"To control the reproduction of the poor people is a piece of cynicism unless they have themselves asked for it and unless they are allowed to take active part in the planning of such a programme. To facilitate people to plan their families according to their own wishes is a different matter of course. If a women finds it essential to limit her number of children, she should be given the opportunity to do so, but she should also be given the right to education, a productive job, a stable economy, a meaningful social standard and other fruits of a well-planned development. Population control means people are controlled by others. Family Planning means that people control themselves. The two concepts are irreconcilable."

- Lars Bondestam, *Poverty and Population Control*, 1980

"If anyone accepted we were beaming with joy": One more acceptance! "People used to say birth control was written on our foreheads." - A field official involved in one of the earliest FP projects in Punjab, quoted in ***The Myth of Population Control****, Mahmood Mamdani, 1972.*

II. Ideology of population control

The Indian Government's overriding emphasis on the small family norm and the consequent trends in its FP policy need to be understood in the context of the world Population Control Establishment's obsession with bringing down birth rates in the developing countries. So total is the hold of the population bogey on the minds of the literate sections in this country that it is also necessary to examine the myth and reality of the poverty-population syndrome. The two sections in this chapter attempt to outline the total picture which in turn will offer a basis for a critique of the FP programme.

Anatomy of India's FP policy

The year 1921 marked the beginning of rapid population growth in India mainly because of the change in mortality and fertility rates. Life expectancy rose and death rates declined as a result of plague eradication, famine relief and control of malaria and smallpox. Public health measures and medical technology also helped. However, while various health programmes have had an impact on the survival of children crossing the age of five, infant and child mortality are still very high and this remains a crucial factor determining the trends in birth rate.

The 1981 census placed the current population of India at 685 million, second only to China's 971 million. The present growth rate is estimated at 2 per cent which means that about 13.7 million people are being added to the population every year.

The World Population Plan of Action (UN 1974) had stated that "countries which consider that their present or expected rates of population growth hamper their goals of promoting human welfare are invited to consider adopting population policies". Most developing countries today, including India, pursue an "anti-natalist" policy to discourage fertility. The concept of 'planning' or 'planned parenthood' coupled with a policy of using incentives and disincentives is a characteristic of the anti-natalist policy.

India was the first independent country in the world to adopt in 1951 a policy of reducing population growth through a government sponsored national family planning programme. Earlier, in 1941, the population sub-committee of the National Planning Committee had already identified population growth as a *cause* of poverty and underdevelopment. (This false equation remains the basis of the population ideology of the Establishment.)

Plan period 1951-85: FP has been given a progressively higher priority in each plan, and higher budgetary allocation. **However, at least in principle, the Planning Commission has never considered population control as a substitute for socio-economic development.** (As many writers have pointed out, the Indian FP scene is characterised by a yawning gap between stated policies and actual goings-on at the field level.)

An FP cell was set up in the Planning and Development section of the Directorate-General of Health Services in 1952. FP from the beginning has been the responsibility of the Health Ministry, a Centrally sponsored and financed programme implemented by the states. By the Third Plan, a full-fledged department of FP was established within the Health Ministry under a Minister of cabinet rank. It was also redesignated as the Ministry of Health and Family Planning. ('Planning' was changed to 'Welfare' by the Janata Government in 1977 in an effort to neutralise the unsavoury aura which came to surround the very phrase 'family planning' after the excesses of the Emergency.)

In 1966, the Central Family Planning Council was set up with the Health Minister as Chairman, with similar councils in the states. The same year, a Commissioner of FP was appointed to head the Department of FP, whose rank was elevated in 1974-75 to that of a Joint Secretary. Though the commissioner's post was held by a medical doctor, the upgraded post has always been held by an IAS officer.

In the states, the State Family Welfare Bureau is headed by a Joint Director of FP and Maternal and Child Health, with an officer of the rank of Secretary to head the cell in the Secretariat. Implementation of the FP programme is through the PHCs while the urban family welfare centres have patterns of staffing varying with the size of population to be covered.

Four different styles of approach have been tried out over the decades in an effort to bring down the birth-rate.

BOX 4

Too many people?

