BACKGROUND MATERIAL

on

The People's Tribunal
on
Coercive Population Polices
and
Two Child Norm

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Organised by :

Human Rights Law Network; UP & Bihar Health Watch; SAMA; The Hunger Project;Jan Swasthya Abhiyan

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India's Population Policies: A Critique

Introduction

On the 11th of May 2000 India's population reached one billion. A girl child was symbolically chosen to represent this watershed. While this could have been a moment for somber reflection on India's development and what this meant to her population, it was used instead as an occasion to set demographic alarm bells ringing.

Over the years while concerns in family planning have contoured health sector development, by the early nineties it was increasingly being realized that the programme -- one of the largest public health initiatives in the world -- had reached a dead end. In part due to this realization, partly as a consequence of the pressure generated by women's groups and health groups in the country calling for a radical reconsideration of the programme, and in part in preparation for the third decennial International Conference on Population and Development (ICPD) at Cairo in 1994, the Government of India appointed an Expert Group to chart out a new population policy. The Report[1] of this group, commonly known as the Swaminathan Committee Report, proclaimed a policy that it described as pro-poor, pro-nature and pro-women.

The Committee proposed a holistic approach, visualizing over-all social development as the goal. It proposed the idea of merging family planning with the health department so that the importance of family planning as one, and only one, aspect of an overall health service could be emphasized. The Committee had resolutely rejected both the target and the incentive approaches several months before these were to enter the ICPD agenda for action. Further, the Committee had flagged the importance of using institutional arrangements for development offered by the 73rd and 74th Amendments to the Constitution. Yet it came in for criticism for the manifest disjunction between its policy perspective and recommendations.

In 1996, based on the recommendations of the Expert Group, and on the understanding that "if our population policy goes wrong, nothing else will have a chance to go right", the Government of India announced a Draft Statement on National Population Policy (GOI: 1996:13)[2]. In February last year this draft was modified, accepted by Parliament and a National Population Policy (NPP) 2000 announced.

The National Population Policy 2000

The National Population Policy announced "affirms commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services" (GOI: 2000:2)[3].

The immediate objective of the NPP is to meet the unmet need for contraception and health infrastructure. The medium-term objective is to bring the Total Fertility Rate to

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[1] Government of India (1994), Ministry of Health and Family Welfare, *Report of the Expert Group on Population Policy*, New Delhi.
[2] Government of India (1996) Ministry of Health and Family Welfare, *Draft Statement on National Population Policy*, New Delhi
[3] Government of India (2000) Ministry of Health and Family Welfare, *National Population Policy 2000* New Delhi

replacement levels by 2010 through inter-sectoral action and the long-term objective is to achieve a stable population, consistent with sustainable development, by 2045.

Towards this end the goals set out include:

1.Making school education free and compulsory up to age 14;
2.Reducing IMR to below 30 per 1000 live births;
3.Reducing the Maternal Mortality Ratio to below 100 per 100000 live births;
4.Promote delayed age at marriage;
5.Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons;
6.Universal access to information and counseling, and services for contraception with a wide basket of choices;
7.Hundered per cent registration of vital events – births, deaths, marriages and pregnancy;
8.Prevent and control communicable diseases, especially AIDS.

The strategies to achieve these goals include twelve items. Some of these are: decentralized planning and program implementation through Panchayati Raj Institutions (PRIs); convergence of health services at the village level; empowering women for improved health and nutrition; ensuring child survival interventions; involving diverse health care providers; strengthening IEC; developing increased partnership with NGOs and the private corporate sector; and finally, encouraging a range of clinical, laboratory and field research on maternal, child and reproductive health care issues. All these strategies are to have a special focus on under-served populations, namely, urban slums, tribal communities, hill area populations and displaced and migrant groups. Efforts are also to be directed towards increasing participation of men in the programme.

Over the same period, several state governments also announced population policies of their own. This paper seeks to briefly comment on some aspects of these policies in the light of India's experience with the development of her health and family planning programmes.

II

It is widely recognised, although reluctantly accepted, that health and population are governed by larger socio-economic issues, indeed determined by them. The Working Group on Population Policy[4] for instance recognised that population and development are two sides of the same coin; and that if levels of fertility are to decline, attention will have to be paid to increasing employment, income, food security, literacy, levels of health and so on. These in turn would induce declines in infant and child mortality even as they generate an increasing demand for family planning services.

In contrast, the NPP is deafeningly silent on these larger issues contouring health and population. The questions that thus need to be considered are: what have the macro-economic reforms of the nineties meant for these critical determinants of health? How do these in turn impinge on issues in family planning? How have they affected structures of delivery of these services? It is now recognised that reforms have meant a deceleration of employment in both rural and urban areas[5], a significant casualisation of the work-force, especially involving the

[4] Government of India, Ministry of Health and Family Welfare (1980), *Report of the Working Group on Population Policy*, New Delhi.
[5] Sen, Abhijit (2002), "Agriculture, Employment and Poverty: Recent Trends in Rural India", paper presented at the *International Conference on Agrarian Reforms and Rural development in Less Developed*

female labour force[6], and a sharpening of income inequalities with a contraction of incomes in the lower deciles of the population[7]. India also sits on a shameful and growing mountain of food stocks while at the same time an estimated 350 million people are unable to meet their minimal calorie requirements. Is it any wonder then, that as the Table I makes evident, Infant Mortality Rates (IMR), accepted as one of the most crucial determinants of family planning, have been stagnating during the nineties? Between 1981 and 1990, the all-India IMR declined from 110 per thousand live births. to 80; between 1990 and 1999 the IMR declined from 80 per thousand live births to merely 70. The rate of decline annually thus decelerated from 2.72 per cent in 1981-91 to 1.56 per cent in 1991-99. What is even more worrying is that this overall decline is accompanied by an increase in IMRs in several states in the country.

Table I: All India Infant Mortality Rates

Year	Total	Rural	Urban
1981	110	119	62
1982	105	114	65
1983	105	114	66
1984	104	113	66
1985	97	107	59
1986	97	105	62
1987	95	104	61
1988	95	102	62
1989	91	98	58
1990	80	86	50
1991*	80	87	53
1992*	79	85	53
1993*	74	82	45
1994*	74	80	52
1995*	74	80	48
1996*	72	77	46
1997*	71	77	45
1998 (ii)	72	77	45
1999 (iii)	70	75	44

* Excludes Jammu and Kashmir. Sources: (i) Office of the Registrar General of India (1999). *Compendium of India's Fertility and Mortality Indicators*, Sample Registration System (SRS), New Delhi.
(ii) Office of the Registrar General of India (2000), *Selected Socio-Economic Statistics: India 1999*, New Delhi.
(iii) ORGI, Sample Registration System (2001), *SRS Bulletin*, Vol.35, No.1, April

A significant feature of liberalisation has been the dismantling of social welfare activities of the state, inadequate as they were. Thus while the Public Distribution System for food was

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Countries, Kolkota. See also Radhakrishna, R.(2002), "Agricultural Growth, Employment and Poverty: A Policy Perspective", *Economic and Political Weekly*, Vol.XXXVII, No.3, 19th January

[6] Unni, Jeemol (2001), "Gender and Informality in Labour Market in South Asia", *Economic and Political Weekly*, Vol.XXXVI, No.26

[7] Dev, S Mahendra (2001), "Economic Reforms, Poverty, Income Distribution and Employment", *Economic and Political Weekly*, Vol XXXVI, No.26.

being whittled down. India's commitment to universal and comprehensive Primary Health Care, as a signatory to the Alma Ata Declaration and as enunciated in the National Health Policy of 1983, has been significantly weakened. As a result, universal and comprehensive Primary Health Care finds no mention at all in the NPP. Indeed that we have the announcement of a NPP without links to a National Health Policy, which is yet to be unveiled, is abundant evidence of distorted priorities.

As the data in Table II make evident, health expenditure has shown a secular decline, particularly marked in the programmes for the control of communicable diseases, while that for family planning has shown a continuing increase. At the same time, the state has provided impetus to the growth of the private sector in health care through a range of subsidies and schemes. It is thus not surprising that even as health care becomes more inaccessible, and expenditure on health care is emerging as the leading cause of indebtedness[8], reports of starvation deaths and outbreaks of epidemics have started pouring in[9].

Table II: Expenditure on Health and Family Welfare (in rupees crores).

Plan	Period	Amount	Total Plan Investment (All Development Heads)	Health (Centre and States)		Family Welfare		Control of Communicable Diseases	
				Out-Lay/ Exp.	% of Total Plan	Out-lay/ Exp.	% of Total Plan	Out-lay/ Exp.	% of Total Health
First	51-56	Actuals	1960	65.2	3.33	0.1	0.01	23.1	16.5
Second	56-61	Actuals	4672	140.8	3.01	5	0.11	64	28.4
Third	61-66	Actuals	8576.5	225.9	2.63	24.9	0.29	69	27.7
Annual	66-69	Actuals	6625.4	140.2	2.12	70.4	1.06	23.1	10.2
Fourth	69-74	Actuals	15778.8	335.5	2.13	278	1.76	127	11.1
Fifth	74-79	Actuals	39426.2	760.8	1.93	491.8	1.25	268.12	11.5
79-80		Actuals	12176.5	223.1	1.83	118.5	0.97		
Sixth	80-85	Outlay	97500	1821	1.87	1010	1.04	524	27
Sixth	80-85	Actuals	109291.7	2025.2	1.85	1387	1.27		
Seventh	85-90	Outlay	180000	3392.9	1.88	3256.3	1.81	1012.7	7.7
Seventh	85-90		218729	3688.6	1.69	3120.8	1.43		
90-91		Actuals	61518	960.9	1.56	784.9	1.28		
91-92		Actuals	65855	1042.2	1.58	856.6	1.3		
Eighth	92-97	Outlay	434100	7582.2	1.75	6500	1.5	1045	4.2
Ninth	97-02	Outlay	859200						

Source: Government of India, Planning Commission (1997), *Ninth Five Year Plan, 1997-2002*, Vol.II, New Delhi.

The collapse of the public health system, without which of course even the NPP cannot be implemented, has been hastened by macro-economic policies initiated by the government. This has not only led to cuts in public health expenditure, but by introducing cuts in expenditure in

[8] Krishnan, T.N. (1999), "Access to Health and the Burden of Treatment: An Inter-State Comparison", in Mohan Rao (Ed), *Disinvesting in Health: The World Bank Prescriptions for Health*, Sage, New Delhi.
[9] Baru, Rama V. and Sadhana, G. (2000), "Resurgence of Communicable Diseases; Gastroenteritis Epidemics in Andhra Pradesh", *Economic and Political Weekly*, Vol.XXV, No.40.

other crucial sectors of the economy, undermined the grounds for health in the population. That the health and well-being of the population is not the central concern of the NPP is also evidenced by the central place afforded to a Reproductive and Child Health (RCH) approach.

It is frequently argued that the health of women in the country is appalling, as indeed it is. It is further argued that providing family planning services to women would lead to declines in unwanted births and thus the maternal mortality, which is unconscionably high. These arguments, partially true, were familiarly used earlier as the justification for the Maternal and Child Health programme. In the 1990s, the argument that women suffer huge -- and unquantified -- reproductive morbidities, even as the spectre of AIDS loomed large, was used to justify the new RCH approach.

There are, however, significant problems with this approach that assumes that reproductive causes alone largely account for the mortality load borne by women. Data on deaths among females in the country reveals that deaths due to reproduction, high as this is, account for merely 2.4 per cent of all causes of deaths. Within the reproductive age group of women, they account for about 12 per cent of deaths. The focus of the RCH approach in the NPP is thus epidemiologically misplaced[10]. In all age groups among women, including the reproductive age groups, communicable diseases and anaemia, account for a significantly higher proportion of deaths. Indeed deaths among women with anaemia, who are not pregnant, are twice the number of deaths among women who are. In other words, given the prevailing distribution, causes and load of deaths, a RCH approach addresses merely the tip of the iceberg. This pattern of diseases and deaths, dominated by the quintessential diseases of poverty and hunger, can only be dealt with by a comprehensive system of universal Primary Health Care. Even this limited RCH package of services, epidemiologically blinkered, can only be delivered by a public health system considerably strengthened.

Indeed, noting that vertical programmes had not been successful, and that a vertical family planning programme had considerably weakened health care, the Expert Group had boldly proposed the integration of programmes in order to strengthen health care. While this has not been heeded, the NPP has accepted the need to "incorporate advances in contraceptive technology and, in particular the newly emerging techniques into programme development". What this refers to, of course, is injectable contraceptives and implants. Indeed earlier this year the Ministry of Health and Family Welfare announced plans to initiate trials with injectable contraceptives Net En in twelve medical colleges around the country.[11]

While Net En has been available in the private sector since 1994, its use was restricted since it was felt that the use of such a contraceptive required medical care and follow-up not readily available in the country at large. In a large trial carried out by the ICMR in the 1980s, close to 45 per cent of users had discontinued the method by the end of two years citing complications. Indeed the ICMR trial revealed not just a high drop out rate but also that a significant proportion of users had failed to regain fertility on cessation of use, making the method unsuitable as a temporary contraceptive[12]. Moreover, a high rate of failure had been

[10] Qadeer, Imrana (1998), "Reproductive Health: A Public Health Perspective", *Economic and Political Weekly*, Vol.XXXIII, No.41.
[11] Rao, Mohan (2001), "Population Policies: States Approve Coercive Measures", *Economic and Political Weekly*, Vol. XXXVI, No. 16.
[12] Bal, Vineeta *et al*, "Injectable Contraceptives: Recognising Potential Risks", *Economic and Political Weekly*, Vol.XXXV, No.50

reported within the first six months of use, raising the vexed question of the risk to the foetus *in utero*.

One very real fear is that given coercive population control policies, the vast potential for misuse of this contraceptive will become a reality. With a target-driven population control policy, despite the NPP's commitment to the contrary, the needs of a woman user are overlooked in the haste to bring down birth rates. Indeed it was this very feature at a camp in Andhra Pradesh in 1985 that led women's groups to file a petition in the Supreme Court against injectables[13].

While the NPP is unequivocal in rejecting any form of coercion, the incentives to be given to couples and to Panchayats for generating acceptance of family planning sits uneasily with this commitment. Yet it is the population policies announced by various states that blatantly violate the letter and spirit of this commitment of the NPP. These state policies, with a slew of disincentives, have brought in coercion. Thus the policies of Uttar Pradesh, Madhya Pradesh, Rajasthan and Maharashtra disqualify persons married before the legal age at marriage from government jobs, link financial assistance to Panchayats to family planning performance, and in a move recalling the period of the Emergency, the assessment of medical officers and other health personnel to performance in the RCH programme. The MP policy links the provision of rural development schemes, income generating schemes for women, and indeed poverty alleviation programmes as a whole, to performance in family planning. Both Rajasthan and Maharashtra make "adherence to a two-child norm" a service condition for state government employees. Maharashtra in a G.O., since rescinded in the face of protest, announced the two-child norm as an eligibility criterion for coverage under a range of schemes for the poor, including access to the PDS and education in government schools. Andhra Pradesh, which has many of the above features in its policy, goes further and links construction of schools, other public works and funding for other rural development schemes to performance in family planning. Allotment of surplus agricultural land, housing schemes, benefits under IRDP, the SC Action Plan and the BC Action Plan are also linked to acceptance of sterilisation. In a macabre metaphor of the lottery that is the life of the poor in the country, awards of Rs.10,000 are to be given to three couples per district, chosen by lottery, sterilised after two children.

These policies are in complete disjunction with the NPP and indeed with the commitments made by the government of India at the 1994 ICPD in Cairo. It is curious that policy makers, so anxious to control numbers, need to be reminded that such policies are completely unnecessary as a significant demographic transition is underway in large parts of the country. And that areas where this transition has lagged behind need assistance towards strengthening their health services and augmenting their anti-poverty programmes and not measures that punish the poor. As the NPP itself points out, there is a large and unmet need for family planning services. In such a situation, without meeting this unmet need, to propose punitive measures is both irrational and absurd.

The disincentives proposed are anti-poor, anti-dalit and anti-adivasis with these weaker sections having to bear the brunt of the withdrawal of a range of measures meant precisely to mitigate poverty and deprivation. The National Family Health Survey (NFHS) for 1998-99 reveals that the Total Fertility Rate (TFR) is 3.15 for SCs, 3.06 for STs, 2.66 among OBCs and 3.47 among illiterate women as a whole[14]. In contrast it is 1.99 among women better-off and thus educated beyond Class 10. Imposition of the two-child norm and the disincentives proposed in

[13] Bal, Vineeta et al (2000), *ibid.*

[14] International Institute of Population Sciences (2000), *National Family Health Survey: India, 1998-99*, Mumbai.

the state policies would thus mean that significant sections among these already deprived populations will bear the brunt of the state's withdrawal of ameliorative measures, as pitiably inadequate as they are. In addition to privatisation that de facto deprives SCs and STs of jobs in the organised sector, these explicit policy measures will further curtail employment opportunities available to them in the public sector.

The dalits, the adivasis and the Other Backward Castes bear a significantly higher proportion of the mortality load in the country. The NFHS reveals that the IMR among the SCs, STs and OBCs was 83, 84 and 76 respectively compared to 62 among others. Similarly the Under Five Mortality Rate is 113 among the SCs, 126 among the STs and 103 among the OBCs compared to 82 among others. Clearly then, to impose a two-child norm under such circumstances is immoral. Instead of dealing with the causes of these differentials, what the population policies seek to do is to punish victims of deprivation.

The disincentives proposed are also anti-women since women in India seldom decide the number of children they wish to bear, when to bear them and indeed have no control over how many of them will survive. Debarring such women from contesting elections to Panchayats makes a mockery of policies to empower women. They will further provide an impetus to some women to resort to sex-selective abortions, worsening an already terrible sex ratio in the country. Interestingly, a study in Mumbai revealed that a majority of doctors performing sex-selective abortions stated that they did so in order to control population growth[15].

These are also anti-minorities since the marginally higher TFR among some sections of these communities are a reflection of their poorer socio-economic situation. It need hardly be added that just as the Hindu rate of economic growth is a chimera, so is a Muslim rate of population growth. Finally the policies are also deeply anti-democratic and violate several provisions of the Constitution (the right to privacy, the right to life, the right to livelihood, amongst others) and several international covenants that India is signatory to, including the Rights of the Child.

What, then, is the import of these population policies? While there is rhetorical use of the language of rights and gender justice, they imply a deep distrust of the poor and an utter lack of concern with their health and well being. With the health system in shambles, and macro-economic policies, further marginalising large sections of the population, they will be victims of the drive to control their numbers. The crowning irony of course is that this is being done supposedly to remove a demographic stumbling block to socio-economic development.

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[15] FRCH study cited in Gupta, J.A., *New Reproductive Technologies, Women's Health and Autonomy: Freedom or Dependency?*, Sage, New Delhi, 2000.

Population policy

8

A Summary of the National Population Policy and the State Population Policies of Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra, and Andhra Pradesh

This paper seeks to summarize the population policies of five Indian states; namely, Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra and Andhra Pradesh. In the year 2000, the Government of India released the National Population Policy (NPP) document which made an explicit commitment to" voluntary and informed choice and consent of citizens while availing of Reproductive and Child Health (RCH) services and continuation of the target free approach in administering family planning services."

The NPP also acknowledges a "need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of RCH services by government, industry and voluntary NGO sectors working in partnership."

The NPP lists its objectives in terms of three time frames: its **immediate** objective is to address unmet needs for contraception, healthcare infrastructure and health personnel and to provide integrated service delivery for basic reproductive and child health. The **medium term** objective is to bring the TFR back to replacement level by 2010, through vigorous implementation of intersectoral operational strategies. The **long- term** objective is to achieve a stable population by 2045,at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

In pursuance of these objectives, the NPP lists fourteen sociodemographic goals to be achieved at an all- India level by 2010. These include addressing the unmet need for basic RCH services, supplies and infrastructure, increasing access to schooling, reduction in Infant Mortality Rates (IMR) and Maternal Mortality Ratios (MMR), universalisation of immunization, delayed marriage for girls, universalising the number of deliveries by trained personnel and increasing, the number of institutional deliveries, achieving a delayed average age at marriage for girls, increased access to information and counselling, universal registration of vital events, control of communicable diseases, convergence of RCH programmes and Indian Systems of Medicine and Homeopathy(ISMH), and convergence of different social sector programmes.

The NPP stresses the need for decentralised planning, the empowerment of women for population stabilisation, child health and survival, collaboration with the voluntary and NGO sector, and encouragement of research in contraceptive technology.

In order to promote the policy, it lists a number of measures. These include rewarding of Panchayats and Zilla Parishads for exemplary performance in Family Welfare and maternity benefits for mothers who give birth to their first child after the age of nineteen. Also, a family welfare-linked social insurance is to be given to couples below the Poverty Line with two or less children who undergo sterilisation. The government proposes to

reward couples who marry after the legal age at marriage, regis[illegible]eir marriage, have their first child after the age of 21 years, accept the small fa[illegible] norm and adopt a terminal method after the birth of their second child. It is a[illegible]roposed to have a revolving fund for income generating activities by village lev[illegible]f help groups who provide community health care services, the establishment of [illegible]hes and child care centres in rural areas and the urban slums, a wide choice of con[illegible]eptives, facilities for safe and legal abortion, and vocational training for girls.

One of the central features of the policy is a commitment to a ta[illegible] free approach and a refusal to use disincentives or coercion in order to achieve the [illegible]ographic goals set by the state. The NPP also stresses the need for involvement of l[illegible]s bodies at the lowest level- i.e. the Panchayati Raj Institutions (PRI's)-in the achieve[illegible]t of the goals that make for population stabilization. It suggests the devolut[illegible] only of rights, responsibilities and powers to the PRI's but also of funds and re[illegible]e generation. This latter is extremely critical in order for decision making to be truly [illegible]tralised. In doing so, the NPP extends the scope of population policy to a broader no[illegible] of democracy and welfare.

With the NPP as the background, we move on to examine the state level policies.

1.Uttar Pradesh:

The population policy of Uttar Pradesh links the growth of population to pressure on natural resources, and declares the inability of the state and its gove[illegible]ent to improve the quality of life of the people, in the face of this growth in population [illegible]essure. It mentions the need to address issues of gender and child development in the [illegible]ttempt to stabilise population growth.

In terms of its specific objectives, the following are mentioned:

- The need to reduce TFR from 4.3 in 1997 to 2.6 in 2011 to 201[illegible]
- Proportionate increases in use of contraceptive methods by inc[illegible]sing demand for the same.
- Increase in average age of the mother at the birth of her first ch[illegible]
- Reduction in unmet need for both spacing and terminal method[illegible]
- Reduction in MMR from 707/ 1000,000 live births in 1997 to [illegible]94 in 2010 to below 250 in 2016.
- Reduction in infant mortality from 85/1000 live births in 199[illegible]3 in 2010 and 67 in 2016.
- Reduction in incidence of sexually transmitted diseases (ST[illegible]d reproductive tract infections (RTI's).
- Increase awareness of AIDS.

The strategies to be adopted to improve RCH include raising the average age of effective marriage, introducing and focusing on adult education, empowerment of women and enhancing the involvement both of the private and voluntary/NGO sector and the role of PRI's.

The policy lists a number of incentives and disincentives to achieve its objectives, which include some of the following:

- Disqualification of persons who marry before the legal age at marriage from eligibility for government jobs.
- "Performance- based " disbursement of 10 per cent of the total financial resources for PRI's. Panchayats which "perform" well in the provision of RCH services will be rewarded. While the total transfer of funds will amount to only four per cent of state revenue, the PRI's are to be entirely responsible for advocacy, identification of contraceptive needs and recording of vital events.
- The performance of medical officers and health workers is to be based on their performance in the RCH programme. While ostensibly, this would mean more efficient RCH services, it would perhaps place extreme pressure on health workers to reach targets with regard to limiting of family size. Also, linking performance appraisal of individuals to performance in RCH would probably result in lopsided health services provision, leading to an overemphasis on family planning and a neglect of other aspects of primary health care such as control of communicable diseases.

The document also calls for "an active dialogue with the GOI for wider availability of injectables and other new technologies through private, commercial and government channels in the state". The state thus intends to actively push the introduction of these newer technologies.

Finally, the explicit commitment to charging user fees ostensibly to improve the quality of services will place a further burden on the poor to pay for the entire gamut of health services. The decision of the government to disallow those who marry before the legal age and who have more than two children from government service will adversely affect women who may have no say in their age at marriage. In this case, even the implementation of 33% reservation for women in elected bodies and employment will not necessarily result in greater gender equity, except in a narrow sense for some sections of women.

2. Madhya Pradesh

The population policy of Madhya Pradesh stresses the need to curb high fertility and mortality, which impinge upon the quality of life and the balance between population, resources and the environment. The policy document mentions the process of demographic

3. Rajasthan

The population policy of Rajasthan, like those of Madhya Pradesh and Uttar Pradesh, also links deceleration in the population growth rate to sustainable development. It mentions the need to reduce infant mortality, gender discrimination and undernutrition, and to increase household security.

With regard to its specific objectives, it mentions

- The need to increase the median age at marriage for girls from 15 in 1993 to 19 by 2010 through education and increasing awareness.
- Increase institutional deliveries from 8% in 1995 to 35% by 2016 and assistance by trained persons in child delivery from 35% in 1995 to 75% in 2010.
- Educate all women in the reproductive age groups about antenatal services and on establishing linkages between female health workers, anganwadi workers and trained dais at the village level.
- Improved child health is to be achieved through assuring better quality ARI care, strengthening links between ICDS and health workers, and coverage of all children for immunization and Vitamin A dosage.

With regard to operational strategies, it mentions the need to encourage men to use low-cost sterilization services, and recognizes that quality of the sterilization and spacing methods need to be improved. While the thrust of the policy is on provision of RCH services, improvement of management of service delivery systems, encouraging involvement of PRI's, NGO's the private sector,and co-operatives , and on information, education and communication (IEC).

There are, however, a number of incentives and disincentives mentioned, which include the debarring of persons with two or more children from contesting elections. It is also mentioned that "the same provisions can be considered for other elected bodies like co-operative institutions and as a service condition for state government employees..." The policy also states that "the legal provisions barring people with more than two children from election to panchayats and municipal bodies is a testimony of the firm political will and commitment to population control."

The policy is cautious on the question of introducing new reproductive technologies, although the policy draft mentions that " new contraceptive methods, as and when approved by the GOI will be introduced to make new technology accessible." Finally, it mentions the need to address issues of infertility, RTI's and female literacy.

decentralisation underway in the state and speaks of the need to change the thrust of family welfare from female sterilization to include raising the age at marriage for women, provision of RCH services, universalization of education and empowerment of women.

The specific objectives of the MP policy include:

- Reducing total fertility rates from 4 in 1997 to 2.1 in 2011.
- Increasing contraceptive usage and sterilisation services
- Increasing the age of the mother at the birth of her first child from 16 years in 1997 to 20 years in 2011.
- Reduction in MMR from 498 to 220 between 1997 and 2011 through greater registration of pregnant women, increases in proportions of institutional and trained deliveries and pregnancy testing centres.
- Reduction in IMR through increases in immunization, use of Oral Rehydration Solution (ORS) therapies for diahorrea in rural areas, reduction in incidence of Acute Respiratory Infections (ARI's), coverage of pregnant women and children with Vitamin A, Iron and Folic Acid (IFA) tablets.
- Increases in levels of HIV testing.
- Services for infertile couples.
- Universalizing access to primary education by 2005; with a goal of ensuring that 30% of girls in the age group of 14-15 years in 2005 would complete elementary education.

