CHAPTER - 5

POPULATION PROGRAMME

5.1 MEANS OF POPULATION POLICY

According to Berelson, "Population policy aims at optimizing 'quality of life' by controlling 'quantity of life' and factors such as population growth and congestion."[1] The 'means' of population policy are to be determined by the government and the people. Berelson has categorised the means under five headings.

The first heading 'Information and Education' pertains to population education in schools and information on fertility control and its benefits, improved health practices, job opportunities and local propaganda.

The second heading 'Voluntary Programmes' pertains to national family planning programmes and legalised abortion, governmental health programmes, resettlement projects such as inexpensive travel arrangements for refugees in order to encourage migration or differential job markets in order to attract labour.

The third heading 'Social Institutions' pertains to extension of education, liberation of women, female partici-pation in labour force, industrialisation, extended family, kinship network, housing, standards and norms on child labour.

The fourth heading 'Incentives/Disincentives' pertains to social welfare measures such as social security

provisions, family and children allowances, maternity benefits, housing preferences, tax provisions, monetary payments for contraception and 'Push and Pull' schemes for rural to urban migration and land incentives.

The fifth heaving 'Coercion' pertains to laws on marriage age and marital status, anti-contraception and abortion laws and decrees, compulsory fertility control measures, such as fertility inhibitors in water or salt, prohibition of the fourth child, government health requirements and standards.

From these categories it is obvious that population policy is a policy of means, not of ends ... and the key issues are demographic, economic, political, ethical, medical and ecological as stated by Berelson.[2]

5.2 INDIA'S NATIONAL POLICY

The Government of India, realising the need of population control in the developmental efforts, decided to set up the administrative machinery necessary to promote family planning from the beginning of the First Five Year Plan. In the beginning, the work regarding family planning was twofold. One part consisted of compilation of information regarding the attitudes of people towards the problem of population control and the methods of contraception in diverse socio-economic groups in several regions of the country. The other part comprised the organisational work to facilitate and promote the family planning practice

in the rural and urban areas of the country. The Government of India, in 1952, was the first in the world to adopt family planning as a national policy.

The analysis of population trends during last three decades has brought to light two important problems : rapid growth of population with the prospect of acceleration and the increasing tendency of the population to concentrate in and around a few metropolitan areas. The first one would have the effect of multiplying the efforts to develop the economy and the second one would bring pressure on the already strained civic facilities in the urban areas. The central and the state governments have adopted certain policies and programmes with a view to check these tendencies. These are reviewed below :

The need to propagate family planning among the masses was recognised long ago by the political leaders and social workers. There x was however no state population policy untill after India gained Independence.

The Health Panel of the Planning Commission in 1951 strongly recommended that family planning should be supported officially in order to aid the national economy by reducing the birth rate concurrently with death rate. The facts of 1951 census helped to intensify the need for further action. In 1953, the Planning Commission recommended that the programme of Family limitation in India should be to -

(i) Obtain an accurate picture of factors which

contribute to rapid increase of population;

(ii) gain fuller understanding of human fertility and the means of regulating it;

(iii) devise ways of educating the public and

(iv) make family planning advice and service an integral part of the services in hospitals and health centres.

Thus, early in the first five year plan the promotion of family planning was firmly established as a public policy.

Dr. Karan Singh in the capacity of Minister of Health and Family Planning, very aptly brought out the dire need of population control when he said, " Our population growth is so formidable and the time factor so pressing that we cannot wait for education and economic development to bring about a drop in fertility. Population control is the only way to get out of this vicious circle of increasing numbers, slow economic growth and poverty."[3]

5.3 ADMINISTRATIVE SET-UP IN MAHARASHTRA

In Maharashtra the first birth control clinic was established in 1925 in Bombay city. The Family Planning Association of India was established in Bombay in 1949. The first family planning centre was established in the same year. The state government undertook family planning as its official programme from 14th November, 1957. A Special Bureau of Family Planning has been established in the Directorate of Public Health at Poona with a full-time

officer-in-charge of family planning matters. A number of group leaders also have been appointed. Each group leader is required to cover 4 to 5 districts to address meetings, to disseminate information, to encourage peoples' participation and to mobilise public opinion in favour of family planning.