Doesn't the fact that there are now at least 500 million undernourished and starving people prove that there isn't enough food or land for everyone to be adequately fed?

To diagnose the cause of hunger as scarcity of food and land is to blame nature for people-made problems. In doing the research for **Food First: Beyond the Myth of Scarcity** we have learned that the earth's natural limits are not to blame. Hunger exists in the face of abundance; therein lies the outrage.

The world is producing each day, two pounds of grain - more than 3000 calories and ample protein - for every man, woman and child on earth. A third of this grain now goes to feed livestock. On a global scale the idea that there is not enough food to go around simply does not hold up. But global figures mean little. What counts is whether adequate food-producing resources exist in countries where so many people go hungry. The resources **do** exist, we have found that they are invariably underused or misused, creating hunger for many and surfeit for a few.

According to the FAO, less than 60 per cent of the world's cultivable land is now being cropped. Grain yields in the underdeveloped countries could more than double before reaching the average yields of the industrial countries. In most of these countries, land presently harvested once yearly could provide two or even more harvests. Barriers to unleashing this productive capacity are economic: Wherever there is unjust, undemocratic control over productive resources, their development is thwarted.

In most countries where people are hungry, large landholders control most of the land - and they are the least productive. Land monopolised by a few is inevitably underused. The wealth produced is invariably **not** reinvested for rural development but drained off for conspicuous consumption and for investment in industries catering to the fancies of urban and foreign well-to-do.

Low productivity also results from economic and social injustices. The influential landowners monopolise access to extension services, markets and non-usurious credit. Without individual or shared ownership of land, how can tenants, sharecroppers and landless labourers either be motivated or have the wherewithal to conserve and improve the land for better crops?

Co-operation is the most essential ingredient for development. To build and maintain irrigation systems or control pests, everyone in a village must work together to be effective. But, co-operation is unlikely when there is grossly unequal ownership of land and productive resources.

Apart from measuring underused potential, we must also assess the **misuse** of resources. When the majority do not have the buying power, agricultural resources will be made to serve those who can pay the domestic upper strata and high-paying markets abroad. Luxury crops expand while basic food crops are neglected. In 1973, 36 out of 40 of the world's poorest countries - those classified by the UN as being the most seriously affected by inflated world food prices - exported agricultural commodities to the U.S.A.

When the earth's tremendous productive capacity is underused and when its bounty is increasingly siphoned off to feed the already well-fed, scarcity can hardly be considered the cause of hunger.

Condensed from: **Food First: Beyond the Myth of Scarcity**, 1978, by Frances Lappe and Joseph Collins with Cary Fowler. (Institute for Food and Development Policy, USA)

CHRONOLOGY OF THE AMERICAN POPULATION MOVEMENT: 1921-1974

Related developments in history	Focus of concern for the population establishment	Strategy for control of world population	Year	Important events of American Population Control Movement
Russian Revolution (1917)	Fear of "race suicide"	Birth control "to stop multiplication of the unfit", more children for the rich and the superior; immigration restriction policies	1921-1945	Establishment of American Birth Control League (1921)
Great Depression (1929-39)	Eugenics			Passage of Immigration Restriction Act (1924)
World War II (1939-45)				Establishment of first research instituion on population (1922)
				India considers national birth control programme (1935)
				Large-scale birth control programme approved in US possession Puerto Rico (1937)
				Merging of eugenics and birth control movements (1940)
Independence movement of colonies (1945-55)	Scarcity of resources from countries with "exploding" populations	Formulation of strategies to control the "exploding" world population	1946	UN accepts Joint Anglo-American proposal for establishment of *Population Commission*
Chinese Revolution (1949)			1948	Establishment of International Planned Parenthood Federation (IPPF)
Korean War (1950-55)			1949	US State Department's Malthusian explanation for the "loss of China"; Vogt's book "Road to Survival" *published*
Cuban Revolution (1959)	Preparation of necessary means to implement strategy of world population control, development of contraceptives, *collection of demographic* data, social science research to identify determinants of population growth	"Conquest of public opinion" and building of coalition to pressure US government to fund *population control programmes* in developing countries	1952	Williamsburg Conference for establishment of the Population Council
Alliance for Progress (1961)			1954	World Population Conference (Rome); widespread distribution *of Hugh Moore's* "The Population Bomb"
			1958	Ford Foundation grants $9 million to assist India's national family planning programme
		Efforts to win international support for world population control; "population control is necessary condition for development"	1959	Draper Committee urges US government to give foreign aid for *control of population in developing* countries
			1960	Rockfeller pleas to shift burden of population control from private sector to government
			1961-1963	Beginning of series of full-page advertisements in major newspapers by Moore Fund to urge public to pressure government