The strategies advocated by the policy document include the need to involve PRI's, and to empower women in the endeavour to reach population stabilisation. A number of initiatives are suggested such as

- making men realize their responsibility to empower women.
- strengthening local women's groups.
- reducing the burden of housework and drudgery on women by providing cooking gas connections and electricity to rural households.
- Reservation of 30% of government jobs for women.

However the MP policy also has a number of disincentives. These include

- Debarring of persons who marry before the legal age for marriage from seeking government employment.
- Persons who have more than two children will be debarred from contesting Panchayat elections.
- The provision of rural development schemes in villages will depend upon the level of family planning performance by Panchayats. The flow of resources to PRI's isalso to be linked to performance in RCH. While there is no specific commitment to increasing devolution and control of resources to PRI's, these institutions are to be made responsible for the implementation of the RCH programme.
- Performance by Panchayats in family planning is also to be linked to the starting of income generating schemes for women and poverty alleviation programmes.

4. Maharashtra

The population policy of Maharashtra begins with a statement of the need to bring down the rate of population growth. Its specific objectives include:

- Reducing TFR to 2.1 by 2004.
- Reducing CBR to 18 by 2004.
- Reducing IMR to 25 by 2004.
- Reducing neonatal mortality to 2 by 2004.

The policy extract lists a number of measures in order to achieve these objectives. These include:

- The provision of subsidies and perquisites to government employees is to be linked to acceptance of the small family norm or permanent methods of family planning by couples.
- Service in government jobs is also to be dependent on the acceptance of the small family norm.
- Provision of village health schemes will also be linked to the performance of panchayats in the RCH programme.
- Assessment of medical officers will depend upon their level of performance in the RCH programme.
- Persons having two or more children will be debarred from contesting panchayat elections.
- Other schemes include cash incentives to couples undergoing sterilization after the birth of one or more daughters, training of dais, and strict enforcement of the Child Marriage Restraint Act, the ban on prenatal sex determination testing, etc. Also, women's self- help groups are to be set up at the village level.
- Funding of PRI's will depend upon performance in the RCH programme.

The policy makes no provision for the representation of women in elected or other bodies. It also does not mention the devolution of resources or decision-making powers to PRI's.

5. Andhra Pradesh

The Andhra Pradesh population policy links population stabilization to improvements in standards of living and quality of life of the people. It states that "production of food may not keep pace with growing population....pressure on land and other facilities will increase further, resulting in social tension and violence... housing in both rural and urban areas will become a serious problem...there will be an increase in unemployment....there will be serious pressure on the country's natural resources causing deforestation, desertification and more natural calamities."

The demographic goals as stated in the policy include:

- Reduction of natural growth rate from 1.44 in 1996 to 0.80 in 2010 and 0.70 by 2020.
- Reduction in CBR from 22.7 in 1996 to 15.0 by 2010 and 13.0 by 2020.
- Reduction in CDR from 8.3 in 1996 to 7.0 in 2010 and 6.0 in 2020.
- Reduction in IMR from 66.0 in1996 to 30.0 in 2010 and 15.0 in 2020.
- Reduction in MMR from 3.8 in 1996 to 1.2 in 2010 and 0.5 in 2020.
- Reduction in TFR from 2.7 in 1996 to 1.5 in 2020
- Increase in Couple Protection Rate from 48.8 % in 1996 to 70 % in 2010 and 75 % in 2020.

These objectives are to be attained by:

(a) The promotion of spacing, terminal and male contraceptive methods.
(b) Increasing the coverage of pregnant women for TT inoculation and provision of IFA tablets.
(c) Increasing the number of trained and institutional deliveries.
(d) Strengthening of referral systems and equity in accessibility of services.
(e) Eradicating polio, measles and neonatal tetanus by 1998.
(f) Reducing diahorreal deaths, deaths due to ARI's and incidence of low birth weight babies.
(g) Increasing female literacy levels, increasing the median age at marriage for girls and reduction in severe and moderate malnutrition among children.
(h) Reduction in the incidence of child labour.

The policy lists a number of operational strategies relating to promotion of terminal and spacing methods, ensuring safe deliveries as well as safe abortions, prevention and management of RTI's and STD's, increasing the average age at marriage of girls, and increasing female literacy and child survival. It also mentions a role for NGO's and the private sector in social marketing of contraceptives and delivery of health care.

The document explicitly lists a number of incentives to be used in the achievement of its objectives. These include the following:

1) At the community level, performance in RCH and rates of couple protection will determine the construction of school buildings, public works and funding for rural development programmes.
2) Performance in RCH is also to be made the criterion for full coverage under programmes like TRYSEM, Weaker Section Housing Scheme, and Low Cost Sanitation Scheme.
3) Funding for programmes under the DWCRA and other social groups will be dependent on RCH performance.
4) At the individual level, cash prizes will be awarded to couples adopting terminal methods of family planning.

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5) Allotment of surplus agricultural land, housing sites, as well as benefits under IRDP, SC Action Plan, BC Action Plan to be given in preference to acceptors of terminal methods of contraception.
6) Special health insurance schemes for acceptors of terminal methods of family planning.
7) Educational concessions, subsidies and promotions as well as government jobs to be restricted to those who accept the small family norm.
8) Cash awards on the basis of performance to service providers.
9) An award of Rs. 10,000 each to 3 couples to be selected from every district on the basis of lucky dip, from the following categories: (a) 3 couples per district with two girl children adopting permanent methods of family planning (b) 3 couples per district with one child adopting permanent methods (c)3 couples per district with two or less children adopting vasectomy.

The policy document mentions the need for involvement of people's representatives, religious leaders, professional social bodies, professionals, chambers of industry and commerce, youth, women and film actors and actresses. While it underscores the need for delegation of rights to PRI's, there are no provisions for delegation or devolution of resources to the panchayats.

To summarize, the National Population Policy lays the groundwork for a policy of population stabilization based on the premise that the provision of health, safety, security and protection of vulnerable groups is a precondition for population stabilization. It also affirms the need for a policy based on the ethics of informed choice and consent. In doing so, it eschews any measure that would be ethically hazardous or coercive. However, the state policies all suggest some measure of disincentives in order to achieve their targets.

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Population stabilization: Why penalties are meaningless?

A. K. Shiva Kumar[1]
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India has re-affirmed its goal through the National Population Policy announced in March 2000 to rapidly achieve population stabilization. Public discussions and debates around the population question are, however, shrouded in confusion and misunderstandings. Particularly disturbing are the moves to impose disincentives of various kinds that penalize people for having more than three children. States like Maharashtra seem to have issued such orders, and many other states are contemplating such unnecessary measures. This brief note lists the many arguments against the use of penalties and disincentives for achieving population stabilization.

Any discussion on penalties and disincentives, however, needs to be situated within the overall thinking relating to population stabilization.

Common myths

There are many myths surrounding population. Two however cloud people's reasoning and perceptions the most.

First, many believe that India is a poor country because of its large and growing population. Many argue that India's per capita income is low because there are just far too many people. Such reasoning has very little basis. The fact is that population size is not associated with economic prosperity in any predictable manner. China, for instance, the only other country with a larger population – 1.26 billion in 1998 – reported a GNP per capita of US$ 750 in 1998 against India's figure of US$ 440. Similarly, Malaysia and Nepal have almost the same population – between 20-21 million. Yet GNP per capita in Nepal was $210. And in Malaysia, it was $3,670. Within India too, Andhra Pradesh and Madhya Pradesh reported similar levels of population – 73 million and 78 million respectively in 1998. Yet in 1997-98, per capita Net State Domestic Product in Madhya Pradesh was only Rs.8,114 – almost 30% lower than the per capita State Domestic Product (Rs. 10,590) in Andhra Pradesh.

There is a related myth – that India's large population is the reason why the economy is growing so slowly. This again is not true. Between 1975-95, China's GNP per capita grew annually by 6.8%, and India's by only 2.6%. Even in the 1990s, after the initiation of economic reforms, India's growth record has not been as good as China's. Between 1990-98, India's GNP per capita grew by 3.8%, and China's by 9.2%. Within India too between 1991-98, per capita State Domestic Product grew by 7.6% per annum in Gujarat – a state with an estimated population of 47 million in 1998. On the other hand

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per capita State Domestic Product grew by only 2.8% per annum in Punjab even though the State has a smaller population -- estimated at 23 million in 1998.

The reality is that large population in itself is not the reason for low incomes and slow growth. Economic well-being has little to do with population size, and much to do with how effectively society invests in its people -- in their health, in their education, in their well-being. The more secure people are, the more prosperous a nation is

Second, another common myth is that a large and growing population is responsible for the persistence of widespread poverty in India. This leads many to arrive at a wrong conclusion: that by rapidly lowering birth rates, India can eliminate poverty and improve standards of living. This again is not true In 1999, for instance, the birth rates in Gujarat and Orissa were similar -- 25.4 births per 1,000 population in Gujarat and 24.1 in Orissa. Yet 48.6% of Orissa's population lived below the poverty line in 1993-94 – almost twice the proportion in Gujarat (24.2%). Similarly, both Kerala and Haryana reported very similar rates of poverty in 1993-94 – around 25%. But the birth rates in the two states are vastly different. In 1999, Haryana reported a birth rate of 26.8 whereas in Kerala, it was only 18.

The link between fertility reduction and improvements in standards of living is neither obvious nor automatic. Bangladesh, for instance, reduced its Total Fertility Rate (TFR) dramatically from 6.8 to 3.1 between 1975-98. But this has not alleviated poverty in any significant way. Similarly, Kerala has lowered its fertility rates to less than 2 – and yet it is difficult to claim that there is no poverty in the State. Even in Europe and the United States of America, where fertility rates are relatively low – often well below the replacement rates – poverty persists. Human poverty has its roots in a denial of opportunities that can persist in countries irrespective of population size and fertility rates.

Blaming population size for low incomes, slow economic growth and human poverty is indeed a mistake. Those who do so are merely using population as an excuse – an alibi - to cover up for serious policy failures.

A major misconception

There are a number of misconceptions surrounding population. Quite unfortunately, one in particular dominates current thinking on ways to achieve population stabilization Many argue that coercion and an authoritarian approach are what will yield the quickest results. Some even go to the extent of advocating that India should emulate China's one-child policy. There are at least ten good reasons why India should stay clear of penalties and disincentives.

First, even in China, the coercive population policy went hand-in-hand with a broad and equitable expansion of social and economic opportunities for women -- the proven way to reduce population growth And so it is not entirely clear how much of China's fertility decline can actually be attributed to the one child policy

Second, enforcing a one-child policy may be possible in an authoritarian country like China, but such measures are likely to have disastrous political consequences in any democracy. In India, the political and human wounds of the population 'control' measures initiated during the Emergency rule under Mrs. Indira Gandhi, some 25 years ago, are still to heal.

Third, in countries of South Asia and even in China, where there is a strong son preference, such restrictions will inevitably promote further discrimination against girl children. Instances of female feticide and even female infanticide are likely to increase. This is a particularly serious concern given that the most alarming and disturbing feature of the preliminary results of Census of India 2001 is the worsening female-to-male ratio in the child population aged 0-6 years.

Fourth, imposing restrictions on the number of children violates people's freedoms and individual rights. Family planning decisions by their very nature are intimate personal decisions relating to love, affection, family security, and togetherness. Why should the State or any political party want to forcibly interfere?

Fifth, why should coercion be used when there exists a well-proven alternative route of investing in social development and people's capabilities? Bangladesh and Indonesia have been able to lower their fertility rates without use of coercion. Within India itself, we have Kerala's example – a state that has invested well in people's health and education. And the social development route yields very quick results. Kerala, in fact, had a higher fertility than China in 1979, but by 1991, its fertility rate of 1.9 was lower than China's 2.0. And now, Bangladesh has shown that it is possible to reduce fertility rates rapidly without use of any coercion – by empowering women, educating people and improving access to reproductive health care.

Sixth, it makes little logical sense to impose penalties when people indeed want to have fewer children. Survey after survey points out that most people – even the poorest, those living in rural areas, and belonging to minority groups – all want to have fewer children. For instance, according to the National Family Health Survey-2, in 1998-99, almost half (47%) of ever-married women consider two to be the ideal number of children, and 72% consider two or three to be ideal. At the same time, people's knowledge of family planning methods is also high. The same Survey reveals that the knowledge of contraceptive methods is nearly universal, with 99% of currently married women recognizing at least one method of contraception and at least one modern method of contraception. Ignorance is no longer the issue. The reality is that a majority of women lack adequate access to safe and appropriate reproductive health services, and the freedoms to make choices. Why penalize people if the State is not able to fulfill its obligation of ensuring adequate provisioning of basic social services?

There are also serious problems associated with the implementation of disincentives and penalties.

Seventh, penalties tend to get reduced to tokenism, and they are difficult to implement. For example, political parties and some state governments want to debar those with more than two children from contesting for elections – or holding elected office. If

anything, such a move is impractical. How can the State or political parties meaningfully track births, deaths, marriages, remarriages and divorces among party members (existing and potential). The country does not have a well-developed civil registration system. According to MICS 2000 – an extensive survey on children carried out by UNICEF - barely 35% of all births is registered. When this is the situation, what are the prospects of establishing a proper monitoring system? Many loopholes are already being discussed. There are, for example, already talks of how the pull of political office and the lure of power is promoting 'divorces on paper' and even 'adoption on paper." Pushing any kind of ban on political participation is likely to reduce the entire system of elections to a mockery of democracy. This is indeed a heavy price to pay.

Eighth, penalties tend to be unfair and inequitable in terms of how they affect different groups of people in society. The National Family Health Survey – 2 for 1998-99 reveals that India's total fertility rate (TFR) - the number of children a woman would bear during her reproductive years – is 2.85. The TFR is 2.27 in urban areas (where only 26% of the population reside) whereas it is 3.07 in rural areas with 74% of the country's population. Similarly, the TFR among Scheduled Castes is 3.15; it is 3.06 among Scheduled Tribes, 2.66 among Other Backward Castes, and 2.66 among the rest of the population. Similarly, the TFR among illiterate women is 3.47 whereas it is 1.99 among women who have been educated beyond Class X. The proposal therefore to ban people with more than two children from contesting for elections is clearly biased against rural and tribal populations, against less educated persons, against those belonging to S.C. S.T. and Other Backward Castes, and the poor in general. It favours urban residents and those who have had access to education and proper health care, and discriminates against the majority of the rural poor and the disadvantaged. Such a measure will unfairly benefit the fortunate few who have historically enjoyed an unequal access to opportunities and so far to a majority of Indians. Any measure that debars people with more than two children from contesting for elections is also strongly and unfairly biased against women, and it ignores the reality of the poor.

Ninth, imposing penalties has little ethical or moral justification. For example, some State governments like Maharashtra want to deny the third child the right to free education. This is blatantly absurd. The Constitution of India assures every child the right without discrimination – the right to free and compulsory education up to the age of 14. Denying the right to education -- if the child happens to be the third - seems arbitrary and unconstitutional. It is shameful to penalize a child for no fault of hers. Such a move clearly violates the Convention on the Rights of the Child that India has ratified.

Tenth, the most popular argument advanced in favour of imposing penalties is that by doing so senior politicians will set an example to others. Do politicians truly believe that the electorate is so naïve? Citizens are concerned about the ethical and moral values of politicians, about the corruption and misuse of office, and about their lack of commitment to addressing serious issues of poverty and human deprivations. Politicians who believe that they can redeem their political image by advocating and having less than three children must be living in a make-believe world. Younger politicians themselves find the proposal quite ridiculous. Very often, it is advocated by those who are way beyond their reproductive (and productive) years. But such statements are also typically enhanced in comfortable living rooms by those who are educated, who have secure jobs, who have

access to good health care, and who have not experienced child deaths in their families for several generations. Stabilizing India's population can hardly be achieved though such farcical and superficial interventions.

Conclusion

Population stabilization is not a technical issue that has a technical solution. The answer does not lie in pushing sterilization or chasing targets. For population stabilization, it is important to improve people's access – and women's access in particular – to quality health care. Immediate steps are needed to revitalize community health programmes throughout the country. At the same time, the contraception mix needs to be enlarged. Women must have access to emergency obstetric care even in remote areas. But mere physical provisioning is not the solution. It is critical to involve people – and enable women in particular to participate in decision making and to have a say in decisions relating to reproduction and livelihoods.

The argument is often made that India is too poor to afford the many investments needed to stabilize population. Can India afford to expand contraception choices, ensure universal access to safe and appropriate reproductive services, and ensure health for all? Or for that matter, can India afford to universalize elementary education? Investing in basic health and education is not entirely a matter of resources. It has much to do with priorities and the political will to address issues of population and human development. The issue is more than merely one of affordability. It is a matter of getting priorities right.

It is well established that high incomes are not a prerequisite for social development. Several countries like China, Cuba, Costa Rica, Sri Lanka, and even Kerala in India have recorded remarkable gains in health and education at relatively low levels of income. Nations do not have to become rich in order to provide for people's health and education. On the contrary, the only way for them to become rich is to invest first in people's health and education.

At another level, the world is now discovering the obvious – that women's empowerment is critical for human development. There is a closely related issue – that of gender equality and the influence it has on the ability of women to exercise their choices freely and without fear. The roots of the population issue lie in social realities – and in social constraints (or unfreedoms) that women in particular face. Sustained and informed advocacy is needed to change mindsets to enable women to act with greater freedoms.

Reducing infant and child deaths is essential in order to restrain population growth. It has been established all over the world that reductions in infant mortality (or improvements in child survival) precede reductions in fertility rates. Several mechanisms connect lower child death rates to lower birth rates – including the replacement factor and the insurance factor. Reducing child deaths can help societies move towards family building by design than by chance. The interventions for improving child survival are well known – better education, improved access to health care, better nutrition, higher earnings, safe drinking water, and better sanitation. Not surprisingly

these are the same interventions that are needed for empowering women, for improving standards of living, and for stabilizing population.

India, however, has much ground to cover in terms of improving child survival. Current trends under the period of economic reforms are disturbing. Despite the higher growth rates in the 1990s, there has been almost a halving in the annual rate of reduction in infant mortality. India's infant mortality rate has been stagnating at around 70 deaths per 1,000 live births for the past four or more years.

The time has come to stop counting people, and to begin counting on people. Public action is required to expand people's capabilities, to enlarge opportunities, to invest in their education and health, and to promote women's empowerment. The simple *mantra* to population stabilization is: take care of people and population will take care of itself.

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Governance for Population Stabilization in India: Need for a Paradigm Shift

A. R. Nanda

The population issue has mostly been perceived as a demographic or numerical concern of the elites rather than a genuine concern of the individual or the family particularly of the poor and the marginalized. This neo-Malthusian mind set has by and large pervaded the planners, policy-makers, administrators, elitist scholars and the rich and upper middle class of citizenry. It has been, to quote Amartya Sen, one of 'authoritarianism' rather than 'cooperation'.

A balanced non-judgmental two-way linkage between population stabilization and sustainable development laced with cross-cutting perspectives of human rights and dignity as well as gender equality, equity and justice, constituted the basic perception of Mahatma Gandhi, when he countered the arguments of the exponents of international birth control movement trying to make India an arena for their experimentation in the 1920s and 30s. While stating that "uncontrolled reproduction was a social problem" and that "Indians should have smaller but healthier families", Gandhiji advocated women's empowerment and gender equality to enable women to take decisions on child-bearing and resisting and negotiating with their husbands for abstinence. He believed in 'Gram Swaraj' - rule of the community, by the community and for the community. As would be seen later, the fundaments of the paradigm shift in approach to the population and development problem in ICPD Programme of Action 1994 and the National Population Policy (NPP), 2000, are in tune with the spirit of Gandhiji's vision in respect of the population problem in India.

Scholars and thinkers of pre-independence India like P.K. Wattal, B.L. Ranadive and Radha Kamal Mukherjee were influenced by Western eugenists, Neo-Malthusians and birth controllists in viewing population control and family planning as a panacea for removing backwardness, poverty, unemployment and all other hardships in Indian society. A bureaucrat in British India, Leonard Rogers (a longtime health adviser to the India Office) is quoted as saying that he might have been "better employed in finding a lethal gas which might put the excess population out of its misery". Radha Kamal Mukherjee, who headed the sub-committee on population of the 'National Planning Committee' of the Indian National Congress in the 1930s, convened the first Indian Population Conference in Lucknow in 1936, and influenced the lop-sided narrow mindset on population problem in India, which became very pervasive in the process of policy and programme formulation and implementation in the post-independent India. The reports of demographers and scholars in the post-World War II cold war era were skillfully utilized by US and other Western countries to give a 'scientific' cloak to view the population problem of India from a negative and narrow perspective of numbers. The fear of 'population bomb' and 'population explosion' was unleashed on the same pedestal of anxieties as the nuclear war', which engendered quick-fix, short-cut and dehumanized policy prescriptions, and 'top-down targets' of family planning bereft of the recognition of a two-way linkage of population

and development, and the primacy of women's health and rights in the process. The cause was discredited for various reasons which included failure of early fertility limitation programmes leading to coercive measures, unfulfilled prophesies of a global famine, as well as divisions and oppositions in the family planning coalition from newly powerful constituencies like environmentalists and feminists.

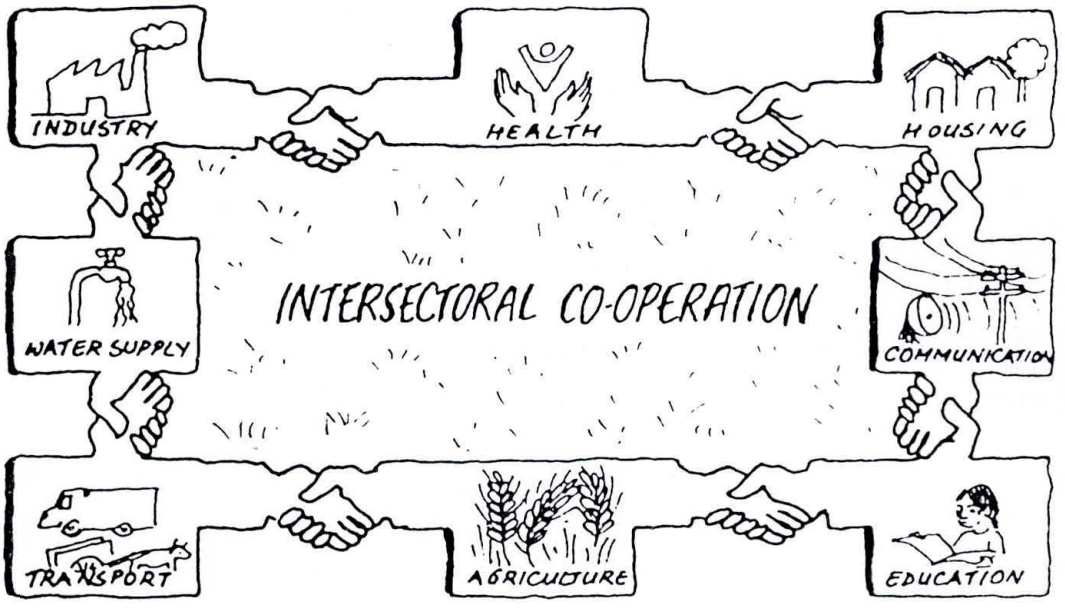
The mindset to go for a policy of compulsory birth control persisted, starting in the global arena from 1927 Geneva World Population Conference through the 1979 China's 'One-Child Policy' to the attempts, off and on, by some Indian politicians, bureaucrats and scholars for 'two-child norm' policies. All this reflects fundamentally an alarmist and over-simplistic view of a complex issue, which is required to be perceived with care, empathy and circumspection. One could see a common thread running through the mental make-up of people who present their arguments, theories, and suggest solutions of this type. Whether the pure demographers, population pseudo-scientists or bureaucrats present theories empirically, interpret data or statistics or suggest policy, strategy and programmatic prescriptions, they, by and large, have not been able to get over their basic Neo-Malthusian and elitist mindset and obsession with numbers in treating this complex and human issue. The mathematical formulas and statistical analysis with 'scientific' rigour are not sufficient to provide satisfactory explanation to the issues of a complex human behaviour in family, community and psycho-social-cultural settings. To quote Greenhalgh: "an over-reliance on quantitative research has constrained our understanding of the full complexity and context of fertility".

The evolution of population stabilization efforts in India by government goes back to the onset of five year development plans in 1951-52. A national programme was launched which emphasized 'family planning' to the extent necessary for reducing birth rates to stabilize the population at a level consistent with the requirement of national economy. A clinic-based approach with equal emphasis on natural method like rhythm as on some contraceptives was taken cautiously, along with awareness building and research on new contraceptives and their acceptability. A Family Planning Research and Programme Committee was constituted, which in its first meeting at Bombay in July 1953 took quite a comprehensive and broader view of the family planning. To quote their report:

"The committee emphasized that the family planning programme should not be conceived of in the narrow sense of birth control or merely of spacing of the birth of children. The purpose of Family Planning was to promote, as far as possible, the growth of the family as a unit of society, in a manner designed to facilitate the fulfillment of those conditions which were necessary for the welfare of the unit from the social, economic and cultural points of view. The functions of a Family Planning Centre would include sex education, marriage counseling, marriage hygiene, the spacing of children, and advice on such other measures (including on infertility) as necessary to promote welfare of the families".

Around the same period in China, the new Communist Government under Mao Tsetung looked at population basically as an asset, and took many benign measures of social development which brought in more equitable access to basic health, education, assets (including revolutionary re-distribution of land) and income over next 20 years. The concept of family planning services that China followed was in tune with what the Bombay family planning research and programme committee had conceptualized.

Instead of a top-down prescriptive target approach, China went in for a localized community approach. The Cultural Revolution made the bureaucrats and service providers more responsive and accountable to the local party hierarchies, the communes and the Production Brigades, and purged them of their elitist-intellectual hatred or indifference for the peasants. They became more alert to the needs of the communities and were responsible to meet these needs in an equitable manner. Such a style of governance brought in quick results in all indicators of social development including women's status; and the fertility rate came down very sharply by 1970s. The perception of the families and that of the state converged, when it came to acceptance of a small family norm. Only with the contagion of western education, the threat perception of growing numbers took deep roots in the mindset of some Chinese scholars, and leaders, and they advocated many restrictive population policies like the 'One-Child policy' which appears to have created more societal and family problems like skewed sex ratio, female infanticide and foeticide, rather than helping in smooth stabilization of population. There are thus lessons to be learnt from the Chinese experience in governance. We tend to misrepresent the Chinese story, whenever we compare the Indian situation for advocating coercive policies like "two-child norm" and the concomitment regime of incentives and disincentives to solve our population problem quickly.



It is a pity that our bureaucrats, advisors, planners and policymakers paid a lip service to the rational and sane advice of the Family Planning Research and Programme Committee in 1953, and instead, adopted disjointed, verticalised and top-down contraceptive programmes with targets of sterilization. A Department of Family Planning was created in the Health Ministry in 1966; the programme was made 'Centrally-sponsored'; financial incentives were introduced for sterilization acceptors; and sterilization was made target-oriented. Although the programme was integrated with maternal and child health during the Fourth Plan (1969-74), and further with health and nutrition in the Fifth Plan (1974-79) with creation of multi-purpose workers, introduction of mass motivational efforts and population education, the primary objective was to achieve targets of male and female sterilization imposed from above. The compulsory and coercive nature of the programme during 1975 and 1976 made it highly unpopular.

