Diagnostic Study of Population Growth, Family Planning and Development, 1971-81

Gujarat

THE FAMILY PLANNING FOUNDATION
198, GOLF LINKS, NEW DELHI-110003

DIAGNOSTIC STUDY OF POPULATION GROWTH, FAMILY PLANNING AND DEVELOPMENT IN GUJARAT, 1971-81

by

V K RAMABHADRAN

THE FAMILY PLANNING FOUNDATION
198, GOLF LINKS, NEW DELHI-110003

FOREWORD

The Family Planning Foundation as a funding and promoting organisation has selectively addressed itself to diagnostic research on major population issues. As soon as the 1981 census results were published, the Governing Board of the Foundation expressed the need to find out why the population growth rates varied considerably among the states and bring out the programme and policy implications. In operationalising this suggestion, it was felt that in view of the significance of the study and the need to have a high level liaison with the states, the Foundation should directly undertake the study. For this purpose the Foundation invited Mr V K Ramabhadran to undertake the study.

The study covers 5 states with different demographic and economic settings—Gujarat, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh. This Brochure presents the main findings and recommendations in respect of ~~Rajasthan~~ Gujarat. This would, we hope, stimulate an informed discussion on the Status of Population in Gujarat and pave the way for a more vigorous and effective action programme in family welfare.

The Foundation would like to place on record its deep appreciation for the willing cooperation of the state governments, particularly of the Departments of Health and Family Planning.

New Delhi
February 1, 1985

J C KAVOORI
Executive Director

INTRODUCTION

1. The decennial Census of India has always been regarded both as an evaluator of past population policies and indicator of future policy requirements. The Census of 1981 has performed a similar role by disclosing a decadal growth of 25.00 per cent in 1971-81 compared with 24.80 in 1961-71. The reaction to the Census disclosure has been somewhat mixed:

> Some relieved that the momentum of population growth (as a legacy of high fertility in the past) has been contained;
>
> Some anxious that the expected decline in growth rate (as a result of the family planning programme) has not taken place.

2. While the above is the picture at the national level, behind the 'static' decadal growth rate of population at the national level, the picture is highly variegated at the state level. An important feature brought out by the 1981 Census is that the problem of rapid population growth in India is essentially a regional problem. Among the 14 major States of India (with a population of 10 million and above excluding Assam), the growth rate in 1971-81 has varied from 17.50 in Tamil Nadu to 32.97 in Rajasthan, with 27.67 per cent for Gujarat.

3. This project entitled "Diagnostic Study of Population Growth Family Planning and Development in 1971-81 in Gujarat" is a part of the five-state study project (which includes Gujarat, Orissa, Rajasthan, Tamil Nadu and Uttar Pradesh). The project has its genesis in the disclosure by the 1981 Census of a constant growth rate at the national level, but a highly variable growth rate at state level. The principal objective of this study is to identify the causes responsible for such variation in demographic behaviour against the background of both the family planning programme input (which is a centrally supported scheme on a uniform basis) and the social setting in different states (which depends mainly on state policy and initiatives in development) as well the likely synergism between these two factors. These diagnostic exercises do not aim at establishing hypotheses or quantitative relationships nor are they expected to lead to instantaneous solutions to problems. But it is hoped they would expand understanding of the problems and the potential

MAIN FINDINGS

The Demographic Scene

— The population growth rate (27.67 per cent) in Gujarat in 1971-81 has been higher than the national average (25.0 per cent) as in the previous decades.

— But the growth rate is lower than the highest growth rate (29.39 per cent) recorded in 1961-71. The critical question is whether the downturn in population growth has begun in 1971-81.

— Gujarat is a state with a historical high fertility.

— The high population growth rate in Gujarat is due to two plausible reasons:

i) high fertility with a declining mortality;
ii) immigration.

— The characteristics of high fertility in Gujarat are:

i) higher live birth rate (41.2 in 1970 compared with 36.8 at national level),
ii) higher age specific marital fertility rate, particularly among women 25+,
iii) high parity births (40 per cent of rural births of parity 4+).

— In the rural areas, birth rate declined in 1971-81 by 14 per cent while death rate declined by 37 per cent. In the urban areas, the decline was 16 per cent and 30 per cent respectively.

— According to the 1981 Census, Gujarat has recorded the second highest immigration rate for males (next to Maharashtra). This is attributed to the rapid industrialisation of Gujarat.

— According to a 1976 Census of Ahmedabad, 40 per cent of the slum population comprised occupational migrants from neighbouring states.

