of the new approach. It was decided to provide the services not in isolation but as part of an integrated health and family welfare programme.

Right from the beginning, adoption of family planning has remained a voluntary programme. The choice of method is also entirely voluntary. The services have a "Cafeteria Approach" so that a couple is free to choose any method from operation to contraceptive devices to natural precautions. Education and information, advice on suitability of a method in individual cases, and services are by and large available free of cost.

In communication activities, to create motivation, the direct approach of emphasising benefits of family planning to the state, family or an individual in an impersonal way was seen to have a limited effect. It was difficult to identify demonstrable gains in individual cases. The strategy was modified to encourage attitudes in individuals which directly favour the adoption of the small family norm. Education, particularly for girls, acquiring of skills again particularly by women, raising the status of women all were proven factors favouring promotion of family planning and spacing of children. Family planning was projected as a passage to modernity and a step towards higher qualities of life as against mere existence.

In the case of services also, great emphasis was placed on maternal and child health programmes as it was realised that (i) better health of mother and reduction in infant mortality were strong motivating factors and (ii) MCH services serve as an entry-point for family planning services.

VI. FAMILY PLANNING METHODS

There is no doubt that even with a cafeteria approach the terminal method of sterilisation operation, whether for men or for women, has always found favour with programme implementation agencies. Probably it suits better for the socio-economic profile of population as well. For one, it is a sure index of the couple protection rate. All other methods are fallible or are associated with some hazards. It is difficult to work out a correct statistics with users of the other methods resulting in faulty assessment and defects in forward planning. There is no doubt that the desired reduction in birth rate can be brought about in quicker time if the greater

majority go in for a terminal method like sterilisation, allow sufficient interval between the births of children, give equal importance to girls born in the family and think in terms of higher qualities of life. This is the transition from the early clinical approach to the development approach. The higher qualities of life cannot solely depend on just health measures: there are several other concomitants. The realisation came that adoption of family planning will be faster and meaningful in an atmosphere of total development. Conceptually therefore the programme has moved from family planning to family welfare planning as an inseparable part of the total development process.

For the record, the different methods which are propagated through the programmes include conventional contraceptive for prevention of birth and as a spacing method; oral pills and IUDs for women for the same purposes; surgical operations both for male and female and natural methods such as rhythm. In appropriate cases medical termination of pregnancy is also available.

VII. SERVICES

The facilities are available at all hospitals and health centres in the country run by the Central and State Governments. In addition, hospitals and health centres run by private institutions, voluntary organisations, organised sectors and charitable institutions all provide service in varying measures. The total number of service centres under the Central and State Governments including the number of personnel engaged in the field are shown in Table 2.

Table 2
Family Welfare Service Centres in the Country

A.	Urban F.W. Centres (as on 31.3.84)		
	(i) run by State Governments	-	1,502
	(ii) run by Local Bodies	-	357
	(iii) run by Voluntary Organisations	-	322
	(iv) attached to Post Partum Centres in Hospitals	-	574
		Total	2,648
B.	Rural F.W. Centres (as on 1.4.86)	-	5,435
C.	Primary Health Centres (as on 1.4.87)	-	14,145
D.	Upgraded PHCs/Community Health Centres (as on 1.4.87)	-	905
E.	Sub-Centres (as on 1.4.87)	-	98,987
		Total	119,472

Contd

Table 2 (Concl.d.)

I. Staff in position (as on 30.6.83) in Urban Centres			
(i)	Medical Officers	-	1,166
(ii)	Extn. Educators	-	263
(iii)	Lady Health Visitors	-	1,128
(iv)	Auxiliary Nurse Midwives	-	2,041
(v)	F.W. Workers (M)	-	1,237
			Total 6,822
(vi)	Store Keeper-cum-Clerks	-	8,325
			Total 15,147
II. Staff in position (as on 31.3.86) in Rural Centres			
(i)	Medical Officers	-	6,022
(ii)	B.E.E.	-	5,283
(iii)	L.H.V.	-	9,681
(iv)	A.N.M.	-	56,904
(v)	F.W. Health Asstts.	-	11,327
(vi)	Computers	-	4,663
(vii)	Store Keeper-cum-Clerks	-	4,910
(viii)	Drivers	-	3,412
			Total 102,202

In addition to above there are community workers which include about 5.54 lakh trained traditional Birth Attendants (Dais) and about 3.94 lakh Village Health Guides who cater to the health and family welfare service needs of the rural population all over the country.

Mass education and media activities for family planning communication are carried out by specialised units both at the Centre and the States. Strategies are worked out to meet the challenge, demands and as a fillip to the service available in particular areas. Very often concentrated campaigns are carried out offering service backed by information and education in selected areas.

VIII. PERFORMANCE

The results over the years have been an effective coverage of just 39.8% of the total number of eligible couples in the country (year 1986-87). Table 3 gives details of the performance during the different plan periods.

Table - 3
Performance

	Sterilisation			Equivalent		Percentage of Couples (effectively) protected by all Methods by the end of the period
	Vasectomy	Tubectomy	Total	I.U.D.	C C Users	
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Second Plan (Jan.56 - Dec. 60)	70,965	81,712	152,677	-	-	0.2
Third Plan (Jan. 61 - March 66)	1,068,638	304,528	1,373,166	812,713	582,141	3.0
Inter Plan Period (1966-67 to 68-69)	3,816,583	875,413	4,391,996	2,057,436	960,896	8.7
Fourth Plan (1969-74)	6,571,106	2,432,520	9,003,626	2,149,160	3,009,995	14.7
Fifth Plan (1974-75 to 77-78)	8,437,064	4,795,491	13,232,555	1,945,648	3,252,570@	22.5

Contd.

Table 3 (Contd.)

(1)	Sterilisation			Equivalent		Percentage of Couples (effectively) protected by all Methods by the end of the period (7)
	Vasectomy (2)	Tubectomy (3)	Total (4)	I.U.D. (5)	C C Users (6)	
(Revised) Sixth Plan (1978-83)						
1978-79	390,922	1,092,985	1,483,907	551,551	3,469,072@	22.4
1979-80	472,687	1,305,237	1,777,924	634,509	3,068,779@	22.3
	863,609	2,398,222	3,261,831	1,186,060	6,537,851	
(Revised) Sixth Plan (1980-85)						
1980-81	438,909	1,613,861	2,052,770	627,650	3,808,936 @	22.8
1981-82	573,469	2,218,905	2,792,374	750,539	4,559,475 @	23.7
1982-83	585,489	3,397,700	3,983,189	1,096,671	5,948,102 @	25.9

Contd.

Table 3 (Concl.)

	Sterilisation			Equivalent		Percentage of Couples protected (effectively) by all Methods by end of the period
	Vasectomy	Tubectomy	Total	I.U.D.	C C Users	
(1)	(2)	(3)	(4)	(5)	(6)	(7)
(Revised)						
Sixth Plan (Contd.)						
1983-84	661,041	3,871,181	4,532,222	2,134,102	8,389,909 @	29.5
1984-85	549,703	3,534,880	4,084,583	2,562,408	9,795,505 @	32.1
	2,808,611	14,636,527	17,445,138	7,171,370	32,501,927	
Seventh Plan (1985-90)						
1985-86	639,477	4,262,132	4,901,609	3,273,860	10,744,180 @	34.9
1986-87	808,184	4,219,980	5,028,164	3,938,962	11,602,190 @	37.5 *
1987-88*	754,085	4,184,852	4,938,937	4,355,953	13,390,187@	39.8*
	1,447,661	8,482,112	9,929,773	7,212,822	22,346,370	

● Includes equivalent Oral Pill Users also.
* Provisional.

The crude birth rate today is estimated at around 32.9 (1985) per thousand of population. The crude death rate is around 11.8 (1985). This gives a national annual growth rate of 2.11%. To achieve the goal of NRR = 1 by 2000 AD, we need to increase the couple protection rate to 60% and lower the infant mortality rate to at least 60 per thousand live births. The target birth rate is 21 and the death rate is 9 per thousand

IX. PERSPECTIVE

The moot question is whether these goals bear relation to realities. In other words, whether these are products of wishful thinking or objective assessment of the situation after studying all the trends and prospects. Table 4 will provide an interesting perspective.

Table 4
Goals for Different Years

	<i>Current Level</i>	1985	1990	2000
Crude Death Rate : Around	11.8 (1985)	12	10.4	9.0
Crude Birth Rate : Around	32.9 (1985)	31	27.0	21.0
Net Reproduction Rate (NRR)	1.48 (1981)	1.34	1.17	1.0
Growth Rate (Annual)	2.24 (1971-81)	1.90	1.60	1.20
Family Size	4.4	3.8	-	2.3

The programme of the description and magnitude outlined earlier should encourage every body that it is within our powers to bring about the desired changes in the growth pattern. Cold statistics, however, gives a shiver. From the mid 70's till today, we seem to be moving along a plateau whereas we should have crossed the peak by this time and moved toward moderately declining trend. There have been fears and apprehensions that we may enter the 21st century not as a proud nation which has achieved its goal but the one struggling to achieve goals as early as possible. The rapidly increasing population may still be straining our resources and we may still be struggling at subsistence level.

Where did we go wrong? Without subscribing to the prophecies of doom, it is worthwhile to search for the truth not evading the reality. The Public Accounts Committee (PAC) of Parliament in its latest report has been very critical of the performance. It says in no uncertain terms that despite huge expenditure and efforts,

there has been no perceptible gain. It says "even though family welfare programme has been in operation for more than 35 years with an expenditure of over Rs. 2400 crores incurred thereon up to the end of the 6th five year plan, it has not been able to check growth of population at all".

In PAC's view "the programme has been implemented without any enthusiasm like any other routine programme with the result that the growth rate of population remained unabated." The PAC noted that although certain demographic goals for reduction of birth rate were made explicit at the beginning of various plans, achievement in targetted years has fallen much short of planned targets. It took due note of the consequences of the failure. "Perhaps the most alarming aspect of the runaway birth rate has been the creation of a broad base age pyramid with 40% of the population below 14 years of age which not only raises the dependency burden on the country but will also result in a continuing high fertility rate in the coming years." The report casts doubts on the Government's claim of having brought more couples under effective family planning. It says "it is at a loss to understand as to how and why the birth rate has remained almost stationary since 1977 despite the fact that couple protection rate has gone up considerably from 22.5% in 1977 to 34.9% by March, 1986."

Strong words, indeed, but even the most vociferous champion of the official family planning programme would have to admit that the results have been far from satisfactory. Since mere fault-finding and blaming the authorities would get us nowhere, we have to make constant efforts to identify the weaknesses and find remedies to the extent possible. Population planning has to succeed. We have to turn the tide before the situation goes totally out of control. Any delay in achievement of demographic goals is making situation worse in social and demographic development of the people and the country. Need of the hour is to take the movement in the right direction and put in the right and best efforts to achieve the goals.

X. PROBLEMS

Some of the basic problems are all too evident. The annual reports of the Ministry of Health and Family Welfare candidly recognise these handicaps. India is a multi-lingual society with wide variations in demographic situation and socio-economic conditions. People practise different religions and there are numerous cultural identities. Varying social customs and beliefs favour large family size and impede the process of change which could accelerate the adoption of modern methods of contraception. The universal desire to have at least one or two male children and the mean age of marriage of women at 18.3 years are contributory factors to large families. The infant mortality rate though came down to 97 in 1985 from 140 in 1975, it is still quite high to induce couples to go in for larger families and ensure the survival of desired number of children. The literacy rate, a direct factor favouring family limitation, is still abysmally low.

Besides unfavourable socio-economic factors in the acceptance of small family norm, the family planning programme has not been able to convince people of either disadvantages of large family size or advantages of small family size. This is particularly so for people living in rural areas where about 80% of India's population lives.

A study of the problems will lead us to the identification of the weaknesses of the official family planning programme. Some of these are in the conceptual field, some others are in areas of management and services. But some of the major weaknesses originate from the socio-economic conditions of our country which militate against fuller development of larger segments of our population, which find the message of family planning of little consequence in their struggle for existence. Since socio-economic changes which can make small family a favourable proposition is a slow process, the family planning programme has to be made more attractive. More effort has to go in strengthening information, education and communication elements to increase demand for the services and the quality of services has to be improved so that it can generate its own demand. Both these components of the programme have to receive emphasis; the intensity of efforts should be so much that acceptance of this programme services becomes a part of life of people.

The programme has always been projected as a way to development. In the lives of millions, however, this is a distant goal. In their case, socio-economic development has to precede adoption of family planning. At least, the process of change must be perceptible to them in their everyday experience of life. The message of family planning as propagated links happiness and prosperity with number of children but it cannot convincingly establish the link between national prosperity and individual prosperity, or how the national gain is going to be shared by the individual who makes the decision to limit the family size. The demonstrable gains should be in the fields of employment, education, health, housing, drinking water, all season roads and the like. The message of family planning can be best delivered in a package of such development efforts and not as an independent programme with distant links with measures which directly affect the lives of the people. To quote Shri Ashok Mitra former Secretary Planning Commission :

“Few people at their levels of poverty, in rural and urban areas, can afford to remain unemployed for even a whole week. As a result, population growth and the increasing size of the labour force have led to work sharing and a perpetuation of low-income levels. It is difficult for a poor family, to whom an extra child is the only cheap capital asset that it can think of to perceive (a) how a smaller family is going to improve its lot, because of the limited scope for improvement, (b) how fewer children can mean anything but a lessening of its strength in the struggle for existence. More children, especially sons, still mean a net inflow of wealth from children to parents over lifetime.”

"The message of family planning thus threatens a radical restructuring of the traditional Indian household economy without a concomitant restructuring of the national economy. This is the unresolved conflict that the programme of family planning faces today and will face for an indefinite length of time until work is assured for every adult on a level of remuneration, health and comfort, that will be at least the minimum envisaged by the late Pitamber Pant. A large family to the majority of Indian households is still perceived as very much of an asset. This perception is far more real and important to the majority of our households than the supposed benefits of small families."

The desire for sons has also to be viewed in this context. Ordinary rural people want at least two sons for more than one reason. Two sons will ensure at least one surviving son. A male child is needed to provide muscle power to the family, for work and for protection. A son can be sent to places when needed. He will maintain the family line and is old age security. None of these can be done by daughters who will anyway go to others' families after marriage. In order to have two sons, a family is prepared to have three or more daughters ignoring family planning. It will be meaningless to preach that daughters are as good as sons unless the general status of women does not improve or the girls get equal opportunities to develop and earn. A system of social security for the old, lowering of infant mortality and gainful employment for family members can remove the son complex and bring out dramatic changes in reproduction behaviour.

In a recent seminar, the Chairman of Law Commission, Justice Desai observed that some 30 million children in the school going age are out of schools. His suggestion was to make education compulsory for children up to the age of 14. Any one familiar with the conditions in the country knows that there is still large scale exploitation of children as labour and money earners. Commenting on the new Act on child labour, Desai said, this unfortunately does not ban child labour but only legitimises it by asking for welfare measures for child labour.

The official family planning programme also suffers from serious administrative and managerial problems. These stand in the way of whatever success could be reasonably expected, commensurate with the services, manpower deployment and efforts. The services have expanded in terms of hospitals, clinics, health centres, family planning centres over the years. But mere numbers do not present the real picture. The Indian Council for Medical Research made a survey of 198 primary health centres in 99 districts between May, 1987 and April, 1988. The study presented at the meeting of the Central Council of Health and Welfare shows :

- (a) All the surveyed PHCs have chronic inadequacy of staff, medicine and labour and operating room facilities.
- (b) One third of the 132 family planning camps surveyed had been using instruments that were either not sterilised or insufficiently sterilised. All categories of medicines were not available, specially vital antibiotics.

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- (c) Only 15% PHCs had the requisite number of auxiliary nurse midwives.
 - (d) None of the PHCs surveyed had been maintaining records of infant and maternal deaths. Birth weight was either not taken or not registered.
 - (e) Most of the ANMs were concerned only with the family planning aspects of their profession instead of advising on and helping mothers with postnatal care.

Let us not search for the true picture elsewhere than in the annual report of the Ministry of Health and Family Welfare. It says that various studies conducted through private and other organisations have highlighted that the existing infrastructure is not being optimally utilized, mainly because of its inadequacy to provide proper services and relatively unfavourable attitude of the people towards it. The major inadequacy is related to poor quality of service, non-availability of staff, lack of sympathy of the staff and poor management.

A very serious allegation against the official family planning programme is the belief of many social scientists, demographers and researchers that the success claimed to have been achieved by the State governments may be cooked up. Computing the claims in the field of couple protection and the almost static birth rate for over a decade, these quarters feel that the reality of the failure in controlling the population explosion does not quite tally with the impressive targets set by the Government. It is felt that the target itself has become the goal for the official planning programme instead of being the means of achieving a lower population growth rate. The feeling is that a target-oriented approach had led to the complete alienation of the medical community. Several other studies have indicated that because of administrative pressure to fulfill the targets, the field level workers often present grossly inflated performance figures making data collection and processing faulty and leading to wrong conclusions. The report of the Public Accounts Committee has also been skeptical of the performance figures claimed by the Government.

There is another trend which social scientists and development planners consider even more alarming than the short-fall in performance. Family planning movement was picking up, albeit slowly, till the middle of 70s when an aggressive sterilisation campaign put the entire momentum in the reverse. After some years of confusion the programme again regained its importance in the 80s and has been limping along. What has been noticed is that the programme is not being seriously discussed in public forums as before. Public interest seems to be on the wane. There is a sense of resignation in the mind of field workers. The media seems to be taking only casual interest in the matter with occasional editorials and articles which do not go to encourage the hearts of the people seriously involved in the promotion of family planning. The country seems to be suffering from a national ennui.

This trend will have to be reversed with courage, vigour and rededication. There has to be a combination of dedication at the field level and imaginative administrative action to make population planning a success in the shortest possible time.

The programme embraces people of all communities, professions, all religions, speaking all languages and residing in all states. The official family planning programme has strong components involving organized sectors, trade unions, voluntary agencies and social service institutions. Each one of these will have to lend its total weight to ensure the success of the programme. The organised sector in particular is in an advantageous position to achieve optimum results.

ORGANISED SECTOR

There are about 25 million employees in the corporate sector. A greater percentage of this population comes under eligible category and hence deserves a special thrust. It will be seen that many of the serious handicaps from which the general family planning programme suffers are largely under control in the organized sector. It is in the interest of the management to keep the workers healthy and knowledgeable with an assured income which can take care of their bare necessities and generate hopes for a better future through the efforts of an entire family unit. An organized unit can create these conditions. In other words, it is an ideal control area which researchers look for to draw a valid comparison with an area left open to diversified forces. Planning of any kind is much easier in the control area and family planning should not be any exception. If the management and the workers' representatives can join hands in this task to bring about significant achievements, the benefits of such planned parent-hood would be demonstrable, and will set an example for others. In fact, it is possible under the organized sector to achieve almost cent per cent success provided all out efforts are made and a rapport is struck through effective communication between the service agencies and the target groups.

During the last two decades or so, a more favourable climate has been created in the organized sector for the promotion of the family planning programme, thanks to the pioneering efforts of some of the well known socially conscious large industrial houses like TVS-Lucas Group of companies in Madras and the Tatas in Jamshedpur. The TVS-Lucas initiated F.P. programme as far back as 1938 and the Tatas had created the necessary infrastructure and offered both education and services on a massive scale both to the employees of the industries there, as also to the people at large coming from the surrounding areas numbering more than 7.50 lakhs, even before the Government launched the official family planning programme in 1952. As a result, the coverage in family planning in Jamshedpur rose to over 60 per cent, much above the national acceptance rate. This laudable efforts of the Tatas are indeed worth emulating by all other progressive industrial units. In

fact, it has already caught up in the Corporate sector and more and more industrial units have since joined the mainstream of the national family welfare movement generated by the combined efforts of the Government and the large number of voluntary organisations.

That the realisation has dawned on the Corporate sector is also evident from the fact that they have created family planning nucleus infrastructure in some of their regional level and central organizations to devise ways and means to tackle this gigantic problem more effectively and systematically through organized efforts in close cooperation with the Central and State Governments, international agencies and voluntary organizations. During the last few years, the Government have initiated and organized a number of successful population control projects in the corporate sector in collaboration with industrial units, their associations and international agencies, drawing rich and varied lessons. It is time that there is an exchange of experiences of different kinds in the effort to tackle this most baffling problem of extraordinary population growth to control which one almost has to enter the privacy of one's bedroom to give them the required information and to encourage them to change their most intimate and personal behaviour.

XI. WARNING

As far back as August 1971, speaking on India's Green Revolution vis-a-vis the grim population problem, Dr. Norman E. Borlaug, the Nobel Laureate, popularly known as the Father of the Green Revolution cautioned us in the following words :

"If the progress of the Green Revolution is extended aggressively to other crops, it can buy a few years of respite from the specter of hunger - but it cannot solve permanently the hunger problem resulting from exploding population growth. The time has come to face up to the monster of exploding population growth. The current rate of population growth must be drastically reduced as soon as possible by effective human voluntary methods effectively extended by the Government's Family Planning Programme. Unless this is done the population growth monster will first destroy democratic Governments, then present-day civilisation, and eventually the species - Homo Sapiens.

" At the present time, the world population is growing at the rate of 2.2 per second, or approximately 70 million per year, we are falling farther and farther behind in providing a decent standard of living for all, who are born into this world. The time is late - we must turn and fight the population monster if we are to build a happier life and a better world. I hope that the Department of Family Planning of the Government of India will be equally as successful in dealing with population problem, as their counterparts have been on the food production front."

XII. HOPE

On the national scene there are certain developments which held out promise that we have at last started to move in the right direction. The idea of integrated planning is gaining ground. The annual report of the Department of Health and Family Welfare is testimony to this realisation when it speaks of the future policy approach. It says :

“Population control can no longer be the responsibility of one ministry or department. It has to be total governmental approach and effort reflecting the total and complete political and administrative commitment of the Government across the board, embracing all Governmental agencies, developmental and non-developmental. The entire planning process must be geared towards controlling population. Every action of Government must be evaluated in terms of its impact on population. All Ministries, Departments and Agencies must accept population stabilisation as one of their main objectives and reflect it in their programmes, in their messages, in their extension work and in their normal day-to-day activities. The Planning Commission must review the performance of States in terms of their efforts to stabilise the population and evaluate the activities of various departments in terms of their contribution towards holding population growth. The planning and development process of this country must indicate the adoption of Small Family Norms as the objective of all programmes. The Governmental agencies must also communicate to non-Governmental agencies in the country the need to work for the programme and work effectively.”

In recent times there are definite indications that effective power would flow to grass root levels to enable people at local level to chalk out and carry on developmental programmes more meaningfully. A national perspective plan for women is also on the anvil to raise their status and to provide training for acquirement of skills leading to gainful employment. The Ministry of Health & Family Welfare also have announced that the Panchayats and other local bodies will be totally involved in the implementation of Health & Family Welfare Programme. All these are indications that the weaknesses of the planning process at the grass root levels have been recognized and many of the irritants which tend to stall the progress of population planning are proposed to be resolved through peoples' initiatives with encouragement from the Government. Sceptics may immediately point out that like all Government intentions, planning at the grass root level may also get bogged down in the bureaucratic quagmire. But we live in hope and not in despondency. The country's future will be what we make of it.

FAMILY WELFARE EDUCATIONAL ACTIVITIES IN INDUSTRIAL SECTOR – EXPERIENCES AND AN OPERATIONAL GUIDELINE

P.P. TALWAR * & K.L. GABA **

I. BACKGROUND

Recognition of the fact that population is one very important parameter in the equation of development led our planners to think of making family planning programme a part of developmental efforts. India became the first country in the world to initiate national family planning programme in 1951 to contain population growth. Efforts started in a slow fashion by allocation of small budget to this programme and successive plan periods showed greater determination and commitment, with allocation increasing several folds. Planning Commission has clearly indicated that money will not be a constraint in making this programme effective and all worth while schemes will be provided funds in order to bring down the population growth rate to a low level at the earliest. A large infrastructure has been built to inform and educate people about benefits of the programme services and to provide family planning services to all those who ask for them.

All these efforts have yielded reasonable returns. About 40 per cent of couples are using contraceptives to plan their families and about 95.30 million births have been averted since 1956. The programme thus has been responsible for partly reducing pressure on the limited resources which the country has. The level of birth rate has come down to about 32 births per 1000 population from the level of about 42 in the sixties – a reduction of about ten points. The level of population growth rate has peaked to about 2.2. per cent compared to as high a level as of 3.0 per cent in several other developing countries.

But this achievement is not enough; the target is much higher. Our socio-economic achievements have been greatly reduced because of rapidly increasing population. The programme has lagged behind; it should achieve birth rate of 29 by 1990 and 21 by the turn of the century; a modest goal in view of our large base population and the limited resources. This goal is probably a minimum requirement in our pursuit of raising quality of life which is goal of all the planning efforts. Any delay in its achievement will have disastrous social and economic consequences for the country. There is no alternative but to do everything to ensure that the

* Professor of Health and Head of the Deptt. of Statistics & Demography, National Institute of Health & Family Welfare, New Delhi.

** Research Officer, National Instt. of Health & Family Welfare., New Delhi.

demographic goal which the country has set for itself is achieved as non-achievement is a harbinger of the hard days ahead and poor quality of life for our people. The modest demographic goal is achievement of Net Reproduction Rate of unity by the year 2000; this goal when translated to more understandable language means that the country has to achieve :

Crude Birth rate of 21

Crude Death rate of 9

Couple protection Rate of 60

Infant Mortality Rate of less than 60

II. STRATEGY

There is no denying the fact that the programme needs strengthening in all its components. A few, however, have greater relevance than others. The existing programme infrastructure needs to be made more effective. People have to be informed and educated about the benefits of utilising family welfare services. They should have easy access to good quality programme services; the quality has to be so good that not only they be satisfied with their own acceptance but be able to recommend to others with confidence. The selection of available family planning methods need also be broadened so that people may pick and choose various available methods. The programme should not confine itself to only sterilisation programme; it has to spread all other methods. For instance, availability of spacing methods in Indian programme still needs to be strengthened – their client group is still under-represented among the programme acceptors. In addition, there are a few population groups where special efforts are needed; among them special mention may be made of urban slums, backward classes of the society and the industrial sector. Though each of this population group forms an important beneficiary group in its own right, the importance of industrial sector is great because of its unique features (to be described later). The return for programme investment in this sector is high. For this reason, this paper attempts to suggest an operational guidelines how the family welfare programme can be made more effective in this group. In addition to large numbers of people who belong to this group, this group assumes significance because of its ripple effect on the other population groups.

III. INDUSTRIAL SECTOR

The organised sector employs 25.3 million workers of the 222 million in the labour force (**) and thus forms about 11 per cent of the labour force. If cooperative and semi organised sectors are also added to the organised sector, then this group will form about 15 to 20 per cent of the total labour force population – quite a large

** Government of India, Ministry of Planning (1988). Monthly Abstract of Statistics, Central Statistical Organisation.

group. The government has recognised importance of this sector not only because it forms a large group in itself but because of its potential for a ripple effect in urban informal sector and rural areas. The Ministry of Health and Family Welfare has been maintaining a small unit to look into the programme in the organised sector. The Ministry of Labour is maintaining an office of Director General (Welfare) because less worries and less tension of workers and their overall welfare will be for their better productivity, thereby increasing their contribution in the national wealth and prosperity.

Three typical characteristics of this (industrial worker) group make it a unique priority group for the family welfare programme : (i) they are easier to motivate because of their own socio-economic characteristic and favourable surroundings; (ii) they can give greater return for the investment because of its spread effect, and (iii) they are located in contiguous area where it is easy to conduct educational activities and provide services. That is why, every study has shown more than average acceptance of family planning programme in this group. (*) (**) Besides, provision of family planning education and services has been accepted as obligation of the management (employers and managers) to the society and an important element of the package of welfare to the workers. A successful family planning programme in the industry can bring a good deal of benefits to the employers by (i) giving more buying power to the employees and thus increasing demand for goods and services and (ii) reducing the cost of benefit schemes. Though such realisation has come among employers and top management, yet not very many industries have shown sincere efforts in this direction of introduction of family welfare educational and service programmes.

Most of the organised sector workers belong to younger age groups – about 80 per cent of them are in the age group where women/wives are in the age group 15-44 more towards earlier reproductive ages than later. They thus form crucial group for the family welfare programme. The educational level of this group is also higher than the general population. They are in actual contact with ideas of modern living, can see association of small and planned family with better quality of living with their own eyes and in their own surroundings. They are exposed to new ideas, enjoy more income, health facilities and higher security. All these characteristics are found to be associated with higher aspirations. These circumstances of an individual have been found to lead to easy acceptance of the small family norm where (i) standard of living could be better, (ii) children could be better educated, and (iii) health of the family could be better. This group thus could be motivated to accept programme

* Talwar P.P. et al, Final Evaluation of UNFPA/ILO Tripartite Collaboration Project on Promotion of Family Welfare Activities in the Organised Sector, Ahmedabad, National Instt. of Health and Family Welfare, New Delhi, September, 1987;

** Talwar P.P. & Goel O.P.; Base Survey of Insured Persons under Employees State Insurance Corpn. in Uttar Pradesh and Madhya Pradesh, NII IFW New Delhi, November, 1986.

services with much greater ease than the general population. This is often shown in studies in the industrial sector.