From 1977 onwards, a damage control exercise began by re-christening Family Planning as Family Welfare with voluntary acceptance of contraceptive targets without any coercion as the key strategy and recognition that it is an integral part of a comprehensive policy covering education, health, maternity and child care, family welfare, women's rights and nutrition. However, demographic targets and goals along with contraceptive targets did little to motivate the workers and supervisors to look beyond 'couple protection rate' for integration. The 'Action Plan' of 1986 did make a distinction between eight "family planning measures, and six "beyond family planning" measures; but a few measures were taken up for implementation as Centrally sponsored, with very little ownership and commitment from state governments and district administrations.

The Karunakaran Committee set up by NDC in 1991 missed the wood for the tree by emphasizing on disincentives around two-child norm in the form of disqualification for MPs, MLAs and other elected representatives. A Constitution amendment bill was introduced in Rajya Sabha thereafter, and is pending for consideration even now. Some state governments have gone in for legislations on the same measure for panchayati raj and urban local bodies. It is well-known that such measures for population stabilization alienate the poor, marginalized and women from political empowerment, and are counter-productive.

In 1993, the NDC proposed the formulation of a national population policy to "take a long-term holistic view of development, population growth and environmental protection", and to suggest policies and guidelines for formulation of programme, and a "monitoring mechanism with short, medium and long-term perspectives and goals". The expert group headed by M.S. Swaminathan prepared a draft Population Policy in 1994, which contained many positive and innovative recommendations. The International

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Conference on Population and Development, 1994 adopted a Programme of Action, which constitutes a paradigm shift in thinking and action on population issues globally and in each country's context including India. Based on the experience of containing population growth in various countries and the negative fall-outs of demographically-led insensitive policies, and strategies, the Programme of Action gave primacy to human rights (reproductive rights within these rights), gender concerns, 'quality of care' indicators rather than demographic indicators as well as social health and development.

The prescription for governance in such a policy framework was for need-based, demand-driven, client-centered services and products of population and development from governments. Government of India acquiesced in this POA and abolished all contraceptive method - specific targets from above in a Target-Free Approach (TFA) in 1995-96 and launched the Reproductive and Child Health Care approach from 1998. The first ever comprehensive and holistic NPP was formulated and announced in February 2000, followed by a 'National Health Policy' in 2002.

The NPP 2000 started with a premise that the overriding objective of economic and social development is to improve the quality of life of people, to enhance their well-being and to provide them with opportunities and choices to become productive assets in society. It very clearly recognized the close inter-relationship and two-way linkage between population stabilization and socio-economic development and enunciated goals and strategies – both social and demographic – which would have to be simultaneously pursued in a synergistic manner. Decentralization of Planning and programme implementation, convergence of service delivery at community levels, women's empowerment for improved health and nutrition, child health and survival, meeting the unmet needs for all family welfare services, with particular emphasis on underserved population groups including adolescents, increased male participation in planned parenthood, public-private-NGO partnership, mainstreaming Indian systems of medicine, better IEC and motivational measures, and provision for older population constituted the operational strategies with reproductive rights, gender equity and quality of care as the cross-cutting concern. A 100-point Action Plan was suggested to be pursued "as a national movement" for achieving multi-faceted objectives – short, medium and long term through a "multi-sectoral endeavour, requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society". Spread of literacy and education and women's participation in the paid work force together with a "steady, equitable improvement in family incomes" have been recognized as important as equitable access, quality and affordable reproductive and child health services aimed at population stabilization.

The governance for implementing the strategies and programmes / Action Plan of the NPP need to be suffused with a transformation of the conventional mindset and style of functioning of the bureaucrats, technocrats and service providers vis-à-vis the approach to population issues, accountability, planning, monitoring, and coordination and synergy – vertical as well as horizontal. Positioning family planning in the wider canvas of reproductive health with a life-cycle approach and the overall arena of primary health care and other key programmes of education, nutrition, water, sanitation, employment and poverty alleviation (in fact, the entire gamut of gender-sensitive, rights-based and equitable social development) with a participatory community needs assessment periodically for every village and for every ward of a town should be the starting point in any exercise of planning and designing of programme implementation. The authoritarian top-down target settings and bureaucratic monitoring of targets need to be replaced with work-plans based on CNAA with the active participation of PRIs, urban local bodies and community-based organizations like self-help groups, particularly of women. Such holistic plan for health, population and social development is to be prepared for each of the 6, 40, 000 villages and each ward of 6,000 urban areas. The district plans, state plans and the Central plan should be based on the community level plans reflecting the perceived needs of each family, and each community. Implementation of the work plans for each community should be monitored by the elected members of the ward of the panchayat / urban body with technical and financial assistance from government – NGOs – private sector, and all elements of 'social audit' built into this. 'Quality of Care' indicators should be the most important ones to be monitored rather than the quantitative targets per se. Only then could the efforts at population stabilization proceed on a smooth course, and could turn into a people's movement produce desired results.

This write-up is based on the Convocation Address delivered by the author at the 46th Convocation of the International Institute of Population Sciences, Mumbai in 2004

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Re-examining Policy Approaches: The National Population Policy 2000

Introduction

On the 11th of May 2000 India's population reached one billion. A girl child was symbolically chosen to represent this watershed. While this could have been a moment for somber reflection on India's development and what this meant to her population, it was used as an occasion to set demographic alarm bells ringing.

Over the years while concerns in family planning have contoured health sector development, early in the nineties, it was increasingly being realized that the program, one of the largest public health initiatives in the world, had reached a dead end.

In part as a result of this realization, in part as a result of the pressure generated by women's groups and health groups in the country calling for a radical reconsideration of the program, in part in preparation for the third decennial International Conference on Population and Development (ICPD) at Cairo in 1994, the Government of India appointed an Expert Group to chart out a new population policy. The Report of this group, commonly known as the Swaminathan Committee Report, proclaimed a policy that it described as pro-poor, pro-nature and pro-women.

The Committee had proposed a holistic approach visualizing over-all social development as the goal. It proposed the idea of merging family planning with the health department so that the importance of family planning as one, and only one, aspect of an overall health service could be emphasized. The Committee had resolutely rejected both the target and the incentive approaches several months before these were to enter the ICPD agenda for action. Further, the Committee had flagged the importance of using institutional arrangements for development offered by the 73rd and 74th Amendments to the Constitution. Yet it came in for criticism for the manifest disjunction between its policy perspective and recommendations.

In 1996, based on the recommendations of the Expert Group, and on the understanding that 'if our population policy goes wrong, nothing else will have a chance to go right', the Government of India announced a Draft Statement on National Population Policy (GOI: 1996.13)[1]. In February this year this draft was modified, accepted by Parliament and a National Population Policy (NPP) 2000 announced

[1] Government of India, Ministry of Health and Family Welfare, *Draft Statement on National Population Policy*, New Delhi.

The National Population Policy 2000

The policy announced "affirms commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services" (GOI: 2000:2)[2]. The immediate objective of the NPP is to meet the unmet need for contraception and health infrastructure. The medium-term objective is to bring the Total fertility rate to replacement levels by 2010 through inter-sectoral action and the long-term objective is to achieve a stable population, consistent with sustainable development, by 2045.

Towards this end the goals set out include:
1.Making school education free and compulsory up to age 14;
2.Reducing IMR to below 30 per 1000 live births;
3.Reducing the Maternal Mortality Ratio to below 100 per 100000 live births;
4.Promote delayed age at marriage;
5.Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons;
6.Universal access to information and counseling, and services for contraception with a wide basket of choices;
7.Hundered per cent registration of vital events – births, deaths, marriages and pregnancy;
8.Prevent and control communicable diseases, especially AIDS.

The strategies to achieve these goals include twelve items. Some of these are: decentralized planning and program implementation through Panchayati Raj Institutions (PRIs); convergence of health services at the village level; empowering women for improved health and nutrition; ensuring child survival interventions; involving diverse health care providers; strengthening IEC; developing increased partnership with NGOs and the private corporate sector; and finally, encouraging a range of clinical, laboratory and field research on maternal, child and reproductive health care issues. All these strategies are to have a special focus on under-served populations, namely, urban slums, tribal communities, hill area populations and displaced and migrant groups. Efforts are also to be directed towards increasing participation of men in the program.

At the same time as the Union government announced the NPP, several State governments including Rajasthan, Uttar Pradesh, Maharashtra, Madhya Pradesh, and Andhra Pradesh announced population policies of their own. Other states are in the process of doing so.

The Singamma Sreenivasa Foundation, Bangalore, and the Centre of Social Medicine and Community Health of Jawaharlal Nehru University, New Delhi, felt that this was an opportune moment to reflect on these policy initiatives both at the Centre and the States. At the same time, it was necessary to raise issues and concerns regarding certain critical areas impinging both on health and population. The issues on which the colloquium sought to focus on included concerns in public health, the relationship to macro-economic changes with particular reference to equity, women's agency and the possibilities offered by decentralization. Towards this end they organized a Colloquium on Population Policies in Bangalore on the 19th and 20th of November 2000. The colloquium involved academics, representatives from health and women's groups, elected women

[2] Government of India, Ministry of Health and Family Welfare, *National Population Policy 2000*, New Delhi, 1996.

representatives from PRIs in Karnataka and Kerala, and representatives from NGOs involved in developmental work. The participants were largely from the southern states and comprised of persons with a history of serious engagement with health and population issues. Officials from the Ministry of Health and Family Welfare at the Centre both and from Karnataka joined them during selected sessions. What follows is a brief summary of the presentations and discussions.

Salient Issues: Equity and Social Justice

Dr.Devaki Jain initiated the discussions and outlined the agenda. Over the last several years there had been a quantum leap forward both in our understanding of issues related to population and in articulate networks engaged in research and advocacy. The areas of great salience included the links between the economic and social sectors, between the macro and micro. She argued that the forward movement offers an opportunity for those interested in poverty eradication, in equity, in social justice to reflect on social policies with special reference to the socially excluded groups. The National Population Policy (NPP), following the ideas of the Swaminathan Committee Report had attempted to move away from both the two-child norm and target-based approach. There was however a subtle disincentive approach in the sections dealing with the institutional arrangements for delivering the policy. At the same time, the NPP also emphasized the importance of high quality social development services at the ground level as being the most crucial arrangement for enabling people who would like to have fewer children to exercise that will. The NPP also highlights the importance of local government structures and the need to give them much more space to design, implement and monitor social policies.

The colloquium was a coming together, to tease out the implications of the policies and to bear influence on both policy and programs at various levels. Some participants at the colloquium, she observed, were members of the Population Commission headed by the Prime Minister; others were members of several Working Groups set up under the aegis of the Commission. They could carry the insights and concerns from the colloquium into the discussions in these groups. Further, the colloquium could build a wider constituency of informed persons to bear influence on State-level policies and programs. Her particular concern was that in poor countries, characterized by extreme inequalities, the language of rights that should inform state policies was blunted by the very poverty and inequality. She also shared her concern regarding the instruments of delivery of health and population policies and the need to have real devolution of power to the grass-roots, and to women in particular. What is required is to use the knowledge that is available to put on the ground progressive policies that are enabling and empowering.

Mohan Rao, in his introductory remarks, argued that the colloquium ought to examine three related sets of issues. At the conceptual level, the question to be asked is do we have a population policy or a family planning policy? Imbricated in a population policy ought to be a vision for development, with macro-issues of income, employment, food, health and rights as the focus and not merely strategies for generating acceptance of contraceptives. Second, what are the instruments for such policy? How are macro-economic forces shaping the enabling conditions necessary for health and family planning? What, then, are our priorities with specific reference to the poor? How are issues of livelihood, poverty, inequality, hunger and ill health reflected in the NPP? Finally, there was a need for reconsidering some of the tools to attain the goals of the NPP, specifically the

move to induct long-acting, provider-controlled and women-centered hormonal contraceptives in some states and policies of incentives and disincentives in all of them.

Mala Ramanathan and Sanghamitra Acharya pointed out that the fundamental premise of the NPP was questionable. This was the concept of population stabilization. This concept emanated from the exercise of constructing Life Tables in a population and was thus a statistical abstraction. Further, there are no historical precedents of populations achieving replacement or below-replacement levels of fertility without preceding structural changes in the economy. Finally, they pointed out that the language of rights emanating from the ICPD at Cairo was marked by its absence in the NPP. Padma Prakash argued that the fundamental question elided in the NPP related to the nature and pattern of development. It was evident historically that while the relationship between population and socio-economic development was complex and contingent on a number of inter-related factors, population was the outcome of socio-economic factors and not the other way around. Blindness to this lead to the incoherence in policy we witness today. On the one hand we pursue a path of marginalizing and displacing populations through development projects as at Narmada. On the other hand, we have coercive population control policies. The question she mooted was, given this pattern of development, is it possible to have a people-oriented population policy?

Padmini Swaminathan drew attention to several myths regarding population and development. One overwhelmingly popular is, of course, the concept of over-population. But perhaps equally significant was a misunderstanding of processes involved in demographic transition. Thus not only had the wrong questions been posed, the wrong lessons were frequently drawn. Tamil Nadu's fertility transition thus indicated to some people that we did not need the high achievements in social development that had characterized Kerala. Political will, and female work participation rates were isolated as an explanation for T.N's case. Questions related to the nature and type of work participation were bypassed in arriving at simplistic policy lessons. Again, questions related to how macro-economic policy affects female work participation rates have not been raised. Detailed district level analysis on female literacy and work participation, however, revealed problems in these associations: districts with high female literacy and work participation rates were also districts with high fertility while the converse was also true. There is thus a need to rethink the simplistic understanding of complex issues related to population and socio-economic change. Development thus did not automatically ensue from a reduction in numbers. There was also a fundamental need to bring back issue of equity and structures of governance into policy discourse.

Thelma Narayan pointed out that the NPP was based on a certain assumption regarding the relationship between population and resources that was questionable. She wondered if the NPP is a reflection of pressure from institutions such as the World Bank, which guide not only economic policy but also health policy? Field experience indicates that what is expressed in policy documents is not reflected in practice. Thus although the program is said to be target-free, this is not the actually the case. Indeed Karnataka had come up with a pulse-IUD approach, subsequently abandoned, that had no sanction from policy. Narayan drew attention to the fact that even in Karnataka, a state with a relatively well developed and better performing health system than in other parts of the country, financial cuts had meant that health funds were adequate only for salary expenditures of personnel. As a result health services were crumbling with training programs at a

standstill. Indeed PHCs did not have adequate supplies of even iron and folic acid tablets. Issues of women's nutrition and education, and their linkages with family planning, were thus not on the agenda. It would not be exaggeration to state that the family planning program had contributed to increase discrimination against females. When the health system could not generate reliable data on births and deaths, it is difficult to believe we can have a sound policy in either health or population.

A member of Karnataka's Task Force on Health, H.Sudarshan substantiated Narayan's arguments. He drew attention to the fact that we do not have a health policy to which the population policy could be linked. Population after all cannot be separated from health, drinking water and sanitation as a minimum. These together, and in a synergistic manner, have to be combined with other inputs such as income, employment, education etc. He drew attention to the need for decentralized structures for implementation of programs, especially for the empowerment of grassroots workers, the ANMs.

Andhra Pradesh was one of the first states to announce a population policy. It was based on a singular reading of Tamil Nadu's success in achieving demographic transition wherein the political commitment of the state was seen as the primary determinant. This, Sheela Prasad maintained, must be seen along with the World Bank led and funded health reform package that is being implemented in the state. The question of sustainability of such reforms was not addressed. Instead, policy commitments to the contrary, the state had pursued family planning targets with a vengeance. Activists from health and women's groups had therefore come together to launch a forum known as GATS, an acronym for Groups Against Targeted Sterilization. The state was deaf to protest from GATS, yet the World Bank, sensitive to its image, had intervened and persuaded the state to go soft on targets. The question she raised was at what cost to women's health had A.P. realized its demographic goals? The scenario even in rural Andhra was that very young women were getting sterilized, and due to problems following, were being advised hysterectomy. The boom in private nursing homes had contributed to this in no small measure. She cautioned that the RCH approach and its emphasis on adolescents not mean that adolescent girls now become the focus of the program.

Ravi Duggal argued that what we have is not in fact a population policy but a family planning policy. There is a distinct difference in tone between the National and the State population policies with the latter more forthright in methods of achieving demographic goals. It is perhaps significant that Futures Group, an U.S. based consultancy firm, had drafted many state policies These states have unveiled a policy of disincentives and incentives that, despite the Centre's affirmations to the contrary, are ushering in elements of coercion in the program. Thus Maharashtra's policy for example recommends withdrawal of PDS and education facilities and a host of other welfare schemes for the third child onwards, while such mothers are ineligible to contest in elections.

Duggal drew attention to the overall withdrawal of the state, manifested in the collapse of primary health care and the completely unregulated growth of the private sector as a result. The private sector has little commitment to social goals, and thus it is regrettable that the NPP envisages a larger role for this sector, at public cost. He also noted that experience with vertical programs in the past had revealed their manifest limitations. Without a strong PHC system, even a gender-sensitive RCH approach would run aground. It is thus surprising that the NPP does not reflect the

need for strengthening Primary Health Care, and not merely primary level care, which is distinctly different.

Mohan Rao in his presentation dilated upon this last point. Data on deaths due to reproduction, high as this is, accounted for merely 2.4 per cent of deaths among females in the country. A focus on reproductive health among females was thus epidemiologically misplaced. In all age groups among women, including the reproductive years, communicable diseases and anemia accounted for a significantly higher proportion of deaths. This pattern of diseases and deaths, dominated by the quintessential diseases of poverty, can only be dealt with by a comprehensive system of universal Primary Health Care. He drew attention to the fact that macro-economic policy had led to deterioration in enabling conditions for health: in access to incomes, employment, food etc. This had been compounded by state withdrawal in its commitment to primary health care. This perhaps explained the alarming increase in infant mortality rates in ten states in the country.

Rao argued that the NPP did not adequately address these necessary, enabling conditions. What is more disturbing is that co-opting the language of rights, there is a move to introduce long-acting and injectable contraceptives into the program in the name of choice. Here too, the systematic erosion of public institutions had played an important role: contraceptive research was being guided not by public interest or the interests of women's health but by multi-national drug companies and other private interests while the Drug Controller of India turned a Nelson's eye.

Jaya Velankar forcefully argued the case for opposing coercive population policies initiated in some states. Recalling the policies under the period of the Emergency, the Maharashtra State Population Policy, for example, states that acceptance of a two-child norm is essential for eligibility to the government's welfare schemes, niggardly as they are. Further, assessment of performance of bureaucrats is to be on the basis of performance in family planning. Acceptance of a two-child norm is, again, made mandatory for qualifying for election to local PRIs. At the level of villages, group incentives are being proposed, which if history is a guide, will mean that dalits will bear the brunt of the policy. These are only a few of the range of incentives and disincentives proposed that are anti-poor, anti-women and anti-democratic. The induction of hazardous contraceptives like Neten and Norplant, exposes the hollowness of the claims to gender sensitivity of the policy.

Several speakers joined Sabu George in drawing attention to the worsening of women's status and health in the country with a sharpening of anti-women ideology. This was reflected in various ways: the use of reproductive technologies for female feticide, the burden of ill health imposed on women due to sterilization, the deterioration in sex ratios across the country, including Kerala. A practicing obstetrician, Shama Narang drew attention to the dangers of new reproductive technologies such as preimplantation genetic diagnosis (PGD) that could be used for the abortion of female embryos. Decisions regarding the use of health technologies cannot be left to doctors alone but must be guided by a moral vision of a society.

Ena Singh argued that the present context provided a window of opportunity to concerned people. The main positive feature of the NPP was its commitment to a program without coercion. There were other positive features such as the commitment to decentralization and to quality of care that should be welcomed. It might be pertinent too to recall that it was donors who were opposed to targets in the program. However, there was a disjunction between the national policy

and state policies. Further, state actions such as targets and disincentives are inconsistent with state policy. It is thus important to document what is occurring on the field and to recommend concrete measures and indicators to the Working Groups of the Population Commission. Indeed it is entirely possible that the Commission could set up one more Working Group to safeguard against any form of coercion and to monitor the program.

While no one would contest the desirability and need for decentralization, K.R.Nayar cautioned that decentralization could not by itself be seen as a panacea. There are various forms of decentralization and it is thus important to be clear about the nature, content and context of decentralization. For instance, even privatization could be considered a form of decentralization. What we have today in the country is deconcentration and not really decentralization. In this context we need to focus on what is actually happening at the level of PHCs and Subcenters. Above all, we must be aware of political structure at the local level which shape the process of decentralization. Nayar also drew attention to the need for public health research, not clearly spelt out in the NPP. The focus on technology missions in the NPP is misplaced. We need social research that is epidemiologically and socially relevant, and not donor driven.

Aleyamma Vijayan observed that women's needs and issues are not reflected in any other policy. It is therefore curious that women are pushed centre-stage only when a population policy is pronounced. The fact of the matter is that things are getting worse for women even in Kerala. Yet because Kerala has achieved replacement level fertility, there is a great deal of complacence. The fact that sex ratios are worsening in Kerala indicates not only the spread of anti-female ideology and practices but also the very success of family planning. Kerala's success needed to be qualified. While the experience with decentralization had been positive on the whole, health institutions had not really changed and had led to an alarming growth in the private sector.

Lijja, an elected member of a Panchayat from Kerala, substantiated Aleyamma's observations. She noted that privatization of medical care is taking place imposing a tremendous burden on the people. The second worrying feature of the health care scenario in Kerala was the medicalization of health. She noted that the Primary Health Care system suffers from neglect and concentrates only on family planning and immunization. As a consequence even natal care is not provided at PHCs. Only the very poor who have no other options, and are unable to avail of loans to access private care utilized, the PHCs. She drew attention to the fact that Kerala was an extremely masculinized society, unlike what most social scientists believed. Thus men bear no responsibility for family planning while abortion has emerged as a spacing method of contraception. Given the poor state of PHCs, the unregulated and ruthless private sector is filling the gap

The PRI representatives from Karnataka unanimously pointed out that while they had grown individually since their involvement in local level politics, they felt they had not been able to shake the anti-female bias in the Panchayats. Women were in a minority in Panchayats and were pushed into certain areas of responsibility like anganwadis, while men took over other areas. The major problems they identified for women in rural areas were poverty, lack of employment, water, poor state of schools, poor health care, male migration and land for housing. They were all concerned with the poor state of public health services and the expense involved in private sector medical care that grew as a result of the government's failures. Furthermore, the preoccupation in

the PHC system with family planning meant that even basic medical care was not available. They pointed out that in their districts of Northern Karnataka, it was educated and rich women who availed of private medical care for sex determination of the fetus followed by abortion if it was a female. This practice, they averred, had spread to almost very village. They were also unanimous that Panchayats are given responsibilities without power. Further, there was little support to their initiatives from higher levels. Despite all this they can now make certain that health workers are on the job and schoolteachers too report to work and anganwadis are working. Their own first priority would be to get more funds to get the health and education system working.

Reflecting on the discussion of health administration, Devaki Jain pointed out that currently social development schemes were delivered through departmental functionaries but Elected Women Representatives (EWRs) of the PRIs were asked to take the responsibility for effective implementation. This was not possible, as they had no jurisdiction and authority over either funds or personnel. The component plan scheme, by which 30 per cent of development funds from all sectors was to be spent on women, was in fact being handled by a committee of extension departmental functionaries. Even in Kerala where there is a process by which EWRs and functionaries design the utilization together, the component plan funds could not be utilized appropriately. It was thus necessary that social development programmes, including the funds related to them, could be devolved into committees of EWRs, and community-based organizations. The capacity of these persons to design, implement and monitor these programmes needed to be strengthened. Within the health sector, the personnel and the funds for availability of care, including access to reproductive health, could be placed in the hands of the EWRs. It is well established that women's capacity for self-determination is constrained by the authority of men and other hierarchies and traditions. For this to be opened up, it is crucial that gender relations are shaken and women are able to reclaim power or agency through the recasting of power structures. For such a transformation to take place, the political sphere and financial power are crucial levers that Panchayat Raj system offers. It has thus to be made a part especially in implementation of services to the poor and marginalized.

Areas of Concern

Given the wide-ranging nature of the discussions, the colloquium prioritized the following areas of concern.

It is clearly necessary to distinguish between the philosophy and actions towards a population policy, and those towards a family planning policy. The former should include, besides demographic concerns, larger issues of sustainable and equitable development. In this context it is necessary to spell out the links between macro-economic policy and population. The government's repeated stress on the need to stabilize the size of the population as a precondition for economic development misjudges the linkages, and sidesteps the lack of effective and equitable development policies

The NPP is not linked to an effective and equitable health policy. The fact that health itself receives low priority among planners is a matter of great concern. It is desirable, and eminently possible, that at least five per cent of GDP be earmarked for health.

It is unambiguously clear that the state, and state alone, can play the necessary role in the universal provision of comprehensive Primary Health Care, irrespective of people's ability to pay. Primary Health Care, as envisaged at Alma Ata, to which India is a signatory, not only implies preventive, promotive and curative health services, but all inter-sectoral efforts to promote health and prolong life. It is thus deeply disturbing that the NPP appears to regard Primary Health care as merely primary level care.

The increase in the incidence and prevalence of communicable diseases, in Infant Mortality Rates and in maternal mortality attests, among other factors, to the erosion of public health services in the country. There is an urgent need to arrest this alarming trend. Technology-determined vertical programs that are expensive and ill designed cannot achieve this task. No financial or human commitment to RCH can improve women's health without the necessary enabling conditions outside the health sector, and in the absence of universal and comprehensive Primary Health Care.

The dilution of the state's commitment to public health, and the subsidies given to the private and NGO sectors in the name of efficiency, bode increasing inaccessibility to health care for the people of the country. There is an urgent need to regulate the private sector that is currently not accountable to any institution, while simultaneously improving managerial and supervisory capacities in the public.

Disincentives, incentives and targets have no place in a family welfare program. First, they are unnecessary, as birth rates have commenced a decline in large parts of the country. Second, as experience in the past indicates, they are ineffective and serve only to generate false program performance data. Third, the financial allocations for incentives are a drain of scarce resources that ought to be utilized for strengthening Primary Health Care. Fourth, they inflict damage on the credentials of a so-called welfare program by deeply alienating people, the poor and powerless in particular, from the health care system. Finally, they profoundly violate democratic rights. Indeed considering the NPP is framed in the discourse on rights, it is fundamentally at variance with policies of incentives, disincentives and targets.

There is an urgent need to strengthen MCH services that have suffered as a consequence both of the collapse of the public health system and the focus on the family planning program. Given the state of women's health in the country, and the state of public health services, there is absolutely no place for the inclusion of long-acting, provider-dependent, hormonal contraceptives in the family planning program. Thus the induction of Neten, Norplant, or other such contraceptives must be firmly resisted. At the same time, there is a need to promote user-controlled, safe, effective and temporary methods of contraception. Equally important is the need to monitor and systematically study the health implications of contraception, including sterilization.

Training at all levels, from medical colleges to training programs for grass-roots workers needs to be reconceptualized. Health personnel have to be trained to respect and be sensitive to people. Training programs for public health personnel have been sorely neglected as a consequence of fund cuts.

Strengthening the PRIs is an important step in the right direction even though the experience has not been the same all over the country. PRIs need to have a real devolution of powers, including financial powers, from Zilla Parishad down to Panchayat levels. They have a crucial role in the planning, monitoring and implementation of all health and family welfare programs, but cannot supplant the role of the state.

The exiting data collection system leaves much to be desired. This has to be strengthened as part of the overall strengthening of the health care system rather than by initiating parallel systems of data collection or launching ad-hoc studies.