One Central Family Planning Field Unit has been established by the Government of India for undertaking special studies in regard to communication, research, acceptability of various contracetives, etc.

A divisional family planning section has been opened at Nagpur which supervises and guides programmes in Nagpur and Aurangabad divisions. The Bureau is responsible for the work in Bombay and Pune divisions. The programme is being implemented through the existing district health organisation which from 1st May, 1962 has been taken over by the newly formed Zilla Parishads. The Public Health Officer of the Zilla Parishad is in overall supervisory charge of family planning clinics.

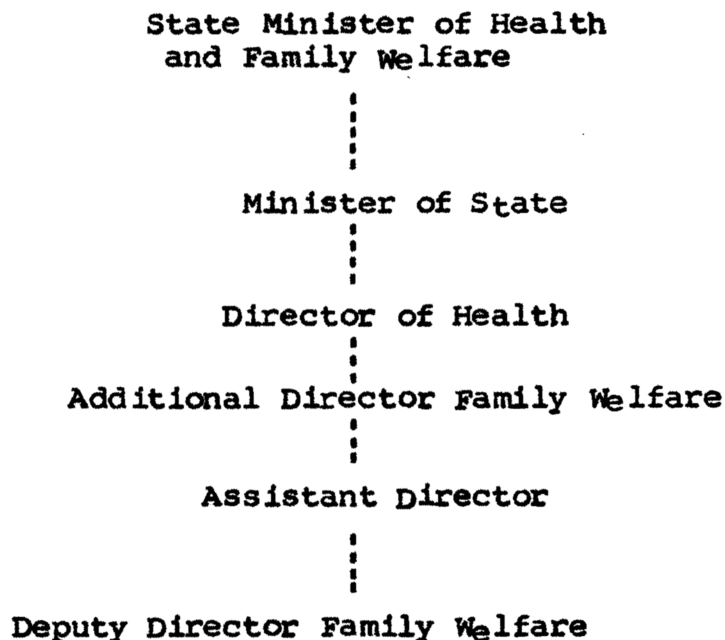
Although the state lays emphasis on sterilization all available methods of contraception are explained by clinic workers and the choice is entirely left to the individuals. Contraceptives are distributed not only through family planning centres but also through primary health centres, their sub-centres, dispensaries and hospitals. In rural areas, all contraceptives are distributed free of cost.

In urban areas, they are given free to those with income of less than Rs.300 per month.

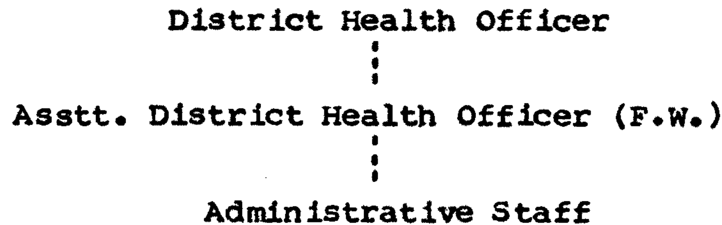
The State Government has adopted the propagation of family planning as a matter of public policy. It has built up an administrative structure to implement various programmes directed towards reducing birth rate.

The following chart express the administrative set-up in Maharashtra for implementation of the family welfare programmes.[4]