The cost-effectiveness of the family planning programme related efforts in industry are also relatively favourable. Not only it is relatively easy to get acceptors among industrial workers for the same degree of efforts and investment but it has additional advantage of spread-effect. The workers in the industry keep their contact with villages or the areas from where they came and where their families belonged. They keep on visiting areas where their roots belonged and where their kith and kin resided. They are looked upon as models, ideals and leaders who need to be followed by their brethren who still live in the areas from where the industrial workers moved to take benefits of social and economic development of the country. They are considered fortunates. Their advice thus carries weight and is likely to be accepted or at least seriously considered. In such a situation and with such a clout if these workers can be educated and motivated for small family norm, they can be very effective spokesmen or salesmen for the programme. Thus returns of the family planning programme efforts among industrial workers could be several folds: they could be made acceptors themselves and they could effectively spread message of the programme among their near and dear ones back home and make several of them acceptors.

Another favourable point for programme in the industrial sector is an easy accessibility of the client population. All workers are available in the industry, they come in contact regularly with the welfare officers like labour welfare officers, medical staff and union leaders who are their well wishers. Thus it becomes easy to talk to them, motivate them and even to put peer group pressure on them for accepting planned family norm. In quite a few industries they live in the residential colonies or jhuggi jhompries in the neighbourhood of the industry – all live together and in close vicinity. Thus their accessibility is good and it becomes easy to conduct and carry out educational activities and hammer the idea of planned family repeatedly. In contrast, general population is very spread-out and thus poor in accessibility. It thus becomes relatively easy to educate and motivate the industrial worker and get better results for the same degree of efforts.

Another point favourable to the industrial sector is availability of medical and health facilities in most of the industries. Some have large hospitals attached to them, some have some medical staff for consultation, others may have only paramedical staff. But every unit has some sort of medical facilities and thus technical information on family planning and MCH services can be passed on to the client population correctly. The informants are those who have better rapport with the clients as they are looked upon as keepers of health and welfare of all the family members.

It is thus easy and much cost-effective to conduct family welfare educational and motivational activities in the industrial sector. The results of the efforts would

be much greater; the family welfare programme can get a lot of support from this section towards achievement of its goal.

IV. FAMILY WELFARE PROGRAMME EFFORTS IN INDUSTRIAL SECTOR

A number of organised sector entities, both private and public, have been pioneers in the field of family planning. They had shown foresightedness and took initiatives even before or during early stage of national programme. The earliest initiatives were taken by the TVS-Lucas group of companies in Madras in 1938. (*) The Tata group of industries also embarked on family planning programmes around 1950. Other early starters were Alembic Chemicals (1956), Godrej (1957), Hindustan Spinning and Weaving Mills (1962) and Indian Oil Corporation (Gujarat Refinery 1964). Credit is also due to textile mills of Kohinoor, Century, and Bombay Dyeing where inspired employers made some purposeful efforts in this direction. Among others, mention may be made of Tea Estate Population of Assam where cautious beginning in family planning with the help of Family Planning Association of India was made as early as 1950, a time when even national family planning programme did not exist. By 1968, the family planning programme of Indian Tea Association, which covered 70 per cent of the planted area in Assam and includes 8,00,000 workers had reached maturity. The level of birth rate among the Assam Tea Garden workers came down from 43.4 per 1000 population in 1960 to 22.7 in 1968(**). Among the South Indian Plantations, due to active interest of United Planters Association of India (UPASI), the family planning programme was organised in the mid-sixties as part of a comprehensive Labour Welfare Scheme. In 1966, a novel scheme, popularly known as "No Birth Bonus" scheme was introduced in some plantations of South India which provided deferred payment.

The Tata Iron and Steel Company Limited in Bihar (TISCO) started its family planning activities in 1951. In the beginning, emphasis was laid on the educational efforts. By 1958, the management decided to make contraceptives available, free of cost, to its lower income group employee. In 1967, the management of the Tata group of companies decided to go all out for popularising family planning by offering attractive incentives to those adopting sterilisation and other means of contraception. There are several other examples of industries playing pioneer role in publicising family planning among their workers.

Since 1970, this movement picked up momentum. Many other industrial houses of the country have particularly responded to national endeavour and have established meaningful family planning programme for the benefit of their employees

* ILO Regional office for Asia and the Pacific (1988). Family Welfare within and beyond organised sector : A Comprehensive Plan of Action – A Report to the Government of India.

** Saksena D.N. : Family Planning in the Industrial Sector and Asian response, A Bibliography Reviewed, Demographic Research Centre, Department of Economics, Lucknow University, Lucknow, India, December, 1976.

either on their own or in cooperation with the Central Government and/or leading voluntary organisations of the country. An important event in the involvement of industrial and business houses in the family welfare programme was the institution of the Family Planning Award by the Federation of Indian Chambers of Commerce and Industry in 1968. A number of other industrial, commercial and employer organisations had also taken up promotional activities in family welfare – slowly in the beginning but picking up as the time elapsed. They have subsequently intensified their involvement and shown more initiative and emphasis. The Employers' Federation of India (EFI) conducted a survey in 1975 to find out how far their constituents had taken to this national programme. It was found that out of 345 respondents, 278 undertakings had taken some positive action in this direction.

In the public sector, the Defence Services had set up their family welfare centres in military units supported from unit funds first in 1951. The Railways, Post and Telegraphs and several large industrial undertakings followed suit and have since stepped up their activities.

The International Labour Organisation (ILO) gave impetus to the movement of family planning activities in the industry. Recognition of the fact came in the sixties that rapid population growth was frustrating the ILO's goal of employment creation, expanding vocational training and raising workers' living standards in the developing countries. A distinct population programme was set up within the ILO's high priority World Employment Programme in view of the close links between population and employment to provide a broad base for the population activities. Their activities can be grouped in three broad categories : (i) they sensitised the national family welfare agencies about the role organised sector can play in their overall family planning programme; (ii) prepared a number of manuals, technical material, educational literature which could help in the incorporation of family welfare component in relevant programmes such as workers and cooperative education, occupational health, social security, employment, training and so forth, and (iii) executed research and action projects with the assistance of UNFPA in the organised sector for the promotion of the population/family welfare educational activities.

The organised sector thus has shown initiative and has launched activities related to the family planning programme. The success stories have only been a few as all the necessary steps have not been taken. There is therefore need to introduce more sincerity and seriousness in their efforts.

V. EXPERIENCES OF FAMILY WELFARE PROGRAMME IN ORGANISED SECTOR

The authorities in national programme have clearly understood the potentials of the organised sector in achieving family welfare programme goals. They have responded to the tapping of this potential by (i) having a unit in the Ministry of Health & Family Welfare to coordinate efforts in this sector, (ii) providing money (only

limited money) to this sector to initiate family welfare activities – more to serve as a catalyst, (iii) involving the organised sector organisations like Federation of Indian Chambers of Commerce and Industry (FICCI), Standing Conference of Public Enterprises (SCOPE), Punjab, Haryana and Delhi Chamber of Commerce & Industry (PHDCCI), (iv) giving income tax exemptions to the expenditure committed to this welfare programme, and (v) seeking support of international organisations like UNFPA, ILO to support such programmes by funds and technical assistance. What is required is more aggressive role to be played by this unit, so that recognition of the importance of this sector is actually tapped to achieve goals of the programme by building strong family welfare programme in this sector. This administrative unit may perhaps also need support of technical wing in the Ministry or outside for regular monitoring of such activities and providing technical guidance to the industries where such programmes have been launched.

The cardinal principle of programmes in the organised sector is to utilise the existing infrastructure and wherever complementary or compatible, to graft on it population and family welfare elements. This approach is cost effective and permits the continuation of family welfare activities on an institutional footing at the end of the initial period of effort and adaptation. Some external support or seed money is required in this initial stage to serve as incentive to the industry and for initial one time investment on the activities related to the programme.

Though the idea of family welfare programme has been accepted by all organisations and individual industries, the programme has however been started only in a few of them. The acceptance of the principle has not been translated into actual effective programme in most of the industries, though some semblance has been created. Such half-hearted efforts do not serve the real purpose. Some more funds are needed and so is needed more technical support to the industries to have effective programme. More and more organised sector institutions like FICCI, SCOPE, PHD Chamber of Commerce, All India Organisation of Employers (AIOE), Employers' Federation of India (EFI), Co-operative Societies should be involved by supporting population/family welfare units. These units should have managerial and technical skills and should be able to persuade and help their constituents by doing ground work of initiating the programme. They should also be able to provide them necessary support.

The industries where such programme have started have also shown varying degrees of efforts ranging from marginal to quite intensive. There is need to bring sincerity and seriousness in these efforts so that their effectiveness can be enhanced. The elements where work is needed start from development of project activities to actual implementation, training of manpower, monitoring and assessment. Strengthening all these elements is likely to give much better returns than what is being achieved now. Careful planning, systematic implementation and tight monitoring and control of these activities is very much required. The national programme has been and should continue to serve as the Central resource for organised

sector family welfare programmes. It should provide help for (i) project formulation and development, (ii) project for initiating activities, (iii) conducting base line surveys and preparation of eligible couple registers, (iv) training of managerial, medical, paramedical and educational project staff and (v) development of monitoring and evaluation system.

Currently it has been observed that most projects do have all these elements covered but efficiency in them is limited. The organised sector should have easy accessibility to the technical advice in these efforts which are new to their usual working style.

There is need to involve the top and middle level management, workers and trade unions in this effort. Though not all of them have to be equally involved, it is absolutely necessary that sincerity should exist at all levels. The lip service type of support as it exists in most of industries today will not lead to desired results. This sincerity of involvement has to be ensured through a consultative and review machinery, though responsibility of implementation and day-to-day working is of different agency. A senior and effective official from the Personnel or Health Department should be designated as the focal point for family welfare activities in the industry. He should be made answerable (to the top management) for the effective implementation and functioning of the programme. For this purpose, periodic review by a committee headed by the top level management is a must. Such committee is likely to maintain seriousness in the operation of the programme at all levels.

One suggestion to generate healthy competition among industries is an annual award for better performance. The government should give recognition to good work in this area. Some award scheme may be created for industrial units so that more interest is generated in the industry.

VI. WHAT CAN BE DONE - A GUIDELINE

Many industries have implemented family welfare educational/motivational activities in their industries but seriousness given to this task is not befitting the importance of this programme. It requires total involvement of people at four levels - top and middle level management, worker and trade union - and meticulous planning at each of these levels. This section will utilise experience of programmes in various industries and attempt to list activities which can systematise the operation of the programme and thus bring greater effectiveness. Ultimately this task is to be carried out by (i) involving industrial, commercial and employer organisations, (ii) blessings of the top level management, (iii) involving middle level management, (iv) activating worker-motivators at plant level, and (v) making trade unions as partners.

The activities to be undertaken at each of these levels are listed below :

1. All the industrial, commercial and employer organisations are to be encouraged to create population cells to work with individual industries in the development

of population/family welfare educational programme. These cells themselves should have necessary skills to be able to help and advise the industries. They should also be able to seek support from government or other research institutions for any specific type of technical assistance. These population cells will (i) actively follow up the industries to conduct family welfare activities, (ii) advise them as to how to strengthen the programme activities and (iii) review periodically the progress of the programme activities to suggest measures which need consideration. These cells will also form a mechanism to maintain interest of the top and middle level management in this programme so that family welfare programme activities become a regular activity of the industry.

2. Committed support has to be secured from top level management to conduct this activity. This could be done in a workshop/seminar setting wherein the political leadership or the organisational leadership (like FICCI, SCOPE, AJOE, EFI, etc.) may be involved. Idea is to sensitise the top level managements in such seminar and to take their commitment. Afterwards, these managers should be followed up in the industry to secure blessings and put commitment into actual implementation of the programme.
3. Well-designed incentives are an effective complement to family welfare services since they can have a key bearing on family planning decisions. Top level management are particularly well-placed to provide innovative but simple-to-manage incentives to acceptors which could be over and above the government incentives. They can further provide recognition and encouragement to worker-motivators, para-medical staff for their good work in this programme. Therefore, additional incentives may be procured for acceptors. Ways are to be devised to acknowledge contribution of those who act as motivators in such acceptance. Public acknowledgement and appreciation has often been found to serve as incentive to this group.
4. The government, industrial, commercial or employer organisations may stimulate efforts for these activities in industries by instituting awards. Different types of awards can be devised so that healthy competition may be generated among industries to carry out educational and motivational activities with greater interest at all levels.
5. Top level management and trade unions be made to include family welfare services and family welfare educational activities as part of the total welfare package for the employees.
6. Top level management may be persuaded in the seminar/workshop and later on followed up in the actual industry (i) to appoint a committee consisting of people from middle level management, active workers and trade union leaders to oversee implementation and progress of the programme in the industry, (ii) to continuously have meetings with this committee to review the progress of the programme activities and (iii) to request large industries to act as big

brothers by giving support to the nearby small industries in providing services and conducting family welfare educational activities. This type of involvement of top level management is essential for smooth and effective functioning of the programme activities.

7. The actual responsibility of implementation and operation of the programme has to be taken by a few active middle level managers who will be members of the committee appointed by the top level management. This committee initially has to develop familiarity with the programme. For this purpose, they may have to take training/orientation covering principles of management and administration, have discussion with local family welfare programme personnel, nearby voluntary organisations and research organisations to learn and get ideas how the programme should be implemented in the industry. In other words, the committee members should get oriented to the programme and know what programme related resources are available to them within and outside nearby the organisation which they can use for their own programme in the industry. Such orientation should be arranged by the top level management. After such exposure and familiarity, the family welfare educational activities should be implemented in the industry carefully; help may be secured by co-opting members from the government programme machinery, voluntary organisations and other nearby institutions which have experience in implementing, monitoring and/or evaluation of the programme. Even population cells at the organised sector institutions or national institutions could be approached at this stage of planning. Total implementation activities have to be planned by this committee well and carefully.

The following aspects may be considered during planning :

1. Formulation of strategies of the programme implementation – how the educational activities will be conducted, how the services will be imparted, and how the supply of condoms and oral contraceptive pills will be procured and given to the workers.
2. How to bring forth involvement of the wives of the top level management in the programme activities.
3. In what form family welfare educational activities can be integrated with the other educational activities for the workers; help from outside agency, if necessary, may be taken.
4. Development of records and reports necessary for programme monitoring and management.
5. Selection of worker-motivators who could carry out educational activities among workers either individually or in groups. The choice has to be made carefully.

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6. Imparting training to the worker-motivators – the content and venue where they could be trained/oriented, should be decided.
 7. Preparing and regularly updating eligible couple registers to identify couples requiring various family welfare services. These couples be motivated to accept those services. In this way, the activities can be made need-based.
 8. Choice of worker-motivators should be made very carefully as they are the main strength of the organised sector for family welfare educational programme activities. They should be large in numbers so that together they can feel a group in itself rather than lone hand. Some desirable criteria in the choice of worker-motivator are (i) influential with fellow workers, (ii) leadership qualities, (iii) interest in welfare work, and (iv) preferably acceptor of family planning methods or at least have strong conviction of small family. They should belong to the working class so that they have day-to-day communication relations with other workers who are to be motivated.
 9. The training to worker motivators should cover (i) technical matters of morbidity, health, MCH and family planning methods, (ii) communication/motivation, so that they can explain and convince other workers about benefits of family welfare services. The worker-motivators should be thoroughly trained and periodically exposed to refresher training. These workers should be guided and supported by higher level officers – middle level managers, during their activities and in periodic meetings.
 10. The worker-motivators should be supplied with motivation materials. This material should be adapted to the target audience so as to be able to communicate messages in the language and terminology with which workers are familiar.
 11. The worker-motivators should be assigned specific worker-population for motivation. Award scheme in the industry will be incentive for the worker-motivators. Such schemes are likely to generate more enthusiasm in them and they are likely to take more interest in the programme activities.
 12. Work of worker-motivators should be reviewed through reports and actual participation in their activities. They should be provided support wherever needed. It is necessary that they should get feeling of group-backing rather than working as an isolated worker.
 13. The educational/motivational activities of the worker-motivators should also be conducted in the residential areas of the workers – the spouses should also be covered by the programme messages. This programme relates more to women and children and thus has great and quick appeal to them. It is therefore necessary that wives should be reached in the educational activities. This is
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particularly possible in situations where work force of the industry is living together in housing provided by the factory or set up in the neighbourhood of the industry. Such extension activities outside the industry will be easier by taking help from voluntary organisations and the government machinery engaged in family welfare programme. Wives of the top and middle management could also be effective force in such motivational activities.

14. The educational and motivational activities of worker-motivators should also include (i) display of family planning literature at various places in the company and residential areas; (ii) organisation of exhibitions; (iii) organisation of well-baby clinics, and (iv) organisation of health camps. Periodic organisations of these activities will reinforce regular interpersonal and group activities.
15. Continuous monitoring of the programme in industry by the committee is essential to make programme more effective by timely actions. This process should be made a part and parcel of implementation of the programme. Most of the agencies do not take advantage of sound monitoring system. There is need to have one – technical help may be sought, if necessary.
16. Activating worker-motivators is basic to the success of the family welfare activities in industries. Therefore a close working relations with them through periodic meetings is very essential. So is necessary their skill development through periodic orientations. Their contribution to the welfare activities should be acknowledged and suitably rewarded. They should receive payment for out-of-pocket expenses. It will be preferred if some performance-related payment scheme is developed so that better work becomes an incentive. There is also need for periodic meetings of worker-motivators to exchange experiences.
17. Some mechanism needs to be developed so that workers receive supply of contraceptives when they go for home leave. This type of arrangement will have spread-effect as spouses of the workers may talk about contraceptives to their friends.
18. Support of trade unions is vital to the success of the family welfare programme in organised sector. Involvement of trade union leaders will bring credibility to the programme activities.

The steps listed above will systematise the process of undertaking population/family planning activities in industries. This is essential to bring about desired results.

ROLE OF EMPLOYERS' ORGANISATIONS IN PROMOTING FAMILY WELFARE PROGRAMME*

R C PANDE**

The employers in India have been involved in promoting family planning among the workers since long. As of fact many business houses had taken up family planning programme before the Govt of India came in the scene. There are quite a few large industrial houses which, over a period of time, have involved themselves in similar activities either exclusively or along with rural development programmes. Apart from individual employers, apex employers' organisations like the AIOE, the EFI and the SCOPE and chambers of commerce like, FICCI, PHDCCI, etc. have also contributed considerably in creating awareness among the members about the importance of such programmes.

Following paragraphs focus on family welfare programmes promoted by the three constituents of the Council of Indian Employers, namely, the All India Organisation of Employers, Employers' Federation of India and the Standing Conference of Public Enterprises. An account of the initiative taken by the Indian Tea Association and UPASI is also included in the following pages since these two bodies have done exemplary work in promoting small family awareness.

I – FAMILY WELFARE AND THE CONSTITUENTS OF THE COUNCIL

a) All India Organisation of Employers (AIOE)

The All India Organisation of Employers has been involved in promoting family welfare programme since 1978, when with the assistance of the ILO and the UNFPA, it took up family welfare activities in three centres, namely, Ludhiana, Kanpur and Patna. The main thrust of the programme was to motivate Individual Members (industrial establishments) of the organisation to promote family welfare among their workers. All these programmes were carried out through the regional employers' associations in the respective states.

The major achievements were :

- Population and welfare cells were established in the Secretariat of the Bihar Industries Association and Employers' Association of Northern India;

* This article is based on the information provided by AIOE, EFI, SCOPE and from the publication titled 'Family Planning in Industry in the Region : Part III Field Experiences' by ILO, 1979.

** Secretary, Council of Indian Employers.

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- About 607 establishments employing nearly 80,000 workers were covered under the project and the work was carried out by 700 trained worker motivators;
 - As a result of the project, several enterprises had undertaken family planning activities in their respective enterprises.

The long term impact of the project were :

- The need for enhancing incentives for promoting small family norm was felt by most of the establishments;
- There was an increased supply of family welfare services, including conventional contraceptives to the factory workers;
- There was improvement in the general awareness of family planning programmes among the workers;
- Population cells set up during the project life continue to function even now.

Encouraged by the results of the first phase, the Organisation took up similar programme in three more centres with the ILO and UNFPA financial assistance. In the second phase commencing in 1985, three more centres were selected under this programme at Jaipur, Begusarai and Coonoor.

In the second phase about 90,000 workers were covered, 30,000 in each centre. The employers' organisations involved were Employers' Association of Rajasthan, Jaipur, for Jaipur, Bihar Industries Association, Patna for Begusarai and United Planters Association of Southern India, for Coonoor.

The major thrust in the second phase was on motivating the management personnel, alongwith the workers, and in improving monitoring of the project activities. One of the positive results was that the trade unions in these centres took deeper interest in project activities.

The AIOE has now embarked upon similar family welfare programmes with the financial assistance from Enterprise Program (USAID) in three centres, Alwar, Bokaro and Mangalore. The main objectives of the present project are :

- To strengthen the existing population/family welfare cell in the AIOE to enable it to provide better consultancy and advisory services to all its constituents in the importance of family welfare education and programme.
- To help setting up family welfare cells in the employers' organisation in the three centres selected for the project activity.

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- To persuade the managements to constitute bipartite committees in their establishments.
 - In case of small-scale units, attempts would be made to motivate them to jointly implement programme through 'cluster approach'.
 - To provide intensive family welfare education to about 90,000 workers (30,000 in each centre) and the population in the surrounding areas through motivational activities. About 80 worker-motivators would be trained in each centre.
 - To improve the couple protection rate by 10 to 12 per cent amongst workers and their families and in the neighbourhood in the three centres.
 - To motivate managements to continue with the family welfare programmes by appropriating the funds even after the project comes to a close.
 - To persuade the managements to extend family planning services to non-working population as well.

b) Employers Federation of India (EFI)

The Employers' Federation of India with large number of regional employers' associations and individual companies as its members, has under the leadership of its past-President, Late Mr Naval H Tata, supported the cause of family planning in industry for nearly more than 30 years by actively engaging itself in urging and assisting employers to undertake family welfare programmes for their workers.

The Federation has consistently impressed and urged employers about the need to play an active part in the formulation and execution of the national population policy. It has taken active steps to organise seminars, workshops and meetings, etc. to motivate its members to take up family welfare work for employees as part of their regular welfare activity.

The Federation in 1971, set up an all-India committee at its headquarters for promotion of family welfare. In 1973, the Federation carried out a nation-wide survey in respect of family planning in industry covering 345 industrial units. Thereafter in 1974, it organised an in-depth training course in family planning for medical officers employed by the units.

The EFI also established a family welfare cell in 1979 at its headquarters and undertook two projects with the technical and financial assistance of ILO/UNFPA. In the first project, spanning three years from 1979 onwards, some 150 industrial enterprises employing about 1 lakh workers were covered. As an outcome of the project, in about 70 units, family welfare officers were appointed and about 1300 worker motivators trained. These enterprises introduced monetary incentives and

provided other facilities such as stocking and distribution of conventional contraceptives and oral pills. In one of the areas covered, i.e. Pimpri and Chinchwada area, the birth rate came down from 40.72 per thousand workers in 1979 to 30.91 per thousand workers in 1982. In the second phase which commenced in January 1988, an intensive educational and motivational campaign was carried out through workers trained to work as worker motivators.

c) Standing Conference of Public Enterprises (SCOPE)

The specific objectives of SCOPE for Family Welfare Programme are :

- a) The introduction of the concept of population and family life education to employers and Senior Managers in the public sector.
- b) Spreading the message of small family norm and its impact on family life of the workers, management and workers in the public sector.
- c) To motivate senior managers to provide family welfare programmes and family planning services as a part of establishment level health and other labour welfare services.

The population unit of SCOPE came into existence in November, 1985 with the support of the ILO/LAPTAP and the receiving public enterprises in India.

Although, ILO/LAPTAP sponsored project came into being in 1985, a beginning was already made in collaboration with ILO in 1983, when SCOPE agreed to host ILO's inter-country seminar on family planning and family welfare education in public enterprises, in which the participants were from Bangla Desh, Indonesia, Pakistan, Philippines, Sri Lanka and India. The main objectives of the Seminar were:

- To provide a forum for the exchange of views and experiences and discussions on the most practical means by which public enterprises could promote population orientated activities and set-up population education and family welfare programmes at plant level.
- To review population programmes in public sector enterprises in each of the countries represented.
- To identify the most successful ones and examine the factors contributing to success.
- To evoke interest of Government representatives and also of management of public enterprises by convincing them of the advantages and benefits of taking up population programmes in their institutions.

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- To provide a set of guidelines for public sector enterprises in setting up their own infrastructure for such programmes.
 - On-going project with the SCOPE is to help intensify the population education programmes in public sector enterprises in particular.

According to a preliminary study, conducted by SCOPE, public enterprises have been doing enormous work in educating the workers to adopt small family norms. Simultaneously, several meetings were held with the Chief Executives of public enterprises. It was found more useful to organise high level educational programmes for the population officers, personnel managers, labour officers, in-charge of population activities in various units of public enterprises so that they are able to guide and direct the activities down the line.

The SCOPE has conducted a survey of population education activities, incentives etc. in public enterprises. The future plan for the population cell includes activities listed below :

- It is proposed to hold seminars in various regions in collaboration with Ministry of Health & Family Welfare.
- Preparation of case studies on successful activities, programmes undertaken by various public enterprises, with the purpose of motivating others.
- Publication of a manual to help as a reference material; to employ motivators, programme co-ordinators, etc. This manual would provide necessary information for educating workers.

II – FAMILY PLANNING ACTIVITIES IN PLANTATION SECTOR

a) Indian Tea Association, Assam (ITA)

The family planning programme of the Indian Tea Association for the tea plantations of Assam had a rather modest beginning. The idea of launching a family planning programme came from an awareness of the fact that an excessive growth of population resident at the different estates could cause multifarious problems for the estate managements as well as for the residents. The objective from the beginning was fairly clear; stabilisation of the estate population at a reasonable level by curbing the excessive rate of growth. The actual programme was developed from experiences gained from year to year. A cautious beginning was made as early as in 1950, even before a proper national family planning programme started. From that year, estate medical officers who attended the training and refresher courses run by the Rose Institute were given instructions on birth control and family planning techniques. Nevertheless, the question of launching an active programme for limiting the size of the families by birth control was still viewed by the Indian Tea Association

with some diffidence because there were doubts about the attitude of Government and the reaction of the workers. These doubts were removed when Government adopted family planning as an integral part of the Five Year Plans and the rules framed under the Plantation Labour Act prescribed maintenance of family planning clinics in the estate hospital. In 1957, the Indian Tea Association sought the active assistance of the Indian branch of Rose Institute for tackling the problem of family planning. Active work on the programme started the same year.

With the assistance of Family Planning Association of India, attempt was made to develop motivational programme for the workers. It was found that there was overwhelming response from the workers. In several institutions, a number of women workers arrived uninvited because they had heard that they could obtain device on restricting their families. Between 1958 and 1959, as a result of the programme, at least 77 per cent of the estates in the membership of the Association had medically trained officers and almost all estate hospitals had contraceptives.

In 1961, a meeting of the senior tea estate managers, chief medical officers and others was held to draw up a family planning programme. It was decided to set up a high powered standing committee to plan and execute the work. A training course was organised for the hospital midwives and nurses. The instructors were provided by the Family Planning Association of India. The fertility survey was also carried out which revealed that by the time average women workers reached the end of her reproductive life, she gave birth to 7-8 babies. The data were of considerable assistance for determining the target group for motivational work.

By 1963, the family planning programme of the Indian Tea Association had made good progress. The vital statistics show that the birth rate had come down from 43.4 in 1960 to 38.6 in 1963. By 1968, it had come down to 22.7*. By then, although the proposal for setting up a training centre for estate social workers could not be carried out for lack of funds, motivational and education work was being carried out by the estate medical officers and other medical staff. The family planning services were provided to the workers free of cost and there were monetary incentive schemes also.

Over a period of time, family planning programme launched by the Indian Tea Association has created great impact in the region. The programme almost totally was financed by the tea industry and was carried out with the encouragement and guidance from Family Planning Department of the Government of India, which also with the assistance from the ILO extended some token financial assistance. The ambitious programme for training social workers for estate could not take off the ground because of lack of funds. However, in other respects, the programme has achieved a great deal. Regular evaluation of the programme is also being carried out by the Indian Tea Association with the assistance of Rose Institute.

* 'Family Planning in tea plantations in India' from 'Family Planning in Industry in the Asian Region', by ILO, P. 58

b) United Planters Association of Southern India (UPASI)

In the designing of the programme for family planning motivation, UPASI had to learn its lesson from the experience already gained by some of the estates and the trends revealed by the data compiled from the statutory returns of the plantations. While it was found that it was easy to follow the general practice in family planning activities in plantation, information and clinical facilities and some incentive and worthwhile advance in motivational procedure depend on qualitative improvement in the system of motivation and more effective management of the total programme. As it was felt that this could not be achieved without reliable information in many critical areas, UPASI carried out a survey and mailed questionnaire between 1966-67 to collect information of birth rate, infant mortality, death rate, number of infant deaths, etc. It was found that the birth rate had been constantly fluctuating between 43.1 at a time when the national birth rate was showing signs of dropping to an average of 41 per thousand population. This encouraged UPASI to launch an effective family planning programme.