Research should be an on-going activity of all health and family welfare programs rather than end-term project appraisals that lead to neglect of process oriented research. Research funding should not be centralized but should be available at different levels for appropriate, epidemiologically and socially relevant inter-disciplinary health research. There is no place for donor-driven agendas of research that are all too frequently epidemiologically misplaced. In this context, there is an urgent need to strengthen public institutions of research that at one time produced nationally and internationally acclaimed epidemiologically relevant studies but are now suffering the consequences of systematic neglect and fund cuts. Public health research is too important to be left to private bodies and institutions that have their own agendas or NGOs not equipped to carry out epidemiological research. This has been the case especially with contraceptive research as illustrated by so-called research carried out with quinacrine and with Norplant. In this context, the role and position of the Office of the Drug Controller of India has to be substantially strengthened.

PRIs should be involved in the ethical review of research since ideas of informed consent have proved problematic in the Indian context. There should be a renewed focus on the family, on groups such as landless laborers, dalits, and other marginalized groups, especially in the light of globalization and SAP.

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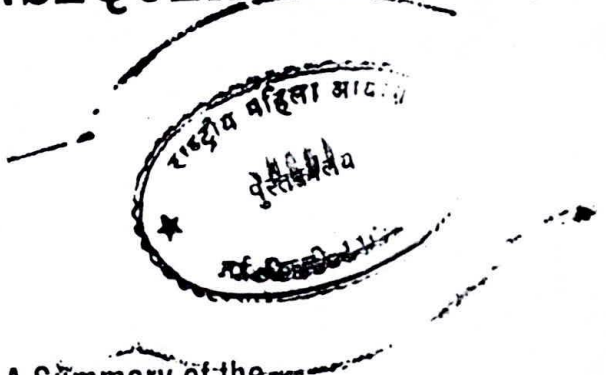
PANCHAYATI RAJ
AND
THE 'TWO-CHILD NORM':
IMPLICATIONS
AND
CONSEQUENCES



A Summary of the
Preliminary Findings of Exploratory Studies
in
Andhra Pradesh, Haryana,
Madhya Pradesh, Orissa, and Rajasthan

Mahila Chetna Manch
January 2003

Panchayati Raj and the 'Two -Child Norm': Implications and Consequences

A Summary of the Preliminary Findings of Exploratory Studies in Andhra Pradesh, Haryana, Madhya Pradesh, Orissa and Rajasthan

Introduction

India's National Population Policy (NPP) of 2000 is a significant move towards a humane and effective development policy aimed at improving the overall quality of life by promoting better awareness of and access to health-care options with a focus on women. As a signatory to the International Conference on Population and Development (ICPD) Plan of Action in 1994, India focused on inter-linkages between population, development and gender. This new approach was implemented at a time when widespread grassroots changes were taking place in India as a result of the 1992 Constitutional Amendment. This amendment aimed at revitalizing and guaranteeing regular election of local bodies – *panchayats* — that brought forth a critical mass of women and underserved sections of society into these institutions of decentralized local governance.

At variance with the NPP, many states had come forward with legislation that would disallow persons having more than two children to contest *panchayat* elections and would disqualify elected members of *Panchayati Raj Institutions* (PRIs) who had a third child after a stipulated date. This clause, however, did not apply to a person who already had more than two surviving children before the stipulated date,

unless s/he had an additional child after this date. This measure, commonly known as the 'Two-Child Norm', was seen as a way to regulate family size and thereby contain population growth. It also positioned elected representatives as 'role models'.

Some states extended this norm beyond *panchayati raj* elections to cover municipalities, agricultural produce committees and cooperatives, and also to exclude persons from various state-sponsored programme benefits such as loans, subsidies, poverty alleviation programmes, and eligibility for government jobs.

This legislative measure has caused concern amongst experts and women's organizations because it is often implemented in a non-equal opportunity environment, where women and underserved groups stand to suffer the consequences of acts that fall beyond their control. The measure is therefore of a nature to potentially encroach on nationally and internationally agreed upon principles of informed choices and on reproductive rights. It could have implications for democratic participation, as well as for women's autonomy. It was argued that the measure could be coercive and, in a highly patriarchal society such as India, could ultimately penalize women who had little or no control over reproductive decisions.

These concerns have, however, remained unexplored, warranting detailed studies to examine various dimensions and fallouts of the legislative measures. An informed public debate could guide policy formulation. It was with this view that the Ministry of Health and Family Welfare, Government of India, commissioned studies, supported by UNFPA, in Andhra Pradesh, Haryana, Madhya Pradesh, Orissa, and Rajasthan.

The Studies

The Mahila Chetna Manch, Bhopal, undertook these studies in 2001-2002 with a common framework. The five states where the studies were conducted have slightly different histories in terms of the introduction of the Two-Child Norm for *panchayati raj institutions*. Rajasthan was the pioneer in introducing this norm for *panchayats* and municipalities as early as in 1992, but the norm became operational in the state only in November 1995. Andhra Pradesh, Haryana and Orissa also had the norm in place in 1995. These studies are thus the first to examine the experiences in some depth and set the tone for discussion, debate, and further research.

Study Objectives

The studies seek to capture the experiences and perspectives of those who have been disqualified or have been subject to the process of disqualification on the basis of the Two-Child Norm provision, as well as of those who are indirectly affected, such as the spouses of disqualified persons. The studies also include perspectives of those implementing this measure. The studies examine how different groups in civil society, and how the media, perceive this measure.

The study objectives were to:

1. Understand and analyze the implications and consequences of the Two-Child Norm on men and women, with special reference to their reproductive rights;

2. Draw out and document legal and other constraints and experiences of implementation of the norm from the viewpoint of those who were affected directly or indirectly, legally or otherwise; and

3. Make recommendations based on perspectives emerging from the studies.

The concerns covered can broadly be grouped under two heads: a) identification and socio-economic profiles of those disqualified because of non-adherence to the norm, the effect of the disqualification, and mechanisms adopted to avoid disqualification, and b) issues related to implementation, including legal action thereof. The details covered are as follows:

- The historical perspective
- Consequences of disqualification across gender, caste and class
- Socio-demographic profile of disqualified persons
- Constraints in accessing and adopting family planning services
- Abortions and related responses among women PRI members and wives of male PRI members
- Implementation issues: filling vacancies, mechanisms to avoid disqualification
- Content analysis of court rulings
- Rationale for linking population stabilization with disincentives.

Methodology

The studies are essentially exploratory and participatory in nature and use primary and secondary sources of data. Secondary data on memberships in *panchayats* and related information have been obtained from offices of the Election Commissioner of respective states. State population censuses have been used for demographic data. Desk reviews of policy documents, instructions, legislative debates, judicial rulings and press-clippings have provided additional information crucial to the studies.

Primary data were generated through fieldwork that was carried out from July 2001 to March 2002 in two to three phases. The research teams were briefed about the Two-Child Norm and its related aspects, and were given intensive training for three days. This included a one-day practical training in the field. In each state, a minimum of two districts was purposively selected, assuming that the data would be available in official records. However, district-based pursuit of information did not yield results because either none or very little basic data on disqualified persons were available with concerned authorities (with the exception of Haryana and Rajasthan). Hence, the final selection of districts was based on availability of cases. When informal sources pointed to the existence of affected or disqualified cases based on local knowledge, these cases were pursued. Consequently, the number of districts studied increased in all states. The districts included, and some of their study-related characteristics, are given in Table 1.

Table 1: Districts Included in the Field Survey

States/districts	Some characteristics
Andhra Pradesh	
1. Nalgonda	Limited information on disqualified members; low urbanization
2. Ranga Reddy	Limited information on disqualified members; high urbanization
3. Mehboob Nagar	Limited information on disqualified members; high urbanization
Haryana	
4. Ambala	Relatively large number of disqualified members
5. Gurgaon	Cases at various stages of inquiry, appeals and litigation; Mewat was selected here as the most backward area of the state; Muslim population
6. Faridabad	Relatively large number of disqualified cases; industrially advanced
Madhya Pradesh	
7. Betul	Better CPR, declining decadal growth rate and declining sex-ratio
8. Vidisha	Low sex ratio, higher decadal growth rate, agriculturally rich
9. Hoshangabad	New cases of disqualification
10. Sehore	New cases of disqualification
11. Neemuch	New cases of disqualification
12. Bhopal	New cases of disqualification
Orissa	
13. Cuttak	Limited information on disqualified members
14. Khordha	Limited information on disqualified members
15. Dhenkanal	Limited information on disqualified members
16. Puri	Recent case of disqualification
17. Angul	Limited information on disqualified members

Table 1: Districts Included in the Field Survey (contd.)

States/districts	Some characteristics
Rajasthan	
18. Ajmer	Ajmer and Alwar identified for special population policy measures, high CBR, large number of PRI representatives and also of disqualified members
19. Alwar	
20. Sawai Madhopur	Identified for special population policy measures, high CBR
21. Jaipur	Identified for special population policy measures, high CBR

A total of 262 respondents were interviewed with the help of eight semi-structured interview schedules meant for different segments of respondents as categorized in Table 2. The interview schedules were prepared in English and were also translated into Hindi. However, the regional language was used wherever necessary. In addition, twelve Focus Group Discussions (FGDs) were conducted with community members at the village level and forty in-depth case studies were prepared. The following table provides details of those who were interviewed in various capacities

Table 2: Statewise Number of Respondents Interviewed

Respondents	AP	Haryana	MP	Orissa	Rajasthan	Total
Policy Makers	2	1	3	6	2	14
Programme implementers	4	2	3	5	4	18
Health and Medical officers	2	2	1	1	3	9
Lawyers	3	4	6	3	4	20
Media Persons	4	4	5	3	3	19
NGO persons	7	6	8	5	5	31
Anganwari workers	2	3	4	2	2	13
Panchayat representatives	23	22	38*	29**	26	138
Total	47	44	68	54	49	262

* 20 affected, 18 non-affected

** 20 affected, 7 non-affected (plus one chairperson and once ex-chairperson of Puri municipality who were interviewed in the same schedule.)

Those respondents who brought out important concerns about the law and its consequences were selected for case studies. These concerns related, for example, to abortion, sex selection, wife desertion, or legal battles.

Table 3: State Wise Case Studies Conducted

Andhra Pradesh	9
Haryana	9
Madhya Pradesh	9
Orissa	6
Rajasthan	7
Total	40

In addition, 12 FGDs were conducted with questions on various issues related to the norm. Their break up is: -

Table 4: State Wise Number of FGDs

Andhra Pradesh	2
Haryana	2
Madhya Pradesh	4
Orissa	2
Rajasthan	2
Total	12

The FGDs were held at the village level. The 25-30 participants included community members of all age groups and different social groups, but did not include *panchayat*

representatives. Participants shared their perspectives on the law, its implementation, and its consequences. In MP, additional FGDs were conducted as part of a second phase of fieldwork since disqualifications started only in November 2001.

Constraints and Limitation of Data

Data on disqualifications had to be collected at district and block levels. Even where some information was available at the state level, there were discrepancies. In several instances actual numbers, when seen at the district and block levels, surpassed those recorded at the state level.

There was uneasiness and reluctance of officials in some states to reveal information or to give interviews on the subject of disqualification. Given the sensitivities involved with the Two-Child Norm and its implications, difficulties encountered in eliciting responses of *panchayat* members, especially women, had also to be kept in view.

Inadequate and inconsistent data on disqualified persons (except in Rajasthan and Haryana to a certain extent), official reluctance to part with information, the limited timeframe, and nature of issues to be investigated meant that very systematic samples could not be drawn. Nor was it possible to have 'control groups' i.e., a similar number of *panchayati raj* representatives with identical socio-demographic backgrounds, but not disqualified. There was an added dimension due to the fact that some of these persons had exceeded the norm but had not faced disqualification. This also meant that the sampling techniques followed in these studies were not through rigorous procedures characteristic of large sample and quantitative techniques. The nature of this study is such

that though the data are qualitatively indicative and methodology rigorous, the findings are not statistically representative.

In Madhya Pradesh, though the law had come into effect in January 2001, the disqualifications started when fieldwork was almost over in November 2001. The consequences were therefore captured in the second phase of the study.

Data/Information Available at the State Level

Where data were available from various sources, they showed large numbers of disqualifications on the basis of the Two-Child Norm. In Rajasthan, there were 63 disqualifications in the one and a half years after the 2000 elections. Between 1995 and 1997, 412 cases of disqualifications had been documented. One study in Rajasthan had estimated 1,579 disqualifications but with no break-up of social group. In Haryana, in one and a half years after the 2000 election, the list included 275 disqualifications. The actual number for the state as a whole could be higher as the three study districts alone showed as many as 166 cases in one and a half years after this election. In Madhya Pradesh, the law became effective from January 2001. There was no awareness or action taken till October 2001, but from November 2001 onwards, i.e. almost a year later, 52 cases were reported from 7 of the 45 districts in the state. These were reported in a four-month period. In Panna district, 164 representatives had been given notice by the end of March 2002. By then 8 districts in the state had about 200 cases.

In Andhra Pradesh and Orissa very little data were available at any level. The Orissa State Election Commission dealing

with *panchayats* gave a list of 7 cases in 9 districts. However a quick visit to 10 districts showed 27 cases in 9 districts. There are admittedly a large number of disqualifications for which data are available in individual case files. For instance, the district which gave details of 7 cases (which formed part of the above-mentioned 27 cases) reported that information on about 20 cases existed but that it would be inaccessible, even at the block level. Data were similarly not available in Andhra Pradesh. Most cases in Andhra Pradesh were pending in civil courts with stay orders on disqualification notices.

Emerging Concerns

While the efficacy of the norm achieving intended outcomes has not been proven, there seem to be a large number of unintended outcomes influenced by the implementation environment and socio-political realities. These are reflected below.

Proper information dissemination not in place

- It has been observed that the process of disqualifying defaulters starts only if a complaint is lodged against any candidate's nomination at the time of the election or after election. It has been noticed that people are generally uninformed about the provisions of law and come to know of the norm at the time of nominations or when they receive notice, but do not fully understand its implications. This happens more often with women.

- Case studies and FGDs unequivocally show that low levels of literacy in general, combined with ignorance about the law even amongst educated

contesters, and in particular among implementers, has meant wastage of resources – both human and financial – for those who were subsequently disqualified. For example, amongst those disqualified, slightly more than half (54 percent) were either illiterate or had primary education, whereas 3 percent were graduates or postgraduates. The rest were educated up to middle level (16 percent) and higher secondary level (27 percent).

- FGDs and interviews with NGOs and media persons show that the norm has gone unquestioned. No debate is taking place on the implications and potential consequences of the norm on human, democratic, and reproductive rights.

Economically and socially most vulnerable sections are the worst affected

- The norm-based disqualifications of persons and others affected in the process (such as their spouses) consist of a higher share of socially weak sections of the population: 78 percent of all cases studied belong to scheduled castes (SC), scheduled tribes (ST) and other backward castes (OBC).

- At least 70 percent of affected persons have an annual income below Rs. 30,000/- per annum whereas 30 percent were in the lowest annual income group of Rs. 11,000/- per annum.

Norm a potential tool for misuse

- First and foremost, disqualification hinges upon birth of a third/additional child after a stipulated

date. Manipulation and misrepresentation of date of birth are common and relatively easy because of a high prevalence of home deliveries and non-registration of births. On the other hand, disqualifications were also being contested on the basis of false certification of sterilization.

US is a Backward Caste, 7th standard pass, young female *sarpanch* in a *panchayat* that has traditionally been the political stronghold of the upper caste/class. After three children, she had a sterilization. She was elected *sarpanch* in the August 2001 elections. The problem started after the election results were announced. She was physically attacked by rowdy elements when she was coming in a procession organized by her supporters. Chilly powder was thrown on her face. Her opponents filed a case against her in October 2001 saying that her third child was born after May 1995. Everyone in the village knew that US had neither the knowledge nor the money to defend a case in court. Her husband is a bus conductor. US feels that rich politicians, to keep control and power in their hands, are misusing the Two-Child Norm law. She also feels that potential candidates, who are poor like her, will not be able to run around courts and spend money defending their cases, and that this law is not in favour of the poor.

(Case study from Andhra Pradesh)

- It has been observed that complaints usually start from opposing camps after nominations are filed or after elections are held in order to settle old scores or to retaliate.

- It has been observed that prolonged court procedures and stay orders benefit some PRI members by giving them time to complete their tenure.

- Policy makers assumed that this law would influence fertility decisions of *panchayat* members towards a small family size, and that others would follow their example. The case studies indicate that such an assumption may not hold true. There are many instances of disputing the age or date of birth of the last born child, tampering with records and evidence (such as *anganwadi* immunization records and pulse polio campaign records), procuring false certificates, collusion with local officials, and getting stay orders, etc.

- Case studies across states show that the norm has been used as a strategy to either pre-empt potentially promising political rivals or remove them after their election. Conversely, it is possible for some to violate the Two-Child Norm, yet work around political factions and continue in their posts.

KB is a *dalit* (Schedule Caste) and occupied the position of *sarpanch* from 1995 to 2001. When his wife became pregnant and he was threatened with disqualification by opposing political factions, KB sent his wife to her natal home and did not bring her back for more than two years. When people enquired about his wife, he told them that she was sick and had gone to her parents. In the two years that his wife was away, he married again. This second wife also had a son who was about one and a half years old at the time this research was being undertaken.

(Case Study from Andhra Pradesh)

- As high as 95 percent of the disqualified persons belonged to the age cohort of 21-39 years. There were cases where much older relatives replaced younger, albeit disqualified persons, because of the stipulated cut-off dates set for disqualification. This defeated the very purpose of reducing the age from 26 years or more to 21 years for contesting *panchayati raj* elections and encouraging the younger generation to participate in PRIs.

- There are other contested issues such as stillbirth and birth of twins. While some states factored in the stillbirth of the third child, or subsequent infant or child mortality in determining applicability of the norm by having 'two live children' as the basis, other states only had 'two children' as the basis. Similarly, in the case of twins, the applicability of the norm varied in different states, as only Rajasthan's law addresses this issue.

Women face double-edged challenge

- Forty percent of all candidates were disqualified or involved in legal processes, 50 percent of scheduled castes and 38 percent of backward castes were women. In Orissa, women constituted about 55 percent of all such cases; in Andhra Pradesh this category constituted about 48 percent. Thus, women are further marginalized by this legislation.

New women entrants in *panchayats* showed participation across wider social and economic classes as compared to earlier patterns when most came from dominant castes and classes and from higher age groups. This has been possible with the family support they now receive. At the same time, however, the Two-Child Norm acts as a barrier for them because they are not in a position to stop their child-bearing after a certain numbers of children, particularly in the face of a prevalent son preference.

(Based on case studies from Haryana)

- The nexus between the norm and violation of reproductive rights is complex and not always statistically quantifiable. Yet cases have been observed of abortion, desertion, divorce, extra-marital affairs, (because the legal wife was sent to her natal home to hide the third pregnancy or child) and of giving away of children in adoption.

- Although it is extremely difficult to access information on a subject as sensitive as prenatal sex determination and sex selective abortion of the female foetus (people did not easily speak of it), the case studies have documented four instances of prenatal sex selection prompted by the need to adhere to the norm.

SB, a 30-year old Schedule Caste woman, was elected ward member in 1997. She and her husband earn a living by making leaf cups and plates. They have four children. The first three are daughters. The

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youngest is a son. She underwent sterilization when her son was 6 months old. During her fourth pregnancy, she had a sex determination test and was told that it was a female. She had an abortion. In her next pregnancy, she had the test done again and learnt that it was male. She continued the pregnancy and delivered her fourth child, a son.

At the time that she was removed from her post as ward member, she had four months of her tenure left. At that time, she told the District Collector that since so many other PRI members also had four children, they too should be removed. In reply, she was informed that there were no complaints against the others. In her case, the Block Development Officer (BDO) had conducted an enquiry and verified the facts from the *Anganwari* record, in which her children's names had been entered. SB stated that the complaint against her and one other ward *panch* was made by the male *panchayat* secretary as she, along with the village people, had had him removed for misappropriating funds of the monthly remuneration of ward *panches*.

(Case study from Orissa)

- In the studies, some reported cases of induced abortions and attempted abortions seem to be linked with stopping the birth of a girl child as the third/additional offspring. There were a few cases where the male foetus was retained even in the face of disqualification, because for these parents the benefits of having a son far outweighed

the benefits of being a *panchayati raj* representative. This issue needs further probing.

RP, a *sarpanch*, has six children through three wives. The last child, a boy, was born in February 2001. When asked about the Two-Child Norm, he took this very lightly and said that he had heard about it from the *panchayat* secretary. When informed that he was subject to disqualification because of his son, he replied, "The *sarpanch*'s post is not going to support me during my old age, but my son will. It does not really matter if I lose the post of *sarpanch*."

(Case Study from Madhya Pradesh)

- There was evidence of women getting discouraged in view of long drawn out court cases, enquiries and mental trauma resulting from the dilemma between continuing in the post and a simultaneous desire for a son or a large family. The mental trauma is noted especially where the law has been in place for some time. This defeats the intent of the 73rd Amendment that attempts to facilitate and encourage entry of women across class and caste into *panchayats*.

S.M. is an educated Other Backward Caste (OBC) woman who was selected as a *pradhan* of a *panchayat* committee in 1995. She continued until 1998 when she was disqualified. Her natal family was politically well connected. She had contested on a general seat. The birth of her third child had been a major source of tension, though she tried to suppress evidence

and pretend that the baby was from her husband's fictive first wife. She did not want the third child, a second son, but her husband did. "Two sons are like two eyes," he would say. "We end up producing children due to men, women are not to be blamed", laments S.M. She had three abortions after the election.

S.M. showed visible signs of extreme tension. As a lactating mother, she could not openly feed her undeclared child or take it to meetings. Despite being politically connected, knowledgeable about the *panchayati raj* system and wanting to work, her functioning was clearly impaired by her tense state of mind.

(Case study from Rajasthan)

In Sum

Population growth is an issue that requires a multi-pronged strategy and the Two-Child Norm for *panchayati raj* representatives has been seen as one of the ways to achieve it. The five studies in Andhra Pradesh, Haryana, Madhya Pradesh, Orissa and Rajasthan attempted to understand the impact of this norm on governance and on fertility decisions and reproductive rights. Although qualitative in nature and drawing from limited primary data, they demonstrate that the way the norm is conceptualized and currently implemented is not without serious unintended negative consequences. It becomes exclusionary, particularly of those at the lower end of the caste and class hierarchy, and discourages women from participating in grassroots decentralized governance though PRIs. The

manner in which fertility decisions are impacted by the law is not in keeping with the client-oriented spirit of the National Population Policy or the rights-orientation articulated in the Plan of Action of the International Conference on Population and Development.

It appears that to the legal mind, the Two-Child Norm is firmly positioned against issues such as population explosion, resource depletion and sustainable development, requiring measures to contain population growth. The norm, therefore, is not seen by the legal mind as directly interfering with the right of any citizen to take a decision in the matter of procreation, as they see it as only generating a legal consequence for a person who has had more than two children on the relevant date of seeking elected office under the Act. Given the composition of disqualified persons, it is the persons from socially disadvantaged groups and their spouses – women - who are likely to bear the brunt. More importantly, the entire question is that of the efficacy of an externally imposed norm that is inherently coercive when seen from the perspective of informed choices and reproductive rights. The Two-Child Norm for *panchayati raj institutions* thus requires further informed critical public debate and appraisal.

Several research issues have emerged from the studies. These include, for example, the need for documentation and maintenance of a database over time; the need for critical analyses evaluating the efficacy of the Two-Child Norm from a political, legal and socio-economic perspective; assessment of the long-term effects of the norm on reproductive health and reproductive rights; and the implications for women's autonomy.

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The Myth of Population Explosion:
Reflections in NPP and State Population Policies

Dr. Almas Ali

At the outset let us start by asking ourselves a very important and pertinent question i.e. "in India, even today when we talk of population why is there such an overwhelming concern for "numbers"? No doubt, I agree, "numbers" are always fascinating and usually carry with them the ring of "so-called" inevitable truth. But, unfortunately enough, in our country population related numbers have become matters of grave concern and often misinformed public debate.

It is a fact that, in the last five decades India's population has increased from 36 crores in 1951 (around the time of Independence) to over 102 crores in 2001. The growth in numbers of India's population has become a perennial source of worry for everyone – politicians, public leaders, administrators, bureaucrats, development planners, public health experts, demographers, social scientists, researchers and even to the common man. To be frank, there is some sort of a "fear psychosis" about numbers – some kind of a "number phobia". Whenever, there is any discussion on population issues it invariably begins with such expressions like: "India has over one billion people," – "it is the second most populous country in the world," – "in near future it will cross China and will become the most populated country in the world," "large population of India is the real reason for high levels of poverty, low per capita income and slow economic growth" and it is often stated that an uncontrolled explosion is responsible for holding India's progress an economic growth and is identified as a significant hindrance for the country's development.

First of all I must take on the question – yes, a very difficult question whether India is going through a population explosion or put it simply whether India's population is still growing at an alarming rate. The question admits of a simple answer-surely a definite NO. But this straight-forward answer on its own will not convince any one and take us very far. We have to ask many other related questions as well as we have to understand some basic issues.

Let me begin with the most basic issue i.e. the issue of population growth. It has to be understood that population growth occurs naturally and has taken place everywhere in all regions of the world and India is no exception.

In order to understand this in a correct perspective, there is a need to understand the concept of demographic transition is usually presented in terms of three stages of demographic evolution:

- First stage is high birth rates and high death rates (high balance)
- Second (intermediate) stage is high birth rates and low death rates (high rate of natural increase) and
- Third stage is low birth rates and low death rates (low balance).

With the advancement of economic and material progress, education, women's empowerment and availability of contraceptives birth rate start declining slowly at first and rapidly thereafter and soon a stage is reached i.e. third stage where the birth and death rates are equal once again i.e. low balance. This cycle of changes which occurs in any population is known as demographic transition.

Let us have a closer look at the second (intermediate) state, which is of high rates of natural increase as a result of faster decline in death rats (mortality) with birth rates maintaining their initial high levels.

This scenario characterized the world demographic growth in second half of the 20th century with an unprecedented growth rate. World's population doubled from 3 to 6 billion in less than forty years between 1960 and 1999 and increased from 5 to 6 billion in just 12 years (from 1987 to 1999) while it had taken four times as much to double from 1.5 to 3 billion and nearly a millennium to reach the first billion. What triggered this growth in the second half of 20th century starting from 1950 onwards, shortly after the Second World War was the rapid and steep fall in the death rate? This sudden decline in death rates (mortality) was primarily the result of achievements in the then economically advanced countries and the unexpectedly low cost of applying the benefits of modern medicine and replicating them in developing countries. Knowledge acquired in curbing the spread of killer diseases and epidemics was transferred to the developing countries whose natural growth rate was near stagnant (which was a reflection of high mortality and high fertility). While the death rate fell drastically, fertility and reproduction maintained their high levels (i.e. birth rates remained high). This resulted in unprecedented high levels of natural growth.

India was no exception, and in our country also from around Independence, the death rates started declining rapidly while birth rates continued to remain high. This led to a phase of rapid growth in population from 1951 to 1981.

As seen from the above table in 1951 the total population of India was little over 36 crores which grew to about 44 crores in 1961 and to about 55 crores in 1971. During the decade 1951-61 absolute increase in population was about 8 crores, decadal growth rate was 21.6% and average annual exponential growth rate was 1.96. The period between 1961-71 recorded the highest ever decadal growth rate of 24.8% with a corresponding average annual exponential growth rate of 2.22 with an absolute increase of about 11 crores. The period between 1971 and 1981 recorded a marginal decrease in decadal growth rate from 24.8% in 1961-71 to 24.6% in 1971-81.