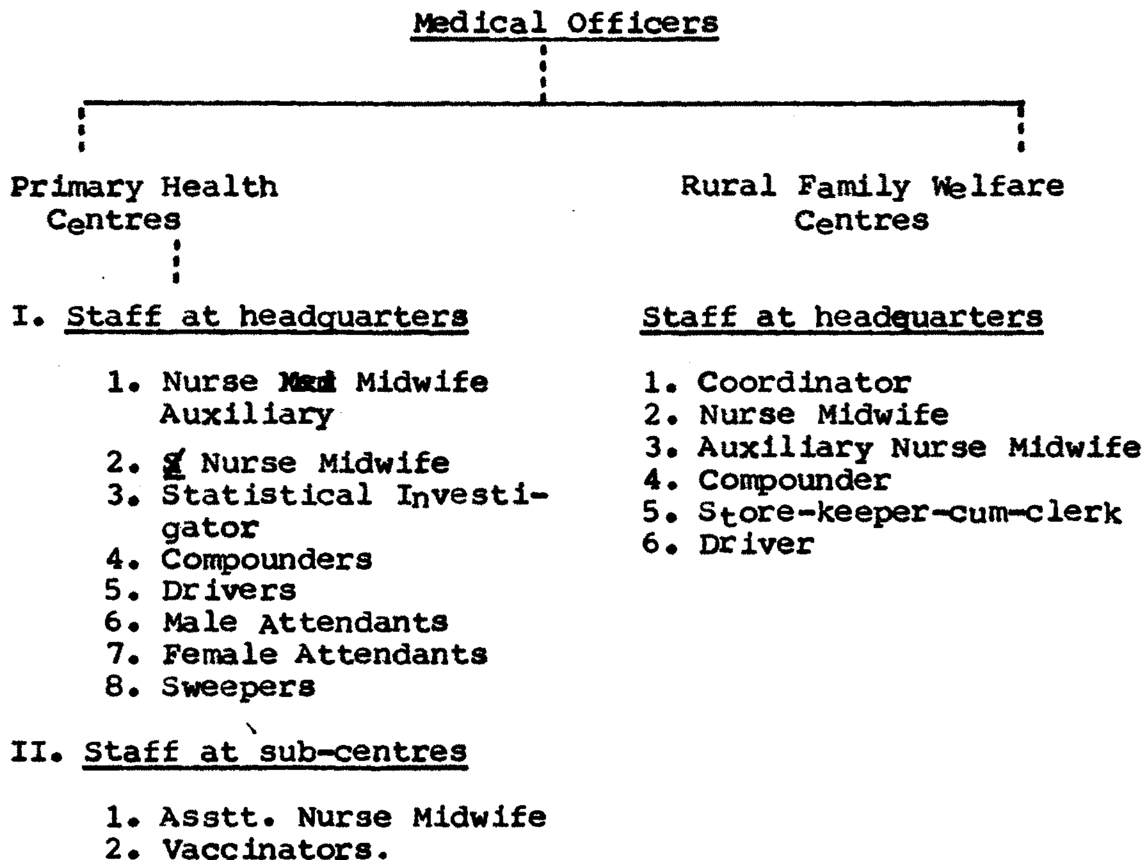
(A) TOP LEVEL HIERARCHY



(B) DISTRICT LEVEL HIERARCHY



(C) TALUKA LEVEL SET-UP



5.4 ROLE OF PRIMARY HEALTH CENTRES

The idea behind establishing Rural Health Centres was to render effective basic health service for group of villages. The Health Survey and Development Committee, or the Bhore Committee in its report in 1946 had made a number

of concrete suggestions when the idea of primary health centres was spelt out in clear terms. The Committee advocated a small but strong unit at the peripheral level for rural areas where people were almost totally deprived of much needed health services.[5]

FUNCTIONS

(1) To make effective measures to control communicable diseases; to arrange for primary and secondary vaccination to take all possible precautions against cholera and typhoid, provide immunisation against diphtheria, whooping cough and tetanus and to supervise the malaria eradication programme.

(2) To render school health service, periodical medical check-up and its follow-up action, supervision and guidance to school feeding programmes, advice on sanitary conditions in and around the school premises, and the arousing of awareness amongst teachers, parents and guardians regarding these matters.

(3) To varry out periodical disinfection of drinking water sources.

(4) To advice and guide the village administration on rural sanitation and hygeiene, sanitary type of latrines, composting of village refuse, sanitary disposal of night-soil, soakage pit, smokeless stoves and making adequate sanitary arrangements for fairs, festivals and bazars.

(5) Maintenance of accurate vital statistics - particularly of births and deaths, causation of deaths, population records of each village by age and sex and morbidity records,etc.

(6) To propagate family planning and other services at the centre, sub-centres and through home visits.