— While the rural growth rate (21.9 per cent) it higher than

births. There is a decline in the proportion of births only in the fifth and sixth birth orders.

— Marital fertility is higher in urban areas also which indicates that there could be an occupational culture in the business community to have a lineage system requiring sons to carry on the activities of the asset-owing classes (business community).

— One dubious distinction which an affluent state like Gujarat shares with the poorer states of India is the high level of infant mortality.

— The infant mortality rate (IMR) in Gujarat during the decade 1971-81 ranged from 109 to 161 and was substantially higher than in Punjab and about three times the IMR of Kerala.

— One of the reasons for high IMR is the high risk faced by the high parity children (4+), which constitute nearly 39 per cent of births in Gujarat.

— In Gujarat (as in many Northern states), the female IMR is higher unlike in Southern States.

— Also the neo-natal mortality is higher than the post-natal mortality in contrast with the Southern States.

— A high neo-natal mortality despite a large number of births attended by ANM or trained TBA shows qualitative deficiencies either in the training or in the application of their training.

— The mortality push effect of fertility is also evident as live births with a retrospective interval less than 18 months are the most vulnerable with an IMR exceeding 200.

— A significant reduction in IMR is obtained when the spacing is above 30 months, which underlines the crucial role the spacing methods of contraception can play in moderating IMR.

The Social Setting

— In Gujarat, the nuptiality pattern has changed significantly. The percentage of young marriages (15-19) has dropped from 39.5 to 26.9 in 1971-81.

— The average age at marriage of female has increased from 18.6 to 19.6 years.

— Muslims constituted 8.4 per cent of the population in 1971.

— The scheduled castes (7.2 per cent) and scheduled tribes (14.2 per cent) constitute 21.4 of the Hindu population in 1981.

— South Gujarat has a concentration of tribals.

— The fertility among rural Muslims is not much different from that of Hindus (unlike in Uttar Pradesh).

— The fertility among scheduled castes and scheduled tribes of Gujarat is not much different from the non-scheduled castes and tribes (unlike in Orissa where the former had lower fertility).

— To sum up, the social setting against which the State Government has to embark on the arduous task of moderating fertility has necessarily to contain the following elements of a segmented approach :

i) improving the status of women both through literacy and expanded opportunities for employment (the elected Panchayats of Gujarat have a special role in this effort).

ii) organisation of women in rural areas by establishing Rural Women's Association (RWA) at the rate of 30 RWA per development block (the experience of Gandhigram Institute of Rural Health and Family Welfare, Madurai Tamil Nadu may be useful).

iii) special efforts to moderate the fertility of urban Muslims by involving religious leaders and an effective programme of incentives and disincentives.

iv) special efforts to moderate the fertility of younger couples among scheduled tribes in urban areas probably based on intensive health and family welfare inputs and incentives.

v) innovative efforts by social workers to moderate the son-preference attitude among the asset owning classes.

The Development Scenario

— The *per captia* income of Gujarat during the decade 1971-81 was the second highest among the states next to Punjab. The decadal average real income was Rs. 809 compared with Rs. 1,229 in Punjab.

— The real income at 1970-71 prices fluctuated between Rs. 650 in 1972-73 to Rs. 914 in 1978-79 depending upon the monsoon. There has been no steady growth in income.

— Trained medical attention of infant at death was 38.0 in Gujarat compared with 41.7 at the national level.

— However, Gujarat has the distinction of having the highest immunisation status of 89 per cent among children below 1 year in the rural areas.

— In Gujarat nearly one-third of the villages had medical facilities (sub-centre, PHC, hospital etc.) beyond a distance of 5 Km.

— The high fertility-high mortality combination is a challenge to the 'integrated approach' though Gujarat is committed to the Seven Point Programme (GOBI-F[8]) for improving child care and reducing infant mortality.

— Unlike in some other states, the MPW scheme which is one of the planks for integration, is working reasonably well in Gujarat.

— The medical profession in Gujarat is taking to family planning naturally. Though the doctor render services, they are probably less enthusiastic about motivating the eligible couples.

— Because of the functional expansion of services in PHC, the MOPHC needs to have techno-managerial competence.

— The MCH and EPI programme provide several 'contact points' with eligible women for promoting family planning. But these have not been fully utilised.

— The State Government has judiciously applied the scheme of incentives.

— Most of the incentives are built around sterilisation.

— Besides direct cash incentives, the State Government has introduced purpose-oriented cash incentives such as for construction of hut, purchase of cloth, labour welfare etc.

— The incentives appear to have attracted the poor tribal population.