However, after 1981, in fact the population growth rate (both decadal growth rate and average annual exponential growth rate) has reduced considerably. In the last 20 years the decadal growth rate and annual average exponential growth rate has come down from 24.6% and 2.22 during 1971-81 to 23.9% and 2.14 during 1981-91 to 21.3% and 1.93 respectively during 1991-2001. In fact, the recent decadal growth during 1991-2001 registered the sharpest decline since independence.

This means in India, population growth rate has definitely been declining steadily over the last two decades. Moreover, Fertility has also declined in the past, say in 1951, a woman would have an average of over 6 children (though many of them would die early) but now the average is little over 3. That is, what

Population of India at a Glance: 1901 – 2001

Years	Total Population in CRs.	Absolute increase (in Crs.)	Decadal growth rate	Average annual exponential growth rate	Phase of demographic transition
1901-1951	23-36	13	-	-	Near stagnant population
1951-61	36-44	8	+21.6	1.96	High growth
1961-71	44-55.	11	+24.8	2.22	Rapid high growth
1971-81	55-68	13	+24.6	2.20	
1981-91	68.84	16	+23.9	2.14	High growth with definite
1991-2001	84-102	18	+21.3	1.93	signs of fertility decline

we call in technical terms TFR (Total Fertility Rate), which was as high as 6 or more and has come down to 3.2 in 2001.

The fact is in India couples now having fewer children and most couples out for small families. Then why overall growth in numbers still appears high? It is because of what is called *"Population Momentum"* Past trends in fertility and mortality i.e. from 1951 to 1981 have shaped the *"population age structure"* in such a way that there is a tremendous *"In built growth potential"* and has resulted in the "bulge" in the proportion of people in *Prime reproductive ages*. Moreover improvement in general mortality conditions in aged population and increase in life expectancy has helped to accelerate in built growth. This tendency of growth is termed as *Population Momentum* in demographic literature. In short, India has high proportion of young persons (about 60%) who are in the *"reproductive age group or will soon be so"*. Even if this group produces fewer children per couples the *Quantum increase in numbers will be high*, because the numbers of reproducing couples is high. Thus, the birth rate will be high even though Total Fertility Rate is low.

According to some estimates in the period 1991-2001 the proportion of population growth due to population momentum was as high as nearly 70% (69.7%) while unwanted fertility contributed about 25% (24.4%). Only 5 to 6% (5.92%) of population growth was due to wanting more children. Even if fertility could immediately be brought down to replacement level i.e. TFR 2.1 with constant mortality and zero migration, there will be tremendous population growth in absolute terms in near future and this trend will still continue for next few decades.

India with its large proportion of young persons will take sometimes before the results of

India's Demographic Progress

Sr. No.	Parameter	1951	1981	1991	Current	NPP – Goals for 2010
1	Population (in million)	361	483	846	1028 (2001 Census) 1111 Current (estimate)	1107
2	Crude Birth Rate (per 1000 population)	40.8	33.9 (SRS)	29.5 (SRS)	28.8 SRS 2000)	21
3	Total Fertility Rate	6.0	4.5 (SRS)	3.6 (SRS)	2.9 (NFHS 98-99)	2.1
4	Maternal Mortality Ratio (per 100, 000 live births)	NA	NA	437 (92-93)	407 (1998)	100
5	Infant Mortality Rate (per 1000 live births)	146 (1951-61)	110 (SRS)	80 (SRS)	63 (SRS-2002)	Below 30
6	Literacy Rate as Percentage Persons Males Females	 18.33 27.16 8.86	 43.57 56.38 29.76	 52.21 64.13 39.29	 65.38 75.85 54.16	
7	Contraceptive Prevalence Rate %	10.4 (1971)	22.8	44.1	48.2 (NFHS- 98-99)	To meet all needs
8	Full Immunization of infants (from 6 vaccine preventable diseases)	-	-	-	56%	100%
9	ANC checkup (3 visits)	-	-	-	43.8%	100%
10	Institutional Deliveries	-	-	-	34%	80%

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declining fertility start showing explicitly. Put simply, this decline does not look very rapid and because India is like a fast moving express train whose brakes have just been applied but since it is very heavy and moving very fast, it will take time before it actually stops. The important thing to note is that the brakes have been applied.

The current high population growth rate in some parts of the country is due to:

- The large size of the population in the reproductive age group (estimated contribution 60%).
- Higher fertility due to unmet need for contraception (estimated contribution 20%)
- High wanted fertility due to prevailing high Infant Mortality Rate (IMR) (estimated contribution about 20%).

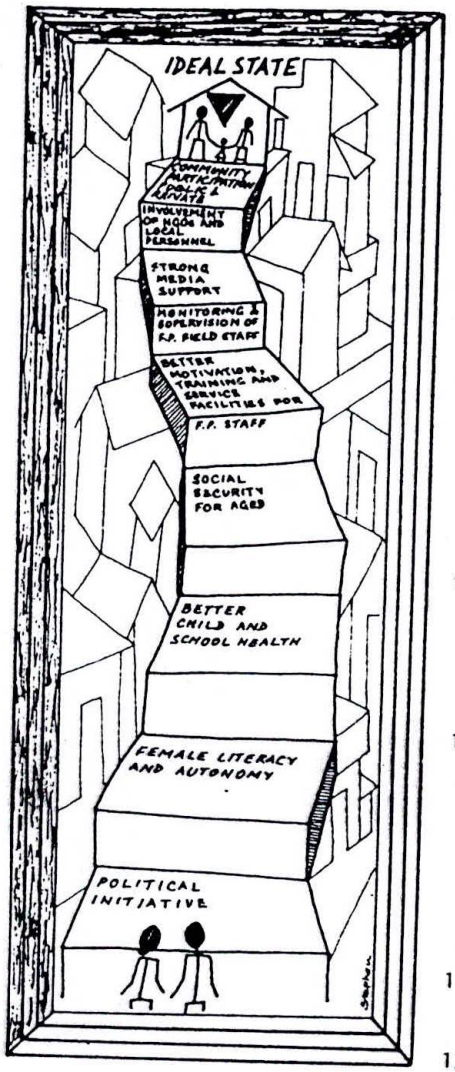
There have been many changes in the thinking on population issues during the last five decades. The international Conference on Population and Development (ICPD), Cario 1994 was in many ways a water-shed in the history of population thinking. It brought about a significant shift in frameworks, strategies and approaches relating to population and public policy issues. It involved a paradigm shift from previous emphasis *demography and population control* to sustainable development and recognition of the nee for comprehensive reproductive health care and reproductive rights. The period after ICPD has seen significant changes in the population field in our country. Most important, the paradigm for thinking about population policies including its language and concepts has shifted away from numbers per se to issues related to reproductive health. At the policy level this includes the enunciation of a Population Policy – the National Population Policy (NPP) 2000.

National Population Policy, 2000 (NPP-2000)

Government of India adopted the National Population Policy in February 2000. The NPP 2000 is in fact a historic document and a significant step forward in the right direction and views the issue of population in a more reasoned and balanced way. It reflects a shift from the earlier demographically driven target oriented coercive policy to one that addresses the special concerns of reproductive health. It courageously rejects force and coercion. The NPP asserts the centrality of human development, gender equity and equality and adolescent reproductive health and rights among other issues to stabilizing country's population. The overriding objective is economic and social development and to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society. It is an articulation of India's commitment to the ICPD agenda as applied to the country, and forms the blue print for population and development related programmes in the country. Further, the Policy affirms the commitment of Government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services and continuation of the target free approach in administering family planning services. A cross cutting issue is the provision of quality services and supplies, information and counseling, besides arrangement of basket of choices of contraceptives, in order to enable people make informed choices and enable them to access quality of health care services.

The NPP 2000 provides a Policy framework for advancing goals and prioritizing strategies during the next decade to meet the reproductive and child health needs of the people of India and to achieve net replacement levels (TFR of 2.1) by 2010. it is based upon the need to simultaneously address issues of child survival, maternal health and contraception while increasing outreach and coverage of comprehensive package of reproductive and child health services by Government, industry and the voluntary/non government sector working in partnership. The schemes/programmes have been undertaken to implement the strategic themes listed in the population policy for achieving the immediate objective of meeting the unmet needs for contraception, health care infrastructure and trained health personnel and to provide integrated service delivery for basic reproductive and child health care. Some of the major socio-demographic goals to be achieved by 2010, while will lead to stable population by 2045, are:

1. To meet the demands in full for basic reproductive and child health services, supplies and infrastructure.
2. Reducing infant mortality rate to below 30 per 1000 live births
3. Reducing maternal mortality to below 100 per one lakh live births
4. Achieving universal immunization of children against all vaccine preventable diseases



5. Achieving 80% institutional deliveries and 100% deliveries by trained persons

6. Increasing use of contraceptives with a wide basket of choices

7. Achieving 100% registration of births, deaths, marriages and pregnancies

8. Integrating Indian System of medicines in providing reproductive and child health services

9. Promoting small family norm to achieve replacement levels of fertility by 2010

10. Making school education up to age 14 free and compulsory and reduce drop out at primary and secondary school levels.

11. Promoting delayed marriage for girls

12. Bringing about convergences in implementation of related social sector programmes so that family welfare becomes a people's centered programme

In order to achieve, the above national socio-demographic goals by 2010 the following 12 strategic themes have been identified. These are:

1. Decentralized planning and program implementation

2. Convergence of Service delivery at village levels

3. Empowering women for improved Health and nutrition

4. Child Survival and Child Health

5. Meeting the unmet needs for family welfare services.

6. Under-served population groups:
   a) Urban slums;
   b) Tribal communities, hill area population, and displaced and migrant populations;
   c) Adolescents;
   d) Increased participation of men in planned parenthood

7. Diverse health care providers.

8. Collaboration with and commitments from non-government organizations and the private sector;

9. Mainstreaming Indian Systems of Medicine and Homeopathy;

10. Contraceptive technology and research on reproductive and child health

11. Providing for the older population.

12. Information, Education and Communication

The NPP is gender sensitive and incorporates a comprehensive holistic approach to health and education needs of women, female adolescents and girl child. It also seeks to address the constraints to accessibility to service due to heavily populated geographical areas and diverse socio-cultural patterns in the population. A primary theme running through the NPP is provision of quality services and supplies and arrangement of a basket of choices. People must be free and enable to access quality health care, make informed choice and adopt measures for fertility regulation best suited to them. It is in this sprit that the NPP advocates a small family norm.

A number of State Governments have announced or are in the process of formulating their State Population Policies. The idea of a State Population Policy was in fat to identify and address priority issues pertinent to the specific State within a broad framework of the National Population Policy keeping the letter and spirit of the PoA, ICPD in tact. Unfortunately some States have formulated State Population Policies which are framed in the old population control mindset and have set targets for lowering fertility within a specified time frame. The driving force in some of these states policies and demographic targets, population control objectives and disincentives, despite the fact that the Po, ICPD to which India is a signatory and NPP 2000 strongly rejects such an approach. Whatever may be the reason, the

unfortunate fact is that some of these State Population Policy documents are innocent (ignorant) of any reflection of the major paradigm shift that population policy has undergone both globally and nationally, because either they are unaware of the ICPD paradigm shift (which is indeed difficult to believe in this age of information technology) or the "old population control mindset" is so ingrained which is still very hard to discard.

Given the crucial importance of *Population Momentum* (which in a way assures further population growth in near future, no matter we introduce "two-child"/ even "one-child" norm and unwanted fertility in our country to impose a "two-child"/ one-child" norm to pressurize people to go for less than two children may simply be barking up the wrong tree. This may be neither relevant nor particularly effective in bringing down the growth rate.

The single most important factor that can reduce momentum is rising the age at marriage/ cohabitation especially for girls. The strongest impact of this can come through increasing years of schooling for girls. Therefore, population momentum can only be eased out significantly by policies that encourage women to delay child bearing as this stretches out the time between generations.

As already mentioned earlier, over 50% women in India ages 20-24 years are married before the age of 18, over 60% in the States of Bihar, Rajasthan and UP. At the national level the age at marriage is likely to be achieved by a further rise in the level of female education. Population momentum can also be curtailed, in part, by investing on adolescents with emphasis on raising girls social and economic prospects and enhancing their self-esteem. Measures that would accomplish this include.

- Promoting valued roles for women apart from the motherhood,
- Increasing young women's access to education, income earning work and financial credit
- Providing young women and men with information about reproductive and marital rights, health and sexuality and extending their access to appropriate services and
- Fostering equality between young women and men and improving their perceptions of marital responsibility.

The social development of women in terms of health of women, low infant mortality, education and higher age at marriage are seen as causal factors in the reduction of the fertility. The various proximate determinants of fertility such as age at marriage, contraception etc. are affected through changes in gender relations. When formal education is seen is an essential life skill, norms regarding girls' education change bringing with it an increase age at marriage. Similarly, as more women enter labour force employment, child's care becomes more incompatible. This increases the costs of having children. Smaller families than become desirable. As women get more educated and aware of modern contraception they are able to translate their desire for fewer children into practice provided there is higher degree of inter-spousal communication facilitating reproductive decisions. Better health and well-being of women enhances child's survival. The insurance motivation for high fertility diminishes as a consequence. If this is possible, the role of coercive, target oriented (like two-child/one-child norm) policies become highly debatable.

Recently announced Common Minimum Programme (CMP) of the UPA Government is a very progressive document but among its provisions is a line "A sharply targeted population control programme will be launched in the 150-odd high-fertility districts" (We hope it means multi-dimensional inputs and upgraded livelihood health services for children and mother, keeping their basic needs in line with NPP).

It is indeed a little worrying trend because at a time when the Reproductive and Child Health (RCH) Programme is recording significant structural and long term impact, the Indian experience does not warrant a shift back from the social development approach. There appears to be a very thin dividing line between awareness creation, gentle persuasion, voluntary decision and of course force/ coercion. If this approach is not handled properly, it will ultimately end up in a situation leading to "two child" norm and the chances of widespread sex pre selection and sex-selective abortions of the female fetus leading to distorted sex ratio in 0-6 year's child population. The other probable fall out of this focused campaign mode approach may be that the health functionaries might be pre-occupied again with family planning goals/targets and terminal contraception (citing as voluntary adoption), neglecting services related to women's health and quality of care, the two cardinal features of Reproductive and Child Health (RCH).

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FACTS against MYTHS

VIKAS ADHYAYAN KENDRA Vol VII # 7/2001 INFORMATION BULLETIN

Over-population as Underdevelopment: The Myths behind "Population Control" — I

COMMENT

In India population policy is identical with the policy in population control and is women–targeted. In 1951, it launched the first official family planning programme, later renamed as the Family Welfare Programme. Subsequently, the Alma Mata Declaration (1978) of Health for All by 2001 was adopted by India in 1994 and 'reproductive' health rather than family planning was foregrounded as a new slogan from the Cairo Conference (1994) on Population and Development. But for all this, birth control continued to be the main component of the population policy. During the Emergency a policy statement was issued affirming the priority accorded and commitment to 'population problems'. The 1993 National Health Policy stated the long-term demographical goal of reducing Infant Mortality Rate (IMR) by 2000 but is yet to be achieved! And since 1991 with the imposition of SAP this Policy began to be steadily undermined. In fact SAP led to massive injections of foreign assistance in family planning like the USAID project (1992) worth $325 m. to provide 'innovations in family planning services' in UP and subsequently to the whole of the country. As a result the dangerous hormonal implant, *Norplant*, was used on migrant labour in this State the same year but withdrawn after protests by women's groups. In 1992 it again introduced another dangerous drug, *Depo Provera*, and then *Quinicrine* to produce sterility in women. The case was taken to Supreme Court leading to a ban on *Quinicrine*. The point, however, is that the 'liberalisation' of the drug policy under the SAP regime and foreign aid in family welfare programme raises such a threat, without fulfilling the urgent need for safe and cheap contraception.

Since adopting the SAP-induced population policy which is not to improve demographic balance and well being through greater government investment in the public sector the government has been implementing the neo-Malthusian solution that views birth control as the '*panacea*' for India's poverty and underdevelopment. Population policies since have been careful to avoid any analysis of the impact of SAP on demographic balance and well being.

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For instance the Committee on Population (Karunakaran Committee) of the National Development Council had made objectionable proposals[1] like the bar on government recruitment of girls and boys getting married at an early age, bar on contesting election for people not following the small-family norm, and the use of army and para-miliatary forces to serve the cause of the health and population stabilisation though later some of these obnoxious proposals had been withdrawn. The government on its part while it conveniently overlooked the positive recommendations of the Swaminathan Committee it introduced the 79th Constitution Amendment Bill to the Parliament whereby people having more than two children would be disqualified from contesting parliamentary election. Such disincentives/incentive driven coercive policies and tactics, far from promoting small families, precipitates pressure on women and on the poorer classes, who, even if they are aware of the relevance of small families, have very little control over their own reproductive lives. Already, the politics of population control has become apparent in some of the States where such a exclusive and punitive policy at the panchayat and other levels is preventing democratic participation of women and the poor. According to the Indian Express (17-1-2001) an OBC woman sarpanch in M.P, Shashi Yadav, has become the first victim of this legislation. On giving birth to her third child on September 23,2001, the local District Magistrate imposed Section 36 of MP Panchayat Raj Act legislating that any elected office bearer giving birth to a third child after January 26,2001 is automatically debarred. The new law was made effective after the February 2000 panchayat election through the amendment bills adopted by the State Assembly on March 29. Since then the collector's office has received other similar complaints about violation of the 2-child norm.

In the final analysis, it is not merely issues like SAP and economic globalism but also the dominant ideological pattern, which reinforces changes in the class-biased approach to the demographic question. Historically, an important component in the demographic imbalance was the mass enforced dislocation of population following communal riots during Partition. The recrudescence of communalism and today, fundamentalisms are ideologies that seek in denying people of their basic rights in the name of religion. While unconcerned about providing access to safe contraception and improved quality of life, the approach seeks to punish the marginalised through coercive measures. Hindu communalism specifically exploits this approach in launching a special campaign to control the numbers of 'backward' minorities. By stressing the communal divide in mixed areas and fuelling tensions arising out of limited economic opportunities in a specific area or region, such engineered conflicts lead to the exodus of certain sections of the people from specific localities in States resulting in demographic imbalances (via riots and displacements of people from their habitats) ultimately succeeding in ghettoising a community.

Apart from avoiding any critical evaluation of the SAP-induced analysis of the demographic balance, bilateral and multilateral aid agencies — the World Bank, USAID, UNFPA, etc. — determined to reduce "population growth" — employ various fertility control measures on women in the South. These methods[2] as Dr. S. Brahme explains are, firstly, imposing "population control" as a major condition for development aid; secondly, dumping hazardous contraceptives and techniques on women; and thirdly indulging in an incessant ideological and propaganda war. An illustration of the last is the US, which has touted population growth as a threat to its national security! Quoting the journal, the Washington Quarterly, (1989) Shiva[3] points out: "As difficult and uncertain as the task may be, policy makers and strategic planners in this country have little choice in the coming decade but to pay serious attention to population trends, their causes and their effects. Already, the US has embarked on era of constrained resources. It thus becomes more important than ever to do things that will provide more bang for every buck spent on national security. Policy makers must anticipate events and conditions before they occur. They must employ all the instruments of state craft at their disposal-development

assistance and population planning every bit as much as new weapons systems)".

These policies and ideologies fail to however consider an important aspect of religious fundamentalism viz., the fundamentalism most women are confronted with but left largely unaddressed. Despite its denouncement the Vatican for instance is not considered the best guarantor of women's interest and well being in matters of health and re-production especially in respect to women in the South. Lest we forget: the greatest challenge at the 1994 UN Conference on Population and Development (ICPD), Cairo, was – and it was not met – to transcend the politics of both Washington DC and the Vatican, and place women of the South at the centre of the 'population' discourse: as subjects, determining their lives and health, not as objects of State, or Extra-Constitutional State systems and the demographic Establishment.

In the circumstances it is hardly surprising that India's National Health Policy Draft introduced in August 2001 has been critiqued as being highly inadequate. The Draft had stated nothing significant on the population question, which the health movement has long held to constitute a major drain on primary health care. Moreover, the actual monetary involvement of these aid agencies to primary health care has been correspondingly low yet their influence on health policies is disproportionally high! Instead the Draft repeats the usual tautology that progress in public health has been nullified by population growth. However, as Prof. Malini Karakal noted in "One India, One People" (January 2002) that this *mantra* contradicts all evidence available globally that population stabilisation follows attainment of certain socio-economic standards and do not precede them.

MYTH: ***One of the major goals of India's Population Policy is to empower women by making them free to exercise choice in the variety of new family planning methods.***

FACT: This myth first emerged in the North during the 60s, 70s and in the early 80s. It was later revived into a more refined package by population "experts" by incorporating some of the progressive language of women's' and human rights groups. The former US Administration under President Clinton had focussed on the environment, population and women's rights as driving force for its foreign policy in a new global politics. The underlying motive, however, was the urgency to control population growth in the South because its natural resources must be freed for the growth of US TNCs. And above all "...the US economy will require large and increasing amounts of minerals from abroad especially from less developed countries. That gives the US enhanced interest in the political, economic and social stability of the supplying countries."[3]

What this imperialistic view — the link between resources and population growth – is conveniently blind to is that population growth is sparked off by appropriation of resources from the common people in the South. Such appropriation – which is necessary for diverting resources from people to TNCs – also fuels social and political instability and unrest, as the Zapatista uprising in Mexico highlighted on New Year's Day, 1994.

Moreover, in the liberalised economy in particular the language of 'choice' becomes a handy tool for whole variety of "population control" experts. It makes population control – the denial of the right of the individual to freely and responsibly choose to have or not have children – appear as free choice in the marketplace of contraceptives. But poor women in the South as targets of such programmes are not `free consumers'. Coercion rather than choice characterises their situation in such programmes also a major component of other global aid packages. (However, due to popular resistance to such control measures, governments have dubbed it `Family Planning' and the World Bank masks it as `Safe Motherhood'!)

In India, the myth exposes women to the danger of having hazardous drugs invaded into her, frequently in a guarded and veiled manner and without proper information or monitoring. Since all such drugs target women, she has to bear the major burden of

this "liberalised" approach The conventional sterilisation programmes being already largely women-oriented (96% tubertomy and 3.5% vasectomy in 1993), these changes, instead of moving towards a policy that would protect her, pushes her into further pain and suffering.

Incidentally,'right choice' is also being used by unscrupulous sections of the medical fraternity to promote certain pre-natal diagnostic test for foetal sex-determination. The Pre-Natal Diagnostic Techniqus (Regulation and Prevention of Misuse). Act to regulate this and ban sex determination tests (passed in 1994) is a weak one and not checking the trend, which would, through abortion of the female foetus, not only lead to serious demographic imbalance, but also jeopardise maternal health. Increase in female infanticide in some States has already affected the sex ratio adversely.

Finally, the government by failing to take up any of the positive recommendations of the Swaninathan Committee in 1994 exposed itself as being anti-woman and anti-poor. Instead it went ahead and introduced the 79th Constitutent Amendment Bill to the Parliament, whereby people having more than two children would be disqualified from contesting parliamentary elections believing in the policy of incentives and disincentives. Undoubtedly, disincentives and indirectly coercive tactics of this nature, far from empowering them precipitates pressure on women and the poorer sections.

MYTH: Women having multiple deliveries are an important cause in the high rate of maternal deaths in the South

FACT: This view is related to the one commented elsewhere in this issue but takes into account the particular problem of grand multiparity. It is a well known fact that grand multiparity is linked with inflated maternal mortality figures in the South but to a very limited extent in the more affluent North. An illustration is the very low maternal mortality in the North also in cases of high parity. Studies in Nigeria had also shown that high maternal mortality is associated to high parity only if child mortality is high. This is a parallel to the finding in most countries of the North: what kills the mother is not the parity but the poverty.

Even if it is assumed a poor country with inflated maternal mortality in the high parity range, it can still be concluded, as have been shown in various computer simulation studies, that the elimination of all grand multiparty (> parity 5) completely will mean a less than 5% reduction of maternal deaths. This and similar findings indicate the limited value of targeting grand multiparous women with sterilisation in order to reduce the overall maternal mortality. It must be underscored however, that the vast majority grand multiparious women actually have an unmet need perceived by them, for fertility control. This important maternal health aspect of grand multiparty is distinctly different from one blaming grand multiparity as a major "cause" of maternal mortality.

MYTH: *Birth control also efficiently reduces the maternal mortality ratio.*

FACT: It is clear that zero fertility, will automatically mean zero material mortality. It is less clear what the impact is of fertility regulation in the reduction of the mortality ratio. The latter ratio is defined as the number of maternal deaths to 100,000 live births. In a Bangladesh study in the early 80s it was shown that the impact of fertility regulation was unexpectedly limited. Two villages were set up for comparison, in which one was subject to an intense fertility regulation drive whilst in the other no fertility regulation propaganda was made. In the first village, the fertility was reduced by 26% in relation to the non-fertility regulation village. Unexpectedly, the maternal mortality ratio was identical in the two villages. The explanation was that the intensive fertility regulation programme had not conveyed any increase in the safety at birth in the village. That is, those pregnancies being needed did not enjoy any better protection in the fertility regulation village than in the other village.

A conclusion is that fertility regulation, while reducing the actual number of pregnancies, did not achieve a better safety at birth or could even have been counterproductive to better safe mother.

MYTH: *Birth control, after all, was an important factor in the decline of maternal mortality in the North.*

FACT: In the North the maternal mortality ratio dropped considerably from levels of around 1000 to about 5 maternal deaths per 100,000 live births over a period of 300 years. Much of this decline occurred prior to any kind of modern contraception was available. A similar pattern has been found in other situations. Much more important a factor was the advent of midwifery, particularly in remote areas and the recognition of health and hygiene for the reduction of post-delivery infection. Still further was the availability of antibiotics and blood transfusions and when antenatal care and hospital deliveries were introduced for and utilised by >90% of pregnancies.

Fertility regulation has its own value, which is indisputable. Health-oriented provision of contraceptives in order to empower women (and men) to plan for optimal reproductive health and voluntary spacing of births do not need discussion. The controversial point is when birth control is claimed to be so efficient in the curbing of the inflated maternal mortality in the South that it is given priority ahead of a more comprehensive and efficient maternal and reproductive health care. Studies have since demonstrated conclusively that "efficient health-care is more effective than fertility regulation in preventing maternal deaths."

MYTH: *By effectively addressing the unmet demand for contraception will result in significantly reducing population growth rates.*

FACT: Proponents of the family planning approach cite data showing that in many countries of the South almost half of all women of child-bearing age want no more children but (unfortunately) lack easy access to birth control. Fertility rates would drop by a third if this unmet need were met.

This argument entails a huge assumption: without transforming social reality – especially the powerlessness of women vis-à-vis men and the meagre access of the poor to food security and other resources – women will in fact be able to act on their stated desire for fewer children. But this begs this question whether many women indeed declare their preference for fewer children yet lack the power to act on their preference – even if the technical means of birth control were available?

In other words, to believe that the mere provision of contraception will suddenly allow women to step out of their subordinate role in the family, or alter the fact that children still represent a source of security for many parents in countries of the South, is to ignore the findings[5] of decades of fertility-oriented research.

Moreover, if unmet demand were truly as great as it is assumed, why have population planners had to and still resort to incentives and disincentives? In some cases, outright coercion has been deemed necessary to get people to accept birth control, suggesting that people must be made to set aside their own judgements, about their need for children!

