MOTIVATION FOR FAMILY PLANNING : A Short Critical Review

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An important component of the family planning programme of the sixties and the seventies was motivation which meant planned efforts to persuade the public accept the small family norm as well as the particular method of birth control. This concept of motivation became important particularly in the mid-sixties and several strategies were evolved and implemented over the years – mass education about family planning, mass mailing schemes and the use of incentives and disincentives. The article takes a critical look at these strategies, the social political background which gave rise to them, their implementation and effectiveness. The author further examines the assumptions on which the entire motivational strategy was founded and finds them inadequate and full of deeper fallacies.

Among social development plans of the government in the years since independence, thefamily planning programme has perhaps received greater funds and attention than any other single programme. A central element of the family planning programme. as it evolved in the sixties and seventies, was its attention to motivation. By this was meant conscious and planned efforts to influence the public to accept (a) the small family norm, and (b) a particular method of birth control among the many available. In this paper we will attempt to understand this phenomenon of motivation for family planning in greater detail. We shall do this with reference both to actual strategies adopted for motivation in the period before 1977, (a year which marks a watershed of sorts in the history of the Indian family planning programme), and with reference to the theoretical and intellectual basis on which these strategies were founded.

Motivational Strategy — What It Consisted of

The Indian family planning programme was developed in response to what the planners perceived as the 'population problem'. Briefly stated this meant that they saw a high rate of population growth as a major road block on the path to planned development and had visions of the gains of industrial agricultural growth being swallowed up and reduced to nothing by the growing number of hungry people. Family planning was always an euphemism for a policy of population control and a euphemism based on the faith that the surest way to control the rate of population growth was to get individual families to 'plan' their (small) size, which in any case was in their own interests. In the first decade of independence, the approach to family planning, as to much else, was relatively relaxed. While family planning was designated as a key sector in policy/plan documents, the adoption of specific family planning practices was left for the individual couples to decide upon. The state made available at health care centres, a variety of alternatives in birth control under a cafeteria approach.

The result of the 1961 census showing a decennial growth rate of population that was markedly higher than that of earlier decades (population growth rate was 14.23 percent in the period 1931-41, 13.31 per cent in the period 1941-51 and 21.64 per cent in the period 1951-61) brought on the first signs of panic. The FP bureaucracy felt the need to be radical, and the strategy of community motivation was among its most radical innovations.

The concept of motivation gained importance in the family planning programme in the years following the 1962-1963 report of the Director of Family Planning. This report, known popularly as the Raina Report (1963) seriously questioned the clinic type of family planning services that were then available, and under the broad heading of 'extension approach' laid down the basis for a new strategy, relying on community motivation. It recommended the positioning of an extension educator at each block who would educate and motivate people to become FP acceptors. Hard on the heels of this report, in 1965, came the the IUD breakthrough. All, it seemed that was needed to curb the population growth rate was to (a) motivate the people to have fewer children, and (b) insert IUDs. In 1965 also occurred the first evaluation study of the FP programme by the Programmes Evaluation Organisation (PEO) of the Planning Commission (1965). Following this spate of activity, PF was separated completely from health and established as a separate department. United Nations team that evaluated the programme at the request of the government (UN, 1966) in the

same year spoke optimistically of the education of the public, through opinion leaders, satisfied customers and all available types of mass media. The Mukherjee Committee on IUCD (1965) urged for a mass publicity and communications wing for the new department in addition to the army of staff recommeded by the Raina Report. One of the first results of this decision to go in for mass motivation was thus, a fantastic expansion of the Department of Family Planning. The staffing pattern recommended visualised a Block Extension Educator (BEE) at each of the over 5000 Primary Health Centres, assisted by male FP workers, and female ANMs covering 20,000 and 10,000 population respectively. Full and part-time paid voluntary workers were also employed (numbering over 75,000), in addition to extension staff for the urban clinics. However, in later years, the Kartar Singh Committee was to acknowledge that the actual coverage of extension educators had remained much lower.