Related developments in history	Focus of concern for the population establishment	Strategy for control of world population	Year	Important events of American Population Control Movement
				to finance world population control programmes; advertisements such as "Population Explosion Nullifies Foreign Aid" refer particularly to failure of Alliance for Progress in Latin America
Escalation of Vietnam War Spread of national liberation movement	Implementation of population control programme (mainly bilateral programmes) Debate on "Will family planning programmes succeed?"	Pressure on developing countries to accept population programmes, on developed countries to join in financing them, and on UN to endorse them	1965 1966 1967-1968 1969	President Johnson's historic announcement to "deal with the explosion in world population"; AID begins to fund population control programmes; famine in India (1965-1966) UN resolution to assist nations upon request in field of population Population control condition ("self-help") tied to US food aid, World Bank Pearsor Report coincides with UNA-USA Report and subsequent establishment of UNFPA in 1969 Moore's Campaign to Check Population Explosion continues from 1967 to 1969, culminating in President Nixon's message to Congress on population
Rise of nationalism and intensified opposition in Third World countries to foreign control of resources, UN Special Session on Raw Materials and Development; UN Ocean Conference (both in 1974)	Growing recognition of failure of "family planning" approach; need for broad-based "development" approach	Intensification of pressure. Toward the climax; WPC and adoption of the WPPA; legitimization of global population control.	1970 1971 1972 1974	Marked progress in AID funding of population control programmes in developing countries UN designates 1974 as World Population Year and schedules World Population Conference (WPC) in 1974 Commission on Population Growth and American Future headed by Rockfeller advocates "stabilization" of US population World Population Year, World Population Conference, and World Population Plan of Action (WPPA)

Source: Bonnie Mass; **Population Targets: The Political Economy of Population Control in Latin America,** 1976 pp 44-45.

Clinical approach: When the Indian FP programme started, the Western Clinic model was initially adopted. Voluntary agencies like the Family Planning Association of India (established in 1952 and affiliated to the International Planned Parenthood Federation) and the Red Cross established FP clinics. It was assumed that those who wanted advice on contraception would unhesitatingly visit these clinics. These were heavily funded from abroad. The rhythm method was the officially sanctioned method in the First Plan. (But information on barrier methods was also offered.)

Extension approach: Since clinics had little impact on the birth-rate, the Third Plan stressed a change in approach to "extension" which would include an educational slant aimed at changing knowledge, attitude and behaviour of people in regard to family planning.

Camp approach: Mass vasectomy camps were introduced in 1961 when the first such camp in the world was organised by the Maharashtra government - 1,400 men were sterilised in three days. In 1970, another massive camp was held in Kerala where 15,005 vasectomies were done in a one month period. During 1971-72, about 61 per cent of the 2.19 million vasectomies performed were done in mass camps. Government personnel at all levels were involved in organising camps and an element of coercion soon began to appear in the way some of the camps were organised.

In 1973-74, the camp approach was officially played down and the budget was reduced by Rs. 6 crores. The reason given was that, in a larger perspective, camps were counter-productive as they needed careful management and precaution. Insanitary conditions had already resulted in several deaths. (Despite this, sterilisation camps were the highlight of the Emergency years.)

The National Population Policy announced in April 1976 outlined long-term measures like raising the marriage age and improving female education. The most controversial part of the statement was the proposed legislation for compulsory sterilisation of couples who had had a certain number of children. Only Maharashtra actually tabled a Bill to this effect.