The national campaign in support of family planning had as its symbol the inverted equilateral red triangle. The institutional base was the departmental organisation and maternity and child health centres spread throughout the country. The Government offered the contraceptives free or at concessional rates. But it was found that the message was a negative one and the workers described family planning officials as 'baby killers'.

UPASI felt that it was essential to remove such misgivings. Each estate being more or less a self-contained community centre, thus should interact with the target group which had to be motivated as much as the workers for whom the scheme was intended. The estate managers had considerable influence over the estate community. Involving them in the programme meant motivation of estate leadership, medical personnel and down the hierarchical system, a task which is of very great importance. The unions were approached at the leadership level, both for the general acceptance of the project and its detailed working. There were several sessions of discussions with the estate managers/estate doctors, staff union leaders, labour union leaders and others before operating details of the programme and its performance were finalised.

The initial work was started at three estates with USAID grant between 1966-67. The six districts scheme commenced an year later and covered over 3,50,000 workers.

The main aims of the programme undertaken by UPASI were :

- Establish personal relations and mutual confidence between the project staff and the target groups;

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- To obtain all relevant information necessary to plan and measure progress or change;
 - To improve personal hygiene and cleanliness in and around workers' quarters;
 - To improve creche facilities and obtain better attendance;
 - To promote recreational activities;
 - To reduce the school drop-outs among workers' children; and
 - To secure acceptance of family size regulation, both by spacing and reducing the general birth rate.

More emphasis was laid on the IEC aspect and motivational campaign was broadly planned at headquarters in consultation with the district committees and project staff. Special programmes were designed aiming at the specific target groups, taking into account age, the family size, etc. The cost of the motivational staff in the scheme was met from the USAID grant and later on through the AIOE/ILO project. As regards the additional clinical services, it was carried out by the existing estate medical system. The financial incentives including no-birth bonus scheme were provided by the management of the estate concerned. Since the workers live in the working areas, meeting them in groups in the residential areas was never a problem. Attendance at clinics is treated as working time and falls within the incentive scheme.

Special worker motivators who were drawn from among the workers, were not used in large scale till the AIOE/ILO project became operative in UPASI. However, after these two projects initiated programmes on family welfare UPASI has actively involved in the programme and includes children's health and nutrition as an integrated part of the family welfare activities. It was felt that the intense campaign of contact and discussion, the concern felt for the children's welfare and future, the general community approach which the campaign carried with it and the ease and frequency of the contact between the project staff and the workers created the right atmosphere of trust and acceptance. Under the AIOE Project itself, there was a fall of 15 per cent in birth rate in the region in three years.

MANAGEMENT TECHNIQUES IN FURTHERING FAMILY WELFARE PROGRAMME

Y.P.GUPTA*

I. INTRODUCTION

Since independence, almost 42 years have passed. Seven Five Year Plans have been implemented but still India continues to have a higher birth rate of 32.0, infant mortality of 96 and maternal mortality rate of 3-4. Although, we have gone quite far in providing health and family welfare services and significant achievements have been made, still we continue to be far behind our national goals. Great efforts are required if the objectives of 'Health For All' by 2000 AD, and that of NRR 1 is to be achieved. In order to achieve the objectives of 'Health For All' (or at least reach near the target specially those related to maternal and child health and population stabilization), there is urgent need to improve the efficiency and effectiveness of the Family Welfare programme. It is also required to make the best possible use of scarce resources for achieving greater output. This ultimately requires improving the management of the whole programme.

Before discussing different types of management techniques and their applications, it will be desirable to first understand the management process, various aspects of which have to be developed for achieving better results. This involves the following types of activities :-

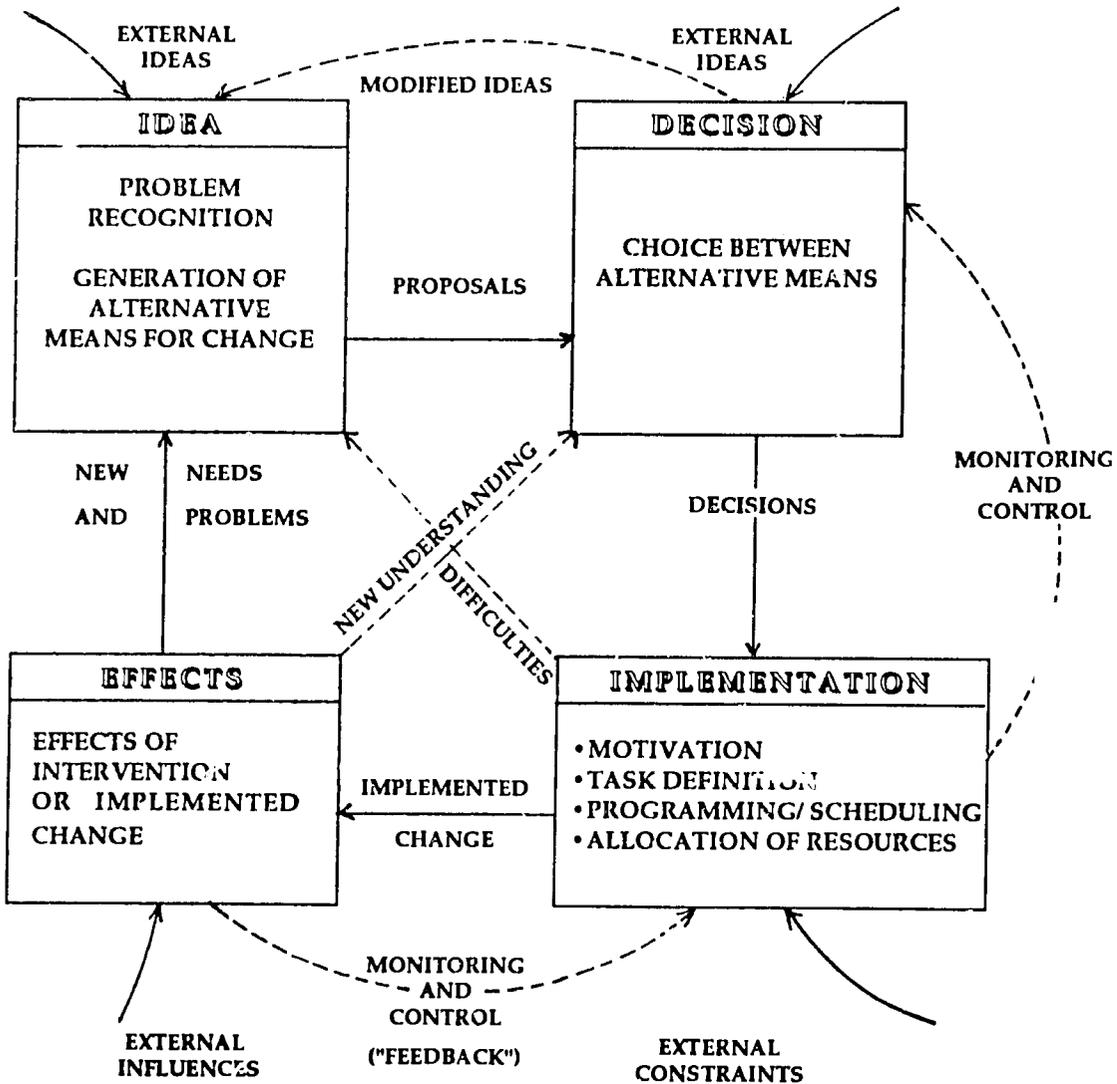
- i) Problem recognition, problem formulation, aims and objectives ;
- ii) Generating alternative means for meeting the objectives, examining them and choosing between them;
- iii) Obtaining (always subject to constraints) resources (material, human and financial) necessary to implement chosen means;
- iv) Defining the tasks (of organisation as well as of individuals or groups) in such a way so as to make effective use of available skills;
- v) Developing and enlarging skills and capabilities;
- vi) Motivating people to accept the objectives and to work towards them by the chosen means;

Associate Professor, National Institute of Health & Family Welfare, New Delhi

- vii) Scheduling of activities or tasks to be performed; and
- viii) Monitoring and control so as to adapt the chosen means in accordance with the experience.

Fig 1 illustrates how in bringing about planned change, several aspects of management process act together in a continuous cycle, each influencing the others

Fig 1. The Management Process



The significance of this for the present discussion is that in attempting to achieve better management of the family welfare programme, the management processes have to be developed. However, without going into details of the various aspects of management process, we shall try to restrict ourselves only to those aspects where some improvement could be made using one or more of the management techniques.

II. MANAGEMENT TECHNIQUES

Management techniques broadly differ from management methods in the sense that while methods are rules of choice; techniques are the choices themselves. For example, in order to draw a sample of family planning acceptors to prepare their profile, the use of stratified sampling is a technique whereas the choice between simple random sampling, stratification and other sampling designs is a matter of scientific method.

The methods referred to above include : systems analysis; programme budgeting; computer-based management information system; organisational and behavioural methods concerned with personnel selection, training, motivation, communication, adaptation to change, working in groups, the design of organisation and so on. Techniques are concerned with the productive use of resources such as work study, network analysis, cost analysis, operational research techniques, etc.

Here, the discussion will be restricted to only management techniques and their applications in furthering the family welfare programme.

The application of different management techniques, details of which will follow, are discussed in the example given hereunder :

Example

An industry is running a family welfare clinic for the families of its workers to provide maternal and child health care and family planning services. In spite of best efforts of the management, acceptors of family planning as well as immunization continue to be low. Even the utilization of clinic for maternal and child health care services is low. It is proposed to improve the functioning of the clinic for its optimum utilization and increasing the number of family planning acceptors. The following management techniques could be used to improve the working of the clinic and acceptors of F.P. methods.

- i) Work Study could be used to analyse the job functions performed by staff and the time devoted by them to different family welfare activities, assess-

ment of the training programme of the health staff to compare whether the trainees could perform satisfactorily the tasks required of them etc. etc. and to bring out the imbalances, if any, in the performance of different maternal and child health and family planning activities.

ii) Cost-effectiveness analysis for evaluating the alternative service delivery systems, namely :

a) Camp approach Vs. fixed clinic approach for increasing immunization coverage and family planning acceptors.

b) Sales bonuses Vs mobile communication team for increasing contraceptive sales through a community based distribution programme.

iii) Network analysis for better planning, implementation, monitoring and control for improving the MCH and family planning programme.

iv) Use of other techniques such as Queuing Theory and Computer Simulation to analyse and simulate various clinic situations to determine the optimum load which the existing clinic staff can take without causing long waiting time to patients as well as to reduce the idle time of doctors.

III. WORK STUDY

Work study may be defined as a study undertaken to identify activities and tasks which need to be carried out to meet identified health/family welfare needs, and the analysis of these activities or tasks with a view to, among other things, establishing job descriptions and curricula for various categories of health workers, and evaluating the effectiveness and efficiency of health services, including manpower.

This definition uses certain terms which are defined below :

Job : The totality of activity and/or responsibilities assigned to a category of health worker (e. g. ANM working in the family welfare centre of a factory).

Function : A broad area of health care included in a job (e.g. maternal and child health care, family planning); a function includes a number of activities.

Activity : A distinct unit or category of work, a part of the function pertaining to a specific job (e.g. pregnancy diagnosis, IUD insertions); each activity consists of a number of tasks.

Task : A specific procedure or unit of work included in an activity (e.g. physical examination).

Task

element : One of the many actions which have to be performed to complete satisfactorily a task (e.g. examination of abdomen, gynaecological examination).

Work studies are undertaken for a number of reasons, the most important of which are :

- i) Planning and management of health manpower (e.g. allocation of tasks to various categories of health workers).
- ii) Evaluation of the effectiveness and efficiency of programmes of services, including performance of the personnel (e.g. does the achievement of targets of family planning programme correspond to the time devoted to this programme).
- iii) Planning and revision of educational programmes (e.g. does the content of curricula relating to family planning correspond to the needs of the programme).
- iv) Assessment of training programmes and of the performance of trainees in the field of their training (e.g. do programmes effectively attain the defined objectives. Can trainees perform satisfactorily the task required of them?)

The work study technique could be very well used to study whether the time devoted to activities relating to family welfare programme for workers of an industry is commensurate to the achievements made in terms of family planning acceptors, because it is commonly said that the health workers devote maximum time to family planning at the cost of other health programmes. This will also bring out clearly the actual time devoted to family planning because it is quite possible that they may be working only with target oriented approach and become complacent after that.

Work studies include a number of activities, some of which are listed below :

- i) Identification of actions to be performed by the medical and para-medical personnel in providing family welfare service (s) to the population of their area;
- ii) Specification of these actions by identifying activities and tasks, and, if necessary, task elements;

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- iii) Analysis of present performance of these activities or tasks; and
 - iv) On the basis of such an analysis the development of work profiles, i.e. job descriptions for various categories of health workers, as and when necessary, skill profiles, etc.

It is not necessary that any one study will be concerned with all these steps. In fact, the use of work studies will vary from one situation to another.

IV. COST-BENEFIT AND COST-EFFECTIVENESS ANALYSIS

The technique of cost-benefit analysis, by relating benefits of a programme to its cost, helps the decision maker in deciding which of the alternative programmes should be given priority and if a particular programme is undertaken, to what extent the programme will be benefited. Cost-benefit analysis has been used in two senses. Narrowly, it is a method of aggregating all costs and all benefits associated with a given project, programme, or decision in monetary terms, converting them to present value and combining them in a single index, such as the present value of net benefits. In the broader sense, cost-benefit analysis is an activity which investigates the cost and benefits that are associated with a project, programme or decision. It may also deal with the distribution of costs and benefits and the sensitivity of results to different contingencies.

In performing cost-benefit analysis, the opportunity cost has to be taken into account; that is, if resources are committed to Family Welfare Programme, then what is the loss of their value for other uses. This would help in justifying allocation of more resources to Family Welfare Programme if the analysis could show that internal rate of return on investment in F.W. programme is at least as much as the investment made in other sectors. If the rates of return is even lower than the bank rate of interest, then detailed investigation need to be made about the programme implementation because major contribution to benefits is the savings in government expenditure during births averted.

The cost-benefit analysis of Family Planning Programme done by National Institute of Health and Family Welfare using computer simulation model developed by Research Triangle Institute, USA, gives a modest estimate of internal rate of return at about 15 per cent based on savings in government expenditure in four sectors alone, that is, public health, education, social welfare and food subsidy due to births averted up to 2000 AD.

In some situations, the purpose of government expenditure is specific and well understood, yet benefits and costs are hard to compare directly because some or all the benefits which accrue due to certain action cannot be expressed in monetary terms. In such cases often Cost-Effectiveness Analysis (CEA) is used in which alternative systems are investigated to determine :

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- i) which of them is least costly when the alternatives are equally effective in achieving the objective, and
 - ii) which of the alternatives is most effective in achieving the given objective when they are equally costly.

Occasionally, an extension of cost-effectiveness analysis is useful for investigating budgetary allocation for a public purpose. In that case, one attempts to measure benefits and costs in different units, detailing the maximum benefit that can be achieved for each amount of expenditure, leaving the final choice of amount to higher level decision makers.

Thus, cost effectiveness models are those that search for the least costly way of achieving a given objective. They do not, therefore, deal with the resolution of uncertainty as such, but with choice among possible actions.

The cost effectiveness analysis could be used to study the alternative models/strategies given as under :

- i) Whether locating Community-based-Distribution (CBD) posts in health settings will be more effective than locating them in private homes or community buildings.
- ii) Evaluation of alternative strategies for delivery of family welfare services e.g. whether use of dai as link worker on fixed monthly salary is more effective than family level volunteer paid on the basis of performance-linked schemes, etc.
- iii) Whether camp approach is effective than fixed clinic approach for promoting family planning.

Problems in Analysing Costs and Benefits

The concept of cost (or input) benefit (or output) provides an extremely useful framework for organising pertinent facts and relationships in dealing with policy problems but there are various problems associated with costs or benefits or both.

- i) **Costs**: What tangible costs are associated with actions regarding personnel, material, capital expenditure? What other kinds of costs are involved – spillover costs, goodwill cost, community disruption, cost of sufferings? In what time period these costs fall? Who will pay them?

However, given the importance of such questions, the problem is from where to get such information.

Many costs, including many of those which are most important, are not computable in financial terms or are not even quantifiable. But they are real costs and may be susceptible to logical analysis.

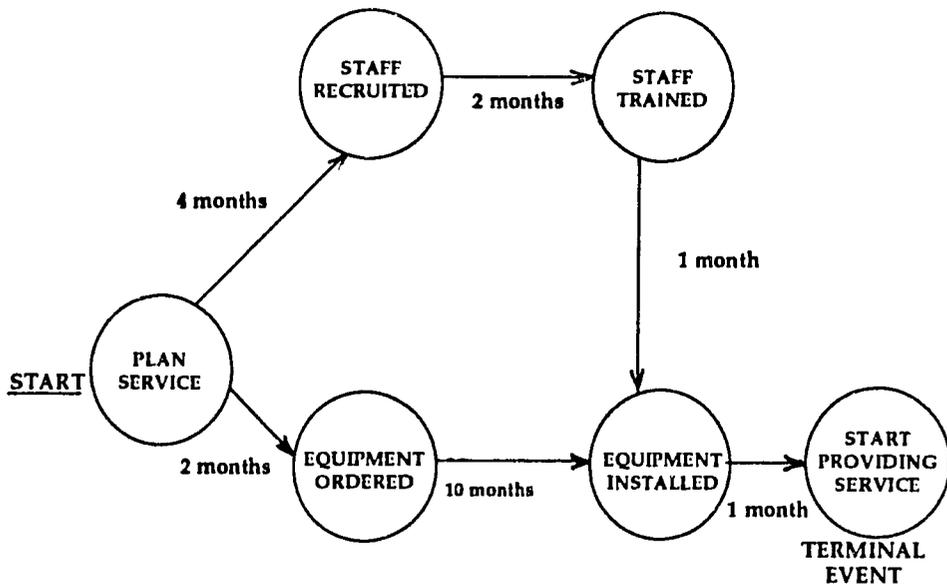
- ii) The second problem is specifying the relationship between inputs of resources and outputs. These relationships are production functions which define alternative courses of action available.
- iii) Third problem is defining outputs or benefits.
- iv) What outputs should be produced.

Benefit-cost analysis is a frame work for keeping our thinking straight in evaluating projects, a framework that demands explicit attention to determining the impacts of a proposal and assigning values to these impacts. It is no more than a tool which provides information helpful in taking decisions.

IV. NETWORK ANALYSIS

This is very useful for implementation of project/programmes in a time-bound manner. The basic principle of network analysis is a simple one – namely, to record in the form of a diagram, such as that shown in Fig. 2, the logical sequence in which events must take place.

Fig. 2 : An example of Network Analysis



By simple arithmetic it is possible with such a diagram to calculate the time by which such activity must be completed and to identify those activities that are critical (i.e. those, if delayed, will delay the whole project). This simple technique provides a basic discipline by which all concerned in a project can know what is expected of them and by what time, and provides a ready means for working out changes in a programme to minimize the effect of any delays or crises that may occur.

Two types of network technique are commonly employed depending upon the situation, namely, PERT (Programme Evaluation and Review Technique) and CPM (Critical Path Method). PERT was developed by the US Navy in 1958 for the Polaris Missile Project whereas CPM was independently developed in 1957 by Walker of the Integrated Engineering Control Group of American Chemical Firm and Kelley of Remington Corporation of the USA in search of new ways for scheduling of projects. The use of both techniques for planning and scheduling of work involves three main stages :

- i) Breaking down the projects into a set of individual jobs, arranging them into a logical sequence and drawing of network similar to the Fig.2.
- ii) Estimating the duration and resource requirements of each job, deducing schedule and finding which jobs control the completion of the project; and
- iii) Re-allocating budget or other resources to improve the schedule.

For using PERT and CPM, certain skill/expertise is needed whereas Gantt Chart could be used by most of the activity managers. These techniques are useful right from planning and scheduling the work to monitoring the progress of project implementation to ensure its timeliness.

These techniques are widely used in the engineering field but in health and family welfare, they have not been commonly employed. However, their application for improving the implementation of family welfare programme is illustrated hereunder by an example.

EXAMPLE

Organisation of a Mass Family Planning Camp for the Workers of an Industry

In order to organise the camp successfully with minimum problems, prepare a plan of action which involves :

a. Listing of all major activities and their expected duration as shown below :

<i>Activity Description</i>	<i>Duration (in weeks)</i>
1. Call meeting	1
2. Formulate programme, obtain approval	2
3. Select venue of camp and take possession	1.5
4. Elicit community Cooperation	1
3. Mobilize staff	1
3. Indent supplies and equipment	2
3. Indent medicines	1
8. Receive medicines	2
3. Indent vehicles	1
9. Receive vehicles	2
3. Update EC registers	4
10. Arrange publicity	4
11. Arrange intensive drive I	1
12. Organise camp	2
13. Arrange intensive drive II	0.5
14. Extend camp	1
15. Submit report	1

b. Scheduling the activities

This involves defining the inter-relationship in time with other activities namely, predecessor, successor or concurrent.

The activity whose start is dependent on completion of the preceding activity is called successor and the preceding one is called predecessor activity. Those activities which are independent and can be started and action can be initiated simultaneously without waiting for completion of any other activity, are called

concurrent. For drawing of network, the scheduling is done by allotting the number of these activities as shown in (a) where successor activities are given the next number of the predecessor activity. Concurrent activities are given the same number. After this, the network can be drawn for using the PERT / CPM.

However, for day to day use for planning, scheduling and monitoring of work, another simple technique called Gantt Chart, also popularly known as bar chart (after the name of Henry Gantt who developed it prior to World War I around 1900) could be used. Here, the activities and their duration are represented by horizontal bars as shown below for F.P. programme.

<i>Sl. No.</i>	<i>Activity description</i>	<i>Duration (Weeks)</i>	<i>Time schedule for completion</i>
1.	Call meeting of MOs and other staff concerned with F.P.	1	
2.	Formulate programme and obtain approval	2	
3.	Elicit community participation	1	
4.	Select venue of camp and take possession	1.5	
6.	Mobilise staff	3	
7.	Procure supplies and equipment	2	
8.	Arrange vehicles	1	
9.	Procure medicines	2	
10.	Update EC registers	4	
11.	Arrange publicity	2	
12.	Arrange intensive drive I	1	
13.	Organise camp	2	
14.	Arrange intensive drive II	0.5	
15.	Extend camp	1	
			Total time required 11.5 weeks

The foregoing representation also shows the total time required for completion of the overall activity. If the time duration is to be reduced, then the inter-relationship of activities is to be examined in more detail to make more activities concurrent and reduce the time duration for completion of various activities by putting more resources, wherever possible.

The utility of the Gantt Chart is further increased by writing against each activity the name of the person responsible for its conduction. Then the project manager can easily monitor the progress of project implementation using Gantt Chart.

Comparison of PERT/CPM

PERT was developed for and has been used mostly in research and development types of projects/programmes which are relatively new and not much information is available. This leads to uncertainty in calculating timings for accomplishment of various activities.

On the other hand, CPM is applied to most repetitive type of projects where activities are standardized and their properties are known. They utilize more or less a standard technology. Changes occur mainly in size, shapes and arrangements rather than in design concepts. It does not allow uncertainties in time estimates and uses only one time estimate (deterministic). Moreover, in CPM, times are related to costs. According to CPM, most jobs can be reduced in duration if extra resources are assigned to them.

The cost of getting a job done may increase, but if other advantages outweigh this added cost, the job should be expedited or crashed. On the other hand, if there is no reason to shorten a particular job – if it has a generous amount of slack – then the job should be done at its normal pace with a lesser assignment of resources. Only the critical jobs need to be expedited. CPM attempts to solve problems such as – which jobs to be expedited and by how much.

V. OTHER TECHNIQUES

Other management techniques include operational research techniques such as Linear Programming, Queuing Theory, Simulation Studies, etc. Linear Programming deals with the choice of a combination of activities having regard to given constraints and to an objective (benefits to be maximized or costs to be minimized). The constraints can be technological, financial, biological or human and express structural factors (e.g. each case sterilized consumes certain time of doctor, paramedical staff and drugs, etc.), resource limitations (e.g. total doctor and paramedical staff time cannot exceed what is available), or imposed constraints that reflect value judgements (as with financial limits). Many practical problems can be formulated

in these terms and computer routines are available for solving large scale and complex problems. For example, determination of optimal mix of contraceptives to be promoted for averting a maximum number of births. The constraints will be in terms of age of the mother and number of living children, etc. Linear Programming could also be used for optimum allocation of resources between various components of the F.W. Programme.

While input – output methods are descriptive, Linear Programming is prescriptive. That is to say, an optimum solution is offered, subject to the given objective and to any constraints that may have been imposed.

Queuing theory is applied to study the problems of congestion. It has been extensively used in situations where a service, such as MCH clinic run by an industry that has a limited capacity, deals with demands that vary and fluctuate in a way that cannot be predicted in detail. In such circumstances, delays or failure to provide service occur even though the capacity is not fully utilized. By relating delays and utilization to the capacities of the various parts of a service system and to the demand for service, queuing theory makes it possible to predict whether postulated changes (say, in the service pattern) will improve the service provided or alter its cost.

There are many techniques which are not possible to describe here. However, the different techniques for different situations are shown in Table 1.

Table – 1 Application of different techniques according to their level of formality and to the level of activeness of management.

<i>Level of Management</i>	<i>Activeness of Management</i>		
	<i>Passive : Regulatory</i>	<i>Service providing</i>	<i>Active Promotion of Health & F.W.</i>
Lower : Functioning Short term		<div style="border: 1px solid black; padding: 5px; display: inline-block; margin-bottom: 5px;">NETWORK ANALYSIS</div> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-bottom: 5px;">WORK STUDY</div> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-bottom: 5px;">SIMULATION STUDIES</div> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-bottom: 5px;">CAPACITY UTILIZATION STUDIES</div> <div style="border: 1px solid black; padding: 5px; display: inline-block;">BEHAVIOURAL SCIENCE</div>	

Level of Management	Activeness of Management		
	Passive : Regulatory	Service providing	Active Promotion of Health & F.W.
Middle : Structural Medium term	INFORMATION SYSTEMS AND RECORD LINKAGE		
	STATISTICS AND FORECASTING		
	MANPOWER PLANNING		
	DEMAND MODELS		
	COST-BENEFIT ANALYSIS		
	SIMULATION STUDIES		
	ALLOCATION MODELS		
	SYSTEMS ANALYSIS		
	TECHNOLOGICAL FORECASTING		
	Higher : Organisation Long term	SYSTEMS ANALYSIS	
STRATEGIC O.R. STUDIES			
PROGRAMME BUDGETING			
COST-BENEFIT ANALYSIS			
MANPOWER PLANNING			
STATISTICAL TRENDS			

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ROLE OF UNIONS/WORKERS IN PROMOTING FAMILY WELFARE AMONG THE EMPLOYEES IN PLANTS AND OUTSIDE

M.A. CHANSARKAR *

I. NATIONAL DEVELOPMENT IN RELATION TO WORKER AND TRADE UNIONS

Trade unions have come to occupy an important position in the social and economic development of a country. This is more significant in a country like India which follows democracy as a way of life and depends on planned economy for her development. Today, the philosophy, concept and approach of trade unions have undergone considerable changes. From smaller organizations engaged in protection and promoting the interests of the workers alone, trade unions have grown up into gigantic organizations capable enough to participate in the social, economic and political activities of a country. This new spirit, energy and dynamism can no doubt be utilised and channelised for the nation-building process.

Trade unions should not be interested merely in the economic pursuits of their members – their wages, bonus, hours of employment, social security and other welfare measures – but should have a broader perspective, national economy and public interest in view. They cannot by-pass public interest and strive exclusively to raise the living standards of the worker community as both are closely linked and one should not be viewed at the cost of other but along with the other.

The workers contribute directly to the economic growth of industry and of the country. They are involved in the development efforts of the country. They should, therefore, share the benefits accruing from this development. The trade unions put up legitimate demands on their behalf for such benefits. However, population increase eats up a good part of the fruits of economic development by hindering saving, investments and capital formation. The result is that individual workers do not benefit to the maximum level possible from the development of the economy to improve their living conditions, in spite of increased production. As a well-organized group of people, their contribution in propagating small family norms is important. It should concern workers' family welfare and the living standards of the working class as a whole which is linked with economic level of the country.

Increasing unemployment and under employment in the country, which is partly due to the rapid increase in the working age population, constitutes a serious

* Ex-Director, Central Board for Workers Education, Nagpur.

threat to the employment security of the workers. It also affects security schemes and other labour welfare measures. These conditions result in constraints on the activities of the trade unions and affect their bargaining power. There are not enough jobs and one reason is the rapidly increasing population. This situation causes unemployment, under employment and a fall in the earnings of workers.