As part of their single-minded effort to promote birth control a number of agencies, globally and nationally along with willing governments have not only sought to respond to existing contraceptive demand, but have actively worked to increase it. While some strategies are relatively innocuous – TV sit-coms promoting new family size norms — a wide variety of incentives and disincentives are used to induce people to undergo family planning measures or to use contraception

MYTH: *Birth control directed towards 'high risk" women will also be particularly successful to reduce maternal mortality.*

FACT: Most maternal deaths occur among women with medium number of children in the family (parity 2-4) within the 20-35 age group. This fact is, however, often overlooked in the risk approach strategy for lowering of maternal mortality.[4] The consequence is that interventions in 'high risk" pregnancies will improve conditions in small groups of women and will have limited overall impact on maternal mortality. This conclusion is derived from various findings. A Bangladesh study (1968-70) was highly revealing. It was calculated that if all births had been averted in women i) below age 20, ii) above age 39 and iii) beyond parity 6, the maternal

MYTH: *Islam does not permit family planning.*

FACT: The basis of this myth emanates from the logic that Islam values the family and encourages procreation. In support of this conclusion, two pieces of evidence are often cited viz., that the *Qur'an* prohibited Muslims from killing their children for fear of want. Second that the Prophet exhorted Muslims to multiply. However, this argument does not do justice to the complexity of the Islamic position and the totality of its teachings. Otherwise, it would be impossible to explain the established fact that the Prophet knew that some of his companions, including his cousin Ali, practised *al-'azl* (coitus interruptus) and yet he did not prohibit the practice.[6]

The bigger picture of the Islamic position on family planning is its departure point in encouraging the life principle. Hence, the Prophet's exhortation to multiply and the Qur'anic prohibition of infanticide, a wide-spread pre-Islamic practice involving born children which was motivated mostly by economic and gender considerations. But such a basic position does not necessitate the conclusion that contraception, or even abortion, is prohibited. Indeed, historically, the majority view among Muslim scholars on contraception has been that it is permissible with the wife's consent, though perhaps disliked in certain cases. The wife's consent is required because Islam recognises the wife's right to sexual enjoyment and procreation.

A leading proponent of this view is Imam al-Ghazali (d.1111) who also notes on contraception that there are no such prohibitions. In fact, the opposite is true. His analogical logic is startling in its simplicity. In one part of his argument, he notes that, despite the prophetic exhortation to multiply, it is nevertheless permissible for a Muslim to remain single. The effect of remaining single on multiplying, he reasoned, is no different than the effect of practising al-'azl. Since the one is permitted, it follows that the other, without more, is also permitted. He further argues that although contraception is permissible, it is `*makruh*' (adjective meaning "disliked or disfavoured") if practised to avoid, for example, female offspring. One major justification for this conclusion is that preference for male offspring is frowned upon in the `*Qur'an*'. Al-Ghazali, however, supports contraception for other reasons such as protecting a woman from the dangers of childbirth, avoiding poverty, and even preserving a woman's beauty.[6]

In the case of family planning through contraception, the wish to avoid poverty does not infringe on the right to life of a born human being. To the contrary, its goal is to preserve a dignified quality of life for those already born. On the other hand, using contraception to avoid having more females reflects a worldview and a value system antithetical to that of the Qur'an. It was thus '*makruh*' and discouraged by scholars like al-Ghazali.

Other jurists agreed with al-Ghazali's basic position on contraception but disagreed on what constitutes '*makruh*' behaviour. Such disagreement may very well have been founded in their disparate historical and cultural experiences. In other words, these are the kind of differences anticipated and tolerated by the principle, viz., that laws change with changes in time and place, and perhaps the other principles of '*ijtihad*'.

Concretely, according to the 1961 and 1981 census reports the number of Muslims in comparison to the total population of India during the last 20 years (1961-81) has risen from 10.7 per cent to 11.4 per cent i.e. 0.7 percent only. Additionally, during

the 1981-89 period Muslims accepted temporary methods of family planning that was enhanced by 11.4 per cent in comparison to previous period whereas Hindus for instance such increase was only 10 percent. Family welfare Operation Camps in various districts of West Bengal during 1980-94 showed that a large number of Muslim women were getting operated along with Hindu women. Most were from low-income families and the daily grind of maintaining 3-4 children were their main driving forces while adopting the permanent method.

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In this context it must be noted that the problems of over-population, merely dumping condoms on them cannot solve the death of women from reproductive-related causes, but they will also not go away without condoms. Furthermore, as some experts and specialists have maintained, abortion has performed a crucial role in most countries that has moved from a high fertility rate to replacement levels rates.[7] Artificial contraception and abortion are not the final or main solution to these problems, but they are essential options.

MYTH: ***The Roman Catholic Church's position to contraception and other artificial forms has no negative impact on efforts to provide reproductive health care services to women and the fight against the AIDS pandemic.***

FACT: The Roman Catholic Church under the aegis of the Vatican exerts enormous power and control to foil any efforts to provide reproductive health care services for especially poor women in the South and to stop AIDS.[8] To illustrate:

- In 1999, the Vatican released an official document stating that providing Catholic women who had been raped in Kosovo with emergency contraception was equivalent to promoting abortion. Previously, in reference to women in Bosnia, the pope went to the extent of stating that raped women should "accept the enemy" and make "flesh of their own flesh";
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mortality ratio would have declined from 570 to 430 per 1000.000 live births. Even with this extremely non-realistic achievement of virtually cutting off all births from recognised "risk" groups, a very limited gain in maternal mortality would have followed. In spite of the widespread belief that age and parity are exceptionally important in any strategy for the reduction of maternal deaths can be concluded that it is not the age/parity distribution of births that explains the lower material mortality in the rich North. Instead, most maternal deaths occur to women at low risk. This seemingly paradoxical point can be explained by the fact that available risk markers are not very efficient in predicting maternal death. For instance, there are no risk markers to predict death from abundant vaginal bleeding due to a non-contracting uterus, nor to death causeway post-delivery infection. But there is one albeit an inefficient risk marker for eclampsia, that is pre-eclampsia (high blood pressure associated with pregnancy). Still, it is known that a significant number of eclamiptic deaths appear quite unexpectedly like "out of the blue."

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FACTS against MYTHS

VIKAS ADHYAYAN KENDRA Vol VII # 8/2001 INFORMATION BULLETIN

Over-population as Underdevelopment: The Myths behind "Population Control" — II

COMMENT

The 2001 State of the World's Population report, published by the UNFPA states that the world population will grow by 50%, from 5.1 b. in mid-2001 to 9.3 by 2050, with all the projected growth taking place in the South. Undoubtedly, population growth is a serious concern but a bugbear especially among population "experts" in the North. The seemingly intractable problems of poverty and under-development of the region invariably ends up in the conclusion that virtually all of its problems are rooted in "population explosion", "over-population", etc. The underlying themes of these problems are that the poor are poor because they have too many children. To illustrate: India is backward "because it has too many people" and similarly other countries of the South are what and where they are because they "are not doing enough to control their exploding populations" and having failed "in meeting population targets". To that extent the only "solution", therefore, is family planning.

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This victim-blaming syndrome has been increasingly evident not only at the national level but also in the global discourse on the future of the planet. The South, with their large populations, are blamed for all manner of social and environmental ills giving rise to a number of assumptions on controlling population growth in the region. The three main ones being

- Rapid population growth is the primary cause of the problems of underdevelopment and threatens the entire natural world;
- The poor of the South must be persuaded to have fewer children whether or not their conditions of poverty change;
- Like other western development schemes, birth control technology can be delivered to women in the South in a top-down, technocratic manner with the right combination of media advocacy. The goal is not to improve health care services but to prevent pregnancy (viewing women as objects of reproduction rather than as subjects of their own decision-making goals and in defining their own life);

This philosophy has since shaped the activities of most population "experts" and organisations and international aid agencies in the South as well as among ethnic minorities and poor communities in many parts of the North itself. In 1958 Sweden became the first government to provide international aid for population control, first to Sri Lanka and then to Pakistan. In 1966 the UN General Assembly reached a consensus about "population assistance" a label that eschewed control and limitation. The label has since become a euphemism for all global funding of condoms, IUDs, the pill and Karman tubes, as well as US university demography department, international bureaucracies and local workshops. These "experts" have also appropriated the language that appears reasonable, progressive and even sensitive – some of it is even co-opted from the women's movement. To illustrate: a 1989 de-classified US National Security Study[3] states that the US support derives from a concern and spacing of children. Thus, it smuggles and fits into its population control policy the language of 'choice' that global financial institutions including institutions like the Vatican also find it convenient to introduce in their rhetoric.

Further, the obsession with the thesis of "over-population" (the Demographic Trap) is one of the biggest global red herrings in the development discourse. Sustainable energy and relative scarce resources, practised in the South, but used within a framework confuses cause and effect. While this confusion is basically ideological, it reveals how ideologies mask reality and determine perspectives. Moreover, it soon becomes clear that the obsession with population is a substitute for a proper concern with social justice: this must be avoided at all costs, for it also calls into question the dominant ideology in the world and mimicked by the ruling bloc in the country. Is it any wonder, then, population growth in India continues to be a seemingly intractable problem with crores having already been invested on its "control". Taking a closer look at the rhetoric of population planning therefore becomes an essential prerequisite in dismantling some long-standing myths that has accompanied it.

MYTH: ***The major causes of hunger and poverty in the world today are uncontrolled population growth and density.***

FACT: Not so!

Western Europe has an average population density of about 98 people per square kilometre (with Holland having over 1,000 per sq.km.); Africa as a whole has an average of only 18 people per sq.km.

assistance and population planning every bit as much as new weapons systems)".

These policies and ideologies fail to however consider an important aspect of religious fundamentalism viz., the fundamentalism most women are confronted with but left largely unaddressed. Despite its denouncement the Vatican for instance is not considered the best guarantor of women's interest and well being in matters of health and re-production especially in respect to women in the South. Lest we forget: the greatest challenge at the 1994 UN Conference on Population and Development (ICPD), Cairo, was – and it was not met – to transcend the politics of both Washington DC and the Vatican, and place women of the South at the centre of the 'population' discourse: as subjects, determining their lives and health, not as objects of State, or Extra-Constitutional State systems and the demographic Establishment.

In the circumstances it is hardly surprising that India's National Health Policy Draft introduced in August 2001 has been critiqued as being highly inadequate. The Draft had stated nothing significant on the population question, which the health movement has long held to constitute a major drain on primary health care. Moreover, the actual monetary involvement of these aid agencies to primary health care has been correspondingly low yet their influence on health policies is disproportionally high! Instead the Draft repeats the usual tautology that progress in public health has been nullified by population growth. However, as Prof. Malini Karakal noted in "One India, One People" (January 2002) that this *mantra* contradicts all evidence available globally that population stabilisation follows attainment of certain socio-economic standards and do not precede them.

MYTH: ***One of the major goals of India's Population Policy is to empower women by making them free to exercise choice in the variety of new family planning methods.***

FACT: This myth first emerged in the North during the 60s, 70s and in the early 80s. It was later revived into a more refined package by population "experts" by incorporating some of the progressive language of women's' and human rights groups. The former US Administration under President Clinton had focussed on the environment, population and women's rights as driving force for its foreign policy in a new global politics. The underlying motive, however, was the urgency to control population growth in the South because its natural resources must be freed for the growth of US TNCs. And above all "...the US economy will require large and increasing amounts of minerals from abroad especially from less developed countries. That gives the US enhanced interest in the political, economic and social stability of the supplying countries."[3]

What this imperialistic view — the link between resources and population growth – is conveniently blind to is that population growth is sparked off by appropriation of resources from the common people in the South. Such appropriation – which is necessary for diverting resources from people to TNCs – also fuels social and political instability and unrest, as the Zapatista uprising in Mexico highlighted on New Year's Day, 1994.

Moreover, in the liberalised economy in particular the language of 'choice' becomes a handy tool for whole variety of "population control" experts. It makes population control – the denial of the right of the individual to freely and responsibly choose to have or not have children – appear as free choice in the marketplace of contraceptives. But poor women in the South as targets of such programmes are not `free consumers' Coercion rather than choice characterise their situation in such programmes also major component of other global a packages. (However, due to popul resistance to such control measur governments have dubbed it `Fam Planning' and the World Bank masks it `Safe Motherhood'!)

In India, the myth exposes women to danger of having hazardous drugs inv into her, frequently in a guarded and v manner and without proper informati monitoring. Since all such drugs t women, she has to bear the major bur

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Incidentally,'right choice' is also being used by unscrupulous sections of the medical fraternity to promote certain pre-natal diagnostic test for foetal sex-determination. The Pre-Natal Diagnostic Techniqus (Regulation and Prevention of Misuse). Act to regulate this and ban sex determination tests (passed in 1994) is a weak one and not checking the trend, which would, through abortion of the female foetus, not only lead to serious demographic imbalance, but also jeopardise maternal health. Increase in female infanticide in some States has already affected the sex ratio adversely.

Finally, the government by failing to take up any of the positive recommendations of the Swaninathan Committee in 1994 exposed itself as being anti-woman and anti-poor. Instead it went ahead and introduced the 79th Constitutent Amendment Bill to the Parliament, whereby people having more than two children would be disqualified from contesting parliamentary elections believing in the policy of incentives and disincentives. Undoubtedly, disincentives and indirectly coercive tactics of this nature, far from empowering them precipitates pressure on women and the poorer sections.

MYTH: Women having multiple deliveries are an important cause in the high rate of maternal deaths in the South

FACT: This view is related to the one commented elsewhere in this issue but takes into account the particular problem of grand multiparity. It is a well known fact that grand multiparity is linked with inflated maternal mortality figures in the South but to a very limited extent in the more affluent North. An illustration is the very low maternal mortality in the North also in cases of high parity. Studies in Nigeria had also shown that high maternal mortality is associated to high parity only if child mortality is high. This is a parallel to the finding in most countries of the North: what kills the mother is not the parity but the poverty.

Even if it is assumed a poor country with inflated maternal mortality in the high parity range can still be concluded, as have been shown various computer simulation studies, that the elimination of all grand multiparty (parity 5) completely will mean a less than 5% reduction of maternal deaths. This and similar findings indicate the limited value of targeting grand multiparous women with sterilisation in order to reduce the overall maternal mortality. It must be underscored however, that the vast majority grand multiparous women actually have an unmet need perceived by them, for fertility control. The important maternal health aspect of grand multiparty is distinctly different from one blaming grand multiparity as a major "cause" of maternal mortality.

MYTH: ***Birth control also efficiently reduces the maternal mortality ratio.***

FACT: It is clear that zero fertility, will automatically mean zero material mortality. It is less clear what the impact is of fertility regulation in the reduction of the mortality ratio. The latter ratio is defined as the number of maternal deaths to 100,000 live births. In a Bangladesh study in the early 80s it was shown that the impact of fertility regulation was unexpectedly limited. Two villages were set up for comparison, in which one was subject to an intense fertility regulation drive whilst in the other no fertility regulation propaganda was made. In the first village, the fertility was reduced by 26% in relation to the non-fertility regulation village. Unexpectedly, the maternal mortality ratio was identical in the two villages. The explanation was that the intensive fertility regulation programme had not conveyed any increase in the safety at birth in the village. That is, those pregnancies being needed did not enjoy any better protection in the fertility regulation village than in the other village.

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12. In view of the discussion held above, the appeal is dismissed. There will, however, be no order as to costs.

(2003) 8 Supreme Court Cases 369

(BEFORE R.C. LAHOTI, ASHOK BHAN AND ARUN KUMAR, JJ.)

JAVED AND OTHERS . . Petitioners;

Versus

STATE OF HARYANA AND OTHERS . . Respondents.

Writ Petition No. 302 of 2001† with CAs Nos. 5355-72, 5380-82, 5385-86, 5397-5450 of 2003, WPs (C) Nos. 269, 316, 315, 329, 362-63, 258, 403, 395, 420, 438, 475, 507-08, 495, 567, 560, 559, 561, 538, 539, 579 of 2001, 19, 30, 32, 1, 49-50, 79, 94, 130, 93, 127, 144, 169, 168, 128, 177, 112, 71, 91, 178, 184, 183, 185, 68 of 2002, 430 of 2001, 213-14, 162, 230, 225, 228, 254, 296, 280, 281, 305, 317, 309 of 2002, CA No. 3629 of 2002, WP (C) No. 306 of 2002, CA No. 4053 of 2002, WPs (C) Nos. 341-42, 395 of 2002, CA No. 4066 of 2002, WPs (C) Nos. 396, 406 of 2002, CAs Nos. 4501, 4487 of 2002, WPs (C) Nos. 402, 336, 424, 355, 381, 380, 430-31, 421, 404 of 2002, CAs Nos. 5080-81 of 2002, WPs (C) Nos. 443, 457, 451 of 2002, CA No. 5270 of 2002, WPs (C) Nos. 462, 491, 495 of 2002, CAs Nos. 5902-03 of 2002, WP (C) No. 278 of 2002, CA No. 7034 of 2002, WPs (C) Nos. 612, 574, 607, 240, 655, 676-77, 547, 645, 620, 682 of 2002, 8 of 2003, 669 of 2002, 18, 28, 40 of 2003, CA No. 2033 of 2003, WPs (C) Nos. 63, 121, 123 of 2003, CA No. 2395 of 2003, WPs (C) Nos. 149, 193, 195, 204, 155, 161, 188, 245, 247-48, 250, 257, 268, 270, 277 and 281 of 2003, decided on July 30, 2003

A. **Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) & 177(1) — Election to the office of Sarpanch, Up-Sarpanch or Panch — Disqualification — Persons having more than two living children disqualified — Arbitrariness — Classification based on intelligible differentia and such differentia having a rational relation to the object sought to be achieved viz. implementation of family planning**

† Under Article 32 of the Constitution of India

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programme as enumerated under S. 21, which is consistent with National Population Policy and mandate of Art. 243-G — Hence classification not arbitrary — Constitution of India, Arts. 14 & 243-G — Classification — Upheld

B. Constitution of India — Art. 14 — Arbitrariness — Test restated

C. Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) & 177(1) — Election to the office of Sarpanch, Up-Sarpanch or Panch — Disqualification — Persons having more than two living children disqualified — Discrimination — Merely because similar provisions are not enacted in connection with election to public offices in other institutions of local self-governance or in State Legislature and Parliament and also in legislations of other States, the provision cannot be held to be discriminatory — After formulating a uniform policy regarding family planning by the State, the same may be implemented in a phased manner by first introducing at the grass-root level institution of local self-governance — Provision not discriminatory — Constitution of India, Art. 14 — Discrimination — Selective/Phased implementation/enactment of policy/law

D. Constitution of India — Art. 14 — Discrimination — Phased implementation of a legislative policy across the country — If discriminatory — A legislation made by one State cannot be held to be discriminatory merely because similar legislations have not been made by other States — Likewise a State legislation in respect of a governmental organ cannot be held to be discriminatory merely because similar legislation not made in respect of other governmental organs of the State — A uniform policy of far-reaching implications devised by the State can be implemented in phased manner by legislation introducing it first at the grass-root level or at the top level — Such legislation cannot be held to be discriminatory merely because the State policy had not been introduced simultaneously at other levels also

In these batch of writ petitions and appeals the core issue was the vires of the provisions of Sections 175(1)(*q*) and 177(1) of the Haryana Panchayati Raj Act, 1994 (11 of 1994). The said provisions disqualify a person having more than two living children from holding the specified offices in Panchayats. The enforcement of disqualification is postponed for a period of one year from the date of the commencement of the Act. A person having more than two children up to the expiry of one year of the commencement of the Act is not disqualified. This postponement for one year takes care of any conception on or around the commencement of the Act, the normal period of gestation being nine months. If a woman has conceived at the commencement of the Act then any one of such couples would not be disqualified. Though not disqualified on the date of election, if any person holding any of the said offices incurs a disqualification by giving birth to a child one year after the commencement of the Act he becomes subject to disqualification and is disabled from continuing to hold the office. The disability is incurred by the birth of a child which results in increasing the number of living children, including the additional child born one year after the commencement of the Act, to a figure more than two. If the factum is disputed, the Director is entrusted with the duty of holding an enquiry and declaring the office vacant. The decision of the Director is subject to appeal to the

Government. The Director has to afford a reasonable opportunity of being heard to the holder of office sought to be disqualified.

a It was inter alia contended that the provision is arbitrary and hence violative of Article 14 and that the disqualification does not serve the purpose sought to be achieved by the legislation. It was further contended that the provision is also discriminatory. It was submitted that though the State of Haryana has introduced such a provision of disqualification by reference to elective offices in Panchayats, a similar provision is not found to have been enacted for disqualifying aspirants b or holders of elective or public offices in other institutions of local self-governance and also not in State Legislatures and Parliament. So also all the States i.e. other than Haryana have not enacted similar laws, and therefore, people aspiring to participate in Panchayati Raj governance in the State of Haryana have been singled out and meted out hostile discrimination.

Rejecting the contentions, the Supreme Court

Held :

c Article 14 forbids class legislation; it does not forbid reasonable classification for the purpose of legislation. To satisfy the constitutional test of permissibility, two conditions must be satisfied, namely: (*i*) that the classification is founded on an intelligible differentia which distinguishes persons or things that are grouped together from others left out of the group, and (*ii*) that such differentia has a rational relation to the object sought to be achieved by the d statute in question. The basis for classification may rest on conditions which may be geographical or according to objects or occupation or the like. (Para 8)

Budhan Choudhry v. *State of Bihar*, AIR 1955 SC 191 : (1955) 1 SCR 1045 : 1955 Cri LJ 371, *relied on*

The classification made by the impugned provisions is well defined and well perceptible. Persons having more than two living children are clearly e distinguishable from persons having not more than two living children. The two constitute two different classes and the classification is founded on an intelligible differentia clearly distinguishing one from the other. One of the objects sought to be achieved by the legislation is popularizing the family welfare/family planning programme. The disqualification enacted by the provision seeks to achieve the objective by creating a disincentive. The classification does not suffer from any arbitrariness. The number of children viz. two is based on legislative wisdom. It f could have been more or less. The number is a matter of policy decision which is not open to judicial scrutiny. (Para 8)

There is no merit in the submission that the number of children which one has, whether two or three or more, does not affect the capacity, competence and quality of a person to serve in any office of a Panchayat and, therefore, the impugned disqualification has no nexus with the purpose sought to be achieved g by the Act. One of the objects of the enactment is to popularize family welfare/ family planning programme which is consistent with the National Population Policy. "Family welfare" being one of the functions and duties enumerated under clause XIX(1) of Section 21 of the Act would include family planning as well. To carry out the purpose of the Act as well as the mandate of the Constitution under Article 243-G the legislature has made a provision for making a person having more than two living children ineligible to either contest for the post of Panch or h Sarpanch. Such a provision would serve the purpose of the Act as mandated by

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the Constitution. It cannot be said that such a provision would not serve the purpose of the Act. (Paras 9 and 10)

A legislation by one of the States cannot be held to be discriminatory or suffering from the vice of hostile discrimination as against its citizens simply because Parliament or the legislatures of other States have not chosen to enact similar laws. Such a submission, if accepted, would be violative of the autonomy given to the Centre and the States within their respective fields under the constitutional scheme. It is not permissible to compare a piece of legislation enacted by a State in exercise of its own legislative power with the provisions of another law, though pari materia it may be, but enacted by Parliament or by another State Legislature within its own power to legislate. The sources of power are different and so do differ those who exercise the power. Similarly, legislations referable to different organs of local self-government, that is, Panchayats, Municipalities and so on may be, rather are, different. Many a time they are referable to different entries of Lists I, II and III of the Seventh Schedule. All such laws need not necessarily be identical. So is the case with the laws governing legislators and parliamentarians. (Paras 12, 14 and 13)

State of M.P. v. *G.C. Mandawar*, AIR 1954 SC 493 : (1955) 1 SCR 599; *Bar Council of U.P.* v. *State of U.P.*, (1973) 1 SCC 261; *State of T.N.* v. *Ananthi Ammal*, (1995) 1 SCC 519; *Prabhakaran Nair* v. *State of T.N.*, (1987) 4 SCC 238, *relied on*

A uniform policy may be devised by the Centre or by a State. However, there is no constitutional requirement that any such policy must be implemented at one go. Policies are capable of being implemented in a phased manner. More so, when the policies have far-reaching implications and are dynamic in nature, their implementation in a phased manner is welcome for it receives gradual willing acceptance and invites lesser resistance. The implementation of policy decision in a phased manner is suggestive neither of arbitrariness nor of discrimination. To make a beginning, the reforms may be introduced at the grass-root level so as to spiral up or may be introduced at the top so as to percolate down. Panchayats are grass-root-level institutions of local self-governance. They have a wider base. There is nothing wrong in the State of Haryana having chosen to subscribe to the national movement of population control by enacting a legislation which would go a long way in ameliorating health, social and economic conditions of rural population, and thereby contribute to the development of the nation which in its turn would benefit the entire citizenry. (Paras 16 to 18)

L.N. Mishra Institute of Economic Development and Social Change v. *State of Bihar*, (1988) 2 SCC 433 : 1988 SCC (L&S) 577; *Pannalal Bansilal Pitti* v. *State of A.P.*, (1996) 2 SCC 498, *relied on*

No fault can therefore be found with the State of Haryana having enacted the legislation. It is for others to emulate. (Para 19)

The provisions for enquiry, appeal and hearing in the impugned legislation satisfy the requirements of natural justice. (Para 4)

Hence, the impugned provision is neither arbitrary nor unreasonable nor discriminatory. The disqualification contained in Section 175(1)(*q*) of Haryana Act 11 of 1994 seeks to achieve a laudable purpose — socio-economic welfare and health care of the masses — and is consistent with the national population policy. It is not violative of Article 14 of the Constitution. (Para 20)

[Ed.: See also *Sunil Kumar Rana* v. *State of Haryana*, (2003) 2 SCC 628]

E. **Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) and 177(1) — Election to the office of Sarpanch,**

Up-Sarpanch and Panch — Disqualification — Persons having more than two living children disqualified — Held, not violative of any fundamental right — It is reasonable and devised in national interest

E. Election — Disqualification — Right to contest election — Nature of — Held, is a statutory right or at the most a constitutional right, but not a fundamental right — Therefore, the statute which confers the right to contest election can prescribe disqualifications for contesting the election

Held :

The disqualification on the right to contest an election by having more than two living children does not contravene any fundamental right nor does it cross the limits of reasonability. Rather it is a disqualification conceptually devised in national interest. (Para 25)

Right to contest an election is neither a fundamental right nor a common law right. It is a right conferred by a statute. At the most, in view of Part IX having been added in the Constitution, a right to contest election for an office in Panchayat may be said to be a constitutional right — a right originating in the Constitution and given shape by a statute. But even so, it cannot be equated with a fundamental right. There is nothing wrong in the same statute which confers the right to contest an election also to provide for the necessary qualifications without which a person cannot offer his candidature for an elective office and also to provide for disqualifications which would disable a person from contesting for, or holding, an elective statutory office. (Para 22)

Jyoti Basu v. *Debi Ghosal*, (1982) 1 SCC 691; *Jamuna Prasad Mukhariya* v. *Lachhi Ram*, AIR 1954 SC 686 : (1955) 1 SCR 608; *Sakhawat Ali* v. *State of Orissa*, AIR 1955 SC 166 : (1955) 1 SCR 1004, *relied on*

N.P. Ponnuswami v. *Returning Officer, Namakkal Constituency*, AIR 1952 SC 64 : 1952 SCR 218; *Jagan Nath* v. *Jaswant Singh*, AIR 1954 SC 210 : 1954 SCR 892, *referred to*

G. Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) and 177(1) — Election to Sarpanch, Up-Sarpanch and Panch — Disqualification — Persons having more than two living children disqualified — Held, not violative of Art. 21, having regard to Arts. 243-G, 243-C, 38, 47 and 51-A and Sch. VII List III Entries 6 and 20-A — It is a legislative measure to check menace of growing population — Constitution of India, Arts. 243-C, 243-F, 243-G, 38, 47, 51-A and Sch. VII List III Entries 6 & 20-A and List II Entry 5

H. Constitution of India — Art. 21 — Right to life — Must be construed in a reasonable and rational manner — Tests of reasonableness stated — Art. 21 to be read along with directive principles and fundamental duties — Hence, does not include right to procreate as many children as one pleases

I. Constitution of India — Parts III, IV and IV-A — Fundamental rights must not be read in isolation but along with directive principles and fundamental duties

It was urged that the fundamental right to life and personal liberty emanating from Article 21 of the Constitution should be allowed to stretch its span to its optimum so as to include in the compendious term of the article all the varieties of rights which go to make up the personal liberty of man including the right to enjoy all the materialistic pleasures and to procreate as many children as one pleases.