During the Emergency, in 1975-77, the number of sterilisations shot up. In 1975-76 it was 2.65 million, a 97 percent rise over the figure for the previous year. In 1976-77, it went up even more to 8.11 million, an increase of 210 per cent. Targets were overachieved, especially in the north, which is traditionally an area with low acceptance. The capital city of Delhi surpassed all other areas with 477.6 per cent achievement of the 1976-77 target.

The intensive sterilisation period was characterised by the use of incentives and disincentives. The range of penalties was large and the sterilisation operation became a pre-condition for jobs, promotions, pensions, housing, education for one's children, ration cards and licences. (Social Science research studies done subsequently abound with examples of how unscrupulous motivators lured by the motivation money, thrived during the period, and brought unsuspecting young men without children to the operating table.) Several deaths resulted from insanitary arrangements. "The National Population Policy was implemented in a manner that was an assault on human dignity."

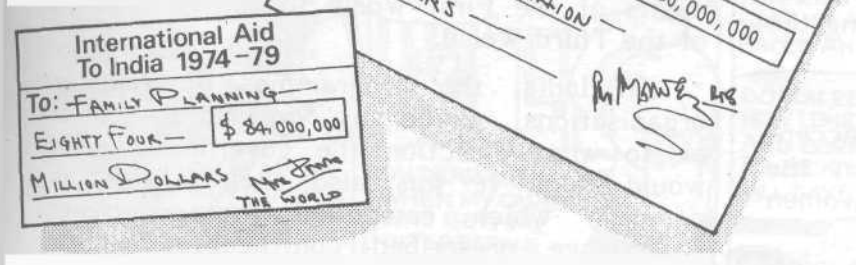
The integrated approach: Although it was recognised in principle even in the first two plans that FP needs to be associated with maternal and child health, the approach to the Fifth Plan spelt out a formal integrated approach reflecting a change in strategy. The Minimum Needs Programme set out in the Fifth Plan covered areas like education, health etc. and initiated this process of integration. At present the FP programme also includes immunisation of infants and children with triple antigen, immunisation of expectant mothers against tetanus, and prevention of nutritional anaemia and Vitamin A deficiency. The multi-purpose workers' scheme, started in 1973, is expected to carry out the integrated FP-cum-health education programme through the PHCs.

In principle, the FP policy is based on a

'cafetaria' approach of offering all available methods of contraception, but at different points of time different methods have been given emphasis. The Medical Termination of Pregnancy Act was passed in 1972. (Abortion is not technically under Family Planning and is not officially described as an FP method but as a health measure. However, it is definitely used as a population control tool.)

During the brief tenure of the Janata Government, FP had a low profile but with the return of the Congress (I) government to power in 1980, the integrated approach found a place in the revised 20 point programme. There has been a renewed stress on the target approach, reviving with it, the disturbing question of coercion, incentives and disincentives. The official approach to FP remains dominantly a camp approach, and is a far cry from the enlightened stand taken by India at the Bucharest Population Conference where Development was described as the best contraceptive.

From the First to the Fourth Plans, the allocation for FP steadily increased while the health sector allocation remained almost stagnant. The trend changed for the first time in the Fifth Plan with its focus on minimum needs and with the recognition in world population control circles that the high rate of infant mortality must be tackled before any impact on birth rate can be made.



During the decades from 1951 onwards, India, like other developing countries, has also received liberal foreign aid for FP from governments, UN agencies, and private agencies. These funds have fluctuated between 8 per cent to 23 per cent of the public expenditure on FP during the 70s. The quantum of aid appears to have been directly related to the stress on target achievement.