The implications of unemployment actually extend into the realm of conditions of work. It shapes and determines the pattern of labour management relations. For instance, under conditions, where there is a surplus labour force, management, most often, holds the upper hand in collective bargaining. The scarcity of job opportunities severely limits options of the organized labour. Thus, the level of income tends to remain low.

In spite of our efforts to control population, the labour force in India is bound to increase alarmingly for the next 15-20 years, posing a serious problem not only to the trade unions but also to the labour force itself.

The quest for a better life by workers and their families depends in a large measure on the national programme for economic and social development and the equitable sharing of gains. The successful implementation of national family welfare programme is an important element in the total development programmes of the country and of its citizens. Trade unions can contribute meaningfully and effectively to the success of population moderation programmes because of their direct contact with the workers and their considerable influence upon them.

Any activity undertaken by a trade union in the field of social and family welfare is a direct contribution to its strength and influence not only among its own members but also in the community and nation as a whole. Trade unions, therefore, have a stake in expanding their activities in order to enhance their position and prestige for the benefits of workers.

In fact, everything that concerns workers' welfare should become a matter of serious concern to trade unions. A limited family helps to bring health, happiness, contentment and well-being to the worker as well as to the members of the family. Trade unions are thus vitally concerned in economic planning including family welfare programmes for their workers. The population situation is one which affects the life of workers and of their families in many ways. It is, therefore, imperative for unions to take up these questions in right earnest.

II. POPULATION PROBLEM IN RELATION TO WORKERS

Population pressure does not only affect overall national progress, but it also affects adversely living standard of workers. A high rate of population growth can reduce employment opportunities, depress wage levels and create shortages of

essential articles. Indian economy could not generate adequate employment opportunities during the previous plan periods to absorb the back-log of unemployed people. Looking to the trend of population pressure and growth rate in the economy, this problem is bound to pose serious difficulties in years to come. One of the main reasons for our inability to reap the gains of technological advances in industrial and scientific fields is due to unmanageable growing population and its alarming increasing trend. This is particularly true for the entire developing world and India is no exception to it.

Population affects incomes and wages of the workers. In turn it affects their living standard. Rapid increase in population has led to low rate of per-capita consumption of essential commodities. Nutrition-content of food has been low. This has affected the health of workers and his family. In view of the many adverse effects of population pressure on workers' life, trade unions are now assigning higher priority to educate their members about the need of a small family and thus enhance welfare of their members. Trade unions no more confine their outlook to their traditional functions, but have enlarged the scope of their activities.

If workers do not plan the growth of their own families, they will not be able to make full use of the benefits achieved by their trade unions in raising their living standards. They will have to spend more on food, housing, clothing, schooling and medical care of children and will be correspondingly deprived of a part of these or other facilities. The effect of family worries is noticed on worker's efficiency and his family life. The rate of labour accidents is higher among fathers of larger families. Insurance companies also state that harassed parents have more traffic accidents than others.

Another point is the educational problems of worker's children. All parents would like their children to reach as high in education and training as possible. But where will a worker find money to send his eldest son to college or an institute, when he has a large family and when his earnings are inadequate to meet the bare necessities of his family?

Organized workers in India have not been able to attain the required need-based wage. Trade unions have to exert much effort to succeed in increasing the wage levels of the workers. With a low level of earnings and larger families, it is difficult for workers to meet the family needs of food, house, clothing and education. Trade unions are now increasingly coming forward with schemes to help workers in this regard. But due to inadequate trade union finances the demand for such assistance outgrows resources and restrict labour welfare activities.

In India today, most of the unionized workers are employed in industry or the services which are located in or around cities where population is increasing sharply. This increase is partly due to a high birth rate, common to the economically

underprivileged groups, and also due to large rural migration towards cities. In the urban areas, this results in unemployment and low salaries. The problems of migration and urbanization are equally grave and adversely affect the earnings and living standards of workers and create difficulties for trade union working.

The ill-effects of these factors are important from the trade union point of view. They should be checked at an early stage by the social and civic consciousness of the masses or by sufficiently strong social institutions. A trade union functions as a powerful social institution for the workers and therefore, it has to evolve a clear policy and programme for workers welfare taking into consideration the effect of the population growth rate on the social and economic life of its members.

III. TRADE UNIONS AND FAMILY WELFARE

Family welfare is now accepted as a welfare measure by all the central trade union organizations in India. They are now committed to extend all possible cooperation in making family welfare programme a success. The trade unions can make family welfare services an issue of collective bargaining. They can impress upon the employers the need to introduce family welfare services as a welfare measure for the workers. They can demand certain facilities and amenities from the employers and the Government, not merely at the worksite but also at their doorsteps. The subject being of vital importance, it cannot be taken casually – all the three parties, namely workers, trade unions and the employers, have to be fully committed. The process of education and motivation will have to go on until the desirable result is achieved. Family welfare which includes motivation and use of contraceptives and sterilization methods would have to reach the working place and the worker's home. Education and motivation would have to reach not only the workers but also his/her spouse if the programme is to succeed.

However, it must be understood clearly that family welfare cannot be a substitute for a plan of rapid economic growth. Family welfare is one of the means which help to achieve economic prosperity. No efforts should be made to divert attention from speedy economic progress. As a matter of fact, socio-economic progress leads to acceptance of small family norms. This interdependence should be properly realized by the trade unions.

Trade union leaders of varying political and ideological affiliations in India have expressed their support for national family welfare programmes and for their extension to trade union members. Nevertheless, the fact remains that trade unions and workers education bodies have made only a limited contribution to these activities so far. No doubt they can, on their own, do more in this area than they have done in the past. But they will need technical and financial support to undertake effective and adequate educational and motivational programmes. Therefore, the competent institutions in the field of family welfare planning should give them

adequate support and guide them in undertaking action in the population field. For this purpose, it would be helpful if the trade union movement could reach a common understanding about the activities relating to population matters – which benefit both the society and the workers.

For efficiency and good service, national trade union organizations are usually divided in sectoral federations (e.g. Textiles, Mines, P. & T. or Plantations) and/or in geographical units (e.g. State or District). It would, therefore, be logical to use the specialized knowledge of a particular group of workers/unions in determining educational and motivational approach. This implies that cooperation between population and family welfare bodies on the one hand and the trade unions on the other should not be limited to an exchange of views at the national level. More specialized contacts and meaningful cooperation should be sought for at the lower levels also.

In family welfare, the "face to face" individual or family approach is an essential part of action. Much of the concrete cooperation can take place at this basic level. This is why special educational efforts are required of the union members to make them understand the programme and give necessary communication skills so that they can communicate effectively with their co-workers. The employers also will have to be in agreement with this policy and will have to extend facilities for carrying out these activities.

Field workers, clinics and welfare or medical services all have the task of giving actual instructions and services concerning the use of birth control methods and devices. But they also have the very important responsibility of informing, educating and motivating workers concerning family welfare. It is at this point that cooperation may be offered by trade unions.

IV. ROLE OF TRADE UNIONS IN POPULATION EDUCATION AND FAMILY WELFARE

Trade unions in our country do not have the infrastructure and/or resources to provide actual "services" to workers for adopting family welfare measures and this is not their role; but they can play an important role in arousing workers' confidence in family welfare programme and motivate them by giving them information so that they become convinced of the need to adopt such practices. This type of role has been repeatedly emphasized in different Regional and National level seminars, symposia and workshops organized by ILO for trade unions and employers' representatives to discuss the urgency of the population problem in the organized sector and to initiate action programmes to tackle this issue. The conclusions reached in these deliberations have established the trade unions' concern in planning family of the workers. It has been accepted that family welfare activities should

be regarded as an integral part of labour welfare and should be given due priority in the welfare package of employers and activity of the trade unions. Some specific suggestions and other ideas for the role of workers and their organizations in the field of family welfare planning are the following :

4.1 Educational and Motivational Activities

- (i) Family welfare may be treated as an integral part of labour welfare. While employees can conduct the activities, the unions can undertake motivational and educational activities and spread the message of small family and planned family with an interval of three to four years between two births.
- (ii) Trade unions can give publicity and undertake educational activities through exhibition of relevant charts, graphs, etc. and by organizing seminars and exhibitions to emphasize benefits of planned family and disadvantages of unplanned family. For this purpose, support can be taken from the Government machinery and other voluntary organizations engaged in such social programmes. Such seminars/exhibitions may be organized among workers at national, regional and plant level.
- (iii) Trade unions can organize training programmes for workers, newly married couples, etc. If financial resources permit, the unions can even appoint full-time trade union welfare officers for this purpose. Unions can also avail of the grants provided by the Central Board for Workers Education/Central Social Welfare Board, etc. for the purpose. Even State/Central and industry's resources can be secured for this purpose.
- (iv) Trade unions and their members may take full advantage of the existing facilities for family welfare services provided by the employers and their various organizations. Where such facilities do not exist, the trade unions should persuade their respective managements to provide those facilities.
- (v) Information on family welfare could reach the workers more effectively through the journals and other publications published by the trade unions which have large circulation. A separate section may be devoted to this important topic.
- (vi) Trade unions may bargain for incentives, financial as well as non-financial, from their employers, in terms of additional increments, leave, preference in promotion, etc. (wherever possible).
- (vii) Trade union leaders may set an example to the rank and file. The idea is that the leaders should themselves believe and follow small family norm. This will have remarkable impact upon the workers as they normally fully follow the direction, guidance and advice of their leaders.

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- (viii) In collaboration with the employers, trade unions can organize from time to time sterilization camps and motivate members to undergo sterilization. Displays and exhibitions of literature and other audio-visual media on family welfare in local languages may be frequently organized in union offices.
 - (ix) Trade unions can explain to the workers the likely adverse effects of having big size family, its possible impact on the individual worker especially on his efficiency. Similarly, the problems of housing, education, health and medical care can also be brought to the notice of the workers.
 - (x) Since a number of workers may have doubts, fears and misgivings about family welfare planning, the sterilization methods and their after-effects, trade unions can seek the services of qualified medical social workers, medical practitioners etc. to clear their doubts and motivate them to undergo sterilization.
 - (xi) Active workers from amongst them (trade unions) can be grouped into worker-motivators. They can be trained in the programme activities and communication skill to inform, educate and motivate co-workers in acceptance of family planning programme services. The financial and other support for this purpose may be sought from the Central and State Governments and the management.
 - (xii) Being a powerful agency for social change, trade unions can motivate the general public also for family welfare planning. Because of its strength, it can bring about the required pressure also on the Government to modify the policies and programmes, if necessary, on family welfare planning.
 - (xiii) Integrate population and family welfare education into workers education and other educational activities undertaken by them.
 - (xiv) Co-operate with and encourage workers to participate in educational programmes on family welfare arranged by employers; labour administrations; national family welfare agencies; voluntary organizations.
 - (xv) Arrange for the appointment and training of trade union family welfare officials who will be required to include family welfare motivation as their priority task.
 - (xvi) Organize regular training classes for trade union leaders to enable them to function as honorary worker-motivators in family welfare work.
 - (xvii) Where engaged in educational work, arrange for the training of trade union education officers to include population and family welfare in workers education activities.
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- (xviii) Give special emphasis to family welfare in educational activities directed towards women workers and women members of workers' families. The most urgent information that could be conveyed to workers and their families in the reproductive age group concerns the different contraceptive methods which they may utilize. This will answer the all pervading questions : Why? and How ? Other information which worker would need relates to the availability of family welfare services and the cost of obtaining or utilizing these services. This information could be imparted through lectures, group meetings, visits to family welfare clinics, and distribution of informational materials.

4.2 Programme Service Activities

- (i) Trade unions may take up the distribution of conventional contraceptives through their organizations.
- (ii) Co-operate in identifying and counselling dissatisfied acceptors and arrange for their treatment; they can also help in giving follow-up services.
- (iii) Encourage and guide workers to seek such service facilities from public centres in cases where the services are not available in the clinics of the undertakings.
- (iv) Negotiate with employers and with national family welfare planning authorities to improve and/or maintain a high level of family welfare services at or near the undertaking.

The listing above is only illustrative and not to be construed as precluding trade unions from exploring other areas of collaboration with employers, with public authorities and with voluntary organizations. It has been found by experience that labour/management co-operation in formulating action programmes generally leads to strong action oriented programmes in the field of workers' education

V. SUPPORT TRADE UNIONS' NEED

Being conversant with the needs and attitudes of the workers, the trade unions can make a major contribution to family welfare programmes through participation in policy formulation. In this connection, it is desirable that trade unions should be given adequate representation on national family welfare planning policy bodies (dealing with programme for the workers) alongside representation of employers and the labour administrations. Trade union leaders may be prepared to represent the workers' view-point and ensure that they are heard on all matters relevant to family welfare programmes affecting workers and their families, at national, regional or local level.

The extent and effectiveness of the contribution to family welfare by the trade unions will depend, in large measure, upon the motivation and involvement of the trade union leaders. Therefore they may be afforded the fullest opportunity to appreciate the relevance and the magnitude of the population problem and its implications in respect of their efforts to obtain a better life for the workers and to eradicate mass poverty and misery. Such opportunities should take the form of seminars, conferences, dialogues and study tours. Trade unions may be provided such opportunities by the Government and other agencies, both national and international. These activities should cover trade union leaders at the national, state, district and local levels so that grass root levels may be reached.

Workers' representatives should be enabled to participate actively in the planning and management of family welfare planning programmes that may be launched in industry. It is highly desirable that an understanding be reached by the two partners in industry that questions pertaining to the provision of family welfare planning and related welfare services are kept within the area of consultation and co-operation. Within the undertaking, this can be effectively promoted by labour/management committees. Trade Unions should actively co-operate in setting up these committees and where several unions operate in an undertaking care should be exercised that all unions are represented.

Family Welfare Planning programmes are comparatively a new venture for trade unions but may find links with their traditional activities. Trade union administrators and leaders may wish to obtain advice and assistance for incorporating such programmes in their regular activities and for conducting them effectively. They may obtain the assistance from the following agencies :

- National Family Planning authority
- Employers and their Organizations
- Voluntary Family Planning Organizations, e.g. Family Planning Association or Planned Parenthood Association/Federation and others affiliated to and assisted by the International Planned Parenthood Federation.
- ILO and other international agencies working for this and similar social programmes.

VI. SUPPORT WHICH CENTRAL BOARD FOR WORKERS' EDUCATION CAN PROVIDE TO TRADE UNIONS

The trade unions can avail the benefits of various training programmes including courses on population education conducted by Central Board for Workers'

Education (CBWE) for workers engaged in different segment of the economy. They can also use educational and motivational material produced by the Board on population and family welfare education under different ILO-UNFPA projects on population and family welfare education.

CBWE has been playing an important role in preparing workers in organized, unorganized, rural and informal sector for active and conscious participation in the economic development of the country. Population and family welfare education has become an integral part of training programmes of the Board conducted at national, regional and plant levels both in the organized as well as rural unorganized and ill-organized sectors.

The population education programme of CBWE developed on the basis of their own experience with several such activities aims at :

- (i) enabling workers to know more about the implications of population increase in the social, economic and family life of the workers;
- (ii) creating an understanding that family welfare planning does not mean only population control but also family and social welfare;
- (iii) stimulating, through educational and motivational processes, the acceptance of the need for small family norms by workers;
- (iv) creating a demand for contraceptive services; and
- (v) realizing the importance and urgency of the problem, and the benefits of accepting small family norms.

The Board has been implementing the activities through Indian Institution of Workers' Education and 43 Regional Centres spread throughout the country.

The Central Board for Workers' Education maintains close links with the International, National and Regional Institutes, voluntary agencies, and the Government Departments which are actively working in the field of Population Education and Family Welfare. There is a continuous and reciprocal flow of literature and visual aids produced by the Central Board for Workers' Education and these agencies, relating especially to motivational and educational material. This literature is suitably used by the Central Board for Workers' Education in its various country-wide training programmes for documentation and preparation and need-based mimeographed material. The Board also renders active co-operations to national/regional organizations in organizing and conducting training programme on motivational and educational aspects wherein the help of medical personnel is sought for discussing the clinical aspects of family welfare planning methods in various training programmes.

The International Labour Organization entrusted the Board with Projects for Curriculum Development and Production of Teaching Aid on Population Education. They were :

- (i) ILO-UNFPA Project on Curriculum Development and Teaching Aids on Population Education and Family Welfare.
- (ii) ILO-UNFPA Project on Population Education in the Organized Sector for production of Educational and Motivational materials for Population Education.
- (iii) ILO-UNFPA Project on Population Education-Phase II.

The Central Board for Workers' Education has been entrusted with the Project on Family Welfare Education for Rural Workers. It has commenced from 1st July 1986 and would run up to 31st December 1989. The project aims at integrating Population and Family Welfare components in the Rural Workers' education programme undertaken by the Board. It also intends to encourage and promote the participation of Rural Workers Organizers in Family Welfare programmes with the assistance of the Regional Centres.

Through these projects, Manuals, Pictorial booklets and Visual Aids have been produced by the Board for Workers Educators, teaching institutes, trade union leaders, local union representatives and active worker motivators in Asia and India. The list of the same is given in the Annexure. This material presents the concept of family welfare as a positive welfare programme linked to immediate needs of the individual family, improving the health care, education of children etc. This material is available to trade unions and also to any other organizations interested to work with industrial workers.

ANNEXURE

The Central Board for Workers' Education has produced the following literature and visual aids (under various ILO-UNFPA Projects) :

1. Manual for Labour Educators – Role of Trade Unions in Family Welfare.
 2. Pictorial Booklet – We Two Our Two.
 3. Filmstrip – Trade Union Goals and Family Welfare.
 4. Posters –
 - (i) Bargain for two
 - (ii) Enough
 5. Folders –
 - (i) How can Trade Unions participate in Family Welfare ?
 - (ii) Some Population Questions.
 6. Stickers –
 - (i) Spacing leads to Family Welfare.
 - (ii) Strive for Small Family.
 7. Hand Book On Population Education for Workers :
 - Level I – For Education Officers and Worker Educators.
 8. -do- Level II – For Teacher Instructors and Middle Level Trade Union Leaders.
 9. -do- Level III – For Local Trade Union Representatives and Active Workers.
 10. Story Book – Stories on Workers' Family Life
– A set of Eight Stories.
 11. Pictorial Booklet – Children are like Plants.
 12. Filmstrip – Stake of Trade Unions in Workers' Family Welfare.
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| 13. Flannel Graph | - | Add Joy, Spread Joy. |
| 14. Stickers | - | (i) Third Child not a Bonus.
(ii) Children by accident endanger safety at work.
(iii) Elect a small family – Select your future happily. |
| 15. Pictorial Booklet | - | Why Family Planning |
| 16. Filmstrips | - | (i) Family Planning
(ii) We Two Our Two. |
| 17. Flash Cards | - | Family Planning |
| 18. Pictorial Chart | - | Population of India |
| 19. Handbook on Population Education for Workers Level - II. | | |
| 20. Handbook on Population Education for Workers Level-III. | | |
| 21. Workers Family Life – A set of Eight Stories. | | |
| 22. Pictorial Booklet – Children are Like Plants. | | |
| 23. Our Population | | |
| 24. Population Profile | | |
| 25. Family Welfare & Home Budget | | |
| 26. Family Welfare and Rural Workers Organizations. | | |
| 27. Family Welfare - Teaching Learning Exercises. | | |
| 28. Rural Co-operatives and Family Welfare. | | |
| 29. Responsible Parenthood. | | |
| 30. Community Health and Hygiene. | | |
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31. Health, Nutrition and Family Welfare.
 32. Family Welfare & Nutrition Education.
 33. Family Welfare and Quality of Life.
 34. (Folders giving talking points).
 - (i) Our Population
 - (ii) Marriage and First Baby
 - (iii) Responsible Parenthood
 - (iv) Protect Your Baby
 - (v) Methods Limiting Family Size
 - (vi) Some Doubts, Fears, Questions about Family Welfare
 - (vii) Home Budget for Family Welfare
 - (viii) Health and Nutrition
 - (ix) Hygiene, Cleanliness and Family
 - (x) What is not Family Welfare ?
 - (xi) My Union My Family
 - (xii) Co-operatives and Family Welfare
 - (xiii) Ecology and Family Welfare
 - (xiv) Our National Policy on Family Welfare
 - (xv) New Approach to Family Welfare
 - (xvi) National Family Welfare Programme.
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35. Prototype A.V. Aids

A. Posters

The following Posters have been developed :

- (i) Our Rainbow Family
- (ii) My Daughter My Son
- (iii) Ishta Putra
- (iv) Gone with the Wind.

B. Slides

About 102 slides on the following topics have been produced by the Board:

(i) Children are like Plants	22 Frames
(ii) We Two Our Two	23 "
(iii) Bargain for Two	1 Frame
(iv) Enough	1 "
(v) Add Joy Spread Joy	1 "
(vi) Elect a Small Family Select Your Future Happily	1 "
(v) Third Child not a Bonus	1 "
(vi) Children by Accident Endanger Safety and Work	1 "
(vii) State of Trade Unions in Workers Family Welfare	24 Frames
(viii) Trade Union: Goals and Family Welfare	27 "
	<hr/>
	102 "

C. The work regarding production of following prototype A.V. Aids is in progress : (position as on 31.3.88)

(i) Flip Book

Rural Workers and Family Welfare

(ii) Flip Charts

(a) A Day in the Life of a Rural Woman

(b) The Role of Rural Workers Organizations in Family Welfare

(c) Some Questions about Family Welfare

The above mentioned material will be translated into Hindi and other regional languages.

ROLE OF INCENTIVES AND DISINCENTIVES IN PROMOTION OF FAMILY PLANNING IN CORPORATE SECTOR

P.S. BHATIA *

I. INTRODUCTION

Provision of incentives has been one of the important strategies of Indian Family Planning Programme. They started in the form of compensation for the time (and thus wages) lost of the acceptor who has to undergo some rest (at least refrain from heavy physical activity) after accepting sterilization operation. Thus it started as a small amount which attempted to compensate for the lost wages, but over the time it took the form of incentives when it became some multiple of the lost wages. Despite several studies, the role of this strategy in the family planning programme is still not precisely known. It is, therefore, of great interest to analyse the evidence on this strategy in accelerating family planning programme acceptance. It is of particular relevance to study its role in the corporate sector because of the fact that (i) several companies have been giving higher amount of incentives to their workers for accepting sterilization services, and (ii) several more companies can adopt this strategy without any problem. This paper, therefore, makes an attempt to discuss the role of incentives and disincentives in the context of family planning programme, covering their various aspects. They will particularly be considered in the context of corporate sector so that informed decisions could be taken in respect of this programme strategy.

II. CONCEPT OF INCENTIVES AND DISINCENTIVES

An "Incentive" may be defined as a tangible or intangible benefit in cash, kind or both, offered to an individual couple or to a section of population in order to stimulate them to accept certain method of family planning to limit their family size. "Disincentives" may be defined as tangible or intangible sanctions applicable, to an individual couple depriving them from certain benefits for having family size larger than some specified number, or to a section of population for not achieving family planning acceptance upto certain level.

III. INCENTIVES IN INDIAN INDUSTRIES **

In order to assess the role of incentives in promoting family planning programme in industries it is essential to know the various types of incentives in vogue in this sector.

* Formerly Asstt. Prof., National Instt. of Health & Family Welfare, New Delhi.

** Cited in, Balasubramanian K. 1988. A Study of Incentives and Disincentives in Family Planning Programme with Special Reference to Indian Programme.

Tata industries were the first to introduce an incentive package to motivate their workers for accepting sterilization. The scheme was first tried by TISCO, a Tata Industry, in Jamshedpur in 1964. For every worker opting for sterilization, an incentive of Rs. 100/- was given. In 1967, the incentive amount was increased to Rs. 200/- and this benefit was simultaneously implemented in all the Tata Industries. (Khan and Prasad, 1977 : 1-2).

No precise information is available regarding the number of industries offering incentives to their employees for accepting family planning methods. An attempt was made to assess the situation in 1982 when the International Labour Organisation circulated a questionnaire to a number of industries in India for getting information on the availability of family planning facilities for their employees. Till 1982, 134 industries had provided information (Khan 1982).

Out of 134 industries, which provided information, 100 were offering cash incentives and the rest 34 did not have any incentive scheme. The amount of cash incentive to an acceptor generally varied from Rs. 50/- to Rs. 500/-. A few industries were offering still larger amount of cash payment to acceptors. For example, Steel Authority of India Ltd., a public sector undertaking was offering Rs. 2,000/- to a tubectomy acceptor and Rs. 1000/- to a vasectomy acceptor. Similarly, Larsen and Toubro a private sector undertaking was offering Rs. 1,000/- for both vasectomy and tubectomy acceptor (Khan, 1982), Godrej Enterprises were providing graded incentives according to the number of children that the sterilization acceptor had. The acceptor with two living children received Rs. 100/- those with three living children Rs. 75/- those with four living children Rs. 45/- and those with five living children Rs. 25/-.

Of 134 industries, 95 had provisions of granting paid leave varying from two days to eleven or more days to their workers who underwent sterilization operations. In case of vasectomy, a number of industrial units were giving average of 10 days paid leave as an incentive. It is important to note that in a few units, two or three days paid leave was given to the worker when his/her spouse accepted sterilization.

None of the industrial units was providing any incentive to the IUD acceptors.

IV. IMPACT OF INCENTIVES ON ACCEPTANCE OF FAMILY PLANNING

The main purpose of offering incentives is to enhance acceptance of family planning. It is therefore, important to study the role of incentives in this regard. A study was conducted in 1969 to assess effectiveness of incentive programme in Tata Industries. It compared adoption rates of sterilization of two sets of samples; (i) 3,988 married workers from Tata Industries which offered Rs. 200/- as incentive money and (ii) 3,872 married workers from five non-Tata Industries of similar size and located nearby where no incentive money or an incentive of less than Rs. 25/- was

offered. The study showed that incentive was significantly associated with high rates of adoption of sterilization. However, zonewise analysis of the same data showed ambiguous results. Khan & Prasad (1980)* made an attempt to evaluate the Tata incentive programme by applying more sophisticated analysis to clear up ambiguities of earlier study. The impact of incentive was evaluated by (i) comparing the sterilization rates of Tata and non-Tata industries at two points time 1969 (i.e. about 2 years after the commencement of the Tata incentive scheme when not many industries were giving incentives) and 1976 (i.e. current sterilization rate when a majority of the industries started giving a varying amount of incentives). The study brought out that in East and West zones, upto 1969 Tata industries had a significantly higher cumulative sterilization rates i.e. 17.9 and 24.6 respectively in comparison to the Non-Tata Industries of 11.8 and 18.5 respectively. The margin of difference (1976 vs. 1969) in sterilization rates in the two types of industries had reduced considerably. It was thus at this stage concluded that the difference in sterilization rate in the two types of industries was mainly because of incentives and motivational work. However, multivariate analysis of data indicated that role of incentives in promoting sterilization among the industrial worker was only marginal, more important factor in predicting acceptance of sterilization was the level of motivational facilities in the industries.

Some reflection on the role of incentives in promoting family planning amongst the industries is available from a mini-survey conducted by the ILO Labour and Population Team in India in 1982 (*). "Most (91%) of the employers and managers of the units where one or other incentive scheme was in operation, felt that the scheme had helped in promoting small family size norm among the workers and many of them had adopted sterilization/family planning." About 6 per cent felt that incentives had no role in promoting family planning while 3 per cent were not sure of its impact.

Bhatia, Gaba and Talwar (1984) ** based on their review of various studies on incentives which included those pertaining to incentives applicable to acceptors from general public and some studies of industrial units have observed : " though one may be inclined to conclude from the studies done so far that incentives for acceptors contribute somewhat in enhancing the adoption of family planning method but it is not possible to quantify such contribution based on the available information."

* Khan M.E. and Prasad C.V.S. 1980. Fertility Control in India, New Delhi, Manohar Publications.

(*) International Labour Organization, Inter-country seminar on Incentives for family planning/family welfare in industrial sector, Puncak (Indonesia) 5-9 October, 1982.

** Bhatia P.S.; Gaba K.L. and Talwar P.P. Role of Incentives in the context of Indian Family Welfare Programme - a critical Review. National Instt. of Health & Family Welfare, New Delhi.

Findings of various studies sometimes give contradictory picture. But overall they lead to the conclusion that incentives tend to give a tilt towards acceptance of services to those who are in the final stages of decision-making about accepting services. Therefore incentives may be useful for the corporate sector employers but the choice of incentives has to be carefully made because it is easy to introduce the scheme but most difficult to withdraw it. Such schemes should be properly weighted to make them optimally effective. Some of the considerations in the choice of a scheme are :

- its sustainability in view of the cost
- its usefulness for the section of workers who need to be brought into the programme
- its administration in the industry
- its degree of impact – both to bring number of acceptors and demographic quality of acceptors
- its reaction among workers and trade unions
- its ethical issues
- its benefits to the management

This paper will consider some of these aspects to highlight that implementation of any incentive scheme is a serious matter and needs to be seriously considered and not taken casually as is done most of the time in the industrial sector.