— Gujarat has to achieve its demographic goal of NRR=1 by 1991 which means that there are only 8 years to bring down the birth rate from 35 to 21 and the IMR from 120 to 60. This

---

GOBI-F[8] : G = growth monitoring B = Breast feeding
O = oral rehydration I = Immunisation.
F[8]= food supplement, family spacing and female education.

Impediment/weaknesses

1. Rural poverty (arising from a decline in agriculture).
2. Poor infrastructure and difficult terrain (sandy, hilly).
3. Low level of medical service outreach in rural areas.
4. Urban slum syndrome.
5. Historical high fertility and high parity births.
6. High infant mortality in rural and urban areas.
7. Lack of techno-managerial competence on the part of the MOPHC.
8. Excessive reliance on sterilisation, particularly tubectomy and the relative neglect of spacing methods.
9 Main reliance on camp approach and low extension activities.
10. Pursuit of quantitative targets with poor quality awareness.
11. Prospects of the programme entering the 'hard rock layer' after 35% couple protection achieved.
12. Inadequate utilisation of the strong operative infrastructure.
13. Feeble voluntary support.
14. Lack of women's organisation in rural areas.
15. The lineage system of the asset-owning class.

RECOMMENDATIONS

1. To convince the people that family planning is not just a Departmental activity or just a Government concern, it would be useful to establish a STATE FAMILY PLANNING BOARD under the Health Minister (as in Tamil Nadu) with the membership of both officials and non-officials to secure participation at the grass-roots level. The suggested composition is:

Officials

Commissioner & Secretary, Health & Family welfare
Director of Family Welfare
Director of Rural Development
Director of Social Welfare
Director of Information & Broadcasting
Director of Labour
Director of Municipal Administration
Director of Panchayats
Chairman, State Social Welfare Board
Director, Population Research Centre, Baroda.

Non-officials

5 MLAs from different political parties
5 MLCs from different political parties

has already achieved a couply protection rate of about 50 per cent should have only a 'low priority sterilisation'.

7. The 'contraception mix' which would be relevant for the different regions of Gujarat consistent with the contraception rate already achieved and the level of IMR appears to be :

South Gujarat : Low priority sterilisation (one sterilisation and 4 spacing method users)

North Gujarat : Medium priority sterilisation (one sterilisation and 2 spacing method users)

Saurashtra : High parity sterilisation (one sterilisation and one spacing method user)

8. Successful family planning in Gujarat in the ensuing years with adequate emphasis on spacing methods requires a caring and continuous service to the acceptors. It is doubtful whether the present structure of an officially led motivation and delivery system can handle a widespread and effective spacing services. A combination of measures is called for :

a) Reorient the functionaries in the programme at all levels so as to bring in more human values in the programme.

b) Introduce among functionaries more social workers.

c) Utilise voluntary institutions, co-operatives and all the informal local level organisations in recruiting clients and supplying contraceptives adopting either the community based distribution system or social marketing techniques.

d) Constantly monitor the demand and supply situation in order to ensure a demand-supply equilibrium at micro-level to avoid frustration among genuine users on the one hand and avoid accumulation of unutilised stocks, on the other.

9. Infant mortality in Gujarat is rather on the high side. Since spacing methods have both health and survival benefits, there is a further justification for promoting spacing methods on a large scale in any package of measures designed to control infant mortality in Gujarat.

10. Family planning programme needs a social change which cannot be brought about by service-oriented functionaries. A good deal of social counselling would be required in promoting spacing methods not only for initial acceptance, but for continuation. There is scope for appointment of a cadre of social workers through the voluntary organisations.

the community in providing sterilisation service through the medical profession. But family planning has now to move to spacing methods, wherein the non-physicians (particularly indigenous medical practioners) have a role to play. The traditional) medical practitioners could not only make the family planning services accessible but also acceptable to the people and what is more important, the programme would be made more sensitive and responsive to local values and individual needs.

15. Though there is need to demedicalise family planning services, it does not imply that the programme could do without the medical profession. Indeed, a medical back-up to the programme is probably the best method of imparting credibility to the programme and the medical profession has therefore both a promotive and creative role in the programme. There is, therefore, a need actually for a deeper professional involvement of the doctors in the programme. A part of the observed superficial involvement of the medical profession at present, is probably due to the medical profession not being exposed to the full dimension of the population problem, the social aspects of family planning and the contraceptive technique available for this purpose. Unless the basis for a radical change in their attitude and their response is laid during their academic career, the commitment to family planning cannot be internalised and the doctors would still regard family planning as an activity extraneous to their academic upbringing. There is, therefore, a strong case for imparting more knowledge and expertise on family planning to the upcoming generation of doctors during their acadmic career by suitably modifying the medical curriculum. We have still not addressed ourselves adequately to the long-term man-power problems in family planning and it is only though the strengthening of their academic training that the doctors could be expected to render professionalised family planning services in the way they are now rendering curative services. (Books such as 'Practice of Fertility Control—A Comprehensive Text Book by S.K. Chaudhari and others, Current Book Publishers could be useful in modifying the curriculum).