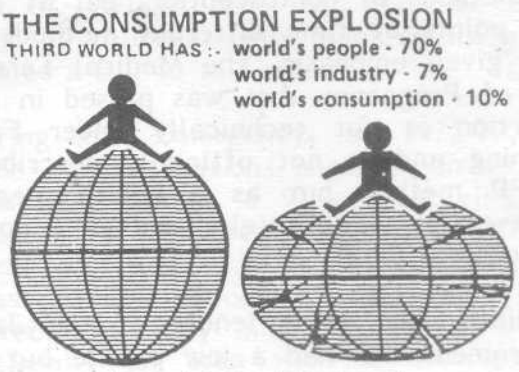
The FP programme, as it exists today, aims at containing population growth not overtly through coercion but by taking advantage of the poorest sections of society. The poor, especially in the rural areas, are enticed into accepting sterilisation because the "compensation" attached to it is much more than what an entire household could have earned in one month. The poor fall prey to this carrot, especially during the lean December-March period when no work is available and their savings are ebbing and survival is precarious. This is also the period when FP personnel mount pressure to achieve their own allotted targets which have to be completed by the end of March. In Maharashtra, for example, in one year i.e. 1982-83, 53 per cent of sterilisation and 69% of IUD insertions were done in the December-March period.

"This bracketing of the poor and under privileged sections of society for fulfilment of the population control programme, along with the rationale that the educated and middle classes generally take care of their own fertility because they are status-conscious, amounts to serving the Malthusian (or neo-Malthusian) end of assuring the survival of the fittest."

Over the years the burden of FP acceptance has also shifted increasingly on the shoulders of women (see Section 2 on *Women as Targets).*

Adapted and condensed from -

Population, Health and Development, (Ravi Duggal, FRCH, 1985, under publication.)



Each child born in industrialised world consumes 20 to 40 times as much as child born in developing world. So small population increase in rich world puts 8 times as much pressure on world resources as large population increase in poor world.

New Internationalist, Sept. 79.

Also see, *The Price of Assistance: FP Programme in India* by Ramala Bauxamusa, Socialist Health Review, March 1985. In this detailed article based on her PhD thesis, the author shows how the evolution of the FP programme has been influenced by foreign aid. Not only FP policy but the methods of contraception promoted were determined by the aid received directly from donor agencies or through international bodies like the UN agencies. She writes: "In the 60s the increased economic crisis, the shortage of food, the growth of liberation movements brought First World governments to focus their attention on the importance of population control to avoid major social and political upheavals. Development aid was increasingly linked to population programmes and there was an increased aid flow from governments of the First World to the governments of the Third World.

"In India, the programmes of voluntary organisations served as important pointers as to what direction the government policy would take. It was also their advice and donation which compelled the government to change prescribed contraceptives during each Plan period. It gave or promoted what it received, and tested what it was asked to, as the economic crisis made them helpless and forced them to accept assistance which led often to indebtedness."

The "population problem" dissected

The entire rationale of family planning is geared towards persuading the poor to accept birth control. If the small family is indeed a happy family, why do the poor reject a programme which is ostensibly for "their own good"? Here are some rational answers to relevant questions.

Why do the poor have so many children?

For millions of people in developing countries where there is no unemployment pay, no sickness benefit and no old-age pension, children are their only security in periods of unemployment, illness and old age. Children are not an economic liability but an economic asset and can be net contributors to family income by the age of seven or eight. They perform essential household tasks like fetching firewood and water, tending animals, cooking, cleaning and looking after siblings, thereby freeing adults in the family to take on wage labour outside. They are thus essential for the survival of the poor family. Because infant mortality is so high in this socio-economic section, and so many babies die before the age of five, it is important for these couples to have more babies to ensure that at least a few survive to adulthood. Rafael Salas,

Chief of the UN Fund for Population Activities (UNFPA) has acknowledged: "Large families in the Third World are an intelligent response to people's economic circumstances."[1]

Would the poor benefit if they could be persuaded to have fewer babies?

The small family norm is a middle class concept directly arising from the cost of raising children. For the poor, whose living standards are already so low, an extra mouth to feed is not seen as a calamity, especially since the economic value of the child will soon be much greater than the cost of raising it. The poor will not benefit from having fewer babies unless the state and society are able to fulfil those economic roles now performed by children. Also, only when wages earned by adults are high enough to ensure the fulfilment of a family's minimum needs, will the cost of raising children be seen as a negative factor by the parents.