4.1 Impact of Incentives on the Demographic Quality of Acceptors

There is a belief in certain quarters that although incentives increase the rate of adoption, the demographic quality of such acceptors may be relatively low i.e. acceptors may belong to higher age groups with lower fertility and sometimes even ineligible cases may be included among acceptors particularly when higher incentives are provided to acceptors and/or when incentives are also provided to service providers and officials in the programme. Though it may be difficult to control quality of acceptors in a programme for general public (it is difficult to verify the demographic characteristics of acceptors particularly their number of children) but in industrial units, the quality of acceptors can be controlled because family details are available. One does not know the demographic quality of acceptors who accept family planning in the industries except in the study of Tata employees where Khan and Prasad (1980) found that Tata industries where higher incentives were

provided were able to motivate workers to adopt sterilization at a relatively lower age and at lower parity than those of non-Tata industries particularly in East Zone where no incentives were provided. It is advised that the corporate sector should make full use of its inherent advantage. It can introduce a scheme wherein those whose demographic quality is better would receive higher incentives. The incentives may be linked with age and/or number of children; if possible age of the youngest child may also be weaved into the scheme to exclude those who are less fertile or infertile. No motivational efforts and incentives are needed for such couples (less fertile or infertile) as their acceptance of any method is not likely to make desired demographic impact.

4.2 How much an Incentive can be Costly ?

While introducing any incentive scheme it is very essential that cost per birth averted for various categories of prospective beneficiaries is worked out as it is not cost-effective if an incentive is going to prove too costly. Some consideration should also be given to who is actually going to be the beneficiary. If most of the beneficiaries are those who should not be given incentives (because they would have accepted family planning anyway), then the scheme needs reconsideration. One example of this type of incentive is an incentive of personal pay not to be absorbed in future increment introduced for Central Government employees in late seventy nine (and later on introduced by some State Governments and Public undertakings).

Bhatia (1987) made a detailed analysis of cost per birth averted for different categories of acceptors from Central Government employees under this scheme. According to him, the cost per birth averted for a male employee whose annual incentive is Rs. 50/- varied from Rs. 4912/- (for an acceptor at the age 30 years) to Rs. 1,12,200/- (for an acceptor at age 49-50) if incentive money till retirement is taken into account. The corresponding cost per birth averted for Class II, Class III and Class IV employee whose annual increment is Rs. 30, 15, and 5 respectively varied from Rs. 4,357/- to Rs. 99,500/-, Rs. 2136/- to Rs. 48,780/- and Rs. 854/- to Rs. 19,520/- respectively. The cost per birth averted for corresponding categories of acceptors if pension benefits during retirement period is also taken into account varies from Rs. 5,668/- to Rs. 1,75,000/-, Rs. 4860/- to Rs. 1,41,500/- and Rs. 2,388/- to Rs. 69,780/- and Rs. 938/- to Rs. 26,520/-. The cost per birth averted in case of female acceptors was comparatively higher than the corresponding categories of male employee. The cost per birth averted according to revised pay scale will be much higher for each category of acceptor. This showed the higher the age of acceptor more is going to be the cost per birth averted and therefore it is not advisable to give any incentive to an acceptor belonging to higher age group.

Another factor which is important in the case of this scheme is the type of beneficiaries. This large amount of incentive money is being paid to the government

employees who are much better off than general public and this large amount to them cannot be justified on ethical ground. Moreover, this group has all the characteristics which will make them to accept family planning even without this huge amount of incentive and therefore this incentive cannot be justified to them. The corporate sector has all the data to control such incongruities and therefore they should keep such factors in mind.

4.3 Benefits to the Management

There are two types of benefits that can accrue to management through investment in family planning, one is tangible money benefit, the other one is non-tangible benefit in terms of improvement in worker-management relationship.

4.3.1 Tangible Monetary Benefit

The industrial units including mines and tea plantations could be broadly divided into the categories, whose employees are not covered under Employees State Insurance Corporation (ESIC) Act and thus they are under statutory obligations to provide maternity benefits (12 weeks wages) to their female employees and medical facilities to their employees and their family members. Some are also under statutory obligations to provide other facilities such as creches, nutritional food and educational facilities to their employee's children. These type of industrial units will have monetary savings if family planning is accepted by their employees. In such cases they can easily justify high amounts of incentive money to their employees. The amount of savings will however depend on the amount of wages of the beneficiary, her age, the number of children that she has, and above all the age of youngest child as the number of deliveries (birth) that she will be saving (by accepting sterilization) will depend on her these demographic characteristics. There is every justification that such industries should introduce incentive scheme and strong family planning programme.

The other category of units, which are covered under ESIC, are not likely to have much monetary benefit of this type (maternity leave benefits and medical facilities being provided by ESIC) but will still have to make payments for creches, nutritional and educational facilities, etc. Their work will also suffer if the worker goes on maternity leave as new worker may not have adequate background to carry out work satisfactorily. Even problems of large family size will affect output of the employees. Therefore family planning programme and incentives for this group of industries are also useful.

4.3.2 Long Term Benefits

There is a general feeling that workers with small families have less socio economic problems and hence have less worries and less absenteeism. Such

workers are likely to lead to better worker-management relationship and hence more production. An opinion survey conducted by ILO Labour and Population Team in India* and analysed by Khan has stated in respect of whether incentive schemes improve work performance in the following words: "Many of the employers/managers believed that the schemes had helped in improving work performance in many respects. For example, employers/managers of 26 units (25%) felt that absenteeism of worker had reduced. Similarly about 16% felt that accidents had reduced and 11% believed that the scheme had contributed in increasing the productivity of the company".

Even this opinion survey suggests that management feels small family of worker is good for their work output. Therefore management should think of family planning programme and give all reasonable incentives to motivate their workers to accept the services.

V. INCENTIVES SUGGESTED FROM TIME TO TIME

Many individuals and working groups have suggested various types of incentives from time to time particularly for the acceptors of terminal methods after having specified number of children. These schemes include, enhancement of cash incentive money, monthly remittance of Rs. 50/- for five years particularly to cover the basic nutritional need of the child, various types of certificates or bonds including security bond for couples who opt for sterilization after one or two daughters, Rs. 10,000/- bond in the name of woman, insurance policies, lottery scheme, free education for first two children, preference for seats in educational institutes, priority in allotment of Government accommodation, telephone and electricity connection, preference in granting bank loans for purchase of agricultural equipment and for establishment of small scale industries in rural areas for couples who limit their family size to a certain number of children.

The Working Group set up by Family Planning Foundation (**) had suggested a number of incentives that could be formulated by each ministry. These incentives according to the Group would fit into the socio-economic development pattern and in particular, the basic minimum needs of people. These will also promote the adoption of small family norm. Their recommendations are listed below:

- i. For regular employees, who undergo sterilization after two children, alternative type of monetary incentives have been suggested in lieu of lumpsum payment. These are: advance increment in salary, ten per cent increase in pension,

* 4, Ibid

** Family Planning Foundation, 1982. Incentives and Disincentives to promote Family Planning, New Delhi: Family Planning Foundation.

educational allowance for two children, prolonged maternity leave with pay for the mother.

- ii. Deferred incentive schemes have been suggested as suitable for regular employees of Public Sector, organized industries, plantations, mines, co-operative societies and educational institutions.
- iii. Bonus to female employees who do not utilize their maternity leave for a certain number of years is considered another effective scheme to delay the first birth or space the second.

Inter Country Seminar * on Incentives for Family Planning Welfare in Industrial Sector has given the following ideas for incentive schemes :

- i. Preference for employment may be given to children of employees who have accepted small family norm.
- ii. Facilities for higher education, and training for acceptors; Scholarships for children of acceptors of effective methods or continuing use of family planning methods.
- iii. Increment in pay, special allowances for acceptors of permanent methods of contraception;
- iv. Life Insurance for acceptors of family planning at the cost of the employer.
- v. Extensions of the age of retirement or optional early retirement with full benefits for acceptors and/or motivators.

From the above suggestions it is obvious that there is no dearth of proposals on new incentives, rather suggestions for incentives are given very freely. They should be used and implemented in the industry as far as practicable. Before this happens, however, they should be considered on various criteria listed earlier.

VI. DISINCENTIVES

The study on Incentives and Disincentives to promote family planning conducted by Family Planning Foundation (**) had suggested the following disincentives (not specifically for industrial workers) which were considered more personal to the parents and affect the child minimally.

- i. For regular employees, no maternity leave benefits for the third or subsequent child.

* Balasubramanian K. 1988. A study of Incentives and Disincentives in Family Planning Programme with special reference to Indian Programme.

** 7, Ibid

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- ii. Low priority in admission of third and subsequent children in educational institutions.
 - iii. Graded increase in accouchment fee charged in maternity hospitals depending on family size (beyond two) and family income.

It is obvious that (ii) above affect directly and maximally the child most and (i) will also affect the child substantially and not minimally. Therefore implementation of disincentives has to be considered very carefully and with great caution. In general, introduction of any disincentives for the promotion of family planning acceptance among workers looks illogical and unjustified because :

- i. When there is no disincentive for general public then what is the justification of introduction of any for industrial workers?
- ii. In a society like ours, where even simple social laws regarding compulsory primary education, registration of births and deaths and minimum age of marriage, cannot be effectively enforced, it is absolutely out of question even to think of introducing any disincentive for promoting family planning acceptance.
- iii. Certain benefits are provided to the industrial workers either through various welfare funds generated under certain Acts or through certain statutory laws. Depriving any worker of any such benefits would amount to violation of law and will lead to litigation.
- iv. Even denial of any benefits to workers, now provided by company on its own (though not required under any statutory obligation) will adversely affect the management-workers relationship.
- v. One of the objectives of family planning programme is to improve the quality of life; so denial of any benefit will, directly or indirectly, adversely affect the quality of life and the life of the child, the future citizen of the country.

VII. SUMMARY AND RECOMMENDATIONS

A number of industrial units are providing incentives to their employees who accept sterilization, and are thus contributing in the national endeavour of promoting small family norms. However, no industry is providing any incentive for IUD acceptors or for acceptors of other methods. Thus the spacing methods seem to be not receiving due importance.

Regarding role of incentives in increasing family planning acceptance amongst industrial workers, one may be inclined to agree that the incentives do help in promoting acceptance but it is very difficult to quantify their impact as not many

studies have been conducted in our country to measure such impact. Similarly, it is rather more difficult to measure the impact of incentive schemes on improving work performance in terms of reduction in absenteeism, accidents and hence improvement in productivity as no scientific studies have been conducted covering these areas. Industries can provide good laboratories to conduct such studies, particularly in those units where higher incentives have been provided and also have been in vogue for quite a long time so that some concrete and meaningful conclusions can be drawn.

It is very easy to introduce any incentive but it is most difficult to withdraw it. It is therefore, imperative that while introducing any incentive scheme, its various implications such as, cost involved and cost per birth likely to be saved, its impact on increasing acceptance and on the demographic quality of acceptors, and acceptance of other methods, its implementation and its after effects, reaction of trade union leaders and workers, etc. should be thoroughly examined. Such considerations should not be viewed as suggesting that incentives should not be given. Their utility and the utility of family planning programme in the corporate sector have been accepted and this should form regular responsibility of the management. Only point to be noted is that some caution should be taken to start an incentive scheme so that it could lead to maximum benefit to the programme.

Various types of incentive schemes have been suggested from time to time. They, after proper modification, in view of some of the considerations suggested here, may be implemented.

Introduction of any kind of disincentive for promoting family planning acceptance amongst industrial workers is not favoured at all because of various reasons. These include non-existence of any disincentive applicable to couples in general public, the unethical aspects, particularly, its harmful effects on children, likelihood of violation of labour laws and unfavourable reaction of workers and trade unions.

THE ROLE OF WOMEN'S ORGANISATIONS IN THE FAMILY WELFARE PROGRAMME

Smt. AVABAI B. WADIA*

The Problem

The 1981 Census revealed that India's population had doubled since Independence and the result of the 1991 Census will provide another shock. At the current growth rate of 2.1 per cent per annum, population will double in 32 years. Therefore, if we are to achieve our major goals of poverty alleviation, social and economic justice and sustainable development, the present growth rate must be brought down as quickly as possible to a manageable level. Even with such strenuous efforts, however, India's population is likely to exceed one billion in another 10 to 15 years.

The adverse results of a rapidly increasing population are already being experienced by all strata of society, whether they are visible and obvious to them or not, by whittling down the gains made from developmental measures and retarding the spread of even minimum basic services to reach ever-larger numbers of the people, both rural and urban. The whole planning process to promote a better quality of life for all, becomes seriously defective for it is like building on shifting sands unless the base, which is the population, is at a fairly steady level.

The Family Planning Programme

Starting from the First 5-Year Plan, a programme of family planning has been spread throughout the country, primarily for health and welfare, but it also serves as a major means by which smaller-sized families can be planned on an individual level, and effect a reduction in population growth on the macro level.

The programme, which started with a purely clinical approach, has undergone several phases. It was broadened by the extension approach and the dissemination of information, education and motivation on a widespread scale, as also by a diversification of services, both clinical and non-clinical. Currently, a third and the most crucial phase is being promoted whereby not only does it strive to bring education and services to the "doorsteps" of the people, but also seeks to involve the people themselves as active participants, both as promoters and users of family planning.

* President, Family Planning Association of India

Implicit in this is the realisation that family planning is a people's movement. Government has a vital role in providing the necessary facilities such as information and services but ultimately, it is only the action taken by the millions of couples which can make family planning a success.

Studies have shown that a large majority of people are now aware of the idea and means of family planning, but the gap between awareness and practice is still too wide, and needs to be narrowed down as quickly as possible. Family planning is not an isolated programme, but closely allied to a whole cluster of measures such as those for promoting health, literacy and education, building up public opinion and legal backing for social change in old and outmoded customs, providing economic opportunities, and, most important, raising the status of women, so that they can make decisions regarding their own reproductive health. It has taken many years for policy makers and planners to recognise the synergy that exists in all these measures of human and social development and the need to promote them through interlocking and integrated programmes.

Other Asian Countries

It is a sad commentary that even after 40 years of work, the progress in reducing population growth has been slow in India even though 80 million births have been averted. Other Asian countries which started the same process long after India had shown the way, have achieved greater success in reducing their rate of growth. For example, the "couple protection rate" of those who have adopted family planning is about 39 per cent of eligible couples in India whereas it is about 57 per cent in Sri Lanka; 70 per cent in China; 70 per cent in South Korea; 42 per cent in Malaysia; 45 per cent in Indonesia; and 70 per cent in Thailand. In all these countries, the maternal and infant mortality rates are comparatively low while literacy and educational rates are high. India lags behind in these indices as well. It should be noted that the correlation amongst these three aspects of maternal mortality, child survival, and high literacy especially among women significantly influences the reduction in population growth.

Younger Couples

In India so far, 55 per cent of the couples protected by family planning have been in the age group 35 to 44, and only 16 per cent are below the age of 30. These are the ones who produce more children. Therefore, the need to bring in younger couples who would space their children, and then limit the family, is imperative for the programme to succeed, and the facilities and methods for spacing should be brought to their attention in an effective way. A serious obstacle lies in the fact that old social customs which are outmoded and retard the quality of life still prevail among large numbers of the population. Among these it has been shown that the practice of early marriage and teenage pregnancies is highly detrimental to the physical, mental and emotional maturity of girls.

The WHO formula for hazardous pregnancies emphasises that high risk pregnancies are those which occur too soon (under the age 19), too late (after age 35), too close (with an interval of two years or less) and too frequently (more than 3 children). 'If these high risk pregnancies can be avoided, child mortality would be halved and maternal mortality would go down substantially.

In India, the regional variations are striking, with Kerala, Tamil Nadu and other Southern States giving a much better showing than the four large Northern States of Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh. But on an all-India basis, the figures show that 6.6 per cent of girls are already married between 10 to 14 years; 43.5 per cent between 15 to 18 years and 88.4 per cent between 20 to 24 years. Early marriages therefore account for more than 50 per cent of all women. Maternal mortality is very high – between 400-500 per 100,000, mostly occurring in young mothers upto age 24. In Sri Lanka it is 98 and in Thailand 80. Infant mortality on an all-India basis is 97 per 1000 live births; (in Kerala it is 31 and in UP it is 115-178, showing how women's literacy and health facilities can make a vast difference). The number of children per woman is about 4.2 in India whereas in Sri Lanka it is 3.6, in China it is 2.5, in Europe and USA it is 1.9.

Family planning is a measure where both men and women have a responsibility, but women have a primary interest in it as a protective measure. Women have at least three roles: the domestic and household role, the role as wives and mothers and their role as individuals and citizens, with all the rights that this implies. In particular, their reproductive role should be in harmonious relation to their other roles, and not turn into a kind of shackle, preventing their participation in the wider life of the community and nation. Family planning is an essential measure which can increase their health and well-being and open up opportunities for activities outside the home.

Voluntary Organisations

In addition to the vast government network of health and family planning services, the mobilisation of non-governmental organisations and groups is absolutely vital to the success of the programme.

It was a women's organisation which first pioneered the promotion of birth control (as it was then called) as a measure to improve the health of the mother and the care of the child. The All India Women's Conference took the lead in 1936 and helped to popularise the idea, establishing some service centres also. Some other smaller organisations also did so. But these were sporadic activities which came to a halt when World War II broke out.

After Independence, the newly established Family Planning Association of India consisting of both men and women, started the work on an organised basis and was also instrumental in approaching and persuading Government to take it up as an official measure. Thus, from the first Five Year Plan, family planning was included in the Health Chapter. Thereafter, Government encouraged voluntary organisations to undertake this work, with the help of government grants.

Unfortunately, many organisations, especially women's organisations, were not able to make much headway, primarily due to lack of funds since government grants were given under stringent conditions and were released in a very dilatory manner and also, the sheer difficulty of promoting this new concept and philosophy of the planned family. Nevertheless, there are a number of NGOs who have persevered and are carrying on family planning activities; but generally they are not made up exclusively of women, but consist of men and women volunteers, usually with some professional staff.

It must be emphasised that such wider spectrum of non-governmental organisations must be involved in different aspects of the programme – not only welfare, social, medical or health organisations, but also all Chambers of Commerce, Trade Unions, public service bodies like Rotary, Lions, etc. and all women's organisations. In particular, a revival of active programmes by women's associations is very necessary for maternal and child health, family planning, primary health care and women's development are inextricably linked together. Although there are thousands of women's organisations, some with all-India character and some others, which are mostly local, have not given family planning the attention it deserves. There are several reasons for this, but in general, they have not received the impetus to undertake this difficult aspect of promoting welfare by way of the necessary personalised guidance and facilities. If this could be done by persons who can empathise with them, that is, those who are from the NGO sector itself, much better responses would be forthcoming.

Key Role of Women

Realising the key role of women in family planning acceptance, the Family Planning Association of India, which has been promoting a multi-faceted programme with various innovative projects, has paid special attention to women's development. It has set up Mahila Mandals in rural areas, and Parivar Pragati Mandals where its urban branches function. This step has served to create 1,058 Mahila Mandals with 28,064 rural women volunteers, and 61 Parivar Pragati Mandals with another 3,665 women volunteers. The aim has been to arouse the interest of women in development and the exercise of their rights and responsibilities for general community welfare, for literacy and education, for skills-training for income generation, the education of their children, and especially for the health care of mothers and children, including family planning.

The results have been quite remarkable in many cases. For by stimulating and helping women to organise themselves, they have emerged out of their isolation and resignation to oppressive customs, and discovered their identity as individuals and activists.

The Mahila Mandals carry out varied programmes including the distribution of contraceptives like condoms, Neo-Sampon tablets and oral pills (with medical backup) through 218 contraceptive depots, which have been set up by them. Of those

members of the Mandals who are in the reproductive age group, 57.8 per cent are currently practising family planning.

The active involvement of Mahila Mandals in health activities has enabled an intensive promotion of the immunisation programme to be carried out in many areas. For example, in five villages of Bhiwandi Block in Maharashtra State, the Mahila Mandals were able to immunise all children below 6 years of age. Likewise, in 18 villages of Agastheeswaram Block in Tamil Nadu, 69% of children below 6 years have been immunised through their efforts.

Nine members of the Kojeswari Mahila Mandal in Gorhe Gram Panchayat in Wada Block have been elected to the Panchayat to become the first all-women Panchayat in Maharashtra, even though one member is illiterate. All of them are promoting family welfare along with measures such as arranging water supply in the village, encouraging small savings, and the immunisation of children.

Many of the Mahila Mandals have set up Balwadis, started income-generating activities and through shramdan (voluntary labour) contributed to improvements in village sanitation, cleanliness, afforestation, fruit-tree plantation and making kitchen gardens. The need for preserving the environment, as also promoting the small family norm, have been linked and have become meaningful for family and community betterment. Having observed the sustained efforts being made by the Mahila Mandals, the rural youth too have started supporting them in these endeavours. Thus, the FPAI has helped to mobilise rural women in bringing about a qualitative change in the welfare of their families and communities in an integrated way, where several aspects like health, education and economic measures are promoted as a package and not in isolated compartments.

There are several other NGOs also who are carrying out similar programmes. Each of these non-governmental organisations have worked out their own methodologies for involving the people in developmental and environmental programmes and the scope for such activities at grassroots level is enormous.

A Bridge between Government and the People

Special care has been taken to establish a rapport between the workers of the FPAI and the government functionaries at the rural base and they cooperate and help each other. In many instances, government assistance which was unutilised, has been brought to the villagers through the FPAI workers. This has been a valuable exercise in bridging the gap between the people and the government.

The results are a clear pointer to the way in which family planning can become a widely accepted practice as a meaningful element in measures for better living. With active encouragement, support and funding from Government, non-governmental efforts can be widely mobilised all over the country for achieving the goals for family welfare.

NGOs, WOMEN MANAGERS AND FAMILY WELFARE

Dr. N. HAMSA*

Introduction

Family planning as an instrument of population control was initiated on a mass scale in India at the beginning of the sixties. At the time, the country woke up to the realisation that the population, which had been more or less steady since the beginning of the century, was rising at a cumulatively fast rate. This extraordinary growth in population was a direct consequence of the interplay between the birth rate and the increase in life expectancy at birth due to qualitative improvement in public health measures. Among the western countries the decline in mortality had been accompanied by a simultaneous decline in the birth rate as part of a general social transformation in the wake of industrial and economic progress. However, India was a long way off the stage of economic and social development where a substantial decline in the birth rate could be expected to occur on its own.

The family planning programme launched by the Government of India in 1951 was designed to achieve a substantial reduction in the country's rate of population growth. As a programme, it was the largest anywhere in the world. It also sought to achieve the most lofty target.

The success of the family planning programme was likely to be contingent on three things : (a) that the programme should be consonant with the peoples needs, values and aspirations about family life and need for children, (b) that the programme should allow participation of the people in its implementation and (c) that the programme implementation should be based on sound management principles to ensure that the goals were achieved with the lowest investment in terms of time and financial and human resources.

In practice, however, as far as people's participation in the planning and execution of the programme was concerned, it was conspicuous by its absence. It was essentially a programme of the Government of India. The reasons for this are two fold. First, family planning work could not really draw any benefit from the voluntary agencies as the whole concept of a small family based on individualism and consumerism was alien to the concept of family and solidarity of the family net work. Therefore, voluntary organisations devoted exclusively to family planning, no matter how sincere and great the devotion of the workers, could hardly succeed in propagating family planning. Second, the procedures of administering grants to voluntary agencies were cumbersome and the method of evaluation of their work was faulty. Even in respect of marginal input the execution of the programme was seriously wanting.

* Sr. Assistant Secretary, Federation of Indian Chambers of Commerce & Industry, New Delhi.

Role of Voluntary Organisations

The old emphasis on fertility control and population reduction has since been virtually abandoned in favour of an approach which places greater emphasis upon promotion of general well-being of the family. The official policy as announced in the Sixth Five-Year Plan emphasized that the family planning programme has to be an integral part of the development package.

The recognition seeks also to inject elements of voluntarism and peoples' participation into the programme. Eventually with this reorientation, problems of an inherent elitist bias and lack of people's participation which characterised the family planning programme from the beginning were very largely taken care of. Increasingly, as the special measures adopted to enlarge the role and participation in the programme are put into practice, a large body of non governmental organisations (NGOs) came forward to promote and popularise family welfare measures in different parts of the country.

However, the ability of these NGOs to carry forward and strengthen the family planning programme in the years ahead is likely to be very largely dependent upon the extent to which these organisations are able to build managerial competence and skills. This is likely, over the long run, to depend on the skills and managerial competence these organisations already possess and on their readiness to allow those responsible for implementing the programme and projects to acquire such skills and competence.

Study Objectives

It is against this scenario, that a study was conducted of the women managers engaged in family planning programme of the NGOs sector in Delhi by the author, for International Council on Management of Population Programmes (Comp), Malaysia. This paper is based on the study report.

The basic objective of the study was to give a concrete shape to the shift in favour of involving the NGOs in family welfare work through an examination of the nature and extent of managerial skills and competence available to them. The study was intended to contribute to the development of specific policy initiatives regarding increasing the managerial skills and competence in the NGOs for effective implementation of the family welfare activities. Towards this end, the study proposed to (a) find out the extent to which women managers are associated with or involved in the execution of family welfare projects in the NGO sector, (b) evaluate the socio-economic and professional profiles of the women managers in order to get an idea of the managerial skills and competence levels already existing in the NGOs, (c) ascertain how available managerial skills and competence of

women managers can be improved through suitable training courses and programmes in project management and implementation, and (d) ascertain and indicate the areas where such training courses and programmes might concentrate for better implementation of family welfare programmes by the NGOs.

NGOs & Women Workers in Family Welfare

According to available information, there are over 600 NGOs in Delhi. For the study, the selection of the NGOs was based on a purposive sampling design, and 30 NGOs working in the field of family welfare were selected. However, as the study proceeded, it was not possible to find NGOs exclusively engaged in promotion of family planning. Therefore, it was decided to include NGOs engaged in women and child welfare as well. In the process, four points clearly emerged:

- 1) Barring a few cases, family planning and family welfare is not an exclusive area of any of the NGOs. Most of them are engaged in work in other areas even if they are involved in family welfare activity.
- 2) Their activities are clustered in related areas which are of direct relevance to family welfare work. For instance, even if an NGO is not directly engaged in family welfare work understood narrowly as family planning, it is very often found to be engaged in programmes relating to welfare of women and children which indirectly relate to family welfare and carry the potential for helping promotion of family welfare.
- 3) Some NGOs are oriented to develop some degree of specialisation in a cluster of closely related activities such as family welfare, women's development and child welfare even if they are engaged in other areas.
- 4) The NGOs Projects and Programmes cover diverse needs and requirements.

Women's Involvement

One of the criticisms often made in the context of developmental work in India is that women are not involved in any large measure. This is particularly a point made in the context of promotion of family welfare. It has often been suggested that if the family welfare programme has to be made a success, women will increasingly have to be mobilized for work in this field. It seems from the study, that while it may be true that the execution of developmental programmes in the governmental sector is very largely in the hands of men, this is not the case in the NGOs. More often than not the NGOs are dominated by women workers who are both having the organisation as well as assuming the principal responsibility for implementation of specific programmes.

In response to a query, whether it made any difference to a programme if it was managed by a woman most NGOs replied in the negative. Their contention was that on the contrary, women being in charge of the NGOs or running its programmes, were very often a positive factor in the success it achieved. It is pointed out that women carry a greater sense of responsibility, work harder and are extremely sincere. These factors make for greater success in the sphere of voluntary work. Accordingly most NGOs thought that involving women in voluntary work was of great positive value.

NGOs also pointed out that several temperamental characteristics of women were particularly suited for working in welfare project. Many NGO heads interviewed observed that the kind of work their NGOs were doing came naturally to women because of the temperament and personality, and they were able to approach the target population with a sense of sympathy often lacking in men. On the whole, therefore, the involvement of women in voluntary work being carried out by the NGOs was not seen to handicap the effectiveness of the programme.

Conclusion

The study findings suggest that NGOs have great potential for undertaking family welfare programmes with emphasis on family planning. As regards the existing NGOs programmes and projects in the 30 NGOs selected for the study, they are generally headed by women managers. However, the women managers have not undergone any formal training in the execution and management of projects and programmes.

Most of them are doing the work on voluntary basis and even when they are working on regular basis the payment they are getting is nominal. This is a basic lacuna in the NGOs.

The findings also indicate that the NGOs do not at present have family welfare as their main activity. Their areas of activities generally cover women's education, protection of women against harassment on account of dowry, legal education for women etc. However, most of the projects and programmes undertaken by them are such the family welfare activity can be integrated with their ongoing programmes.

The NGOs are mostly active only when some issues come into focus, such as, dowry deaths, eve-teasing, etc. As regards income generating programmes, they impart training to women from down-trodden sections of society in sewing and tailoring etc. so that they can make a living and augment family earnings.

Even though, the programmes the NGOs are currently undertaking are undoubtedly laudable in themselves, there is tremendous scope for improvement in the planning and execution for them to become effective. There is need for better managerial inputs and strong organisational and infrastructural base. Except for a couple of NGOs, most organisations lack trained personnel. The remuneration given to them is very low.