Held :

The test of reasonableness is not a wholly subjective test and its contours are fairly indicated by the Constitution. The requirement of reasonableness runs like a golden thread through the entire fabric of fundamental rights. The lofty ideals of social and economic justice, the advancement of the nation as a whole and the philosophy of distributive justice — economic, social and political — cannot be given a go-by in the name of undue stress on fundamental rights and individual liberty. Reasonableness and rationality, legally as well as philosophically, provide colour to the meaning of fundamental rights. (Para 28)

Maneka Gandhi v. *Union of India*, (1978) 1 SCC 248; *Kasturi Lal Lakshmi Reddy* v. *State of J&K*, (1980) 4 SCC 1, *referred to*

The legislative competence of the State of Haryana to enact the legislation is not in dispute. The legislation is within the permitted field of State subjects. Article 243-C makes provision for the legislature of a State enacting laws with respect to constitution of Panchayats. Article 243-F in Part IX of the Constitution itself contemplates disqualification for being chosen as a member of Panchayat. Article 243-G casts one of the responsibilities of Panchayats as preparation of plans and implementation of schemes for economic development and social justice. Some of the schemes that can be entrusted to Panchayats, as spelt out by Article 243-G read with the Eleventh Schedule are schemes for economic development and social justice in relation to health and sanitation, family welfare, women and child development and social welfare. Family planning is essentially a scheme referable to health, family welfare, women and child development and social welfare. Thus the Constitution contemplates Panchayat as a potent instrument of family welfare and social welfare schemes coming true for the betterment of people's health, especially women's health and family welfare coupled with social welfare. Under Section 21 of the Act, the functions and duties entrusted to Gram Panchayats include "public health and family welfare", "women and child development" and "social welfare". Family planning falls therein. Who can better enable the discharge of functions and duties and such constitutional goals being achieved than the leaders of Panchayats themselves taking a lead and setting an example? (Para 38)

Fundamental rights are not to be read in isolation. They have to be read along with the chapter on directive principles of State policy and the fundamental duties enshrined in Article 51-A. None of the lofty ideals envisaged under Articles 38 and 47 can be achieved without controlling the population inasmuch as our materialistic resources are limited and claimants are many. The concept of sustainable development which emerges as a fundamental duty from several clauses of Article 51-A too dictates the expansion of population being kept within reasonable bounds. (Para 39)

The problem of population explosion is a national and global issue for which priority in policy-oriented legislations, wherever needed, is necessary. Legislative means to check the menace of growing population has been held to be valid. (Para 37)

Air India v. *Nergesh Meerza*, (1981) 4 SCC 335 : 1981 SCC (L&S) 599, *relied on*

Therefore, it is futile to assume or urge that the impugned legislation violates right to life and liberty guaranteed under Article 21 in any of the meanings, howsoever expanded the meanings may be. (Para 41)

J. Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) & 177(1) — Election to the office of Sarpanch, Up-Sarpanch and Panch — Disqualification — Persons having more than two living children disqualified — Held, such a provision casting disqualification on contesting or holding the office not violative of Art. 25 — Practice of having four wives is permissible under Muslim law and one can also procreate more than two children but there is no mandate or obligation under any religion not to have less than four wives or to procreate more than two children and hence such a practice is not integral part of the practice of religion — A practice does not acquire sanction of religion merely because it is permitted — Practice of having more than one wife or procreating more than one child can be regulated or prohibited in the interest of public order, morality and health and social welfare and reform — Though there is no general restriction on having more than two children, but legislation can validly prescribe it as a disqualification for the purpose of election — Constitution of India, Art. 25

K. Constitution of India — Art. 25 — Freedom under, is subject to public order, morality and health — It permits legislation in the interest of social welfare and reform as part of public order, national morality and collective health of the people — Religious practice which is not integral part of the practice of that religion is not protected under Art. 25

It was submitted that the personal law of Muslims permits performance of marriages with four women obviously for the purpose of procreating children and any restriction thereon would be violative of the right to freedom of religion enshrined in Article 25 of the Constitution.

Rejecting the submission,

Held :

The freedom under Article 25 is subject to public order, morality and health. So the article itself permits a legislation in the interest of social welfare and reform which are obviously part and parcel of public order, national morality and the collective health of the nation's people. The protection under Articles 25 and 26 of the Constitution is with respect to religious practice which forms an essential and integral part of the religion. A practice may be a religious practice but not an essential and integral part of practice of that religion. The latter is not protected by Article 25. A statutory provision casting disqualification on contesting for, or holding, an elective office is not violative of Article 25 of the Constitution. (Paras 43, 45 and 59)

M. Ismail Faruqui (Dr) v. *Union of India*, (1994) 6 SCC 360, *relied on*

The challenge to the constitutional validity of Sections 175(1)(*q*) and 177(1) must fail. The right to contest an election for any office in Panchayat is neither fundamental nor a common law right. It is the creature of a statute and is obviously subject to qualifications and disqualifications enacted by legislation. It may be permissible for Muslims to enter into four marriages with four women and for anyone whether a Muslim or belonging to any other community or religion to procreate as many children as he likes but no religion in India dictates or mandates as an obligation to enter into bigamy or polygamy or to have children more than one. What is permitted or not prohibited by a religion does not become a religious practice or a positive tenet of a religion. A practice does not acquire the sanction of religion simply because it is permitted. Assuming the practice of having more wives than one or procreating more children than one is

a practice followed by any community or group of people, the same can be regulated or prohibited by legislation in the interest of public order, morality and health or by any law providing for social welfare and reform which the impugned legislation clearly does. (Para 60)

Sarla Mudgal v. *Union of India*, (1995) 3 SCC 635 : 1995 SCC (Cri) 569; *Mohd. Ahmed Khan* v. *Shah Bano Begum*, (1985) 2 SCC 556 : 1985 SCC (Cri) 245; *Mohd. Hanif Quareshi* v. *State of Bihar*, AIR 1958 SC 731 : 1959 SCR 629, *relied on*

State of Bombay v. *Narasu Appa Mali*, AIR 1952 Bom 84 : 53 Cri LJ 354; *Badruddin* v. *Aisha Begum*, 1957 All LJ 300; *R.A. Pathan* v. *Director of Technical Education*, (1981) 22 Guj LR 289; *Ram Prasad Seth* v. *State of U.P.*, (1957) 2 LLJ 172 : AIR 1957 All 411 and AIR 1961 All 334 : (1961) 2 LLJ 247, *approved*

If anyone chooses to have more living children than two, he is free to do so under the law as it stands now but then he should pay a little price and that is of depriving himself from holding an office in Panchayat in the State of Haryana. There is nothing illegal about it and certainly no unconstitutionality attaches to it. (Para 61)

L. Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) & 177(1) — Election to the office of Sarpanch, Up-Sarpanch or Panch — Disqualification — Persons having more than two children disqualified — Held, disqualification is not removed by merely giving the third child away in adoption

Held :

The disqualification is attracted no sooner a third child is born and is living after two living children. Merely because the couple has parted with one child by giving the child away in adoption, the disqualification does not come to an end. While interpreting the scope of disqualification, the evil sought to be cured and purpose sought to be achieved by the enactment must be kept in view. If the person sought to be disqualified is responsible for or has given birth to children more than two who are living then merely because one or more of them are given in adoption the disqualification is not wiped out. (Para 62)

M. Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) & 177(1) — Election to the office of Sarpanch, Up-Sarpanch or Panch — Disqualification — Persons having more than two children disqualified — Argument that the women almost helplessly bear a third child if their husbands want them to do so and thus women are affected most by this disqualification has no merit — If a husband compels his wife to bear a third child, he would disqualify himself as well

N. Constitution of India — Art. 14 — Classification — Underclassification — Disqualification on holding elected office imposed on having more than two children — Helplessness of women against desire of husband pleaded — Assuming the plea to be correct, failure of legislature to carve out an exception in favour of women would not render the provision unconstitutional

Held :

A male who compels his wife to bear a third child would disqualify not only his wife but himself as well. With the awareness which is arising in Indian womenfolk, they are not so helpless as to be compelled to bear a third child even though they do not wish to do so. At the end, suffice it to say that if the legislature chooses to carve out an exception in favour of females it is free to do

so but merely because women are not excepted from the operation of the disqualification does not render it unconstitutional. (Para 63)

a O. **Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — Ss. 175(1)(q) & 177(1) — Election to the office of Sarpanch, Up-Sarpanch or Panch — Disqualification — Provision cannot be challenged on the basis of hypothetical and abnormal situations — Constitution of India — Arts. 32 & 226 and 13 — Constitutionality of any provision, held, cannot be adjudged on the basis of hypothetical or abnormal situations — Exceptions do not make the rule**

b Hypothetical examples were tried to be floated across the Bar by submitting that there may be cases where triplets are born or twins are born on the second pregnancy and consequently both of the parents would incur disqualification for reasons beyond their control or just by a freak of divinity.

Held :

c Such are not normal cases and the validity of the law cannot be tested by applying it to abnormal situations. Exceptions do not make the rule nor render the rule irrelevant. One swallow does not make a summer; a single instance or indicator of something is not necessarily significant. (Para 64)

CONCLUSION

The challenge to the constitutional validity of Sections 175(1)(*q*) and 177(1) d fails on all the counts. Both the provisions are held intra vires the Constitution. The provisions are salutary and in public interest. All the petitions which challenge the constitutional validity of the abovesaid provisions are held liable to be dismissed. (Para 65)

R-M/ANWTZ/28726/C

Advocates who appeared in this case :

e Soli J. Sorabjee, Attorney General, S.B. Sanyal, R.P. Bhatt and P.P. Rao, Senior Advocates (Rishi Malhotra, Prem Malhotra, Altaf Hussain, Anil Sharma, Anil Karnwal, Vishal Malik, M.S. Dahiya, Sanjay Sarin, Ashok Mathur, Arun Agarwal, S.C. Birla, Ms Kusum Chaudhary, B.R. Kapur, Mukesh Kumar, Sunit Kumar, Anis Ahmed Khan, Bhava Dutta Sharma, B.S. Chahar, Ms Jyoti Chahar, Vinay Garg, Suresh C. Gupta, A. Guneshwar Sharma, Sanjay Pal, Ms Shashwati Sen, Kamal Mohan Gupta, Ms Rachna Joshi Issar, Ajay Siwach, Jasbir S. Malik, S.K. Sabharwal, f Dr Ramesh K. Haritash, Ms Alka Rai, Goodwill Indeevar, Hari Shankar K., Ranbir Singh Yadav, Dr Kailash Chand, Sarvesh Bisaria, Ms Nidhi, K.R. Nagaraja, Sanjay Garg, R.K. Talwar, Y.P. Dhingra, Panna Lal Syngal, M.L. Bakshi, S.S. Nehra, R.C. Kohli, Monoher Singh Bakshi, Ms Dipali Chauhan, Debasis Misra, Mahabir Singh, Ajay Pal, Rakesh Dahiya, Irshad Ahmed, A.P. Mohanty, Manoj Swarup, R.D. Rathore, K.K. Gupta, Jagjit Singh Chhabra, Varinder Kr. Sharma, C.D. Singh, L.K. Pandey, Mushtaq Ahmed, Tara Chandra Sharma, Ms Neelam Sharma, Ajai Bhalla, g Ms Abha R. Sharma, Ms Sunita R. Singh, R.C. Pandey, S.K. Bansal, Ms Savitri Bansal, Harbans Lal Bajaj, Ms Lalitha Kaushik, Jagdish Kr. Agarwal, Dr K.R. Punia, Ms Santosh Singh, Ms Vandana Singh, Rakesh Kr. Mudgal, J.S. Maharatta, Rao Ranjit, Somvir Singh Deswal, M.P. Shorawala, Madhukar Agarwal, P.K. Jain, Ms Sandhya Goswami, Ms M. Sharda, Raj Kr. Mehta, B.S. Mor, S.M. Hooda, Gian Singh, R.C. Kaushik, Naresh Kumar, Rajiv Talwar, Ms Naresh Bakshi, Pradeep Gupta, K.K. Mohan, Shakeel Ahmed, Attar Singh, Vishwajit Singh, Ms Praveena h Gautam, R.P. Goyal, S.K. Sinha, Shankar Divate, S.C. Patel, D. Mahesh Babu, Ms Rekha Palli, C.L. Sahu, Dr Surat Singh, Ashok K. Mahajan, Rajesh Tyagi, Ms Aparana Bhardwaj, Baldev Atreya, Praveen Jain, P. Narasimhan, Bimal Roy Jad, Ms

Sunita Pandit, Jaswant Rajpal, M.M. Kashyap, Ugra Shankar Prasad, Rohit Minocha, S.N. Bhat, N.P.S. Panwar, D.P. Chaturvedi, Rishiraj Barooah, J.P. Dhanda, Ms Raj Rani Dhanda, Ms Geetanjali Mohan, Vinay Kr. Garg, Ms Kavita Wadia, Krishnan Venugopal, Uday N. Tiwary, Prasad Vijaya Kumar, Balaram Das, K.G. Bhagat, Vineet Bhagat, Kamal Baid, Nipun Sharma, R.D. Upadhyay, Manish Singhvi and Ashok K. Mahajan, Advocates, with them) for the appearing parties.

Chronological list of cases cited — *on page(s)*

1. (1996) 2 SCC 498, *Pannalal Bansilal Pitti* v. *State of A.P.* — 383*d-e*
2. (1995) 3 SCC 635 : 1995 SCC (Cri) 569, *Sarla Mudgal* v. *Union of India* — 391*c-d*
3. (1995) 1 SCC 519, *State of T.N.* v. *Ananthi Ammal* — 383*a*
4. (1994) 6 SCC 360, *M. Ismail Faruqui (Dr)* v. *Union of India* — 391*b-c*
5. (1988) 2 SCC 433 : 1988 SCC (L&S) 577, *L.N. Mishra Institute of Economic Development and Social Change* v. *State of Bihar* — 383*c-d*
6. (1987) 4 SCC 238, *Prabhakaran Nair* v. *State of T.N.* — 383*a*
7. (1985) 2 SCC 556 : 1985 SCC (Cri) 245, *Mohd. Ahmed Khan* v. *Shah Bano Begum* — 391*e*
8. (1982) 1 SCC 691, *Jyoti Basu* v. *Debi Ghosal* — 385*a*
9. (1981) 22 Guj LR 289, *R.A. Pathan* v. *Director of Technical Education* — 393*g-h*
10. (1981) 4 SCC 335 : 1981 SCC (L&S) 599, *Air India* v. *Nergesh Meerza* — 390*a-b*
11. (1980) 4 SCC 1, *Kasturi Lal Lakshmi Reddy* v. *State of J&K* — 386*d*
12. (1978) 1 SCC 248, *Maneka Gandhi* v. *Union of India* — 386*d*
13. (1973) 1 SCC 261, *Bar Council of U.P.* v. *State of U.P.* — 383*a*
14. AIR 1958 SC 731 : 1959 SCR 629, *Mohd. Hanif Quareshi* v. *State of Bihar* — 391*f-g*
15. 1957 All LJ 300, *Badruddin* v. *Aisha Begum* — 393*f*
16. (1957) 2 LLJ 172 : AIR 1957 All 411 and AIR 1961 All 334 : (1961) 2 LLJ 247, *Ram Prasad Seth* v. *State of U.P.* — 394*b*
17. AIR 1955 SC 191 : (1955) 1 SCR 1045 : 1955 Cri LJ 371, *Budhan Choudhry* v. *State of Bihar* — 380*h*
18. AIR 1955 SC 166 : (1955) 1 SCR 1004, *Sakhawat Ali* v. *State of Orissa* — 385*c*
19. AIR 1954 SC 686 : (1955) 1 SCR 608, *Jamuna Prasad Mukhariya* v. *Lachhi Ram* — 385*b-c*
20. AIR 1954 SC 493 : (1955) 1 SCR 599, *State of M.P.* v. *G.C. Mandawar* — 382*f*
21. AIR 1954 SC 210 : 1954 SCR 892, *Jagan Nath* v. *Jaswant Singh* — 385*a*
22. AIR 1952 Bom 84 : 53 Cri LJ 354, *State of Bombay* v. *Narasu Appa Mali* — 392*b*, 392*g-h*, 393*c*
23. AIR 1952 SC 64 : 1952 SCR 218, *N.P. Ponnuswami* v. *Returning Officer, Namakkal Constituency* — 385*a*

The Judgment of the Court was delivered by

R.C. LAHOTI, J.— Leave granted in all the special leave petitions.

2. In this batch of writ petitions and appeals the core issue is the vires of the provisions of Sections 175(1)(*q*) and 177(1) of the Haryana Panchayati Raj Act, 1994 (Act 11 of 1994) (hereinafter referred to as the Act for short). The relevant provisions are extracted and reproduced hereunder:

> "175. (1) No person shall be a Sarpanch, Up-Sarpanch or a Panch of a Gram Panchayat or a member of a Panchayat Samiti or Zila Parishad or continue as such who—
>
> * * *

(*q*) has more than two living children:

Provided that a person having more than two children on or up to the expiry of one year of the commencement of this Act, shall not be deemed to be disqualified.

* * *

177. (1) If any member of a Gram Panchayat, Panchayat Samiti or Zila Parishad—

(*a*) who is elected, as such, was subject to any of the disqualifications mentioned in Section 175 at the time of his election;

(*b*) during the term for which he has been elected, incurs any of the disqualifications, mentioned in Section 175,

shall be disqualified from continuing to be a member, and his office shall become vacant.

(2) In every case, the question whether a vacancy has arisen, shall be decided by the Director. The Director may give its decision either on an application made to it by any person, or on its own motion. Until the Director decides that the vacancy has arisen, the members shall not be disqualified under sub-section (1) from continuing to be a member. Any person aggrieved by the decision of the Director may, within a period of fifteen days from the date of such decision, appeal to the Government and the orders passed by Government in such appeal shall be final:

Provided that no order shall be passed under this sub-section by the Director against any member without giving him a reasonable opportunity of being heard."

3. Act 11 of 1994 was enacted with various objectives based on past experience and in view of the shortcomings noticed in the implementation of preceding laws and also to bring the legislation in conformity with Part IX of the Constitution of India relating to "the Panchayats" added by the Seventy-third Amendment. One of the objectives set out in the Statement of Objects and Reasons is to disqualify persons for election to Panchayats at each level, having more than two children after one year of the date of commencement of this Act, to popularize family welfare/family planning programme [vide clause (*m*) of para 4 of SOR].

4. Placed in plain words, the provision disqualifies a person having more than two living children from holding the specified offices in Panchayats. The enforcement of disqualification is postponed for a period of one year from the date of the commencement of the Act. A person having more than two children up to the expiry of one year of the commencement of the Act is not disqualified. This postponement for one year takes care of any conception on or around the commencement of the Act, the normal period of gestation being nine months. If a woman has conceived at the commencement of the Act then any one of such couples would not be disqualified. Though not disqualified on the date of election, if any person holding any of the said offices incurs a disqualification by giving birth to a child one year after the commencement of the Act he becomes subject to disqualification and is disabled from continuing to hold the office. The disability is incurred by the

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birth of a child which results in increasing the number of living children, including the additional child born one year after the commencement of the Act, to a figure more than two. If the factum is disputed, the Director is entrusted with the duty of holding an enquiry and declaring the office vacant. The decision of the Director is subject to appeal to the Government. The Director has to afford a reasonable opportunity of being heard to the holder of office sought to be disqualified. These safeguards satisfy the requirements of natural justice.

5. Several persons (who are the writ petitioners or appellants in this batch of matters) have been disqualified or proceeded against for disqualifying either from contesting the elections for, or from continuing in the office of Panchas/Sarpanchas in view of their having incurred the disqualification as provided by Section 175(1)(*q*) or Section 177(1) read with Section 175(1)(*q*) of the Act. The grounds for challenging the constitutional validity of the abovesaid provision are very many, couched differently in different writ petitions. We have heard all the learned counsel representing the different petitioners/appellants. As agreed to at the Bar, the grounds of challenge can be categorized into five: (*i*) that the provision is arbitrary and hence violative of Article 14 of the Constitution; (*ii*) that the disqualification does not serve the purpose sought to be achieved by the legislation; (*iii*) that the provision is discriminatory; (*iv*) that the provision adversely affects the liberty of leading personal life in all its freedom and having as many children as one chooses to have and hence is violative of Article 21 of the Constitution; and (*v*) that the provision interferes with the freedom of religion and hence violates Article 25 of the Constitution.

6. The State of Haryana has defended its legislation on all counts. We have also heard the learned Standing Counsel for the State. On notice, Shri Soli J. Sorabjee, the learned Attorney General for India, has appeared to assist the Court and he too has addressed the Court. We would deal with each of the submissions made.

Submissions (i), (ii) and (iii)

7. The first three submissions are based on Article 14 of the Constitution and, therefore, are taken up together for consideration.

Is the classification arbitrary?

8. It is well settled that Article 14 forbids class legislation; it does not forbid reasonable classification for the purpose of legislation. To satisfy the constitutional test of permissibility, two conditions must be satisfied, namely: (*i*) that the classification is founded on an intelligible differentia which distinguishes persons or things that are grouped together from others left out of the group, and (*ii*) that such differentia has a rational relation to the object sought to be achieved by the statute in question. The basis for classification may rest on conditions which may be geographical or according to objects or occupation or the like. (See Constitution Bench decision in *Budhan Choudhry* v. *State of Bihar*[1].) The classification is well defined and well

[1] AIR 1955 SC 191 : (1955) 1 SCR 1045 : 1955 Cri LJ 371

perceptible. Persons having more than two living children are clearly distinguishable from persons having not more than two living children. The two constitute two different classes and the classification is founded on an intelligible differentia clearly distinguishing one from the other. One of the objects sought to be achieved by the legislation is popularizing the family welfare/family planning programme. The disqualification enacted by the provision seeks to achieve the objective by creating a disincentive. The classification does not suffer from any arbitrariness. The number of children viz. two is based on legislative wisdom. It could have been more or less. The number is a matter of policy decision which is not open to judicial scrutiny.

Does the legislation not serve its object?

9. It was submitted that the number of children which one has, whether two or three or more, does not affect the capacity, competence and quality of a person to serve on any office of a Panchayat and, therefore, the impugned disqualification has no nexus with the purpose sought to be achieved by the Act. There is no merit in the submission. We have already stated that one of the objects of the enactment is to popularize family welfare/family planning programme. This is consistent with the National Population Policy.

10. Under Article 243-G of the Constitution, the legislature of a State has been vested with the authority to make law endowing the Panchayats with such powers and authority which may be necessary to enable the Gram Panchayats to function as institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats, at the appropriate level, subject to such conditions as may be specified therein. Clause (*b*) of Article 243-G provides that Gram Panchayats may be entrusted the powers to implement the schemes for economic development and social justice including those in relation to matters listed in the Eleventh Schedule. Entries 24 and 25 of the Eleventh Schedule read:

"24. Family welfare.

25. Women and child development."

In pursuance of the powers given to the State Legislatures to enact laws, the Haryana Legislature enacted the Haryana Panchayati Raj Act, 1994 (Haryana Act 11 of 1994). Section 21 enumerates the functions and duties of Gram Panchayat. Clause XIX(1) of Section 21 reads:

"XIX. Public Health and Family Welfare—

(1) Implementation of family welfare programme."

Family welfare would include family planning as well. To carry out the purpose of the Act as well as the mandate of the Constitution the legislature has made a provision for making a person having more than two living children ineligible to either contest for the post of Panch or Sarpanch. Such a provision would serve the purpose of the Act as mandated by the Constitution. It cannot be said that such a provision would not serve the purpose of the Act.

11. In our opinion, the impugned disqualification does have a nexus with the purpose sought to be achieved by the Act. Hence it is valid.

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Is the provision discriminatory?

12. It was submitted that though the State of Haryana has introduced such a provision of disqualification by reference to elective offices in Panchayats, a similar provision is not found to have been enacted for disqualifying aspirants or holders of elective or public offices in other institutions of local self-governance and also not in State Legislatures and Parliament. So also all the States i.e. other than Haryana have not enacted similar laws, and therefore, it appears that people aspiring to participate in Panchayati Raj governance in the State of Haryana have been singled out and meted out hostile discrimination. The submission has been stated only to be rejected. Under the constitutional scheme there is a well-defined distribution of legislative powers contained in Part XI of the Constitution. Parliament and every State Legislature has power to make laws with respect to any of the matters which fall within its field of legislation under Article 246 read with the Seventh Schedule of the Constitution. A legislation by one of the States cannot be held to be discriminatory or suffering from the vice of hostile discrimination as against its citizens simply because Parliament or the legislatures of other States have not chosen to enact similar laws. Such a submission, if accepted, would be violative of the autonomy given to the Centre and the States within their respective fields under the constitutional scheme.

13. Similarly, legislations referable to different organs of local self-government, that is, Panchayats, Municipalities and so on may be, rather are, different. Many a time they are referable to different entries of Lists I, II and III of the Seventh Schedule. All such laws need not necessarily be identical. So is the case with the laws governing legislators and parliamentarians.

14. It is not permissible to compare a piece of legislation enacted by a State in exercise of its own legislative power with the provisions of another law, though pari materia it may be, but enacted by Parliament or by another State Legislature within its own power to legislate. The sources of power are different and so do differ those who exercise the power. The Constitution Bench in *State of M.P.* v. *G.C. Mandawar*[2] held that the power of the Court to declare a law void under Article 13 has to be exercised with reference to the specific legislation which is impugned. Two laws enacted by two different Governments and by two different legislatures can be read neither in conjunction nor by comparison for the purpose of finding out if they are discriminatory. Article 14 does not authorize the striking down of a law of one State on the ground that in contrast with a law of another State on the same subject, its provisions are discriminatory. When the sources of authority for the two statutes are different, Article 14 can have no application. So is the

2 AIR 1954 SC 493 : (1955) 1 SCR 599

view taken in *Bar Council of U.P.* v. *State of U.P.*[3], *State of T.N.* v. *Ananthi Ammal*[4] and *Prabhakaran Nair* v. *State of T.N.*[5]

15. Incidentally, it may be noted that so far as the State of Haryana is concerned, in the Haryana Municipal Act, 1973 (Act 24 of 1973) Section 13-A has been inserted to make a provision for similar disqualification for a person from being chosen or holding the office of a member of a Municipality.

16. A uniform policy may be devised by the Centre or by a State. However, there is no constitutional requirement that any such policy must be implemented at one go. Policies are capable of being implemented in a phased manner. More so, when the policies have far-reaching implications and are dynamic in nature, their implementation in a phased manner is welcome for it receives gradual willing acceptance and invites lesser resistance.