(7) To provide basic laboratory services.

(8) To offer institutional services during delivery to the extent possible and provide mid-wifery services at home through trained staff such as Auxiliary Nurse, Midwives (ANMs), registration of pregnant women to facilitate medical check-up to provide pre-natal, natal and post-natal services at the main centre, sub-centres and through home visits and refer complicated and difficult cases to main hospital, care of infant and pre-school children, assistance and advice regarding nutrition.

(9) To provide curative service through out - patients department and make available indoor service whenever possible. To examine patients periodically at sub-centres and provide home service. Visit to sub-centres should be pre-planned, announced in advance and programmes adhered to.

5.5 MEDICAL FACILITIES IN PATAN TALUKA

The primary health centres started at Patan in 1958 and at Dhebewadi in 1960 have played key role in making the people of the region to understand the importance of family planning and family welfare programmes. Besides, these two

primary centres 10 new public health centres are also started in 1984-85. They are at Marali, Morgiri, Tarle, Chafal, Murud, Malharpeth, Keral, Koyananagar, Kalgaon and Salve. Likewise, new sub-centres are started in Patan taluka. These centres mobilise the public opinion and activate people to follow such methods of life by which family planning programme can become instrumental in controlling population growth.

A bird's eye-view of the medical facilities available in Patan taluka over 35 years from 1950 to 1985 can be had from Table 5.1.

Table 5.1

Medical facilities in Patan Taluka since 1950

Year	No.of Hospitals	No.of Dispensaries	No.of maternity homes	No.of primary health centres	No.of public health centres	No.of doctors	No.of vaidyas	No.of nurses
1950	-	3	-	-	-	3	-	1
1960	1	3	-	2	-	8	-	11
1970	1	3	-	2	-	6	4	15
1980	1	3	1	2	1	15	4	33
1984-85	1	3	1	12	2	25	-	53

Source : i) District Census Handbooks,
ii) Socio-Economic Review Reports,
iii) Reports of District Health Office, Zilla Parishad, Satara.

In 1950 there were 3 dispensaries and only 3 private doctors in the region. The number of dispensaries remained unchanged since then but the number of Primary Health Centres hiked from 2 in 1960 to 12 by 1984-85. The number of doctors and nurses increased phenomenally during the 35 year period. Doctors increased from 3 in 1950 to 25 in 1984-85 and nurses from 1 to 53 correspondingly. The outcome of the extension of medical services was inturn of more patients for indoor and outdoor treatment. Table 5.2 gives an idea of this.

Table 5.2

Treatment to patients in Primary Health Centres in Patan taluka.

Year	No. of beds	Indoor patients	Outdoor patients
1950	4	13	21,350
1955	4	17	18,295
1960	31	945	26,435
1970	38	567	27,958
1980	56	6,000	41,000

Source : i) District Census Handbooks,
ii) Socio-Economic Review Reports,
iii) Record of Panchayat Samiti

There were 4 beds which were available in 1950 in different dispensaries, and only 13 indoor patients were treated and 21,350 outdoor patients sought the medicine.

In 1960, 31 beds were available and 945 indoor patients sought treatment through dispensaries and 26,435 outdoor patients were treated. In 1980, 56 beds were available and 6,000 indoor and 41,000 outdoor patients were treated. It indicates that the medical facilities were available to the people and the number of doctors, nurses and beds available where patients can be admitted for close-inspection and treatment, also increased.

5.6 FAMILY WELFARE PROGRAMME IN PATAN TALUKA

The population of Patan taluka increased from 1,46,691 in 1951 to 2,33,265 in 1981. Additions to population due to in-migration being negligible, it is quite likely that the increasing population growth rate can be the result of the rapidly declining death rate on the one hand and the stable or slowly declining birth rate on the other. The implications of a rapid population growth for the social and economic development of the region are obvious. For the rapid development of the taluka a reduction in birth and population growth rate is highly desirable. In this context the success of the family planning movement is of crucial importance. Hence it is necessary to examine the structure and evolution of the family planning programme in the taluka, trend in family planning adoption, the socio-economic characteristics of the adopters, etc. Such an analysis will be of some help in understanding where the taluka stand in its attempt to tackle the problem of unregulated population growth.