Besides, if today a couple agree to have only two or three children in "national" interest, as they are constantly urged to do, that will not necessarily mean a better life for them and their small family. As D. Banerji of the Centre for Social Medicine, Jawaharlal Nehru University puts it:[2]

"A little understanding of the social, cultural and economic profile of our country is needed to realise that to a majority of our people, life is a continuous grim struggle for existence ... If they agree to have only three children, who is going to guarantee that these children would not die and they would lead a healthy life? Who is to guarantee that they will get a better deal from society and their living conditions will be any better than now?"

Umpteen studies and experiences from other countries have shown that when living conditions improve, birth rates fall. People whose basic needs are met do not require persuasion to adopt a norm which will then be in their self interest.

Do the poor then have no felt need for contraception?

People do want to stop having babies when they have completed *their* desired family size. The FP programme, however, does not always succeed in meeting this felt need. People may want a spacing method even if they want no more babies because they want to make sure of the survival of existing children. They may not, therefore, accept the terminal method urged on them. If a single method is promoted aggressively because it is cost efficient, those who find it unacceptable for cultural or medical reasons are rarely offered viable alternatives. Besides, the entire health structure, through which FP is dispensed, is so unsympathetic to poor people's needs, their feelings, fears and anxieties, that they don't get the supportive care they need while using different methods which means they often reject contraception even though they want it.

Would the poor practice birth control if contraceptives were made freely available through mass distribution?

The experience of both Bangladesh and India has shown that a mass distribution programme tends to adopt a method oriented rather than a client oriented strategy and therefore fails to meet individual needs. Poor health-care infrastructure ensures that even those who accept a method drop out soon. In the Bangladesh experiment with the Pill, it was assumed that once the target area was flooded with the oral contraceptive, people would be induced to try it, satisfied users would influence others and so on. "While this may be true with commodities providing tangible immediate benefits and no side effects like soap, tea or soft drinks, the opposite occurred with oral contraceptives which have side effects and no immediate tangible benefits."[3]

What does "planning" mean in the context of poverty?

Deciding when to have the first baby, visualising the desired family size, and the appropriate time interval between births -

all this means "planning" as the very phrase family planning implies. Such an approach to life appears to have no place in the minds of those who struggle for survival. The UNICEF sums it up well:

"Whether or not a husband and wife will decide to plan the number and spacing of their children is closely related to their own sense of control over their lives and circumstances. Malnutrition, illiteracy, ill-health and oppression can leave people with so little sense of control over their own lives and circumstances that they are alienated from the very idea of 'planning'. To expect adults who cannot control or plan any other major aspect of their lives to suddenly start planning just their families is to misunderstand what powerlessness means. If on the other hand progress in health and education, in political participation and economic activity has helped to create a greater sense of mastery over one's own destiny - a sense that decisions can be taken, circumstances changed and lives improved then the idea of family spacing is likely to be welcomed as another opportunity to take more control over one's life."[4]

Why are the rich so concerned over the birth rates of the poor? How does this concern affect the directions of FP Policy?

The developed nations are anxious that Third World population growth should be curbed. In individual developing countries the rich elite minority are keen that the poor should accept birth-control. In India, for example, people like J.R.D.Tata have urged more investment in FP programme while big business houses like Godrej etc., have been introducing incentives and disincentives to persuade employees to accept the small family norm. Why this interest in the birth rate of the poor?

At the heart of the population control ideology is the theory of Malthus who in his *Essay on the Principle of Population* (1926) said that population grows at a much faster rate than food supply. The Malthusian theory offers a convenient explanation for poverty and hunger which actually result *from social injustice* but which are attributed to population growth. "Where unemployment, misery and famine spread and deepen, Malthus' theories offer a rescue."[5] When the exploited grow in numbers, then social upheaval, even revolution may be precipitated. The best way for the rich to maintain the status-quo is to promote the ideology that population control rather than social and economic justice will avert "disaster". Active propagation of this ideology was stepped up by the rich nations around the time when China went 'Communist' in 1949. It shocked the imperialist world which decided it must "Save India at least."[6] Since then, with the propagation of the population bogey and the theory that the poor are poor because they are too many, what is being effectively masked is that it is the rich minority which consumes the greater share of the earth's resources and that their concern over population growth is really because they want to maintain their own privileged position. This is true at the international level as well as within individual countries where economic power is wielded by a small minority. Hence, the tying of international aid with population control schemes and the phenomenon of Third World industrialists pressing for aggressive FP programmes.