The motivational strategy consisted of a massive educational programme supplemented by the field work of the extension educators who directly motivated eligible couples. The strategy for mass education was to flash continuously a few "meaningful and understandable" messages to the public such as "Do ya teen bachhe bas". The country was simultaneously plastered with the red triangle of family planning. This simplistic approach often had no real relevance to the life situation of the public that was being educated; for instance, the slogan "do ya teen bachhe bas" ; was cut down to its present size from "do ya teen bache bas; doctor ki salah maniye", when it was discovered that the average Indian villager had no doctor to consult. Films, radio "traditional media," were all used for educational purposes, and although the degree or support to the programme from the mass media unit of the Ministry of Information and Broadcasting, was impressive, the contents of these media products, were unimaginative and often reflected the upper class bias of the producers and of the programme. A lot of the propaganda was centered around a stereotype of two families, the large family is always shown to be poor, unhappy, rural, dark and desi. The other familly, urban, middle-class and westernised is, needless to say, the small and happy one (Banerji, 1971). Songs were written and sung about FP by famous playback singers. FP fortnights, contests and exhibitions were organised in remote small towns and magazines were encouraged to bring out special FP supplements.

In 1969, was started the Mass Mailing Scheme. This mailed suitable informative literature directly to opinion leaders from all walks of life. Even though research found a "good" response to mass mailing, no precise indications regarding the outcome of this expensive exercise are available.

These remained the main prongs of the motivational strategy throughout the sixties. However, from the late 1960's, two parallel but conflicting trends are visible in the programme and its strategy for motivation. The painful realisation around 1968, that the IUCD had failed to deliver the goods, intensified the reliance on sterilisation, if necessary by coercion At the same time some rethinking took place on the whole issue of community motivation. In practice a "hard" and a "soft" line of action are discernable, and these can be followed up separately for convenience.

The 'hard' line :

IUCD insertion figures came down from 909, 726 insertions in 1966-67 to 478,73 in 1968-69. In hindsight, it appears that there could have been many reasons for this perhaps the natural limits of demand had been reached. However, the interpretation put on this trend by the planners, was that there were shortcomings in the motivational efforts. Community motivation being carried out at great expenses, was not having the desired results. This realisation led to the adoption of cruder measures.

Incentive for sterilisation or IUCD insertions have always been spoken of in official family planning circles as "compensation for wages lost." The 1965 Mukherjee Committee report, had spoken of paying compensation to IUCD acceptors (Mukherjee Committee, 1965). While perceiving tne danger of malpractices that may result, this was thought to be less than the danger that would threaten the programme if compensations were not paid. Compensation was tried on a small scale in some states, for instance Madras, in the 1950s, and was started on a national scale in 1964. The motivator's fees that went along with compensation was admissible not only to private citizens but also to Government Servants including FP workers. Rates of compensation were graded as being higher for sterilisations, and lower for IUCD insertions The rates were revised in 1965, and again in 1966. Incentives and target orientation of the programme led, in the late 1960s, to an increasingly greater emphasis on sterilisation with growing tendency to using coercive methods, in addition to widespread malpractices because of the system of the incentives. Any attempt at cutting down on compensation / incentives was however, strongly resented by the medical FP staff,

The idea of using disincentives finds expression in the 1970 document entitled "Master Plan for total Health Care in rural areas" (GOI, 1970) which fortunately, was never implemented. This advocates the professional access of the FP acceptors to all health services The first non-birth incentive scheme was begun by the United Planters Association of South India (Upasi) in selected tea estates in the Nilgiris under the consultancy of Doctor Ridker of USAID. Female tea pickers who had enrolled had a monthly deposit of Rs. 5/- made into their retirement benefit plan by Upasi as long as they did not get pregnant. Specific amounts of the total sum were forefeited in case of pregnancy.

The first mass vasectomy camp was held in the Ernakulam district of Kerala in 1971 (Kumar, 1972). A very large number of sterlisations were performed during the camp duration. The camp and the district collector who had organised it were hailed in FP circles in India and abroad Such camps were held in subsequent months in several other states, and they were all marked by certain special features. Higher than usual rates of compensation were given in cash in addition to gifts in kind during the duration of the camp and the entire administrative machinery of the government of the area was mobilised for publicity and organisation work during the camp. The Kerala camp also happened to coincide with the leanest agriculture season, when special incentives such as a week's extra ration took on a special significance. The demographic quality of those sterilised in the camps was never properly established by independent authorities and in any case the attendance at such camps fell off after the 1972 Gorakhpur incident in which 11 persons died of tetanus, following vasectomy. The camps were discontinued shortly thereafter.