The performance of the family planning programme depends to a certain extent on how its activities are organised and the nature of the strategy followed in order to popularise the use of contraceptives among couples belonging to the different socio-economic strata of society. For the adoption of family planning methods it is necessary that the couples should have sufficient knowledge of contraceptive methods and secondly there must be a strong desire to have a small family.

5.6.1 STERILISATIONS AND IUDs

Government of India has started to pay attention to family planning programme in 1960. In 1960 to 1970 decade this programme spread even in remote corners of the country. Patan was not an exception. As doctors were made available, dispensaries and Primary Health Centres were also opened, even the mobile hospitals moved in the remote regions of Satara, many kinds of family welfare programmes were started. Since the inception of family welfare programme till 1970, 2548 vasceetomy and 437 tubectomy operations took place. In 1975 the number of vasectomy and tubectomy operations increased respectively to 4,367 and 3,277. In addition, 1671 women accepted intra-uterine-devices (IUD). Between 1975-80, 6,438 vasectomy and 8,012 tubectomy operations were performed, 59 people per thousand under went such kinds of operations in the region and 1,720 women adopted intra-uterine-devices (IUD). During 1980-85 quinquennium, 8,094 vasectomy

and 15,270 tubectomy operations were performed and 7,434 women adopted intra-uterine-devices (IUD). Consequently, 92.5 people per thousand followed the family planning programme. A cumulative picture of the adoption activity is presented in Table 5.3.

Table 5.3

Sterilisation and IUD Performance in Patan taluka (1970-85)

Year	Vasectomy	Tube-ctomy	Achievement per 1000 population	Total sterilisations	Intra-Uterine devices	Achievement per 1000 population
1970	2,548	437	81.1	2,985	N. A.	N. A.
1975	4,367	3,277	N.A.	7,644	1,671	N. A.
1980	6,438	8,012	59.0	14,450	1,720	N. A.
1985	8,094	15,270	92.5	23,364	7,434	29.4

N.A. - Not available

Source : Health Office, Zilla Parishad, Satara.

This performance of Patan taluka can be gauged by comparing it with the rest of the talukas in Satara district by using statistical details in Table 5.4.

Sterilisation of the sexes and insertion of IUDs in the women are the two most important programmes of family welfare which are under consideration in Table 5.4. The figures indicate a cumulative total of the work done since

Table 5.4

Talukawise sterilisation and IUD performance since inception of family welfare programme till 1985 in Satara district.

Taluka	Year	Sterilisation work done since inception (1970)			IUD insertion since inception
		Vasectomy	Tubectomy	Total	
1. Satara	Till March 1982	10,534	17,747	28,281	2,471
	Till March 1985	12,850	25,174	38,024	9,823
2. Koregaon	Till March 1982	7,565	9,917	17,482	1,603
	Till March 1985	9,247	13,756	23,003	6,495
3. Khatav	Till March 1982	5,817	10,164	15,981	1,277
	Till March 1985	7,516	14,856	22,452	6,397
4. Man	Till March 1982	3,850	7,550	11,400	647
	Till March 1985	6,109	11,145	17,254	4,002
5. Phaltan	Till March 1982	6,421	16,514	22,935	726
	Till March 1985	7,516	22,860	30,376	5,248
6. Khandala	Till March 1982	3,039	5,681	8,720	542
	Till March 1985	3,457	8,300	11,757	2,675
7. Wai	Till March 1982	4,354	10,164	14,518	851
	Till March 1985	4,813	14,088	18,901	4,119

Contd...

Table 5.4 Contd...

8. Mahabaleshwar	Till March 1982	3,569	1,158	7,727	452
	Till March 1985	1,407	3,037	4,444	763
9. Jaoli	Till March 1982	1,141	1,945	3,086	120
	Till March 1985	4,139	5,731	9,870	3,451
10. Karad	Till March 1982	12,474	22,016	34,490	2,334
	Till March 1985	14,533	32,424	46,957	11,109
11. Patan	Till March 1982	6,797	10,157	16,954	1,916
	Till March 1985	8,094	15,270	23,364	7,434
Satara District	Till March 1982	65,561	1,16,013	1,81,574	13,036
	Till March 1985	79,730	1,66,592	2,46,322	62,179

Source : Health Office, Zilla Parishad, Satara.