The study has shown that the women heading the NGOs, are also incharge of the programmes undertaken by them. These women come from the upper and upper middle class background with an inclination for humanitarian work. However, despite their zeal and commitment, they are not able to devote enough time to programmes due to other social commitments. To make the activities of the NGOs impact oriented, it is necessary that they should be encouraged to evolve a project management strategy. This requires action in three areas :

- a) Project planning
- b) Strategy for execution and
- c) Re-organization for financial efficiency where necessary.

Side by side with the heads of the NGOs for whom involvement in the work of the NGO is purely voluntary, there is need to employ project directors who can devote full time for every programme to be undertaken by the NGO. These project directors should either have had formal training in social welfare, project management or should be given an opportunity to undergo short term courses in project management.

Since NGO projects are almost always action-oriented, achievement in the form of concrete results is very important. Necessary changes in strategy would be required from time to time. Apart from training, this requires an induct feeling and inclusion. Women managers are likely to be well suited for social welfare programmes.

The study findings suggest four principal recommendations for ensuring effective implementation of family welfare programme by the NGOs :

- a) There should be integrated women's development and social welfare programmes with a family planning component.
- b) There is need to formalise and bring structural changes in the management of the programmes.

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- c) Special training programmes and courses should be evolved either by reputed management training institutes or by the government recognised institutions involved in women welfare and family planning activities.
 - d) There should be more paid project directors devoting full time for project activities and the remuneration should be enough to attract the best talents.

IEC – THE VITAL INPUT IN CORPORATE SECTOR FAMILY WELFARE PROGRAMME

Prof. N. N. PILLAI*

Why IEC

Experience has shown that IEC is an important input in the family welfare programme in developing countries. The objectives of IEC in the programme, be it of the government or organised sector, can be generalised as below :

1. To build on the existing base of awareness about the family welfare programme; to generate increasing demand for family planning and health services through education and motivation; to promote the adoption of one method or more as a means of reducing fertility.
2. To integrate family planning communication into the larger context of community health to gain greater credibility and acceptance in the community.
3. To obtain recognition and support for the health and family welfare programme from other government departments and agencies and private enterprises.
4. To win the approval of social leaders and other influentials for small family norm and family planning methods besides their active cooperation in child and mother care programme.

The objectives of the IEC campaign in specific contexts depend on the audiences to whom the communication has to be addressed. The government programme has within purview people all over the country as its target – the rural and urban population, the rich and the poor, the literate and the illiterate. Besides these beneficiaries, the campaign to aim at another category of audience also. This consists of administrators, trainers, doctors, media specialists and field workers, who are to be motivated to work towards the achievement of the goals, because, the success of the programme depends largely on the involvement and commitment of these functionaries.

A major sub-sector of the national programme is the organised sector which employs about 20% of the 220 million labour force in the country. Besides contributing to the national effort to reduce the birth rate and improve the health status of people, especially mothers and children, the organised sector has certain imme-

* IEC Consultant to Kerala Government & Principal, College of Communication and Management, Bharatiya Vidya Bhavan, Delhi

diate interests in promoting family welfare among their employees. With reduced fertility rate, the productivity and efficiency level of the employees goes up considerably. Many industrial houses and public sector undertakings have realised this and have organised family planning and health care programmes for the benefit of their employees either of their own or in cooperation with the government agencies. Though the need of implementing the programme is appreciated by most industrial units in the country, it is stated that a large number of them are yet to introduce the scheme. Efforts have to be made to bring home to all the units of the organised sector the importance and urgency of bringing their employees under the protection of regular family welfare services.

The Importance and Urgency

As stated above, the managements which have shown imagination and taken the initiative to introduce family welfare programmes in their organisations have benefited from the better health and happier family life of the employees. The improved couple protection rate and health status have resulted in better productivity and smoother functioning. Corporate efforts ensure better adoption of the recommended practices than what the general programme would motivate because of a number of reasons such as :

- a) The employees are a homogeneous group having almost identical needs and attitudes.
- b) Working together and living in the same residential area, they are exposed to the living conditions, family life and aspiration patterns of their reference group and also the progressive peer groups.
- c) The educational level of the employees is usually higher so that they understand the essential prerequisites of a better life. They are exposed to new ideas through media and better mobility.
- d) The women employees and spouses of male employees tend to accept small family norm and health care measures more easily due to the positive influence of the environment.

Planning IEC

The basic step in the planning of an IEC campaign is identifying the target. The objective of the campaign determines the target. Campaigns like family welfare have target audiences who are widely different in their socio-economic characteristics which makes it necessary to have different messages addressed to each audience according to their respective needs, interests, predispositions etc. The audience, thus, is segmented on the basis of certain homogeneous characteristics, common to

the group. A great advantage with the corporate sector is that the targets form homogeneous segments – the employees belong to, say, two categories – the workers and the white collar employees. They fall into two or three well defined categories in terms of income, education, age, professional status etc. About 80% of the industrial labour belong to younger age group where women/wives are in the reproductive age-group 15-44. Their exposure to outside world and their aspirations are also industrial. They are almost a captive audience available in the same place. They are the campaign planner's delight because of this neat and material segmentation.

IEC programme for family welfare in organised sector has another target. That is the management. It has been found that the corporate sector units which have managements committed to the ideal of family welfare have done well in this respect. Just the opposite are the units managed by those who are indifferent or not cooperative. The function of IEC is, therefore, to motivate also the management.

Family welfare communication passes through several stages – from creating awareness among the prospects to motivating them to adopt the method that suits them. These stages have important implications for the target audiences and subsequently for the setting of communication goals and strategies relevant to the target.

In the initial stages of programme development in corporate units, communication needs are centred in staff audiences – administrators, trainers, medical staff, union leaders who should be responsible for developing and implementing the programme. As the programme expands, emphasis changes to field workers in larger units who must be trained and equipped to carry the family welfare message to workers and other employees. Communication media have to be utilized to reach the "ready acceptors" who need only the information on various family planning methods available and where the services can be obtained. The focus of communication simultaneously falls on others who know and even approve of family planning in varying degrees but do not practise. There are yet others who do not practise family planning on religious, social or economic grounds. Communication strategies must deal with problems of persuading these groups because they form the largest vulnerable section who can be persuaded if they are made to see family planning vitally related to their own immediate interests.

Top managers, at least those who deal with the personnel, should be got involved in the programme. They need only an orientation to the advantages of introducing family welfare measures in the organisation and the facilities to be provided for the purpose. Also they should be informed how to tie up their programmes with the programmes of the health and family welfare department in the district.

Role of Managers

The corporate managers have to play an important role in promoting family welfare among the employees. They should take initiative in mobilising the support of the employees to organise Mahila Samajs and Youth Clubs in the factory township and the workers' colonies. Experience in Kerala has shown that the most consistent support for family welfare education and also in motivating people to adopt family planning methods has come from women's organisations which function as Family Education Centres. Youth Clubs take interest in organising health camps and popularising IEC material.

Managements should cooperate with district authorities and make it known that extra incentives would be provided for sterilization including leave with pay for a few days. Progressive managements sponsor women representatives for orientation training courses periodically organised by the District Health authorities. They get information about various aspects of family welfare and clarify their doubts on the consequences of different methods. In industrial townships and workers' colonies interpersonal communication is the most effective IEC and the orientation provided by the district health officers are precisely tailored to equip the women volunteers with necessary knowledge and information.

The Mahila Samajs, Youth Clubs and other voluntary organisations should be encouraged to keep in close touch with the District Information and Media Officials who would supply useful audio visual material including films for promotional services.

There are corporate managements which have earned national commendation for the encouragements they have been giving to the employees for their achievements in promoting family welfare and health care in their organisations. Those organisations which have adopted the neighbourhood areas for development can implement the programmes more effectively if they encourage healthy competition among voluntary agencies and organisations in the adopted area. Large industrial establishments which have their own townships with hospitals and other facilities will be able to make such services available to the people of the adopted area also if it is not far from the townships. The IEC efforts of district health personnel can be effectively supplemented by the corporate management. Small units may not be able to build their own education and health infrastructure, but easily manage to attract the district health and family welfare communication personnel on a regular basis. What is needed is some additional incentives to the employees and the initiative in arranging family planning and health care camps.

Several plantations in the high ranges of Kerala have been having liaison with the district health service authorities for regular extension services in the workers' colonies. Large establishments can produce their own publicity material and have their own communication efforts in the colonies. This need not cause big investments except owning some 16 mm projectors, slide projectors, public address systems, etc. besides having some hoardings, posters, etc. displayed imaginatively to influence and remind the employees on a continuing basis. A larger variety of IEC material such as films, film strips, slides, posters, pamphlets, etc. available with the Health Communication officials at PHC level should be made use of.

Two types of films are available with the District Media Officers of the state governments and the Field Publicity Units of the Central Government which are located in all districts – documentaries which explain the advantages and dispel fears of different methods and short persuasive films which provide entertainment together with information. Corporate managements should establish regular link with the officials for showing these films in women's clubs and in different parts of the colony at frequent intervals. Also these films can be borrowed if the establishment have their own equipment.

The Soul of Communication is the Message

Broadly there are two approaches in designing the message – factual approach and emotional approach. The success of IEC depends fifty per cent on the correct diagnosis of the problem and the other fifty per cent on the correct prescription of the remedy. For instance, if the resistance to family planning is due to economic reasons such as more children means more hands to work and earn, strong factual argument may be required to convince the target otherwise. If the reason for resistance is the fear of the consequences of certain methods, convincing presentation of facts alone will work, if necessary, supported by credible testimonial appeal. The success of IEC depends on deciding what the nature of the message should be, identifying the appropriate media and creating suitable message.

Media as the channels which carry the message to the target is important in IEC as they have their own characteristics which determine the type of audience exposed to them as also the type of creativity required to make the message effective. Most of the corporate units have their own house magazines. This is an effective tool to communicate not only with the employees but also with their family. The potential of this medium should be used imaginatively.

How the mass media can be used independently by the corporate units and also in collaboration with the Health officials has been explained earlier. Besides these, there are certain unconventional media which can be used effectively in industrial townships and colonies. A few of them are mentined below.

Unconventional Media

Schools and institutions like balwadies are to be increasingly used for the promotion of all aspects of family welfare. Nursery rhymes, action songs, riddles, slogans, competitions, etc. will help motivate parents and others in the society and at home. Imaginative nursery rhymes and action songs will be a source of joy to the children; parents and the community will get a different level of message. Children will recite poems which would communicate the message of health and hygiene. Well produced books containing nursery rhymes of this nature should be made available to the children at subsidized price. Inter-school and inter-institutional competitions should be arranged for children which would involve the parents also.

Health volunteer schemes may be introduced in schools to involve secondary school children in the health care activities of the neighbourhood community. The tremendous interest of the children of that age group to take up leadership responsibilities in the community should be encouraged by asking the volunteer groups to monitor regularly and report to the sub centres the health problems of the houses in their neighbourhood. Members of the volunteer corp may be given a short orientation training in the school itself so that they get clear insight into their responsibilities. Such programmes of students' involvement would be of great importance in the communities having labour predominance because the labourers usually find little time to go to the centres or meet doctors even when they are ill.

IEC can yield much more dividend if the target population is receptive. What ultimately decides the receptivity of the target is the ability of that population to understand what is good for them. This sense of discrimination is developed by education, especially the education of women. IEC, therefore, should have as its running theme the importance of female education, as an essential part of the family welfare campaign.

ROLE OF COOPERATIVES IN PROMOTING FAMILY WELFARE PLANNING

H.R. MUNJAL*

Cooperation is product of adversity created by the onslaught of industrial revolution in the 18th and 19th Centuries. Economic policies pursued during that period were extremely in favour of capitalists, whose sole aim was to earn profits irrespective of the means adopted. Society was divided into two distinct socio-economic groups termed as the "haves" and the "have nots". The "haves", who owned the means of production, were a very powerful group and the "have nots", who were actually operating the machines as labourers, were at their mercy.

The highest degree of exploitation led to extreme privation and poverty of the wage earning class from where it was difficult to extricate. This state of affairs continued for about 100 years. Ultimately, when the extent and intensity of exploitation became almost unbearable, the labour class, as a step to mitigate their woes, organised themselves into different groups. While trade unions were organised to demand better working conditions and higher wages, workers also organised into cooperative groups to free themselves from the shackles of mill owners for purchase of daily necessities of life at reasonable prices.

The idea of cooperation germinated in England, and caught up with the imagination of the working class elsewhere in Europe in the middle of the 19th Century. Cooperation, based on the concept of joint efforts by pooling resources in men and material, thus developed as a mass movement aiming at economic betterment on the one hand and social uplift of the common people on the other. The basic principles underlying the concept of cooperation continue to steadfastly hold the ground even today.

The philosophy and ideology of cooperation, therefore, is based on open membership and voluntarism with full regard to the individual's personality as a human being. It is a unique institution combining in itself personal initiative and collective discipline. It abhors exploitation and places human freedom and right to participate in management much higher than the capital.

With the passage of time, the cooperative movement diversified covering almost all aspects of human economic and social life. The famous adage that "cooperation starts with cradle and ends with the grave" is an indication of its diversity. With political, economic and social changes, the role of cooperation has also undergone change without, of course, changing its fundamental principles and fraternal spirit. From the initial indifferent, if not hostile attitude of the State, cooperatives are now recognised as potential instruments of socio-economic planning. This is particularly true in case of the developing nations.

* Secretary, National Council for Cooperative Training, New Delhi.

In the words of Jawahar Lal Nehru, the architect of modern India, "In the economic structure of India, Cooperation is not even a free choice; it is a necessity". In India, cooperation is, therefore, considered as an expedient vehicle to bring about socio-economic transformation in the people, more particularly in the rural areas where poverty is more pronounced and social customs and traditions more deep rooted.

Social Aspect of Cooperation

The present day cooperatives, though more concerned with the economic betterment of its members, work for the ultimate objective to bring about qualitative improvements in human life. Conceptually and ideologically, cooperatives are expected to bring about complete transformation of society based on the principles of equality, non-exploitation, non-violence, mutual respect, fraternal feelings and freedom from poverty and deprivation. An important part of the preamble of cooperation is creation of environments for a happier life for the individual and the society as a whole. In the final analysis, there will be a "Cooperative Commonwealth" where peoples of the world having faith in its ideology and principles will establish a new world order. Conscious efforts are made to create better understanding and congenial atmosphere for the members to lead a fuller and happier life. Social aspects of cooperatives thus cover activities relating to education, housing, health and nutrition for their members and their dependents.

Why cooperatives should be interested in social welfare activities is an oft repeated question. Economic and financial success of any organisation cannot be taken as an end; this is borne out by evolution of economic thought. The State is now equally concerned with the welfare of its people as it is with their economic development. Economic progress is only a means to achieve something higher beyond the realms of material gains in the realm of moral, ethical and cultural achievements. Economic activities by themselves do not generate the feeling of "belonging". Conscious efforts are required to generate the feeling of oneness leading finally to developing finer qualities of life. The end result of an economic organisation, therefore, should be the well-being of the community and its members. Cooperation thus also believes in the development of social and ethical values as much as it believes in the economic betterment of its members.

Cooperative Movement in India – A Profile

The cooperative movement, which started in India in the first decade of the present century, has grown in stature and size. In nearly 3.5 lakh cooperatives, it has a membership of nearly 15 crores with a working capital of about Rs. 48,000 crores. The Indian cooperative movement is by far the largest in the world insofar as membership is concerned. An overview of its activities reveals that :-

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- *Credit cooperatives* disbursed Rs. 4,550 crores agricultural credit to the farmers during the year 1987-88.
 - *Marketing cooperatives* marketed agricultural produce worth Rs. 5,400 crores in 1988-89.
 - *Agricultural inputs* : IFFCO and KRIBHCO produced 19 lakh tonnes of fertilizer nutrients – over 21 per cent of indigenous N & P production; 76,000 cooperative fertilizer retail outlets in the country distributed 35 lakh tonnes of fertilizer nutrients in 1988-89, which is more than 32 per cent of the total fertilizer distribution. Other agricultural inputs worth Rs. 218 crores were also provided through cooperatives.
 - *Sugar cooperatives* : Cooperatives contributed about 58 per cent to the national sugar production in 1987-88.
 - *Oilseeds processing* : For achieving self-reliance in oilseeds sector, 300 cooperative oilseeds processing units have been set up in the country.
 - *Spinning mills* : About 20 per cent of total spindleage capacity of spinning mills in the country is accounted for by the cooperative spinning mills.
 - *Fruits and vegetables* : Cooperative fruit and vegetable processing units marketed produce worth Rs. 28 crores in 1987-88.
 - *Storage* : For scientific storage of agricultural produce cooperatives have created a storage capacity of over 10.9 million tonnes by 1988-89 as compared to hardly 1.1 million tonnes in 1962-63. Over 48,000 primary agricultural cooperative societies and most of the marketing societies in the country now own godowns.
 - *Consumer* : Essential consumer items worth Rs. 2,075 crores were made available to the rural community by cooperatives in 1988-89.
 - *Weaker sections* : For the development of weaker sections such as weavers, fishermen, tribals, scheduled castes, etc., a large number of specialised cooperatives have been set up.
 - *Handloom* : Nearly 58 per cent of the handlooms in the country are under cooperative fold accounting for 30 per cent of the total fabric production.
 - *Housing* : 26,000 housing cooperative societies in the country have completed 0.65 million houses and 0.31 million houses are now under construction.
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Cooperation and Family Welfare

Cooperative institutions, therefore, provide a very wide and ideal social and economic institutional framework in India. The sections of the society covered by the cooperatives are farmers, artisans, tribals and weaker sections, which are the most vulnerable sections as for population growth is concerned. The role of cooperatives in generating national awareness on issues relating to family welfare among this section of the population cannot thus be over-emphasized.

Induction of family welfare activities among the cooperative societies such as providing community service, education, health and medical care, women welfare and social security is not only desirable but is essential keeping in view the national priorities. Family welfare, though, technically speaking, is a social activity, it ultimately leads to higher standard of living of the people. The growth rate of population has a direct impact on the poverty situation. While the developmental activities in India have achieved positive results on account of planned economic development, the impact on the standard of living of the people has been minimum due to the population explosion.

Besides, cooperatives are under statutory obligation to promote social welfare of its members by apportioning part of their resources in the common good fund and education fund. They are supposed to make use of these resources for the construction of public institutions and managing the public services. Adult education and family welfare education are the other subjects with which the cooperatives should concern themselves. As in Japan, where a cooperative society at the grass root level is not merely an input supplying agency, but a living institution that brings up its members right from their childhood and takes care of all aspects of human life, the cooperatives in India should also measure up to this task. Cooperatives, which are peoples institutions at the grass root level are best suited to create meaningful awareness among the lower strata of the society on the advantages of small size family, to them as individuals, to the society to which they belong and to the country as a whole.

Role of Cooperative Training and Education

The role of cooperatives in promoting family welfare was first recognised in the national seminar on "Population Problems and Cooperatives" organised jointly by the Government of India, the International Labour Organisation and the National Cooperative Union of India in December, 1974. It created nationwide awareness about the possibility of integration of family welfare programmes with cooperative training and education programmes. The national seminar was followed by a national workshop in October, 1979, which amongst other things, identified areas and subjects for inclusion in the cooperative training and education curricula.

The National Council for Cooperative Training, an apex body in the country responsible for planning and implementation of training courses for the functionaries working for the growth and development of cooperatives, organised a national workshop (in collaboration with the International Labour Organisation) for the cooperative trainers in December, 1985 at Bangalore. The trainers' workshop identified the constraints and suggested measures for effective coverage of the topics related to family welfare identified earlier by the national workshop referred to above. The trainers' workshop also recommended preparation of resource material and designing of short duration orientation courses on population/family welfare programmes.

The Cooperative Training Colleges were called upon to coordinate with the local family welfare departments and other agencies to mutual advantage. In 1986, a Sub-Committee under the Chairmanship of Chief Director, Ministry of Agriculture, Department of Agriculture and Cooperation was constituted to prepare modules on family welfare through cooperative training programmes. The Sub-Committee comprised of officers from the Ministry of Health and Family Welfare, New Delhi, National Council for Cooperative Training and selected voluntary agencies. The Sub-Committee recommended a framework of subjects to be included in different types of cooperative training courses organised at the Cooperative Training Colleges. In pursuance of the recommendations of this Committee, Government of India in the Ministry of Health and Family Welfare have allocated adequate funds for preparation of training material and training aids such as video films on the role of cooperatives in promoting family welfare amongst the members of cooperatives.

It appears from the above that family welfare education has become an integral part of the curricula of cooperative training programmes organised at the 18 Cooperative Training Colleges located in different parts of the country administered by the National Council for Cooperative Training.

The NCCT has an organic link with the 95 Junior Cooperative Training Centres administered by the State Cooperative Unions generally and the State Governments in certain States. The Junior Cooperative Training Centres are responsible for training of grass root level functionaries of the cooperative societies such as the Managers/Secretaries/Accountants of the primary cooperative societies. Nearly 25,000 subordinate staff receive training in the Junior Cooperative Training Centres annually. While the senior executives' role is to formulate policies and programmes for the cooperatives, intermediate executives have the supervisory and promotional role. It is the grass root level functionaries, as employees of the primary cooperative societies, who are in regular contact with the members of the cooperatives. These employees can play a significant catalytic role in promoting family welfare programmes. It is, therefore, of paramount importance that this section of employees of

cooperatives should be motivated through specially designed intensive training programme.

Cooperative education programmes administered by the State and district cooperative unions is a still more potent scheme to get across the idea of family welfare/family planning to the cooperative members at the village level. The cooperative education scheme envisages educating and motivating the members to accept the concept and ideology of cooperation with the ultimate objective of developing their loyalty towards cooperative societies. The members in two to seven-day classes are told about their rights and responsibilities towards the cooperative society. The cooperative education scheme is administered through the Cooperative Education Instructors, which number 835 at present. Cooperative education scheme is also implemented through 59 Education projects directly administered by the National Cooperative Union of India in some selected States. Annually, about 12 lakh members of cooperative societies are exposed to the cooperative education programmes in the country.

It will greatly help in creating awareness amongst the members if by some arrangements family welfare education is clubbed with cooperative education schemes. So far collaboration is largely confined to cooperative training programmes at the middle level. It has not yet directly covered the cooperative membership at the grass root level. The arrangements with the National Council for Cooperative Training, at best have created awareness among the supervisory and regulatory groups of functionaries. The programme of integration has yet to reach the grass root level. Involvement of primary cooperative societies at the village level in the family welfare programmes will ultimately help in the cooperatives playing the real supportive role to these programmes.

Information – Education – Communication (IEC)

The objective of family welfare is to improve the quality of life of the common people by their voluntary acceptance of family welfare norms. As already noted, the principle of voluntarism is accepted as the basis of cooperation. Population programme is designed to work itself into the whole fabric of social life and help to bring about social change. Enhancing the knowledge and changing the attitudes of the people towards family welfare/family planning is the most critical aspect of the entire scheme.

Appropriate IEC techniques are, therefore, required to secure desired results through the cooperative societies. The scope of family welfare through the cooperatives can be enlarged by developing an effective system of communication process. Such a system must take into consideration the socio-economic background of the members and their interaction with the cooperative society. The scope of

communication is tremendous as a member visits the cooperative society frequently to satisfy his financial and material requirements. He comes to the cooperative society for obtaining credit, fertilizer, insecticides and finally for repayment of the loans. In between also he visits the society for purchase of say essential consumer goods and attending the general body meetings, etc. The IEC, therefore, can be :

- (a) Inter-personal communication.
- (b) Group communication.

Of the two, inter-personal communication can be adopted with great advantage. It ensures timely feed back which is considered essential for developing confidence among the audience. Internal communication and interaction can determine the attitude and behaviour of the individual. Besides, it is natural that in a small group, there are some individuals, whose advice is sought and generally accepted. The advice in matters relating to family welfare is generally quickly accepted if given in the informal work situation. The Secretary/Manager of a primary cooperative can be given the role of a voluntary motivator.

The type of information required by the member should be so designed as to enhance his knowledge on the subject. It not only should be able to change his attitude, the member should also be able to practise the information. The IEC material, therefore, in the cooperative sector has to be of a particular type and should be carefully prepared taking into account the background of the members. The material should be attractive and simple with simple illustrations. The audio visual material can have quick impact on the members provided it is prepared keeping in view the community's specific social background, more so if the characters are selected from amongst them. Care must be taken to display the material at an appropriate time and place so that the idea gets across. It would be ideal if the communication message/material is prepared with the help of the specific member audience.

Scope of Family Welfare Through Cooperatives

Family welfare is one of the means to reach the ultimate goal of the cooperatives. The cooperatives, therefore, must accept promotion of family welfare as their legitimate activity. The emotional-involvement of the cooperative institutions in family welfare activities has to be an essential pre-requisite for effective propagation of the idea. The following can be the areas where cooperatives at the base level can help in promoting family welfare :-

- (i) Amendment of the bye-laws to include family welfare as one of the social objectives of the society.
- (ii) Inclusion of family welfare/family planning camps for its members and their spouses.

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- (iii) Constitution of a sub-committee on family welfare to oversee the activities in this field.
 - (iv) Organising family welfare/family planning camps for its members and their spouses.
 - (v) Coordination with the district family welfare institutions for technical support.
 - (vi) Inclusion of family welfare as an agenda in the annual cooperative week celebrations – organisation of exhibitions, film shows, etc. on family welfare during this week.
 - (vii) Creation of a discussion forum among the members.
 - (viii) Distribution centre for contraceptives.
 - (ix) Distribution of publicity material to the members on their visits to the office of the cooperative society.

Pre-Requisites for Success

Cooperatives would be able to succeed in carrying through the message of family welfare to its members only if they accept the programme as part of their on going social activity. Thereafter, intensive training and education programmes for the Secretaries and selected members (motivators and cooperative education instructors) should be arranged. Success also presupposes effective coordination between the various agencies responsible for family welfare programme with the cooperatives so that the available financial and technical support could be provided to the cooperatives. It is imperative that the State Governments, which have complete control over the functioning of cooperatives, must also accept, as a matter of policy, the role assigned to cooperatives in promoting family welfare programmes.

Family Welfare Cooperative Society – A Model

Thus far, the emphasis has been only on the existing structure of cooperatives as motivating agencies to promote family welfare. The magnitude of the problem and the national urgency attached to it, however, require additional efforts to use the cooperative structure in promoting family welfare. At present there does not exist any cooperative society exclusively for this purpose. Organisation of cooperative societies in this field will help in boosting the programme through the cooperatives. Given below is a broad outline of a National Family Welfare Cooperative Society to be registered under the Multi-State Cooperative Societies Act, 1984.

1. Objects

- To create general awareness amongst the members of cooperative societies on family welfare.
- To develop horizontal and vertical linkages with the cooperatives.
- To act as a resource centre for production of informative material including films, video cassettes, etc. for use by the cooperative societies.
- To coordinate with the Central and State Governments in the related ministries/departments, national and international agencies promoting the cause of family welfare.
- To promote and organise publicity campaigns on family welfare.
- To act as a national warehouse for supply and distribution of condoms.
- To instal and operate a printing press for printing publicity material on family welfare.
- To arrange training of Cooperative Trainers, Cooperative Education Instructors and motivators.
- To promote organisation of primary health and family welfare cooperative societies.
- To monitor and evaluate programmes related to family welfare implemented through the cooperatives.
- To perform any other function promoting the cause of family welfare.

2. Membership

In accordance with section - 19, sub-section-1 of the Multi-State Cooperative Societies Act, 1984, the proposed cooperative society may have membership from the following :-

- (a) Any individual competent to contract.
 - (b) Any Multi-State Cooperative Society.
 - (c) The Central Government.
 - (d) A State Government.
 - (e) The National Cooperative Development Corporation.
 - (f) Any other corporation owned or controlled by Government.
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- (g) Any Government company as defined in section – 617 of the Companies Act, 1956.
 - (h) Such class or classes of persons or association of persons as may be permitted by the Central Registrar having regard to the nature and activities of a Multi-State Cooperative Society.

3. Funds

Following could be the sources of funds :-

- Share capital.
- Income from the printing press.
- Membership fee.
- Government grants.
- Donations.

Section – 59 of the Multi-State Cooperative Societies Act, 1984 also provides for government loans and government guarantee on the repayment of principal and interest on debentures issued by a Multi-State Cooperative Society. In case the society so desires, it can create a "Corpus Fund" and utilise the interest accrued thereupon for planning its activities.

Conclusion

Cooperation as an economic organisation, is recognised as a powerful instrument to bring about economic and social transformation of the society in general and the weaker sections in particular. The movement is basically interested in developing human personality for a fuller and better life of its members. Family welfare can be one of the means to achieve this aim. Cooperatives have a very wide base which no other organised sector has in the country. Membership of the cooperative societies constitutes the vulnerable sections of the population as for population growth is concerned. The scope of implementing family welfare programme through cooperatives is rather unlimited. What is required is the determination and commitment at official and non-official levels. Government and the voluntary agencies responsible for implementation of the family welfare programme would do well to coordinate their activities with the activities undertaken by the cooperatives. Intensive training of the cooperative functionaries in family welfare would be very helpful in pushing across the ideas relating to various facets of the programme.