16. The Medical Officer of the PHC has several responsibilties now under the integrated programme of health and family welfare. Several types of records at the PHC level are to be maintained for follow-up of cases and for monitoring the progresses. The MOPHC needs to have adequate management skill to handle the multifarious functions of the PHCs and also impart a systems approach to identifying and solving problems through a Management Information System. All these point to the need for

for purposes of economic programmes and family planning. Rural Women's Association (RWA) camprising 30 or 40 women have been found to be suitable units in the studies made by the Gandhigram Institute of Rural Health and Family Welfare, Madurai for local level organisation of women called Matharsangam (Mother's Club). It would be a worthwhile endeavour if the Ministary of Social Welfare and the Women's Economic Development Corporation could establish with the help of women's organisations and voluntary bodies, around 30 RWAs in each block.

22. In its future operation, the family planning programme requires a stronger sociological base. It needs a SOCIAL CHANGE which cannot be brought about by service-oriented functionaries. A good deal of social counselling would be required in promoting spacing methods not only for initial acceptance but for continuation without which the spacing methods are not only wasteful but sometimes harmful (such as the 'bouncing effect' in oral pill discontinuance). There is scope for appointment of social workers (preferably females) through voluntary organisations.

23. Once the couples with two children in the age group less than 25 years are identified on the basis of the Eligible Couple Register and they have not been using any contraceptive, such couples should be regarded as the 'Core target' group for motivation by the social workers.

24. Oral pill and Nirodh need to be promoted through a community-based distribution system and/or a suitable social marketing approach (utilising the social workers and the community workers). This would not only ensure better accessibility and supply of contraceptives but would also enable local level monitoring to maintain a high continuation rate which is so necessary for the effectiveness of such contraceptives.

25. Gujarat requires a more vigorous IUD pragramme based on Copper T for which advance planning is necessary to estimate demand and ensure adequate and timely supply. It may be noted that Muslims prefer the IUD.

26. The State Government has sanctioned additional cash incentives to acceptors and service providers and to the organised industry. But all these incentives are related to sterilisation. In order to promote spacing methods on a large scale, which is the dire need of the programme in Gujarat, it would be necessary to introduce several types of incentives in the spacing programme.

32. Mere pursuit of quantitative targets without simultaneously ensuring the quality is a waste of resources. Majority of the tubectomy acceptors are high parity and older women 35+ whose recruitment is less consequential demographically. In this context, since vasectomy has been popular among younger couples, attempts to promote vasectomy would be rewarding. Also spacing methods among the younger couple (wife below 25 years) would not only moderate their fertility at younger ages and confer health benefits but also prepare them eventually to adopt terminal method as a contraceptive continuum.

33. Further fertility trend in Gujarat may be influenced more by the age at marriage and the standard of living which are the two factors that have reduced marital fertility in Gujarat. The development policy of Gujarat in the context of the need to reduce fertility in the short-run has to concentrate on improving the standard of living and raising the age at marriage above 20 years.

34. The higher acceptance of contraception in the tribal districts is a situation which requires to be investigated both from the demographic and sociological angles to dispel doubts about the voluntary nature of their acceptance and the lure of incentives for the poor and adopt a moderation if any 'excesses' are detected. Simultaneously, their is need to promote the family planning programme more vigorously among the non-scheduled caste and scheduled tribe population.

35. The studies and surveys that are considered necessary for making the family planning programme in Gujarat more relevant and responsive to population issues are listed below:

i) The reasons for the lower growth rate (compared with all-India average) of small and medium towns.

ii) In several districts which had recorded a sizeable decline in population growth, the contraceptive protection is lower than the State average. It would be useful to study the non-programme factors responsible for this trend.

iii) The extent to which a lineage system prevails among the business community (and other asset owning classes) needs to be investigated so that a suitable strategy could be evolved to moderate the fertility in this group.

iv) Gujarat is one of the states with a "reasonably higher consumption" of sugar, edible oils and milk. A well designed enquiry is needed to study whether the