1970, the year of active introduction of the programmes as per national population policy.

During 1970-85, sterilisation of women (tubetomy) got a pre-eminence over that of men (vasectomy) since 1,16,013 tubectomies and 65,561 vasectomies were performed. This is in consonance with the all-India trend. It implies that eventhough vasectomy can be performed at less cost and in less time, the male population desires to give

priority to the sterilisation of the housewife. No taluka of Satara district was an exception to this attitude.

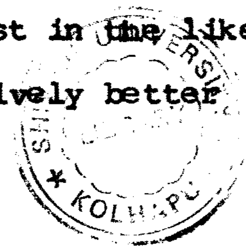
Performance of all the talukas in implementing the family welfare programme as manifest in Table 5.4 can be well compared by ranking them on the strength of their achievements by 1985. It is done in Table 5.5.

Table 5.5

Ranking of the talukas of Satara district based on their performance in family welfare programme.

Taluka	Rank in implementing the programme			
	Total sterilisations	Vasectomy	Tubectomy	IUDs
1. Satara	2	2	2	2
2. Koregaon	5	3	7	4
3. Khatav	6	5	5	5
4. Man	8	6	8	8
5. Phaltan	3	5	3	6
6. Khandala	9	9	9	10
7. Wai	7	7	6	7
8. Mahabaleshwar	11	10	11	11
9. Jaoli	10	8	10	9
10. Karad	1	1	1	1
11. Patan	4	4	4	3

On perusal of Table 5.5, it can be observed that Karad taluka topped the list of all the talukas in all the programmes and Satara taluka was the second best in the like manner. Patan taluka, indeed, put out a relatively better



performance by assuming fourth place in sterilisation total as also independently in vasectomies and tubectomies. In IUDs programme, it had the third rank. This much work at the taluka level can be presumed to have caused a good impact on the birth rate of taluka population. Eventhough, statistics regarding taluka's birth and death rates was not available to make a decisive observation, the details of achievements in implementing family welfare programmes at least indicate the possibility of a favourable impact on the birth rate causing it to fall and leading to the observed declining percentage of population increase.

5.6.2 PROPAGANDA

In order to make people family planning minded it is necessary not only to inform them about methods, facilities and incentives but also to instil into them the merits of birth control. Family planning programme needs to be publicied in all possible ways to achieve this. There are a number of agencies through which publicity can be made; they are newspapers and magazines, pamphlets and book-lets, posters, slogans, radio and television, cinema, slides and feature films and personal contact. These fall under three main heads :

1. The mass media;
2. Public meetings and special publicity at fairs and gatherings and
3. Individual contact through workers and by word-of-month.

The nature of publicity and the emphasis will vary with the degree of awareness, literacy and available means. In India literacy is poor, hence publicity is largely through wall hoardings, feature films and by personal contact.

Public meetings and gatherings provide an excellent opportunity to publicise family planning. Such gatherings can be arranged or they may occur themselves on occasions such as bathing days, cattle fairs, exhibitions and festivals, movies, cinema, slides, lectures, demonstrations, theatrical performances, puppet shows are most effective on such occasions. Lately Family Planning camps have been organised in India in which efforts by all agencies are concentrated. Another useful form of approach is through mobile teams, i.e., gaon sabhas, village panchayats, village level workers of the planning department and of the revenue department, dais, village midwives, ayurvedic and unani physicians, women's organisations, social workers, civil servants and religious bodies.

Family planning has a dual aspect. The first is the wider one which involves the state. If it is an under-populated or a sparsely populated one, the national aspect is not so prominent. In such a country family planning would have a purely individual bias. But in an underdeveloped country like India, the state too has a responsibility because all national progress depends on population control.