FAMILY WELFARE WITHIN AND BEYOND THE ORGANISED SECTOR - A COMPREHENSIVE PLAN OF ACTION

A BRIEF OVERVIEW

JALALUDDIN AHMED *

I. INTRODUCTION

India was the first country in the world to launch a national family welfare programme to reduce fertility as part of development planning. It was also the first country to introduce family planning activities in the organised industrial sector. The International Labour Organisation's (ILO) involvement and initiatives in promoting family welfare as part of labour welfare in the context of the worksetting has drawn inspiration from India's earlier experience. Since the early 70s, ILO/LAPTAP has been working in India in close partnership with the Department of Family Welfare (DFW), Ministry of Health and Family Welfare and the ILO's tripartite constituents (Ministry of Labour, employers' and workers' organisations), thereby contributing towards broadening and deepening family welfare programme in the organised sector.

II. ORGANISED SECTOR

In the organised sector, thanks to the facilities like health care and old age benefits, a properly designed education motivation programme can make the "two-child norm" a reality. There is already some evidence that family planning acceptors under projects of organised sector, although small, is important as a special sector with its potential for a multiplier effect in urban informal sector and rural areas. In addition, most of the organised sector workers belong to younger age groups and almost 80 per cent of them are amongst eligible couples. ILO/LAPTAP has always emphasized the role of the organized sector in promoting family welfare and will also continue to lend its support to this sector while extending its activities to the informal, semi-organized and cooperative sectors.

Given various favourable factors, namely, a better educated clientele with more exposure to modern ideas and outlook, availability of and access to certain basic facilities and services provided by the employer and the desire to improve family life and prospects, the organised sector family welfare programme has no doubt fared better than the overall national family welfare programme. However, within the

* Advisor on Labour and Population, India, Labour and Population Team for Asia and the Pacific, International Labour Organisation, Bangkok.

organised sector itself performance has been uneven depending on the content of the programme at the enterprise level, the motivation and spirit with which it has been pursued and the level and quantum of other social and labour welfare benefits provided to a particular group of workers. Indeed, the concept of family welfare including the emphasis on a small family advocated by the ILO is based on the premise that family welfare/family planning should be considered by all the parties concerned – the Government, the employers and the workers – as part and parcel of a broader concept of labour welfare. This approach alone, the ILO feels, can persuade the employers and the trade unions to see that family planning is in their own interest in addition to the national interest. Once a group or an individual is convinced about self interest, commitment becomes more compelling.

III. ACTIVITIES OF ILO

ILO/LAPTAP's participation in the organised sector programme in India began in the form of organisation/motivation of the Ministry of Labour, the employers and their organisations and trade unions. The next stage of these cooperative efforts with the Ministry of Health and Family Welfare was to initiate and implement nearly 20 projects with UNFPA financial support. The coverage of these projects has not been confined to the organised industrial sector *per se* but has included all types of organisations – education, welfare, administrative and others – in the labour sector proper. Experimental work with apex cooperative bodies to provide family welfare education and services to their members in rural and urban areas has also been undertaken.

By and large, ILO/LAPTAP's projects are exploratory and to a certain extent innovative in nature. They test different approaches for the purpose of replication later. A cardinal principle of programmes designed by the ILO is to seek to utilise the existing infrastructures. And wherever complementary or compatible they graft on it the population and family welfare elements. This approach is not only cost effective but also permits the continuation of family welfare activities on an institutional footing at the end of the initial period of effort and adaptation.

Under the impetus of sustained activities by the ILO, family welfare has entered into the mainstream of the activities in the labour sector. Effective coordination between the organized sector activities and the national family welfare programme – which to some extent, parallels that between education/motivation and services – has been achieved. However, it may be added that while the work done so far has, without a doubt, made an impact with the result that the organized sector programme's scope and coverage today is more enhanced than what it was before 1974. It cannot, unfortunately, be said that its full potential has been harnessed however.

IV. PLAN OF ACTION

In the last few years, Ministry of Health and Family Welfare has taken various measures to achieve a more comprehensive coverage of the organised sector and to extend the programme to cover rural areas, the poorer segments and high fertility groups. Based on its experience in India and other countries, seminar discussions at the regional and national level and research work, LAPTAP has also considered various approaches to reach the same goal. The cooperative efforts of the Department of Family Welfare and LAPTAP culminated in a formal request being made to LAPTAP, in May 1987, by the Government of India to undertake a study for developing a comprehensive plan of action for the Family Welfare Programme in the organized sector. The study was carried out and the report "Family Welfare within and Beyond the Organised Sector: A Comprehensive Plan of Action" was presented to the Union Minister of Health and Family Welfare, Government of India by the Director, LAPTAP.

The Report has analysed in detail the background, the existing programme, potential for additional or fresh activities in each sector or programme area. After this analysis, specific recommendations have been made for action which will lead to refinement of existing activities, expansion of coverage, launching of pilot/experimental activities in new programme/organizational settings etc. Each recommendation clearly outlines the different steps which might be taken by the parties concerned, leading to the achievements of the objectives aimed at.

The recommendations are in the form of an extensive agenda for action on which follow up work could begin almost immediately. Many of the areas for action and the steps recommended may have been previously considered or mentioned in one form or another. However, it is for the first time that the issues involved, possible implications of launching activities in areas not covered so far and expansion of activities in the covered areas have been systematically studied and a step by step approach recommended for action. It is believed that the implementation of these recommendations, over the next couple of years, would achieve comprehensive coverage and participation by the organized sector and related entities in the national family welfare programme. It will also open up new avenues by testing the practicality of including family welfare concepts in areas and programmes which have hitherto not been covered.

In all, there are 41 recommendations involving specific action by the various parties, the Government, different entities in the areas and sectors identified and ILO/LAPTAP. A list has been annexed. Not unexpectedly, it is envisaged that the Government will play a key role in initiating, monitoring and following up on the various forms of action. ILO/LAPTAP assistance and contribution in many of the recommendations have also been indicated and such assistance will be available on request.

MAJOR RECOMMENDATIONS BY LAPTAP

Sector/Areas	Sr. No.	Recommendations
Government Sector	1	In depth review of programme in the Railways to consider its linkages with other labour welfare schemes, participation of representatives of beneficiary groups, use of other available channels, incentive schemes, etc.
Public Sector	2	Review of programme in Coal India Limited (CIL), to examine "adoption" of peripheral villages, stepping up of motivational activities, participation of trade unions, improvement of coverage, etc.
	3.	Review of programme in Steel Authority of India Limited (SAIL) for exchange of experience, and to examine future directions.
	4.	More comprehensive programme/involvement by SCOPE for better coverage through public sector undertakings.
	5.	Strengthen population unit of SCOPE, if necessary, through a UNFPA/ILO project.
	6.	Indian Ports Association (IPA). Compile information and consider steps to improve and expand FW activities.
	7.	State Road Transport Undertakings. Collect, analyse data, prepare action-oriented paper, convene seminar to discuss involvement of SRTUs. Consider UNFPA/ILO project.
Labour Welfare Funds and agencies	8.	Expedite decision on project for Beedi Workers, to launch a much-needed activity for Beedi Workers.
	9.	Assistance to Mica and other Mines. Funds to equip and enable health care facilities to provide FW services.
	10.	Suggested pattern of assistance for support to the Mica and other Mines. Funds for FW to meet their identified needs for family welfare work.

Sector/Areas	Sr. No.	Recommendations
Private sector	11.	Representation of DFW on Governing Body and Managing Committee of National Welfare Fund for Fishermen to open up opportunities for linkage between the Fund's main activities and family welfare.
	12.	Feasibility and plans for State/Union Territory Labour Welfare Boards in Delhi, Gujarat, Tamil Nadu, Uttar Pradesh and West Bengal, to promote family welfare activities through them.
	13.	Feasibility and plans for State Labour Departments of Assam, Bihar, Jammu and Kashmir, Orissa and Rajasthan, to promote their active involvement in family welfare based on the experience in Andhra Pradesh.
	14.	Joint Panel of AIOE & EFI for identification and drawing up of model programmes for industrial associations/enterprises throughout the country.
	15.	Fresh initiatives for area projects with trade unions based on TLA experience.
Plantations	16.	Setting up of a Working Group by Consultative Committee of Plantations Associations (CCPA) for analysis of past work and patterns for further work in plantations.
Cooperatives	17.	NCUI to prepare project proposal for integration of population/family welfare in cooperative education and training programmes at various levels in all parts of the country.
	18.	Further work by and assistance to National Federation of Cooperative Sugar Factories to set up a Population Cell in the Federation, to organize a campaign for more comprehensive work, and to prepare a model scheme and pattern of assistance.
	19.	Review of iFFCO programme for improvement, expansion and replication.

Sector/Areas	Sr. No.	Recommendations
Semi-Organised Sector and Poverty Groups	20.	Policy decision and action by and with Federation of Cooperative Spinning Mills to carry out family welfare activities.
	21.	Consultation with/by Dairy Cooperatives in Gujarat, Maharashtra, Karnataka and Tamil Nadu, for exploring possibilities of pilot projects, determination of criteria, etc.
	22.	Work with/by National Federation of Fishermen's Cooperatives Ltd., (FISH COPPED), Ministry of Agriculture and National Fishermen's Welfare Fund. Pre-selection of 10-15 state federations of central societies, for participation in pilot project.
	23.	Development Commissioner (Handlooms) to expedite preparation of pilot family welfare project for Andhra Pradesh, Orissa, Tamil Nadu and Uttar Pradesh.
	24.	Work with/by Khadi and Village Industries Commission in five selected States, possible pilot project for UNFPA funding.
	25.	Rural Electrification Corporation's (REC) involvement in FW activities through RE cooperatives.
	26.	Work by SCOPE for and with selected national construction undertakings, possible pilot project for the benefit of large number of construction workers.
	27.	Department of Rural Development to study linkages between employment programmes and FW issues, initiate pilot projects and consider integration of FW elements in rural development training institutions.
28.	DFW to promote demonstration projects in women's development programmes particularly in employment-related schemes by selected rural-oriented organizations.	

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- Institutional Framework**
29. Representation of the plantations sector in Tripartite National Committee on Family Welfare Planning.
 30. Representation of national cooperative federations of sugar mills, spinning mills, dairying and fishermen, in the Standing Committee of DFW on the Cooperative Sector.
 31. Strengthening of Organized Sector Unit of DFW for it to better perform its existing responsibilities and to cope with more work to be generated from this study.
 32. DFW should extend assistance in organising "opinion leaders" camps to various "Organised Sector" bodies identified in this study.
 33. Extension of the "village health guides" scheme to organized and cooperative sectors.
 34. Expediting decision on project proposal for national vocational training system in view of its vast potential.
 35. Integration of population/FW elements in suitable on going varied range of training activities of National Labour Institute to exploit and develop its potential to contribute towards family welfare issues in the organized sector.
 36. Further measures by ESIC to revitalize and expand coverage for family welfare.
- Programme Related Issues**
37. Further training and orientation for employers, trade union leaders, cooperative managers, enterprise level personnel, worker educators, etc.
 38. More intensive and more systematic work by DFW with regard to organized and cooperative sectors to improve coverage, performance and to be more responsive to needs of target groups.
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39. Early finalization by DFW of draft scheme of national family welfare awards to industrial undertakings and associations.
 40. Treatment of organized and cooperative sector institutions at par with voluntary agencies for grants-in-aid assistance.
 41. DFW support and UNFPA consideration for financial assistance to LAPTAP for further work arising from the study.

OPTIONS FOR DELIVERING HEALTH AND FAMILY PLANNING SERVICES IN INDIA THROUGH MANAGED HEALTH CARE INSURANCE

HAROLD R. HUNTER* MBA

EXECUTIVE SUMMARY

The paper develops options for the delivery of health and family planning programmes in India under insurance, using various cost containment incentives. Current systems of financing and delivery of health and family planning in India are noted. In the U.S., increased availability of health insurance increased prices while improving health. Price increases generated mechanisms of controlling the cost of health care, including the development of prepaid group practice plans.

Various types of managed care are defined along with their potential to control costs and deliver health and family planning services in India. Preliminary marketing research results are presented which point to acceptance by employers in greater Delhi. India's experience with family welfare is related to the potential managed care configurations in the organized sector and reasons why the organized sector can be a cost effective focus for family planning are enumerated.

The issue of social insurance such as ESIC being a vehicle for health and family welfare is discussed along with supplemental benefits available through employment. Financing and utilization of ESIC benefits is discussed as well as the question of contracting by ESIC for health and family planning. Issues revolving around the feasibility of managed care in India by different industrial and population groups are considered, including the ability to deliver IEC services, relations with NGOs and existing state health facilities.

Factors are analyzed that determine whether a managed care system, such as a prepaid group practice in India, would be economically viable, such as pricing, benefits, enrollment strategy, organizational structure as well as employer and worker attitudes. Other factors include mechanisms of cost control, rate-setting and purchasing services.

Tentative findings indicate that distinct but limited market for managed care exists in India. Segments of the market along with several products are identified. Recommendations include approaching employers about senior and junior management followed by discussions with ESIC to assess interest in contracting for health and family planning services. The advantages and disadvantages of the open panel or IPA model are discussed and management concerns identified. Finally, policy implications are raised that any commitment to privatization through managed care in India needs to be considered.

* Professor and Director, Health Care Administration Program, California State University, Long Beach.

INTRODUCTION

Since Independence, a series of successive five year plans have set goals for economic growth, social progress and improved health for India. While not all goals were met, there has been remarkable economic growth, technological and social progress. Still, while mortality rates fell, due to improved health, with infant mortality rates declining from 151 per 1000 live births, population grew, and today India has 15% of the world's population, on 2.4% of the world's land area. (1, 2)

At the time of Independence, public health was a function of India's states, which it remains today. Yet, over the years, high priority programmes such as family planning, have been pre-empted by the national government. (3) This resulted in high visibility for some programme. The Bhore Report, which conceived India's regionalized health care system, envisioned a primary health centre served by subcentres referring to a district hospital which, in turn, refers to tertiary hospitals. (4)

Since 1948, social insurance for those working in the organized sector (the formal economy) making less than Rs 1600/month, were covered through India's social security system, the Employees State Insurance Corporation. Both industrial workers and, in many areas, their families were served through separate ESIC facilities. The funding for these services, which includes cash sickness benefits and disability, is funded by a payroll tax on employees and employers as well as a state contribution. This contribution is higher if dependents are not covered, creating incentives for family coverage. Another health scheme that has separate financing of health care in India covers government employees through the Central Government Health Services. Unlike many developing nations, India uses existing providers and facilities for this group. (5)

Another system of care is through the many private practitioners that account for 70% of health spending in India. (6) The private practice of allopathic, homoeopathic and ayurvedic medicine appears to be flourishing in India and even the rural and urban poor spend on private health care. Hence, the rationale for developing private sector alternatives rests on the reality of existing arrangements.

HEALTH CARE AND ECONOMIC GROWTH

While state and federal health efforts must continue to concentrate on the rural and urban poor and unorganized sectors, India's recent industrial growth presents opportunities and potential problems. As in many industrializing countries, the value of a skilled labour force cannot be underestimated. From 1970 until 1986, earnings per employee have increased by 122% and output per employee has increased by 145%, putting India well on the road to industrial development. (7) Not

only is a healthy workforce essential to productivity, but fringe benefits in the form of health services or insurance to workers and their families reduces absenteeism and promotes worker loyalty, thus protecting investments in training while improving the health status of the nation.

It is the organized sector throughout the world in which many of the innovations in health care have been made. The first social insurance scheme was developed for workers by Bismarck in Germany in 1883. Other European countries followed suit. Indeed, India marked industrial workers for health benefits through ESIC early in its independence. The U. S. took a different road by creating tax and administrative incentives for private companies to buy health insurance for their workers. The presence of "third parties" (insurance companies, medical service plans such as Blue Cross and prepaid health plans or prototype HMOs) replaced the direct purchase of health care from physicians by patients. (8) Except in isolated industries, the growth of health insurance also replaced the earlier arrangements through direct provision of health care by employers through a panel of physicians. Thus, a free market solution to the problem of lack of accessibility was found through employment.

The result of expanding entitlement to health care was to increase prices and utilization while improving health status. One must ask, is it possible to increase accessibility to services without driving up the costs of care? While India's organized sector is small, it is growing and represents the engine of economic development. Further, the organized sector – those working in the wage economy and their families have a vested interest in both health care and family planning. In fact, some of the most successful and cost effective family planning programmes in India were delivered as part of health services, through employers but, the cost of integrated preventive, curative and family welfare services must be balanced against the benefits.

HEALTH CARE COST CONTAINMENT

There are several strategies to control the costs of private health care in the face of induced demand. The simplest method is to curtail services. This strategy would disproportionately affect the poorest and sickest. Another strategy would be to expand eligibility for ESIC to a great number of the employed population and their families. This would require more money since capacity would need to be expanded. Moreover, many clerical and administrative persons eligible for ESI would continue to pay for private medical care or even go without care. Another option is to strengthen the public medical system to care for the organized sector, but in public facilities in Malaysia, Indonesia and Brazil, primary care units were by-passed while tertiary care hospitals were over-utilized. Therefore, under this option, one could expect that the All-India Institute for Medical Sciences and similar bigger urban

hospitals would be under increased pressure to admit more patients, while PHCs and District Hospitals would remain under-used.

Another strategy for the organized sector is to finance health through the private sector, using managed care techniques. Managed care involves the control of health care delivery by a purchaser through economic and organizational incentives and disincentives. Originally, the term was synonymous with prepaid health plans or health maintenance organizations (HMOs) in which physicians and hospitals serve an enrolled group for a set monthly fee. (9)

TYPES OF MANAGED CARE ARRANGEMENTS

Several models of HMOs evolved in the U. S.; staff models in which physicians are employed by the insuring organization, such as GHA in Washington, D. C., group models, in which the insuring organization contracts with an independent medical group, such as the Kaiser-Permanents Medical Care Program and IPAs or individual practice associations wherein the insuring organization contracts separately with individual physicians. Later, the network model evolved where the HMO or insuring organization contracts with several independent groups.

Some of the incentives and disincentives included payment of providers on per capita basis, removing the connection between the number of services delivered and payment or placing a portion of at risk, dependent on performance measures such as hospitalization as well as prospective or concurrent review of utilization of hospital services. HMOs use half the number of expensive hospital days per 1000 population than unmanaged care. (10)

Managed care has come to include variations such as preferred provider organizations, in which contracts are made with select primary care physicians, specialists, hospitals, nursing homes, etc., for discounted fees and include agreements for utilization and record review. Some employees contract with private firms to act as watch over quality and appropriate use of services. In the U. S. under these broad definitions, most health care is managed, and unmanaged indemnity insurance represents an ever-shrinking proportion of health services. In India, the more stringent definition of an HMO would be more appropriate since privately purchased health insurance is not common.

How then can an HMO-like organization improve the financing and delivery of health and family planning services for the organized sector in India? The Tyagi Foundation is presently engaged in a feasibility study to ascertain whether this type of organization can sustain itself in the Union Territory of Delhi. Assisted by the Enterprise Program, the Foundation is testing the market for different health and family planning benefits. BASIS, a New Delhi-based market research firm, interviewed over 2100 employees of 300 firms located in Delhi about current health

schemes, prices, employees expectations, benefits and patterns of use. Employers were segmented into manufacturing, service, traders and institutions by location in different areas of the Union Territory. They were further categorized into single location firms, firms with multiple branches but headquartered in Delhi (multi-head) and firms with employees in Delhi but whose main office is in another city (multi-branch). Employers interviewed represented senior management, junior officers, clerical and manual workers. Approximately one percent of the 35,000 establishments in Delhi were sampled. (11)

This survey, along with in-depth interviews of prospective employers, actuarial analyses and pro forma projections of various health benefit packages will determine whether health care management through an HMO-like organization is feasible in the organized sector in the Indian context.

Preliminary data seems to point to the presence of market, with 85% of firms offering health benefits to their employees over and above ESI. Of these, 60% reimburse medical bills and another 8% purchase health insurance; 35% of these firms, moreover, believe that the ideal benefit would involve paying more for health in return for guaranteed benefits and facilities. (12) It is these firms who would develop managed care techniques to assure quality, guard against fraud and waste, and control health costs, which have escalated in urban areas of India as they have in other industrializing countries. Group insurance of this type, moreover, can serve to make family planning services acceptable to the organized sector since it is a part of curative and preventive health care.

FAMILY PLANNING AND MANAGED CARE

India's Family Planning Programme was marked by distinct phases. From 1951-1961, it consisted of giving away contraceptives. In 1961, the extension approach was implemented, in which education was stressed and outreach was aimed at couples with three or more children. Community leaders were identified for the purpose of influencing people to accept Family Planning. In 1967-68, Family Planning merged with general health under the *rubric* of family welfare, which included ante-natal care, immunizations, etc. Although ostensibly a voluntary, cafeteria approach, it emphasized sterilization, which was not effective in reducing population growth since it was mainly used by completed families. After adverse publicity revolving around sterilization, the emphasis shifted to child spacing. Family Planning is delivered in government hospitals and clinics and to no cost by voluntary organizations such as the FPAI and the Red Cross. (13)

Family welfare efforts led to reducing Crude Birth Rates for India from 45 in 1980 to 32 in 1985 to 30/1000 today. Crude Death Rates are down to 10.4/1000 and infant Mortality Rates down to 90/1000 live births in 1985 from 151/1000 in 1970. The

present Couple Protection Rate is 42%. Objectives for the seventh five year plan is a Crude Birth Rate of 21/1000; Crude Death Rate of 10.4/1000 (or a net reproductive rate of 1), as well as reducing the infant Mortality Rate to 60/1000 live births. (14) Today, India has nearly 800 million persons and despite having attained self-sufficiency in foodgrains, there is a little room for trial and error policies that could lead to increased population.

Increasing family planning acceptance and practice depends on multi-pronged approach, with cooperation from many quarters and targeting several segments of Indian society. One group that represents a growing and important segment is the organized sector, i.e., those who are formally employed. It is estimated that 30,000,000 of India's population are in the organized sector. This represents approximately 4 percent of India's population. (15) This segment of the population can be a cost-effective focus for family planning efforts for the following reasons :

1. The organized sector is highly visible and organized, both through employment and union membership.
2. Employees can be reached in one place, making delivery of educational and health services easier than for unemployed or rural population.
3. Employees, particularly more educated employees, are opinion leaders and many still have links to rural areas.
4. Many newly urbanized and upwardly mobile employees have high receptivity to family planning and future-oriented benefits such as pre-natal services, immunizations and other preventive activities.
5. Unlike rural and peri-urban slum dwellers, women tend to have more educational and economic opportunity in the organized sector and therefore, are more receptive and influential in limiting the size of their families and adopting healthful behaviours.
6. There is more discretionary income in the organized sector, which gives health expenditures a higher utility.
7. Members of the organized sector are used to services being offered as a fringe benefit of employment and associate health, family welfare and occupational services with their job.

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8. Employees are easily accessible in the workplace and, at least for blue collar workers in industrial housing estates, the mobilization of the organized sector entails both working through employers and residential associations to incorporate family welfare services into packages that represent services that are in high demand. One area that is sought and paid for by employed Indians is curative, medically-oriented health care. The Tyagi Foundation Managed Care Project was conceived to incorporate family planning and preventive services into a comprehensive health delivery system financed through fixed periodic payments by employed groups.

SOCIAL INSURANCE FOR EMPLOYEE HEALTH

A salient part of the background of any health care financing arrangement in India is understanding current public and private schemes. A large portion of the workforce is covered under the Employees State Insurance Corporation. This social security system was founded in 1948 under the influence of Britain's Labour Government and covers workers paid up to Rs. 1600/month. (Legislation passed that has raised that limit at the discretion of the government. A new limit is expected to reach Rs. 2500/month for ESI eligibility). ESI has been marked by expansion from manufacturing to service industries. At present, establishments employing less than 20 workers are required to be covered (less than 10 if external power is used). The employee contributes 2.25% of base salary and the employer contributes 5%, up to a current maximum of Rs. 1600/month. ESIC funds disability, sick leave and workers compensation as well as medical care. (16) Companies can be exempted if they offer equal or better benefits, and many firms such as Tata Industries are exempt since they own or operate medical facilities and arrange for medical care and disability payments. (17)

The law has incentives to pay for permanent family planning methods, since sickness benefits are doubled for vasectomies and tubectomies. ESIC utilizes 50 medical visits per 1000 persons covered and total of 1.5 million specialist referrals and 318,000 hospital admissions. The estimated per capita cost is R.50/month. ESIC, moreover, must certify if any worker absences over three days which places pressure on ESI provides and facilities. (18)

ESIC operates its own clinics and hospitals and is funded not only through a payroll tax of 5% on employers and 2.25% on employees but also through state contributions. Occupational health monitoring is the responsibility not of ESIC but of the State Factory Inspectorate, created under the Factory Act of 1948. (19) The degree of compliance with the ESI tax payment is higher among larger, more formalized firms, (20) and, as in most countries, those who work in small, undercapitalized firms are less likely to have health insurance coverage.

Many companies and establishments also offer cash allowance for sickness benefits. Other companies have their own clinics, panels of physicians and even hospitals. There is provision in the ESIC Act for exemption if benefits at least equal to ESI are offered. Most often the largest firms have an exemption. ESIC facilities in many places are underused, particularly by clerical and other workers, and are seen largely as a place to obtain absence certificates. The most probable initial targets for any Managed Care Project would be those employers that are willing to offer supplemental in-kind health services beyond ESIC.

There are, moreover, different levels of health benefits for different levels of employees, and employers are more interested in providing benefits to key employees, who are more highly paid, on the job longer and better trained. Insurance is available, but health insurance covers very few people, mostly under indemnity policies. Schemes insuring individuals and employees for complete health services exist through private companies or hospitals, but premiums have been driven up by induced demand. Add to this the availability of free care in government hospitals, and one sees that developing a viable Managed Care Plan will involve careful planning, market and product positioning.

The Medical Commissioner of ESIC noted that 75% of ESIC's 2.4 billion rupee (\$ 150 million) budget is for health care. This amounts to Rs. 600 per family per year. There are standards of planning such as 1 bed/1000 population covered by ESIC. It should be noted that ESIC data from absence certificate indicates that, while managers miss approximately 7 days of work per year, (much the same as most industrialized nations), manual workers miss 1 month of work annually. (21) How much of this is because of sickness is not known. It was noted that clerical and other skilled workers were seldom seen in ESI facilities, indicating the existence of a market for employees that can't or won't use ESI.

One area that was tried in ESIC was the panel system. ESI officials indicated that panel arrangements were being phased out because of its higher cost. They also noted that cooperation with an outside agency is difficult and obtained only through the Ministry of Labour. However, it is expected that the panel system would be retained for family planning. (22) Officials noted that in the past exemptions from ESI were given too easily. The strong preference of ESIC to centralize would point away from contracting at the present time.

Health care is a state responsibility and each state contributes 1/8 of the cost of ESIC. Governance of ESIC includes state officials, as well as representatives of labour, management and the federal ministries of Labour and Health. Each state has its own separate authority. There is a separate Directorate for Delhi, with four hospitals and 37 dispensaries. (23)

ESIC has three levels of family coverage – restricted, expanded (outpatient and specialist) and full (including hospitalization), which is most common. (24) 10% of visits result in a referral to a specialist and 10% of those (or 1% of the total) are admitted to a hospital. Some officials note widespread misuse of certificates and the lack of confidence in the system in many places. In some states, trade unions are reputed to have great influence over ESI but this does not appear to be the case for Delhi. Yet, what may be a difficulty for ESIC may turn out to be a benefit by involving trade unions in promoting healthful behaviours and the small family norm.

ISSUES OF FEASIBILITY OF MANAGED HEALTH CARE

Another question salient in the Indian context is whether managed care arrangements are feasible in small industries and small scale units located in clusters.

Small industries can develop a fixed site by pooling their resources if located in an industrial estate or through pooling of risks through an insurance company. The fixed site would require formal cooperation between several firms and fixed contributions according to some formula and would be likely to be feasible where families live close to the worksite. Enrolling small groups into an HMO-like organization can be an underwriting risk. Enrollment in the plan needs to be mandatory to avoid attracting only those with high probabilities of usage.

The most promising development would be if ESIC were to contract with an HMO-like entity. Changes would have to be made in benefit design and delivery mechanisms, since ESI is not fully used but is far less expensive on a per capita basis than other health schemes. If a company can pay the medical portion to an HMO-like plan rather than ESIC, it may allow more responsiveness to employee needs. Hopefully, money now spent on private practitioners could be spent on a social insurance system, allowing more control of costs and quality of care.

In the BASIS study of Delhi, 21 firms had their own panel of providers. (25) This type of arrangement would be difficult for an HMO-like organization to penetrate unless most of the doctor's patients were employees of the firm, in which case managed care incentives could be used and the panel incorporated into the plan. For panel physicians for whom direct company panel arrangements represent a small proportion of their income, this would be much more difficult. In other countries, many HMOs, such as Kaiser-Permanents, developed from panels of physicians who were sole providers for industrial firms.