The declaration of the Emergency in June 1975, brought the family planning programme to the forefront of Indian politics The subtle coercion used earlier was now exercised openly to promote sterilisation. Perhaps the turning points was the announcement of Sanjay Gandhi's 4- Point Programme later in 1975, in which FP played an important part. (FP had not been mentioned in the 20-Point Programme.) Sterilisation figures picked up massively—2.5 million operations were performed in 1975-76 as against 1.35 million in 1974-75 and only 0.9 million In 1973-74.

The growing panic at non-performance in a topheavy programme finds its culmination in the National Population Policy of 1976 (Singh, 1976). Though this document did have some developmental content, for instance, stress on female education, only its most coercive aspects were put into effect. The policy graded incentives according to the parity of acceptors, and advocated disincentives for government servants not practising FP. Compulsory sterilisation was left to the discretion of individual states as the centre lacked the infrastructure to put such a policy into effect. However, to prod the states into activity in this regard it was stipulated that in all matters of aid allocation to the states, the 1971 population figures would be followed till the year 2001, and that eight percent of the total central aid would be specifically linked to performance in family planning In the prevailing political climate this was interpreted by most of the states as a clear directive, and the states vied with one another to fulfil targets, and to give an impression of success. In many states, departments such as police and education were used to mop up people for sterilistation, and states like MP and Bihar, fulfilled the annual target for sterilisation in less than six months of the year 1976-77. One state, Maharashtra, actually passed the bill on compulsory sterilisation, and this was only prevented from becoming a law by the grace of the President. The political consequences of these events are only too well known

The soft line :

The "softer" trend in the programmes of motivational efforts, the carrot that accompanied the stick, remained much less effective, often amounting to a lip service only to liberalism and can be traced from the same period as the beginning of the "hard" line. Like the hard line, the 'soft' line was prompted by the realisation of failure.

Doubts began to be cast on efforts to motivate from about 1970. In that year the, second PEO report found the contacts of the FP staff with the local community to be limited and felt that "carrying the messages of FP to the village people required a knowedge . . . of their . . . norms, values, and experiences." (PEO, 1970 , Some of the pioneering writings on population, for instance that by Mamdani, had already pointed out that a large number of children may be an asset in certain class/production situations, and that in these situations it was unrealistic to expect that people would adopt the small family norm merely because a well intentioned department advised them to do so (Mamdani, 1972). It was also perceived that high fertility had a close

relationship with high levels of infant mortality, and in general, with low levels of development. The PEO report briefly acknowledges these trends when it says that "the desire for a small family is more due to economic reasons rather than due to changes in social norms." (PEO, 1970). No concrete approaches in this direction are however, suggested. Similarly, in 1969, the UN evaluation of the programme complained of "gap in our knowledge of the motivational process" (UN 1969). All the soul searching led to a few "changes and departures" in the programme's strategy to motivate the people, and these can now be taken up.

The fallacy of developing FP in isolation from health was realised, and in 1968, maternal and child health services were integrated with immunisations to children and the theme of reduced infant mortality used to establish contact with eligible couples and to motivate them to accept FP. Since however, this was also the period of targets and incentives it is doubtful if this led to any real changes in the approach or not. Possibly it only meant that the already harassed staff were overburdened with finding time for MCH and that these services actually suffered in consequences. The post-partum programme was launched in 1969 in selected hospitals in the country on the basis of the following philosophy: "the months following delivery or abortion... are significant periods of high motivation during which women can be approached concerning future child bearing". Since however, the actual number of hospital deliveries in India form so insignificant a part of the total, the demographic impact of this programme could not have been very high at the best of times. The Country Statement for India at the 1974 World Population Conference in Bucharest with its slogans "Development is the best contraceptive", is also an acknowledgement that more fundamental changes are necessary before the small family norm can be internalised. (World Population Conference, 1974). The approach document to the Fifth Five Year Plan saw FP as part of the integrated package with health and nutrition in the Minimum Needs Programme (Planning Commission, 1977). However, these pious intentions remained unredeemed and from 1975 onwards, in the holocaust of the Emergency, all voices of reason were drowned.