Unless men and women are psychologically prepared and sufficiently motivated the use of a drastic birth control method is likely to do them more harm than good. Conviction and proper motivation are essential before adoption of one of the irreversible methods of birth control. The various methods are as follows :

1. The Rhythm Method
2. Coitus Interruptus
3. Chemical Contraceptives
4. Diaphragms and Cervical Caps
5. The Condom
6. The Intra-Uterine Device (IUD)
7. The Pill
8. Sterilisation
9. Abortion

The impact of population growth on socio-economic progress has spurred on various governments and private organisations to launch family planning programme. In India, the government has come into the family planning field in a big way.

India is a developing country. It has low literacy rate. What is said about India is also applicable to Satara district and also Patan taluka. The literacy rate in Patan was 28.54 percent in 1961, 28.69 percent in 1971, and 37.33 percent in 1981. This indicates that as a large population is illiterate it brings many difficulties to the population control agencies. As major portion of the population cannot read and write the mass media such as ear-to-ear propaganda,

use of radios, use of films, special camping programmes in different regional annual fairs such as Laxmidevi fair in Patan, Yedoba fair at Yerad, Ram Mandir fair at Chafal, Bahuleshwar fair at Bahule, Naikba fair at Janugadewadi were also seen and used as venues to make people aware about the birth control. Besides, this shibirs were also held at different places to propagate the family planning programmes in the rural masses. Such family planning rallies or shibirs were held at Malharpeth, Dhebewadi, Tarale, Chafal, Koyananagar, Morgiri, Patan from year to year so that people were made aware about the programmes and the desirous people who felt the need of family planning and birth control measures could avail of the expert consultation. In such shibirs of operations for birth control were also performed. Moreover, to attract the people to undergo such operations, different incentives in cash and kinds were given. The government of Maharashtra gave some token monetary help to the people who underwent different kinds of birth control operations. For the persons who underwent vasectomy operation were given Rs.99.50 before 1977; incentive amount was raised to Rs.203.50 in 1981 and Rs.253.50 in 1983. Persons who were operated for tubectomy received Rs.119.50 before 1977, Rs.129.50 in 1981, and Rs.189.50 in 1983. This monetary incentive, in fact, attracted many poor people in their dire economic need and the national programme was also implemented by the consent of the people. Not only this, but on special

occasions different kinds of family utility goods such as clothes for winter season and utensils were also distributed to the persons voluntarily undergoing sterilisation operation.

Various government servants also worked for propagating the family planning and birth control programmes. Basically primary teachers in the area were asked to bring people to get themselves operated for birth control. Taluka Panchayat Samiti servants who worked in the malaria eradication programme were also asked to bring the intending persons for operations. Even the village level servants such as Gramsevak and Talathis also worked for the propagation.

The National Service Scheme Unit of the local college at Patan named Balasaheb Desai College arranged some special NSS Camps at villages Mhavsi, Addev, Yeradwadi, Bibvi, Katvadi, Dhareshwar, (Diwasi) and Helwak and propagated in favour of family welfare programmes.

5.6.3 TECHNICIANS AND EXPERTS

A family planning programme should be necessarily more comprehensive than merely aiming at birth control. Unless the facilities like child care, medical advice and treatment and so forth are given, it will not be able to attract the sort of persons for whom it is meant. In the programme persuasion is necessary. If extra facilities are given people are attracted to the programme. Prof. Jae Mo Yang says, "In order for family planning programmes to become permanently established it is important that the government

or association publicise a purpose which is more comprehensive than just family planning for economic reasons. The additional goals of respect for human life, prevention of induced abortions, protection of maternal health, improvement of family life and welfare, promotion of responsible parenthood should all be emphasised."[6]

If local health services are well organised they can serve as an effective medium for carrying through the programme. Quite often doctors have been more effective than administrators in furthering the family planning programme. Doctors have the necessary technical knowledge. They can exercise quality control on the cases, and ensure that people of the right age group are approached. People have more confidence in doctors than in laymen.