One advantage of the economies of scale inherent in an HMO-like managed care system, is that IEC activities, health education, preventive and promotive activities could be provided. These would be acceptable because it would be part of a

business-based (and possibly labour union-based) medical care system. A managed care system could not only provide information to employees, providers and government but, because of the credibility inherent in its industrial and technological sponsorship, be able to change behaviours in child health, family planning and perhaps in industrial safety, thereby reducing absenteeism due to time required for family responsibilities as well as workers compensation costs. The IEC component could be built into the mainstream health care or a separate IEC-outreach component targeted on workers' families could be developed.

Often families of industrial workers remain in villages or migrate to urban slums. Most often it is the responsibility of local government or NGOs to provide health and social services for these populations. An HMO-like organization can work with these organizations on an *ad hoc* cooperative basis or contract with them for specific services. One possibility is for the HMO to act as a broker and monitor for a variety of services to assure their availability, accessibility and quality. Another mechanism is for the HMO to contract with ESIC, NGOs or local government for specific services such as maternity, family planning or rehabilitation of injured workers or others.

Factors in the Feasibility of HMO's

Price – In a competitive market, price both to the employer and to the employee in the form of a premium compared to alternative health schemes will determine its success. Penetration of the market by managed care systems, reaches 50% in parts of the U. S. and Brazil. (26) Another price factor is out of pocket cost to employees in the form of premium contribution, co-payments or deductibles. When workers are accustomed to free care, it is difficult to begin to charge for health services. The BASIS report found that one product that appears to be popular in Delhi is family planning. Over half the employers surveyed by BASIS indicated they would be willing to pay extra for family planning for their employees. (27) Insurance was available only to executives in about one-third of all companies, to all employees not eligible for ESI in another one-third of companies and available to all employees for the rest of firms surveyed. (28)

Product – The benefit structure will determine the acceptability of the HMO. Most employers expect coverage of hospital (nursing home) care as well as primary care. The facilities used will be a factor in whether an employer would wish to change his medical arrangements. It is possible to have different benefits, facilities and amenities for different classes of workers at different premium levels. An HMO-like organization may wish to target the segment of the market that is not eligible for ESI. An HMO needs to analyze the market segments selected in terms of comparison to competitors. There is a tendency to favour high technology tertiary services such as organ transplants, diagnostic imaging or heart by-pass operations.

Voluntary or Mandatory Enrollment – Many insuring organizations believe that they cannot write coverage for health care unless it is mandatory for all. Some HMOs on the other hand, insisted that a choice be available among health plans. Voluntary enrollment sometimes may lead to adverse selection in which the high using segments of the population choose the most comprehensive plan. This has to be reflected in premium rates. The advantage of choice is that it tends to reduce employee dissatisfaction.

Delivery of Services – In many cases a clinic atmosphere, as is found in some staff or group model HMOs creates dissatisfaction. Upper level employees expect the same amenities as in private practice. This is easier to achieve in an open panel arrangement like an IPA or a PPO. On the other hand, some economies of scale are inherent in group practice, especially in ancillary services such as X-ray, laboratory or pharmacy.

Attitudes of Employer – Since the employers are the purchasers of health schemes, their attitude about prepaid private sector alternatives is critical. Employers have to believe they are getting good value for their investment and that it will result in a healthier, happier, more productive workforce. A major factor of HMO success is its relations with employers.

Attitudes of Employees – The end user of health care is the patient. The confidence of employees and his/her family in the physicians, facilities and organization cannot be underestimated. There is a two step marketing process in selling an HMO. First, one has to convince the employer to offer the scheme and provide access to HMO staff. Then, one has to convince the employees (and where applicable, the labour union) that the decision was sound and that the employee gains more than he loses. This is true even in a mandatory plan.

Utilization Control – Physicians must be motivated and provided with incentives to be judicious in use of expensive benefits such as outside specialist care, hospitals, drugs and other ancillary services, without making the patient feel he or she is not getting enough service. Control by the plan of referral and utilization patterns is a key factor of organizational success. Supervision of UR staff, peer review and monetary incentives and disincentives are techniques of managing use and costs.

Underwriting and Selection – Part of any insurance scheme is the control and balancing of risks. Medical care is affected not only by health status, but by consumer preferences and patterns of use. Options that HMOs may use include medical screening and actuarial estimates, followed by experience rating of groups. One reason that individual insurance is expensive in India is that the smaller the group, the more difficult it is to predict expenses. For this reason, larger aggregations (such as coalitions of small business) present less risk and lower overhead costs. Size of the

group affects overhead and, therefore, rate-setting. Rates must be set above, as-of-yet unknown, marginal costs, and yield enough revenue in the long run to fund reserves and expansion. Careful projections and pricing of different tiers (e.g. one person, two person families, etc.) and benefit levels must be done early and revised often.

Contracting with Suppliers and Purchasers – Getting the best price for services and products, such as hospital care and drugs, require negotiating volume discounts. Sometimes even managing or buying a facility or supplier may be necessary when supplies are constrained. Also contracting with potential purchasers such as ESIC or CGHS may provide the patient volume that will allow the HMO to break even. This requires familiarity with governmental agencies and procurement procedures. In many places, HMOs first and largest accounts were state and federal government employees whose stability of employment facilitates predictability and allows ease of management of enrollees.

FINDINGS AND RECOMMENDATIONS

1. A market for managed care exists in the Urban Organized Sector in Delhi and probably in other large cities in India. While representing a small proportion of the total population, it appears to be able to generate sufficient enrollment to create a financially viable organization to deliver health care.
2. There appears to be an additional market for bundled and fee for service packages, such as complete maternity care and executive health checks, as well as for prepaid comprehensive care, all of which will include preventive benefits and family planning counselling and services.
3. These segments of the market that appear to offer the greatest potential, initially, are the junior and senior managers of multi-site service and manufacturing industry. It is hoped that a demonstration effect will stimulate other employees in the organized sector to alter their preventive and family planning behaviour. At a later time, industrial workers and other geographic areas must be included.
4. The major thrust will be to offer a prepaid comprehensive health care benefit in both high option and low option packages. These will be supplemented by bundled and fee for service maternal and child health, family planning and industrial health services.
5. To reach the bulk of industrial workers, ESIC must be approached to assess their interest in contracting the health care and family planning service for a portion of their beneficiaries in a delimited geographic area. In addition, expansion of managed care in rural areas is critical for the benefits are to be brought to the vast majority of the Indian people.

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6. Essential steps for developing managed care will be costing the prepaid benefit package to compete with existing company sponsored schemes. A large part of refining and projecting the various products will entail costing alternative arrangements with hospitals, including exploring back to back (or wraparound) coverage for hospital care with General Insurance Corporation or arrangements with individual hospitals in which risk is shared. Alternatively, reinsurance arrangements will need to be explored. Companies and individuals favouring in-kind medical protection, largely multi-site companies, will be likely targets. However, companies that give medical allowances rather than service benefits will be difficult to penetrate.
 7. The rapidly rising costs of hospital care in Delhi and Bombay, legal requirements on employers, and capacity limits in urban hospitals serving upwardly mobile families is likely to create cost containment pressures which will be met by various managed care configurations. The Tyagi Foundation Project can be a prototype for these managed care efforts.
 8. An alternative to the fixed site clinic is the IPA or individual practice association. This type of arrangement involves a prepaid health plan contracting with individual physicians for care delivered in their own offices. The physicians organize into a separate entity called the IPA, with its own elected representatives. Ownership of the IPA is often by physicians themselves, much like a physician's cooperative. Shares of ownership can be through an equal partnership or through shares known (in the U.S.) as a Professional Corporation or (in India) as a limited company, to denote limitation of liability. IPA physicians can be paid on a discounted fee for service arrangement, a discounted fee schedule, a fee schedule with a set aside, or withhold account. This latter arrangement is implemented by setting aside a proportion of fees, often 20-25%. The physician is then "at risk" for hospital costs and frequently for speciality care. If utilization and costs of hospital and speciality care exceed budget, the money set aside can be lost. If utilization is lower than projected, the savings are shared with the IPA physicians. In the Indian context, the question that must be answered is how can financial incentives be developed that outweigh commissions physicians can expect to receive from referrals? In the Indian environment, as in the U.S. environment, it is better to contract directly with a limited number of hospitals, specialists, laboratories, pharmacists, etc. to provide leverage in negotiations.

The advantages of the IPA over the fixed clinic with employed physicians (the staff model HMO) or the fixed clinic with a group of physicians under an exclusive contract (the group model HMO) are :

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- A. Expansion is easier without being tied to fixed facilities and permanent employees. It would be possible, in Delhi, for example, to contract with physicians serving South Delhi and later develop contracts in NOIDA and Okhla using a different IPA and a different hospital. Likewise, for the industrial estates of West Delhi. This would segment the market to different populations using geographically, medically and socially appropriate hospitals and specialists. Each IPA should start with at least 10 physicians to provide a critical mass.
 - B. An IPA has lower startup costs since the time and money to develop clinics can be spent developing the provider network.
 - C. Because an IPA can start faster, revenues can be generated sooner. Marketing, however, needs to be more intensive to convince employers and individual enrollees that this is not just another panel, but a plan that operates on prepaid insurance principles and can assure comprehensive, high quality care.

IPA model managed care systems have grown more rapidly than other HMOs, but some have floundered during their expansion phase. (29) Some cautions in developing an IPA or other open panel arrangements are: (30)

- A. It is harder to control patterns when they are geographically dispersed and physicians continue to practise in their own office. The cost savings can be dissipated when physicians incur costs to the Plan for referrals and hospitalization without controls. It is important that each participating physician has enough Plan patients that it makes up a significant portion of his/her income, otherwise incentives will be too weak to change practice behaviour.
 - B. A related problem of IPAs is the difficulty in tracking accounts receivable and incurred but not reported costs (INBRs), since physicians practise independently and lags in communication mean lags in billing. Successful IPAs keep track of referrals and hospitalized patients on a daily basis and book estimated expenses immediately. In addition, the medical director and utilization review (UR) staff must constantly monitor patients who are referred for specialist care, outside laboratory tests and X-rays, hospitalization, or who receive emergency services outside the Plan.
 - C. Management information system must be capable of capturing billing, utilization and claims data. Many IPAs provide personal computers (PCs) to their participating physicians and have claims and billing information on line. The incentive of obtaining and being trained on a PC can be an incentive to a physician to participate.
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- D. In an IPA the number of benefit packages may have to be limited, since patients eligible for different levels of benefits could create complications for the practitioner in solo practice. Also, the billing of patients over and above premiums (and copayments) must be avoided since cash control would be compromised.

KEY FACTORS IN DEVELOPING OPEN PANEL MANAGED CARE ARRANGEMENTS

- Marketing to physicians is essential. Selection of providers will make or break an IPA in India. Marketing should be started early and will require the collaboration of a knowledgeable, committed primary care physician who can talk to younger physicians, who will form the core of the provider network.
- In the Indian environment, it is recommended the primary physicians be paid by capitation (i.e., a fixed monthly amount for each patient on the panel).
- In addition, some incentives and disincentives can be built into the payment : e.g.
 - a bonus for reducing hospital days per patient under an age-adjusted target.
 - a bonus for fewer than budgeted referrals to outside specialists. This must be carefully orchestrated not to create patient dissatisfaction, disenrollments or a reputation for skimping on care.
 - a bonus for providing a minimum number of preventive care, maternal and child health and family planning services.
 - bonus for quality, as judged by standards developed by the medical director, i.e., lower reinfection rates, return to hospital, preventable infant mortality, etc., as well as courtesy and availability to patients.
 - physicians who cannot conform to utilization and quality guidelines must be re-educated and if necessary, replaced.
- It is important that physicians feel a sense of ownership of the IPA. The message that is to be sent is "If we do well" and "we are an elite, professional group." Therefore, ongoing provider relations are critical.

Policy Implications

The introduction of privately administered, managed care arrangements into the states and territories of India has implications for economic development and social equity. The private, organized sector is already establishing the precedent for reimbursement of health for employees. This, along with discretionary individual expenditures, are driving up the cost of medical care which will eventually affect the costs of all production. At the same time, the public system, which serves the majority of the population, is languishing in some places. The point of these privatization efforts is not to increase the gap in health services between the haves and have-nots, but to bring the incentives and techniques of private sector management to bear on the essential areas of health and family planning in a public-private partnership.

Social Insurance, which in India was pioneered through the Employees Insurance Corporation in 1948 should not be abandoned at the time when industrial growth is taking off. Rather the financing should be used more effectively to create choice and efficiency in health care delivery configurations. In many ways, the organized sector and the business community should be exemplars. The innovative use of tax and labour laws can lead to greater efficiency in the allocation of scarce resources while enhancing the operation of governmental responsibilities. Equity in health care, however, requires not only the creation of incentives but their rigorous and fair enforcement. You are to be commended for your concern and your foresight and interest in the health benefits of your employees and ultimately the health of the nation.

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RESOURCE MOBILISATION FOR EDUCATIONAL ACTIVITIES IN FAMILY WELFARE PROGRAMME IN ORGANISED SECTOR

ANIL GUHA*

I. INTRODUCTION

The success of any social programme depends largely on involvement of its people. The government can formulate effective programmes, provide leadership and coordinate activities including mobilisation of services for social needs of people only upto a certain level. It will be wrong to expect that government alone can fully implement all the social programmes that they may launch and achieve the goals. It is always the people that ultimately matter. If any social programme like the family welfare programme has to achieve its objective of reducing the birth rate to a specified level within a given span of time, then there is no other go but to make it a people's programme, or rather the people's movement. How can this be brought about? Is it possible entirely by government efforts? Perhaps not.

II. SETTING UP OF CENTRAL RESOURCE MOBILISATION ORGANISATION

The way out is to mobilise voluntary efforts of individuals, institutions and organisations. This leads to the concept of the establishment of a central resource mobilisation organisation with branches in different parts of the country. Though such mobilisation could cover a larger canvas, the process could start with the educational and motivational aspects of family planning programme.

The family welfare programme is not just a birth control programme. It is a multi-faceted welfare programme which should ultimately lead to the betterment of life of the individual, the family, the society and the nation. We have not only to offer to prospective eligible couples birth control methods/services, we have also to ensure better health care for children and mothers by offering a package of integrated maternal and child health care services like nutrition and immunisation. To make such a programme successful in a vast country like India with many ethnic, cultural, social and linguistic variations, a great sustained effort would be needed to inform, educate and motivate people. Such an educational programme can effectively be launched only through an integrated multi-media campaign, which again has to be continuously monitored by some vibrant central organisation having its branches at different strategic centres.

* Consultant, Council of Indian Employers, New Delhi.

While it may be possible to design an effective multi-media campaign by drafting the services of experts available in the communication field, the crux of the problem is how effectively such a well-designed multi-media campaign can be implemented successfully by government alone. The constraint of funds and paucity of available institutional media resources in the country may thwart the progress and extension of the educational programme. Hence the need for mobilising all the voluntary resources and channelise them through a central organisation with its branches at different places.

III. WHAT RESOURCES TO BE MOBILISED

The first task is to get a multi-media campaign strategy developed and suitable prototype media material designed. Since the members of the employers' organisations are the largest advertisers, it should be possible for employers' organisations to give a patriotic call to the available advertising talents in the country – individuals and established agencies – to contribute free services, if not total, at least partial, for formulating the strategy and design of the educational campaign and prepare prototypes needed for that purpose. There is no doubt that the response will be positive as basically people are patriotic. At this point, a federated agency could be established integrating the services thus made available.

This agency then would take up the task of designing the campaign in close consultation and cooperation with the concerned government departments, studying in-depth the requirements of the programme. Let us assume that the voluntary efforts in cooperation with the appropriate government agencies are able to design the required multi-media campaign and prepare the material and prototypes for various media – both for mass media and the inter personal communication. Now comes the problem of implementation. Even if the government finds it possible to provide adequate funds for effective launching of the campaign, without people's active participation in the implementation of the campaign, it would not be possible to ensure effective results. Alongwith governmental efforts therefore all-out endeavour is required to be made to enlist the voluntary services of individuals and organised bodies. This should be possible if the peer group in the industrial world and the top political leaders jointly make appeals to individuals and institutions.

IV. DESIGNING AND IMPLEMENTATION OF EDUCATIONAL CAMPAIGN

The task is two-fold. First to get the required campaign strategy and the prototype media materials designed, and, secondly, to get the media campaign effectively launched and implemented in a sustained manner. The operational work plan may be as follows :

4.1 To develop the media strategy and prototypes

- i) A list of reputed advertising agencies, commercial artists (renowned individuals), script writers etc. will have to be prepared.
- ii) An approach should be made to them from the leading employers' organisations in collaboration with the concerned government departments, by issuing an appeal at appropriate level requesting for contribution for the preparation of the campaign strategy and media materials.
- iii) Offers of contributions received will be recorded. A working group of executives of reputed agencies could be formed and they may be entrusted to process the offers received from agencies and individuals into the preparation of the campaign. This working group may work in close consultation and co-operation with the expertise available with the concerned government departments.
- iv) It is possible that the offers may come in the form of time, space, piece work, scripts etc. To work out successfully such a media plan, some whole-time staff, both management and technical, would be required. This may be provided by the government or the employers' organisations or by some of the leading agencies participating on a cost basis. Some of the leading agencies may provide whole-time services for the project being partially compensated. The free offers of contributions coming from individual artists, script writers etc. would be utilised by the working group to the fullest advantage.

With regard to the cost of preparation of the prototypes for a multi-media campaign and launching of such a campaign on a massive scale it would be necessary to assess the cost of each item of prototypes required for the campaign and then the cost of multiplying those prototypes as per the requirement. The cost of launching the campaign over a period of time covering different regions, addressed to different target audience groups will no doubt be quite high. The total cost in fact will depend on the magnitude and intensity of the coverage required to be made. But voluntary contribution from the approach suggested above will make such efforts light from financial viewpoint.

4.2 Launching of the Campaign

- i) On the basis of the operational work plan of the media campaign the details of the phased implementation have to be worked out indicating the requirement of time on TV, Radio, Cinema, Theatres, etc., space in newspapers, magazines, house journals, etc. for release of advertisements and sponsored articles etc. and space for outdoor advertising eg. wall-space for wall paintings/wall stencils/hoardings, kiosks, neon signs, glow signs, transslides etc., display spaces on trams, buses, railway coaches etc. The requirements of funds for the implementation of the phased campaign also have to be worked out in details media-wise and item-wise.

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- ii) Lists of Newspapers/magazines/house journals (the names of Mg. Directors/Chief Editors), advertising agencies/advertisers (who could contribute advertising space), owners or Mg. Directors of TV/radio/cinema theatres (if not government owned) etc. to be prepared.
 - iii) On the basis of the requirements thus worked out, further appeals from the leaders of the industries and also from the political leaders should go to different organisations, institutions and individuals requesting for voluntary contributions for the national programme.
 - iv) All offers of contributions that may come in response to the national appeal will have to be mobilised at a central level which may be called the central resource mobilisation organisation. Offers will then be analysed, categorised and credited under appropriate heads to facilitate campaign planning and implementation, media-wise and area-wise.
 - v) Monetary contributions will be spent as and when required for implementation of the campaign where adequate time/space offers are not received.
 - vi) Since the offers would be forthcoming from all parts of the country and the campaign has to cover the entire country it will be necessary to open branches of central resource mobilisation organisation at appropriate regional levels and the 'credits' of free offers received would be directed to such branches for fuller utilisation.

V. An Example

It may be necessary to concretise the above concept by an example. Take for example that the campaign prepared has the following media prototypes as components :

1. A film (2 mts. quickie)
 2. A serialised radio programme (15 mts. duration each)
 3. A TV play (15 mts. duration)
 4. A hoarding design
 5. A poster
 6. A design for bus/tram/train panel
 7. A display advertisement for newspaper/journals
 8. An article written by a reputed social scientist etc. etc.
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Now to implement these we need the following :

- i) For the film we need to make copies for release in cinema theatres and require free time for their showing. Our efforts would, therefore, be to get resources in respect of both.
- ii) For the serialised radio programme, if only one prototype has been prepared the first task would be to get a series of similar software materials prepared in advance, say atleast for 3 months broadcast – if it is proposed to be a weekly programme then atleast 12 such radio programmes should be in hand before the programme starts on the radio. For this purpose, either we try to obtain free services of competent radio play writers or employ such writers on payment basis, funds being made available through voluntary contributions. Next we need time on radio for broadcasting. Since such items are normally broadcast through commercial channels of radio, they will have to be paid for. Efforts may be made to get necessary free time from the radio for the programme. Alternatively both 'software' preparation and 'Time' can be financed by sponsorship of some big advertisers or social/cultural organisations. Some years back a series, titled " love stories of India" was sponsored on the radio jointly by "Femina" a women's magazine and by some 'pill' manufacturers : The Programme had promoted the family planning programme.
- iii) A TV play has two elements : cost on a drama troupe for the show and the TV time cost. Both can be met by sponsorship.
- iv) For the hoarding display, places at strategic points would be required. Normally such sites are commercially owned and rented out. Some sites be obtained free from Advertising Agencies owning them and some sites can be acquired under the sponsorship of big business houses or such organisations as Rotary Clubs/Lions Clubs/Chambers of Commerce, etc. The charges for painting the design if necessary can be met from monetary 'credits' that may be received.
- v) A poster first is to be reproduced in the required quantity – and then distributed and displayed according to a plan. For its production, free offers from printers and paper manufacturers may be tried. Depending on the availability of such offers it can be got produced other-wise with the money received through voluntary contributions. If it is a metallic poster its display spaces at strategic places eg. Post offices, Railway platforms, Cinema hall Lounges etc., may be obtained free.
- vi) A design for tram/ bus/train panel to execute would need work of advertising studio/metal printer for printing/painting, and display space on

tram/bus/train. All this can be obtained free fully or partially. Partly if required, the expenditure may be met out of funds raised through voluntary contributions.

- vii) For a display advertisement to be released in newspapers/journals free space can either be obtained from the papers or expenditure can be met by donation of space by an advertiser.
- viii) An article received from a Social Scientist as a free contribution can be released also free, readership pages being donated by the the newspapers.

VI. FEASIBILITY OF IDEA

That all this is possible can be further authenticated by a few examples.

1. Special articles on family planning contributed free by eminent writers/scholars are getting published in leading newspapers in India – the spaces being donated by some advertisers (Commercial Houses).
2. Lions Clubs, New Delhi organised a fund raising function on 11th December, 1976 in aid of the family planning programme. Mohamed Rafi, a noted singer along with a few selected filmstars gave free performance. The numerous advertisements which were released in local newspapers publicising the function almost daily for a number of days were all free, spaces being donated by various companies.
3. On an appeal from the Department of Family Planning, Govt. of India large number of House journals are regularly devoting their columns for the furtherance of the national family planning programme. Many of them are bringing out special supplements on family planning from time to time.
4. There have been many similar contributions during the last few years from various individuals and organisations for the cause of the national family planning programme. Many companies have also integrated family planning messages both visually and textually with their own messages in their publicity campaigns. While these ensure participation, due to non-mobilisation of such voluntary efforts at a central place no multimedia campaign planning and implementation could be done with such voluntary efforts. The effect of such voluntary efforts would be manifold and in the desired direction if mobilised and channelised through some established Central Agency.
5. It may be worthwhile to note in this connection that few leading advertising agencies in the USA have voluntarily joined together to form the National Advertising Council Inc. (Headqrs. at New York) and carrying on

voluntarily for the last many years special educational campaigns worth millions of dollars through TV, radio, film, newspapers etc. on problems like, Population, Drug Abuse, Forest Fire, Family Planning, Tuberculosis, Summer jobs for students, etc etc. What could be done by the voluntary efforts of a few well-meaning patriotic advertising firms in the USA can also be done elsewhere, if sincere efforts are made at national level.

VII. TO SUM UP

1. The voluntary resource mobilisation organisation plan has its central objective in the involvement of the establishments in the private and public sectors and also individuals to promote and supplement the existing or fresh efforts at population communication and motivation work at national level.
2. The operational work plan may be as follows :
 - i) Preparation of lists of major advertising agencies, advertisers in the press, radio, TV, cinema, theatres etc.
 - ii) To approach them through appropriate authorities at national level responsible for population activities for donations and contributions in cash, space, time etc.
 - iii) To draw up a comprehensive action plan for utilisation of these voluntary offers supplementing the inputs already put into the programme by the national authorities.
 - iv) Preparation of prototype and materials for different media use for which contributions and donations have been received.
 - v) Implementation of the plan ie. mounting of the campaign which would involve production and distribution of different media materials and their placements.
 - vi) Evaluation of the campaign launched so that shortcomings if any found would be rectified in future operations.

For the implementation of the scheme outlined above at national level the division of responsibilities may be as follows :

- i) The plan for a central resource organisation based on outline given above may be prepared by the Apex Body of the industrial houses ie. FICCI in close collaboration with the Govt. of India.

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- ii) Appeals to the institutions in the private and public sectors requesting for contributions and donations and also for the preparation of prototype software could be drafted/issued by the central and regional organisations of trade and industries.
 - iii) The plan could be implemented centrally by the FICCI through a special family welfare cell which will be mainly responsible for such operations as generation of interest in the industrial sector for the promotion of the national family welfare programme, elicit generous donations/contributions for the promotion of the programme, receipt of the donations in cash, kind, space or time and for investing these for educational and motivational purposes.
 - iv) Independent research and evaluation organisation could be entrusted with the job of evaluation and for the introduction of such changes as may be necessary to make the operations more effective and efficient.

LANDMARKS OF THE FAMILY PLANNING MOVEMENT IN INDIA

- 1916 Pyare Kishan Wattal published his book "THE POPULATION PROBLEM IN INDIA".
- 1923 N.S. Phadke starts Birth Control League in Bombay.
- 1923 G.D. Kulkarni establishes a Birth Control League in Poona.
- 1925 Prof. Raghunath Dhondo Karve opened a birth control clinic.
- 1925 The Neo Malthusian League formed in Madras.
- June 11, 1930 The Mysore Government issued orders to open the first government birth control clinic in the world.
- 1931 Census in India draws attention to the Population problem.
- 1932 The Senate of Madras University, the Government of Madras and the All India Women's Conference (Lucknow session) supported birth control. Madras University starts instructions in contraceptions.
- 1933 All India Women's Conference passes a Resolution in favour of birth control.
- 1935 The National Planning Committee set up by the Indian National Congress, under the chairmanship of Shri Jawaharlal Nehru supported family planning.
- 1935-36 Mrs. Margaret Sanger visited India on the invitation of the All India Women's Conference.
- Dec. 1, 1935 The Society for the Study and Promotion of Family Hygiene was formed in Bombay.
- 1936 Dr. A P Pillai, a vigorous advocate for family planning, conducted training courses.
- 1939 'Birth Control World-wide' opened clinics in U.P. and M.P.
- 1939 Col. B.L. Raina started Matra Sewa Sangh in Ujjain, M.P.
- 1940 Shri P.N. Sapru successfully moved a resolution in the Council of States for establishment of birth control clinics.
- 1940 Mrs. Rena Dutta toured extensively in India on behalf of the Family Planning Association, London.
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- 1940 The Society for the Study and Promotion of Family Hygiene became the Family Planning Society, incorporating the Bhagini Samaj Birth Control Clinic in Bombay.
- 1943 The Health Survey and Development Committee appointed by the Government of India recommended provision of birth control services for health reasons.
- 1946 Bhore Committee recommends birth control.
- 1946 Bombay Municipal Corporation accepts a resolution for giving birth control advice in its clinics.
- 1947 Bombay Municipal Corporation opens two birth control clinics.
- 1949 The Family Planning Association of India was formed under the presidency of Shrimathi Dhanavanthi Rama Rau.
- 1949 Indian Army introduces family planning in its Health and Welfare Organisations at the suggestion of General Carriappa.
- Around 1950-51
- a) Dr. Abraham Stone visited India under the auspices of WHO to advise on establishment of studies on Rhythm method as a contraceptive device.
 - b) The Population Council sent Dr. Frank Notestein and Dr. Leona Baugartner to India to study population matters
- 1951, April Planning Commission, Health Panel appointed a Committee to report on population growth and family planning programmes with Dr. Sushila Nayar, Smt. Dhanavanthi Rama Rau, Shri R.A. Gopalaswamy, Dr. Gyan Chand and Dr. A.C. Basu as members.
- 1951 Family Planning included in the First Five Year Plan of India.
- 1951 Family Planning Association of India holds its First All India Conference on Family Planning in Bombay.
- 1952 Family Planning Association of India hosts Third International Conference on Planned Parenthood. Birth of International Planned Parenthood Federation.
- 1953 The Family Planning Research and Programme Committee in its first meeting in July, 1953 stressed that the family planning programme should not be concerned in the limited sense of birth control or merely spacing of children, but to promote the growth of the family as a unit of society in a manner designed to facilitate the fulfillment of those conditions necessary for welfare.
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