The year 1977 saw a change in government, a change that had taken place at least to some extent as a direct reaction to an unpopular FP programme. The new government redesignated the department as that of Family Welfare and seemed anxious not to repeat the zeal for birth control through sterilisation The Policy statement of the department of June 1977, stressed the voluntary nature of the programme, emphasised the cafeterial approach (allowing the acceptor to choose from a wide variety of methods) and recognised the need of linking FP with other welfare programmes. (GOI, 1977). However, it also expressed concern with the high population growth rate. and fixed birth rate targets of 30 and 25 per thousand to be achieved by the end of the fifth and sixth Plan periods respectively, (as against the then current 34.6. in 1973 as per Sample Registration estimates). It was also stated that the policy of linking eight percent central aid to the states to their FW performance was to continue. In a separate publication " guidelines for media and extensions personne" humility of approach and the pro-mother and pro-child nature of the programme were stressed (FWP, 1977). But the Minister for Health and F.W. made it clear in numerous press statements that incentives for sterilisation would continue. In effect, while some lifting of pressure certainly took place, no real change occured, and certainly no basic assumptions were challenged either by the Janata Party government, or by the Congress government that followed.

The Assumptions Behind The Strategy of Motivation: The 'Relevance' of Theory.

We shall now examine the theoretical assumptions on which the entire motivational strategy was founded. Intellectual support for motivational attempts in the family planning programme, were imported mainly from American agricultural extensions and industrial psychology experience. Continued support was provided, once motivation did become the accepted strategy, from KAP (Knowledge, Attitude and Practice) studies in family planning and from 'communications' theory. The periodic evalutions of the programme (twice by the Planning Commission, and twice by the United Nations) also dealt with the theoretical issues.

The classical "diffusion model" that theorised on how and why innovations were adopted was an American agricultural extension creation. It demarcated the following stages in the diffusion of an invention — awareness, interest, evaluation, trial, adoption — and classified the target population into innovators early adopters, non-adopters and so on. Informal sources of information were held to be the most important at the awareness and interest stages, and neighbours and friends were named as

the most important motivators at the evaluation, trial and adoption stages. This theoretical framework was held to have usefulness for "people who are faced with the problem of diffusing new ideas and practices". (Bohlen, 1957).

Of the social and industrial psychology theories that lent support to motivational experiments in India, the following deserve mention :

(a) Maslow's theory of the Heirarchy of Needs that graded human emotional needs as "basic psychological safety, belongingness and love, esteem, and self-fulfilment needs", in that order (Maslow, 1954). Satisfaction of needs at one level motivates the individual to seek satisfaction of needs at the next level, and so on. The most important applications of Maslow's ideas, have been in the labour management and advertisement fields.

(b) McClelland's theory of Need Achievements that stated as a first premise that an individual's success in economic activities was due to his need for achievement or "N-Ach" (McClelland and Winter, 1969). Further premises, developed over several years, were that a society's levels of economic achievement depended on prevalent levels of N. - Ach and that it was possible to teach N-Ach. The last belief had important implications for the Indian FP programme, where much of the motivational strategy was based on the belief that the extension educators could teach the small family norm.

(c) Herzberg's Motivation Hygiene theory which opined that in a work situation, achievement was affected more by the workers' inner urge to succeed than by environmental factors (Herzberg, 1966). The latter had more importance as sources of dissatisfaction.

All these theories had an element of psychological determinism about them. Their view of the individual was that of a 'blank field' that would produce predetermined responses to given stimuli. Developed in the context of early and aggresive capitalist growth, they had a totally atomised concept of a human being who could be egged on through this or that process to have more "N-Ach" or more "inherent urge to succeed". Instead of viewing the individual as a product of a set of social circumstances, they viewed society as the product of differential drive/or N. Ach of its individual components. Only this totally top-sided view of history and society could produce the delusion that 'small family norm' could be taught regardless of its relevance to the life situation of a particular couple.

The other important source of intellectual support came from theories on communications research, developed orginally in the advertising and broadcasting fields, but later studied with particular reference to family planning. Communications research developed an impressive vocabulary of its own. Communication was broken up into its "main elements"- source, message, channel, receiver, bottlenecks, networks and so on. Great importance was attached to identifying particular areas of communication "breakdown" and removing the particular source of a problem. A certain amount of communications research also went into special areas of FP motivation like the whole question of incentives. Incentives were formally classified into positive/negative, acceptor/diffusor, individual/group, immediate/delayed Rogers, a prolific writer on communications, worte regarding incentives, that while they do result in an increase in the "quantity of FP acceptance", they are likely to affect "quality" adversely. Rogers, (1973). However such cautions were seldom heeded by those on the programme bandwagon, and more encouraging findings of communications research have continued to enrich motivation vocabulary.