In Patan taluka this necessity has been understood very well. In 1960, there were 8 doctors, 6 in 1970, 15 in 1980 and 25 in March 1985 working in the taluka. The number of nurses working with them also increased from 11 in 1960 to 53 in 1985. The effect was that in Patan taluka there was one doctor for average 48,897 people in 1951; it dropped to 15,551 in 1981 when the number of doctors was 15. It must have fallen further with the enhancement of the number of doctors to 25 in 1985. Of course, this ratio can be considered still quite high considering the medical needs of the population of a much backward taluka.

5.7 RESPONSE OF PEOPLE

The Indian family planning programme is carried out purely on a voluntary basis which certainly fits in with the democratic character of the general policy of the country.

Population programme depends on the nature of the people for whom the programme is intended their standard of education and receptivity to new ideas and methods, religious factors, etc. In Japan, for example, public co-operation was rapidly obtainable for the family planning programme. The high degree of literacy enabled women's journals, newspapers, and weekly magazines to diffuse ideas about birth control. So much so that in 1965 the Central Government of Japan stopped having any budget for family planning. On the other hand, in India where literacy is low and consequently newspaper approach poor, public cooperation is difficult to get and most of the efforts has to be that of the government alone.

The importance of education in the successful implementation of a family planning programme cannot be overemphasised. Public interest varies with the educational level.

Another factor which can influence a family planning programme is religion. Although religion does not especially prohibit family planning, it may foster an attitude of opposition towards it. It can create a feeling that family limitation is something contrary to Nature.

In Indian villages this superstition is so marked that some persons even think that a vasectomy operation leads to loss of manhood and impotency.

A family planning programme also needs the support of politicians, intellectuals, technicians and experts and, where religion is a compelling force, of the religious hierarchy.

Response of the people of Patan taluka can be realised on the strength of official statistics regarding sterilisation of sexes and insertion of IUDs already presented in Tables 5.3 and 5.4 and the observations made in that context. Before going to that point one doubt regarding the authenticity of official data should be cleared. Very often it is said that official information about family welfare activities is normally target oriented and hence, more often than not, inflated one. Moreover, certain untoward incidents also are often reported. There is some truth in these sayings and incidents. But these facts of experience should not vitiate the entire effort. At the most, one can discount the figures to the extent considered reasonable. With this approach in view, the significance of the statistics is noted.

As noted earlier, Patan taluka ranked fourth in Satara district in sterilisation programme and third in IUD insertions. This itself can be accepted as a measurement of popular response to the programme. Patan taluka is found

to be most illiterate and most backward in Satara district, as per details given in Chapter Four. This background of the taluka is generally averse to ready acceptance of the idea of birth control. But Patan taluka has, in this respect, beaten the better-placed talukas like Wai, Phaltan, Mahabaleshwar and Koregaon. It is a manifestation of the fact that people of Patan taluka received the programmes in good spirit and with rational thinking. All this, however, does not mean that things were and are all well in the taluka. In the course of personal discussions with the executors of the programmes at different levels, it was noted that still cases of resistance are rampant and good deal of efforts are required to motivate the rural people for acceptance of new ideas and means for restricting the size of their family. Yet there is a long way to go.

5.8 CONCLUSION

Family planning and birth control have been accepted by India as its national policy because India's population growth is so formidable and time factor so pressing that India could not wait for education and economic development to bring about a drop in fertility.

For implementation of what is now called the family welfare programme, a hierarchy of administrative machinery has been created from the level of Central Government to Gram Panchayat. Primary Health Centres play a key

role in the implementation of various programmes.

Patan taluka has been quite active in pursuing particularly the programmes of sterilisation of both the sexes and insertion of the IUDs. Its performance in Satara district is commendable since it ranked fourth in sterilisation and third in IUDs. With the increase in the number of Primary Health Centres and private doctors, medical facilities could be well extended to the rural population so that the number of people served by one doctor slashed from an average 48,897 people in 1951 to 15,551 in 1981 when the number of doctors was 15. It must have fallen further with the enhancement of the number of doctors to 25 in 1985.

The performance of Patan taluka in sterilisation and IUDs programme, on the background of its backwardness and lowest percentage of literacy, itself can be accepted as an indicator of encouraging popular response to the programme.

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