Because of this pressure to achieve a drastic fall in birth rate without equally strenuous efforts towards raising living standards through equitable distribution of wealth, the elements of coercion, disincentives, monetary rewards and unleashing of unsafe contraceptives have characterised Third World FP programmes including the Indian programme. The Lyndon Johnson formula that five dollars spent on FP is equal to 100 dollars invested in development has meant in India a coercive vasectomy campaign, a mass IUD drive unsupported by adequate health care, unsafe laparoscopy camps, a proposed mass Pill distribution scheme despite the dangers inherent in such an approach and the imminent introduction of the hormonal injectable and implant neither of which has been approved for contraceptive use in the West. Arguments regarding the safety of hormonal contraception in mass drives are always countered with the statement that the benefits outweigh

the risks. The question which remains unanswered by population controllers is: Whose benefit? Whose risk?

Won't FP acceptance result in a higher status of women?

It is often argued that birth-control will result in raising the status of women, but the Report of the Committee on the Status of Women[7] had rejected such a simplistic causal relationship. The report referred to several studies which have shown that improved status of women, results from a rise in age of marriage, education, employment, better living conditions and greater general awareness and that all these together *have an impact on adoption of FP methods.* The mere adoption of birth control does not necessarily mean better status although better status will make it possible for women to take decisions on birth control. The lack of control which women have over their reproductive role within the patriarchal family structure is often used as an argument by population controllers to promote methods like the injectable because these can be used by women without the knowledge of their husbands and mothers-in-law. Even if women are so desperate as to choose unsafe contraception as preferable to repeated pregnancy, to justify promotion of such methods as being specially responsive to women's situation is to perpetuate the sexist status-quo and in no way enhances the real status of women or their right to make informed and free choices regarding their bodies and their lives.

How does the stress on FP affect other aspects of health care?

Since health services have been geared to give top priority to the achievements of FP targets, all the activities of health personnel are subordinated to the fulfilment of their FP quotas. Their entire career prospects rest on FP performance and inevitably the health care needs of people take a back seat. In Madhya Pradesh in 1984, a government doctors' association threatened an agitation if doctors suspended for "poor FP performances" were not reinstated. The report said that a *dentist* (!) of Chhatarpur district hospital had been suspended for negligence in his duty to implement the FP programme! (Indian Express, March 3, 1984).

Another side to this picture is the mutual perceptions of people and the health personnel, and the inherent inability of the health system to meet either health needs or felt contraception needs. Monica Das Gupta has described this in her study of Rampura village near New Delhi where the PHC is relatively well equipped and well-staffed because of its closeness to the Capital.[8] Yet, the staff are not able to cope with the volume of patients. The PHC is always short of drugs and thus the doctor and medical system don't inspire confidence. Even basic after-care of women who have been sterilised or have IUDs inserted is not done. The clinic workers feel superior to the villagers whom they see as illiterate and ignorant and as persons who need to be harangued to do anything rational. The patients on the other hand need recognition and fulfilment of their individual needs. The doctors' approach to FP is to catch women as they come to the clinic for treatment of a health problem and try to persuade them to accept FP. They have no time to sit and explain the mechanics of different methods. "Faced by a team of people constantly hectoring them, the villagers have become defensive in their attitude, feeling that their own values and needs are not understood, that the gap is unbridgeable - that somehow if only they can get their medicine and escape, they will be happy."

References:

1. *New Internationalist*, Sept. 1979
2. D. Banerji in *Population in India's Development* (Ashis Bose *et al* eds, 1974)
3. *Studies in FP*, Vol.II, No.6, June 1980
4. *State of World's Children*, UNICEF, 1984
5. Political Ideology of Population Control, (Lars) Bondestam, in *Poverty and Population Control*, 1980
6. Ramala Buxamusa in *Socialist Health Review*, March 1985
7. *Towards Equality* (1974)
8. Monica Das Gupta in *Feasibility of Fertility Planning* (Epstein and Jackson eds) 1977