Once the programme was properly launched in India, KAP studies conducted by the department itself, as well as by obliging university faculties, became the main prop of the programme against which motivational strategies were planned and evaluated. Rao and Mullick have reviewed over 200 of these studies, and their main theme is that of a KAP gap in India. (Rao and Mullick, 1974). Awareness of FP methods is high, attitudes towards FP are favourable, but the actual practice of family planning by eligible couples is low. The model is obviously based on the classical diffusion theory outlined above. The methodology of the KAP studies has come under increasing attack in recent years. It is to be doubted if a simple linear relationship between K, A, and P exists in as complex an area as this. The measurement of attitudes through surveys or ordinal scales is again of questionable validity. There is, in any case, a vast difference between an attitude, which is a complex socio-psychological entity and an opinion, which is what the questionaires used in the KAP studies elicited.

Some of the inadequacies of the theoretical bases of the motivational strategy are pointed out above. Certain other and deeper fallacies however, have affected the entire programme and we can now turn to these.

The FP programme was prompted in the main by a fear of population size, that is, by (correct or incorrect) considerations of macro population policy. It being unrealistic to expect that family planning decisions should reflect population policy norms rather than individual life experiences, people were quite dishonestly sought to be converted with the message that the small family norm was good for them; proposition that was simply not correct. Considerable evidence was available even in the late sixties that a large family norm may be more suitable in certain situations (for instance in poor, labour intensive agrarian economies and where poorer classes are subject to heavy depletion in children ever born). Some of this sort of understanding did creep into the programme rhetoric from time to time, but made no real difference, as the real moving force behind the programme was never the happiness of individul families

As far as the macro understanding goes, it is not difficult to see through it at all. The argument that over population eats up the gains of developments is not a new one. Not only does it divert attention from more fundamental questions like models of development or distribution of resources; one also senses behind it a fear of people, people of certain nations, certain races and certain classes. It is another manifestation of the old Malthusian bogey that the poor are responsible for their own poverty because of their large numbers.

Birth control, which was all that family planning ever meant in India, can be advocated on many grounds. But certainly it cannot be advocated as a uniform prescription for all, without any regard for human dignity or individual liberty. The events of 1977 amply illustrated that the people would not buy an irrelevant product, however sophisticated the packaging. The tragedy is that no real lessons appear to have been learnt.

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(Contd. on page 181)

(Contd. from page 170)

tablets. That night the wife received severe beating from the husband. He suspected that his wife had used one foam tablet with another man.

Case 2 : Having got fed up with her husband forcing her to undergo repeated abortions a woman quietly got an IUD inserted. The husband got suspicious and forced his wife to get it removed. Inspite of removing the device, she was thereafter maltreated and beaten up often. After a few months inspite of her being pregnant she was thrown out of the house in the middle of the night, the reason being that she had not taken her husband's permission to get the IUD inserted.

Case 3 : There was a case of a doctor's wife who had to undergo repeated abortions each time after a 'sex determination test' revealed a female foetus.

Case 4 : Women have to bear the burden of looking after the family and also take the responsibility of contraception. There were several instances when a woman could not be offered any method immediately as she required treatment for some gynaecological complaint. The period of treatment was always short — a month or two in each case. Her husband would be asked to use a condom or refrain himself till she was alright. But in most cases the women would conceive during this period and either continue with an unwanted pregnancy or be forced to undergo an abortion.

Any one who has worked in FP clinics has come across women belonging to various religious groups who demand oral pills to postpone their menstrual periods so that they could participate fully in religious and social functions or even go for an outing. If given a chance, women can decide how they would like to utilise scientific discoveries.

Conclusion

In conclusion, the poor women of the third world countries like India get exploited not only by the government, the research institutes, private individuals in the field of contraceptive research but also by men who care very little about their health and their comforts. Research on birth control measures which could be used by men has not been undertaken with any degree of seriousness.

For instance although the condom is really a harmless and effective method for men, no serious studies have been conducted on its being accepted or rejected by men. Women just leave condoms behind at the hospitals if they are distributed knowing fully well that husbands will not use them. The statistics on condoms are based not on the numbers used but on the total number issued. There is no proper follow-up nor any serious effort to promote this harmless contraceptive. Is it because it is to be used by men ?

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