17. The implementation of policy decision in a phased manner is suggestive neither of arbitrariness nor of discrimination. In *L.N. Mishra Institute of Economic Development and Social Change* v. *State of Bihar*[6] the policy of nationalizing educational institutes was sought to be implemented in a phased manner. This Court held that all the institutions cannot be taken over at a time and merely because the beginning was made with one institute, it could not complain that it was singled out and, therefore, Article 14 was violated. Observations of this Court in *Pannalal Bansilal Pitti* v. *State of A.P.*[7] are apposite. In a pluralistic society like India, people having faith in different religions, different beliefs and tenets, have peculiar problems of their own.

> "A uniform law, though is highly desirable, enactment thereof in one go perhaps may be counterproductive to unity and integrity of the nation. In a democracy governed by rule of law, gradual progressive change and order should be brought about. Making law or amendment to a law is a slow process and the legislature attempts to remedy where the need is felt most acute. It would, therefore, be inexpedient and incorrect to think that all laws have to be made uniformly applicable to all people in one go. The mischief or defect which is most acute can be remedied by process of law at stages." (SCC p. 510, para 12)

18. To make a beginning, the reforms may be introduced at the grass-root level so as to spiral up or may be introduced at the top so as to percolate down. Panchayats are grass-root-level institutions of local self-governance. They have a wider base. There is nothing wrong in the State of Haryana having chosen to subscribe to the national movement of population control by enacting a legislation which would go a long way in ameliorating health, social and economic conditions of rural population, and thereby contribute to

3 (1973) 1 SCC 261
4 (1995) 1 SCC 519
5 (1987) 4 SCC 238
6 (1988) 2 SCC 433 : 1988 SCC (L&S) 577
7 (1996) 2 SCC 498

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the development of the nation which in its turn would benefit the entire citizenry. We may quote from the National Population Policy, 2000 (Government of India Publication, p. 35):

> "Demonstration of support by elected leaders, opinion-makers and religious leaders with close involvement in the reproductive and child health programme greatly influences the behaviour and response patterns of individuals and communities. This serves to enthuse communities to be attentive towards the quality and coverage of maternal and child health services, including referral care.
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> * * *
>
> The involvement and enthusiastic participation of elected leaders will ensure dedicated involvement of administrators at district and sub-district levels. Demonstration of strong support to the small-family norm, as well as personal example, by political, community, business, professional and religious leaders, media and film stars, sports personalities and opinion-makers, will enhance its acceptance throughout society."

19. No fault can be found with the State of Haryana having enacted the legislation. It is for others to emulate.

20. We are clearly of the opinion that the impugned provision is neither arbitrary nor unreasonable nor discriminatory. The disqualification contained in Section 175(1)(*q*) of Haryana Act 11 of 1994 seeks to achieve a laudable purpose — socio-economic welfare and health care of the masses — and is consistent with the National Population Policy. It is not violative of Article 14 of the Constitution.

Submissions (iv) and (v): the provision if it violates Article 21 or 25?

21. Before testing the validity of the impugned legislation from the viewpoint of Articles 21 and 25, in the light of the submissions made, we take up first the more basic issue — whether it is at all permissible to test the validity of a law which enacts a disqualification operating in the field of elections on the touchstone of violation of fundamental rights.

22. Right to contest an election is neither a fundamental right nor a common law right. It is a right conferred by a statute. At the most, in view of Part IX having been added in the Constitution, a right to contest election for an office in Panchayat may be said to be a constitutional right — a right originating in the Constitution and given shape by a statute. But even so, it cannot be equated with a fundamental right. There is nothing wrong in the same statute which confers the right to contest an election also to provide for the necessary qualifications without which a person cannot offer his candidature for an elective office and also to provide for disqualifications which would disable a person from contesting for, or holding, an elective statutory office.

23. Reiterating the law laid down in *N.P. Ponnuswami* v. *Returning Officer, Namakkal Constituency*[8] and *Jagan Nath* v. *Jaswant Singh*[9] this Court held in *Jyoti Basu* v. *Debi Ghosal*[10]: (SCC p. 696, para 8)

> "*8.* A right to elect, fundamental though it is to democracy, is, anomalously enough, neither a fundamental right nor a common law right. It is pure and simple, a statutory right. So is the right to be elected. So is the right to dispute an election. Outside of statute, there is no right to elect, no right to be elected and no right to dispute an election. Statutory creations they are, and therefore, subject to statutory limitation."

24. In *Jamuna Prasad Mukhariya* v. *Lachhi Ram*[11] a candidate at the election made a systematic appeal to voters of a particular caste to vote for him on the basis of his caste through publishing and circulating leaflets. Sections 123(5) and 124(5) of the Representation of the People Act, 1951, were challenged as ultra vires Article 19(1)(*a*) of the Constitution, submitting that the provisions of the Representation of the People Act interfered with a citizen's fundamental right to freedom of speech. Repelling the contention, the Constitution Bench held that these laws do not stop a man from speaking. They merely provide conditions which must be observed if he wants to enter Parliament. The right to stand as a candidate and contest an election is not a common law right; it is a special right created by a statute and can only be exercised on the conditions laid down by the statute. The Fundamental Rights Chapter has no bearing on a right like this created by a statute. The appellants have no fundamental right to be elected and if they want to be elected they must observe the rules. If they prefer to exercise their right of free speech outside these rules, the impugned sections do not stop them. In *Sakhawat Ali* v. *State of Orissa*[12] the appellant's nomination paper for election as a Councillor of the Municipality was rejected on the ground that he was employed as a legal practitioner against the Municipality which was a disqualification under the relevant Municipality Act. It was contended that the disqualification prescribed violated the appellant's fundamental rights guaranteed under Articles 14 and 19(1)(*g*) of the Constitution. The Constitution Bench held that the impugned provision has a public purpose behind it i.e. the purity of public life which would be thwarted where there was a conflict between interest and duty. The Constitution Bench further held that the right of the appellant to practise the profession of law guaranteed by Article 19(1)(*g*) cannot be said to have been violated because in laying down the disqualification the Municipal Act does not prevent him from practising his profession of law; it only lays down that if he wants to stand as a candidate for election he shall not either be employed as a paid legal

8 AIR 1952 SC 64 : 1952 SCR 218
9 AIR 1954 SC 210 : 1954 SCR 892
10 (1982) 1 SCC 691
11 AIR 1954 SC 686 : (1955) 1 SCR 608
12 AIR 1955 SC 166 : (1955) 1 SCR 1004

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practitioner on behalf of the Municipality or act as a legal practitioner against the Municipality. There is no fundamental right in any person to stand as a candidate for election to the Municipality. The only fundamental right which is guaranteed is that of practising any profession or carrying on any occupation, trade or business. The impugned disqualification does not violate the latter right. Primarily no fundamental right is violated and even assuming that it be taken as a restriction on his right to practise his profession of law, such restriction would be liable to be upheld being reasonable and imposed in the interests of the general public for the preservation of purity in public life.

25. In our view, disqualification on the right to contest an election by having more than two living children does not contravene any fundamental right nor does it cross the limits of reasonability. Rather it is a disqualification conceptually devised in national interest.

26. With this general statement of law which has application to Articles 21 and 25 both, we now proceed to test the sustainability of attack on constitutional validity of the impugned legislation separately by reference to Articles 21 and 25.

The disqualification, if violates Article 21?

27. Placing strong reliance on *Maneka Gandhi* v. *Union of India*[13] and *Kasturi Lal Lakshmi Reddy* v. *State of J&K*[14] it was forcefully urged that the fundamental right to life and personal liberty emanating from Article 21 of the Constitution should be allowed to stretch its span to its optimum so as to include in the compendious term of the article all the varieties of rights which go to make up the personal liberty of man including the right to enjoy all the materialistic pleasures and to procreate as many children as one pleases.

28. At the very outset we are constrained to observe that the law laid down by this Court in the decisions relied on is either being misread or read divorced of the context. The test of reasonableness is not a wholly subjective test and its contours are fairly indicated by the Constitution. The requirement of reasonableness runs like a golden thread through the entire fabric of fundamental rights. The lofty ideals of social and economic justice, the advancement of the nation as a whole and the philosophy of distributive justice — economic, social and political — cannot be given a go-by in the name of undue stress on fundamental rights and individual liberty. Reasonableness and rationality, legally as well as philosophically, provide colour to the meaning of fundamental rights and these principles are deducible from those very decisions which have been relied on by the learned counsel for the petitioners.

29. It is necessary to have a look at the population scenario of the world and of our own country.

30. India has the (dis)credit of being second only to China at the top in the list of the 10 most populous countries of the world. As on 1-2-2000 the

13 (1978) 1 SCC 248
14 (1980) 4 SCC 1

population of China was 1277.6 million while the population of India as on 1-3-2001 was 1027.0 million (Census of India, 2001, Series I, India — Paper I of 2001, p. 29).

31. The torrential increase in the population of the country is one of the major hindrances in the pace of India's socio-economic progress. Everyday, about 50,000 persons are added to the already large base of its population. The Karunakaran Population Committee (1992-93) had proposed certain disincentives for those who do not follow the norms of the development model adopted by the national public policy so as to bring down the fertility rate. It is a matter of regret that though the Constitution of India is committed to social and economic justice for all, yet India has entered the new millennium with the largest number of illiterates in the world and the largest number of people below the poverty line. The laudable goals spelt out in the directive principles of State policy in the Constitution of India can best be achieved if the population explosion is checked effectively. Therefore, population control assumes a central importance for providing social and economic justice to the people of India (Usha Tandon, Reader, Faculty of Law, Delhi University — *Research Paper on Population Stabilization*, Delhi Law Review, Vol. XXIII, 2001, pp. 125-31).

32. In the words of Bertrand Russell, "Population explosion is more dangerous than hydrogen bomb." This explosive population overgrowth is not confined to a particular country but it is a global phenomenon. India being the largest secular democracy has the population problem going side by side and directly impacting on its per capita income, and resulting in shortfall of foodgrains in spite of the green revolution, and has hampered improvement on the educational front and has caused swelling of unemployment numbers, creating a new class of pavement and slum dwellers and leading to congestion in urban areas due to the migration of rural poor. (Paper by B.K. Raina on *Population Policy and the Law*, 1992, edited by B.P. Singh Sehgal, p. 52.)

33. In the beginning of this century, the world population crossed six billion, of which India alone accounts for one billion (17 per cent) in a land area of 2.5 per cent of the world area. The global annual increase of population is 80 million. Out of this, India's growth share is over 18 million (23 per cent), equivalent to the total population of Australia, which has two-and-a-half times the land space of India. In other words, India is growing at the alarming rate of one Australia every year and will be the most densely populous country in the world, outbeating China, which ranks first, with a land area thrice this country's. China can withstand the growth for a few years more, but not India, with a constricted land space. Here, the per capita crop land is the lowest in the world, which is also shrinking fast. If this falls below the minimum sustainable level, people can no longer feed themselves and shall become dependent on imported food, provided there are nations with exportable surpluses. Perhaps, this may lead to famine and abnormal conditions in some parts of the country. (Source — *Population Challenge*, Arcot Easwaran, *The Hindu*, dated 8-7-2003.) It is emphasized that as the

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population grows rapidly there is a corresponding decrease in per capita water and food. Women in many places trek long distances in search of water which distances would increase every next year on account of excessive groundwater withdrawals catering to the need of the increasing population, resulting in lowering of the levels of water tables.

34. Arcot Easwaran has quoted the example of China. China, the most populous country in the world, has been able to control its growth rate by adopting the "carrot-and-stick" rule. Attractive incentives in the field of education and employment were provided to the couples following the "one-child norm". At the same time drastic disincentives were cast on the couples breaching "one-child norm" which even included penal action. India being a democratic country has so far not chosen to go beyond casting minimal disincentives and has not embarked upon penalizing procreation of children beyond a particular limit. However, it has to be remembered that complacence in controlling population in the name of democracy is too heavy a price to pay, allowing the nation to drift towards disaster.

35. The growing population of India had alarmed the Indian leadership even before India achieved independence. In 1940 the Sub-Committee on Population, appointed by the National Planning Committee set up by the President of the Indian National Congress (Pandit Jawaharlal Nehru), considered "family planning and a limitation of children" essential for the interests of social economy, family happiness and national planning. The Committee recommended the establishment of birth-control clinics and other necessary measures such as raising the age of marriage and a eugenic sterilization programme. A Committee on Population set up by the National Development Council in 1991, in the wake of the census result, also proposed the formulation of a national policy. (Source — Seminar, March 2002, p. 25.)

36. Every successive five-year plan has given prominence to a population policy. In the first draft of the First Five-Year Plan (1951-56) the Planning Commission recognized that population policy was essential to planning and that family planning was a step forward for improvement in health, particularly that of mothers and children. The Second Five-Year Plan (1956-61) emphasized the method of sterilization. A Central Family Planning Board was also constituted in 1956 for the purpose. The Fourth Five-Year Plan (1969-74) placed the family planning programme, "as one amongst items of the highest national priority". The Seventh Five-Year Plan (1985-86 to 1990-91) has underlined "the importance of population control for the success of the plan programme ...". But, despite all such exhortations, "the fact remains that the rate of population growth has not moved one bit from the level of 33 per thousand reached in 1979. And in many cases, even the reduced targets set since then have not been realised". (*Population Policy and the Law*, ibid., pp. 44-46.)

37. The above facts and excerpts highlight the problem of population explosion as a national and global issue and provide justification for priority in policy-oriented legislations, wherever needed.

38. None of the petitioners has disputed the legislative competence of the State of Haryana to enact the legislation. Incidentally, it may be stated that the Seventh Schedule List II — State List, Entry 5 speaks of "Local Government, that is to say, the constitution and powers of Municipal Corporations, improvement trusts, district boards, mining settlement authorities and other local authorities for the purpose of local self-government or village administration." Entry 6 speaks of "Public health and sanitation" *inter alia*. In List III — Concurrent List, Entry 20-A was added which reads "Population control and family planning". The legislation is within the permitted field of State subjects. Article 243-C makes provision for the legislature of a State enacting laws with respect to constitution of Panchayats. Article 243-F in Part IX of the Constitution itself provides that a person shall be disqualified for being chosen as, and for being, a member of a Panchayat if he is so disqualified by or under any law made by the legislature of the State. Article 243-G casts one of the responsibilities of Panchayats as preparation of plans and implementation of schemes for economic development and social justice. Some of the schemes that can be entrusted to Panchayats, as spelt out by Article 243-G read with the Eleventh Schedule are schemes for economic development and social justice in relation to health and sanitation, family welfare, women and child development and social welfare. Family planning is essentially a scheme referable to health, family welfare, women and child development and social welfare. Nothing more needs to be said to demonstrate that the Constitution contemplates Panchayat as a potent instrument of family welfare and social welfare schemes coming true for the betterment of people's health, especially women's health and family welfare coupled with social welfare. Under Section 21 of the Act, the functions and duties entrusted to Gram Panchayats include "public health and family welfare", "women and child development" and "social welfare". Family planning falls therein. Who can better enable the discharge of functions and duties and such constitutional goals being achieved than the leaders of Panchayats themselves taking a lead and setting an example?

39. Fundamental rights are not to be read in isolation. They have to be read along with the chapter on directive principles of State policy and the fundamental duties enshrined in Article 51-A. Under Article 38 the State shall strive to promote the welfare of the people and developing a social order empowered at distributive justice — social, economic and political. Under Article 47 the State shall promote with special care the educational and economic interests of the weaker sections of the people and in particular, the constitutionally downtrodden. Under Article 47 the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties. None of these lofty ideals can be achieved without controlling the population inasmuch as our materialistic resources are limited and claimants are many. The concept

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of sustainable development which emerges as a fundamental duty from several clauses of Article 51-A too dictates the expansion of population being kept within reasonable bounds.

40. The menace of growing population was judicially noticed and constitutional validity of legislative means to check the population was upheld in *Air India* v. *Nergesh Meerza*[15]. The Court found no fault with the rule which would terminate the services of air hostesses on the third pregnancy with two existing children, and held the rule both salutary and reasonable for two reasons: (SCC p. 374, para 101)

> "In the first place, the provision preventing third pregnancy with two existing children would be in the larger interest of the health of the air hostess concerned as also for the good upbringing of the children. Secondly, ... when the entire world is faced with the problem of population explosion it will not only be desirable but absolutely essential for every country to see that the family planning programme is not only whipped up but maintained at sufficient levels so as to meet the danger of overpopulation which, if not controlled, may lead to serious social and economic problems throughout the world."

41. To say the least, it is futile to assume or urge that the impugned legislation violates right to life and liberty guaranteed under Article 21 in any of the meanings, howsoever expanded the meanings may be.

The provision if it violates Article 25?

42. It was then submitted that the personal law of Muslims permits performance of marriages with four women, obviously for the purpose of procreating children and any restriction thereon would be violative of the right to freedom of religion enshrined in Article 25 of the Constitution. The relevant part of Article 25 reads as under:

> "25. *Freedom of conscience and free profession, practice and propagation of religion.*—(1) Subject to public order, morality and health and to the other provisions of this Part, all persons are equally entitled to freedom of conscience and the right freely to profess, practise and propagate religion.
>
> (2) Nothing in this article shall affect the operation of any existing law or prevent the State from making any law—
>
> (*a*) regulating or restricting any economic, financial, political or other secular activity which may be associated with religious practice;
>
> (*b*) providing for social welfare and reform or the throwing open of Hindu religious institutions of a public character to all classes and sections of Hindus."

43. A bare reading of this article deprives the submission of all its force, vigour and charm. The freedom is subject to public order, morality and health. So the article itself permits a legislation in the interest of social welfare and reform which are obviously part and parcel of public order, national morality and the collective health of the nation's people.

15 (1981) 4 SCC 335 : 1981 SCC (L&S) 599

44. The Muslim law permits marrying four women. The personal law nowhere mandates or dictates it as a duty to perform four marriages. No religious scripture or authority has been brought to our notice which provides that marrying less than four women or abstaining from procreating a child from each and every wife in case of permitted bigamy or polygamy would be irreligious or offensive to the dictates of the religion. In our view, the question of the impugned provision of the Haryana Act being violative of Article 25 does not arise. We may have a reference to a few decided cases.

45. The meaning of religion — the term as employed in Article 25 and the nature of protection conferred by Article 25 stands settled by the pronouncement of the Constitution Bench decision in *M. Ismail Faruqui (Dr)* v. *Union of India*[16]. The protection under Articles 25 and 26 of the Constitution is with respect to religious practice which forms an essential and integral part of the religion. A practice may be a religious practice but not an essential and integral part of practice of that religion. The latter is not protected by Article 25.

46. In *Sarla Mudgal* v. *Union of India*[17] this Court has judicially noticed it being acclaimed in the United States of America that the practice of polygamy is injurious to "public morals", even though some religions may make it obligatory or desirable for its followers. The Court held that polygamy can be superseded by the State just as it can prohibit human sacrifice or the practice of *sati* in the interest of public order. The personal law operates under the authority of the legislation and not under the religion and, therefore, the personal law can always be superseded or supplemented by legislation.

47. In *Mohd. Ahmed Khan* v. *Shah Bano Begum*[18] the Constitution Bench was confronted with a canvassed conflict between the provisions of Section 125 CrPC and Muslim personal law. The question was: when the personal law makes a provision for maintenance to a divorced wife, the provision for maintenance under Section 125 CrPC would run in conflict with the personal law. The Constitution Bench laid down two principles; firstly, the two provisions operate in different fields and, therefore, there is no conflict, and secondly, even if there is a conflict it should be set at rest by holding that the statutory law will prevail over the personal law of the parties, in cases where they are in conflict.

48. In *Mohd. Hanif Quareshi* v. *State of Bihar*[19] the State legislation placing a total ban on cow slaughter was under challenge. One of the submissions made was that such a ban offended Article 25 of the Constitution because such ban came in the way of the sacrifice of a cow on a particular day where it was considered to be religious by Muslims. Having made a review of various religious books, the Court concluded that it did not appear

16 (1994) 6 SCC 360
17 (1995) 3 SCC 635 : 1995 SCC (Cri) 569
18 (1985) 2 SCC 556 : 1985 SCC (Cri) 245
19 AIR 1958 SC 731 : 1959 SCR 629

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to be obligatory that a person must sacrifice a cow. It was optional for a Muslim to do so. The fact of an option seems to run counter to the notion of an obligatory duty. Many Muslims do not sacrifice a cow on the *Id* day. As it was not proved that the sacrifice of a cow on a particular day was an obligatory overt act for a Mussalman for the performance of his religious beliefs and ideas, it could not be held that a total ban on the slaughter of cows ran counter to Article 25 of the Constitution.

49. In *State of Bombay* v. *Narasu Appa Mali*[20] the constitutional validity of the Bombay Prevention of Hindu Bigamous Marriages Act (25 of 1946) was challenged on the ground of violation of Articles 14, 15 and 25 of the Constitution. A Division Bench, consisting of Chief Justice Chagla and Justice Gajendragadkar (as His Lordship then was), held: (AIR p. 86, para 5)

> "[A] sharp distinction must be drawn between religious faith and belief and religious practices. What the State protects is religious faith and belief. If religious practices run counter to public order, morality or health or a policy of social welfare upon which the State has embarked, then the religious practices must give way before the good of the people of the State as a whole."

50. Their Lordships quoted from American decisions that the laws are made for the governance of actions, and while they cannot interfere with mere religious beliefs and opinions, they may with practices. Their Lordships found it difficult to accept the proposition that polygamy is an integral part of Hindu religion though Hindu religion recognizes the necessity of a son for religious efficacy and spiritual salvation. However, proceeding on an assumption that polygamy is a recognized institution according to Hindu religious practice, Their Lordships stated in no uncertain terms: (AIR p. 86, para 7)

> "[T]he right of the State to legislate on questions relating to marriage cannot be disputed. Marriage is undoubtedly a social institution an institution in which the State is vitally interested. Although there may not be universal recognition of the fact, still a very large volume of opinion in the world today admits that monogamy is a very desirable and praiseworthy institution. If, therefore, the State of Bombay compels Hindus to become monogamists, it is a measure of social reform, and if it is a measure of social reform then the State is empowered to legislate with regard to social reform under Article 25(2)(*b*) notwithstanding the fact that it may interfere with the right of a citizen freely to profess, practise and propagate religion."

51. What constitutes social reform? Is it for the legislature to decide the same? Their Lordships held in *Narasu Appa Mali case*[20] that the will expressed by the legislature, constituted by the chosen representatives of the people in a democracy, who are supposed to be responsible for the welfare of the State, is the will of the people and if they lay down the policy which a State should pursue such as when the legislature in its wisdom has come to

20 AIR 1952 Bom 84 : 53 Cri LJ 354

the conclusion that monogamy tends to the welfare of the State, then it is not for the courts of law to sit in judgment upon that decision. Such legislation does not contravene Article 25(1) of the Constitution.

52. We find ourselves in entire agreement with the view so taken by the learned Judges whose eminence as jurists concerned with social welfare and social justice is recognized without any demur. Divorce, unknown to ancient Hindu law, rather considered abominable to Hindu religious belief, has been statutorily provided for Hindus and the Hindu marriage which was considered indissoluble is now capable of being dissolved or annulled by a decree of divorce or annulment. The reasoning adopted by the High Court of Bombay, in our opinion, applies fully to repel the contention of the petitioners even when we are examining the case from the point of view of Muslim personal law.

53. The Division Bench of the Bombay High Court in *Narasu Appa Mali*[20] also had an occasion to examine the validity of the legislation when it was sought to be implemented not in one go, but gradually. Their Lordships held: (AIR p. 87, para 10)

> "... Article 14 does not lay down that any legislation that the State may embark upon must necessarily be of an all-embracing character. The State may rightly decide to bring about social reform by stages and the stages may be territorial or they may be communitywise."

54. Rule 21 of the Central Civil Services (Conduct) Rules, 1964 restrains any government servant having a living spouse from entering into or contracting a marriage with any person. A similar provision is to be found in several service rules framed by the States governing the conduct of their civil servants. No decided case of this Court has been brought to our notice wherein the constitutional validity of such provisions may have been put in issue on the ground of violating the freedom of religion under Article 25 or the freedom of personal life and liberty under Article 21. Such a challenge was never laid before this Court apparently because of its futility. However, a few decisions by the High Courts may be noticed.

55. In *Badruddin* v. *Aisha Begum*[21] the Allahabad High Court ruled that though the personal law of Muslims permitted having as many as four wives but it could not be said that having more than one wife is a part of religion. Neither is it made obligatory by religion nor is it a matter of freedom of conscience. Any law in favour of monogamy does not interfere with the right to profess, practise and propagate religion and does not involve any violation of Article 25 of the Constitution.

56. In *R.A. Pathan* v. *Director of Technical Education*[22] having analysed in depth the tenets of Muslim personal law and their base in religion, a Division Bench of the Gujarat High Court held that a religious practice ordinarily connotes a mandate which a faithful must carry out. What is permissive under the scripture cannot be equated with a mandate which may

21 1957 All LJ 300

22 (1981) 22 Guj LR 289

amount to a religious practice. Therefore, there is nothing in the extract of the Quaranic text (cited before the Court) that contracting plural marriages is a matter of religious practice amongst Muslims. A bigamous marriage amongst Muslims is neither a religious practice nor a religious belief and certainly not a religious injunction or mandate. The question of attracting Articles 15(1), 25(1) or 26(*b*) to protect a bigamous marriage and in the name of religion does not arise.

57. In *Ram Prasad Seth* v. *State of U.P.*[23] a learned Single Judge held that the act of performing a second marriage during the lifetime of one's wife cannot be regarded as an integral part of Hindu religion nor could it be regarded as practising or professing or propagating Hindu religion. Even if bigamy be regarded as an integral part of Hindu religion, Rule 27 of the U.P. Government Servants' Conduct Rules requiring permission of the Government before contracting such marriage must be held to come under the protection of Article 25(2)(*b*) of the Constitution.

58. The law has been correctly stated by the High Courts of Allahabad, Bombay and Gujarat, in the cases cited hereinabove and we record our respectful approval thereof. The principles stated therein are applicable to all religions practised by whichever religious groups and sects in India.

59. In our view, a statutory provision casting disqualification on contesting for, or holding, an elective office is not violative of Article 25 of the Constitution.

60. Looked at from any angle, the challenge to the constitutional validity of Section 175(1)(*q*) and Section 177(1) must fail. The right to contest an election for any office in Panchayat is neither fundamental nor a common law right. It is the creature of a statute and is obviously subject to qualifications and disqualifications enacted by legislation. It may be permissible for Muslims to enter into four marriages with four women and for anyone whether a Muslim or belonging to any other community or religion to procreate as many children as he likes but no religion in India dictates or mandates as an obligation to enter into bigamy or polygamy or to have children more than one. What is permitted or not prohibited by a religion does not become a religious practice or a positive tenet of a religion. A practice does not acquire the sanction of religion simply because it is permitted. Assuming the practice of having more wives than one or procreating more children than one is a practice followed by any community or group of people, the same can be regulated or prohibited by legislation in the interest of public order, morality and health or by any law providing for social welfare and reform which the impugned legislation clearly does.

61. If anyone chooses to have more living children than two, he is free to do so under the law as it stands now but then he should pay a little price and that is of depriving himself from holding an office in Panchayat in the State of Haryana. There is nothing illegal about it and certainly no unconstitutionality attaches to it.

[23] (1957) 2 LLJ 172 : AIR 1957 All 411 and AIR 1961 All 334 : (1961) 2 LLJ 247

Some incidental questions

62. It was submitted that the enactment has created serious problems in the rural population as couples desirous of contesting an election but having living children more than two, are feeling compelled to give them in adoption. Subject to what has already been stated hereinabove, we may add that disqualification is attracted no sooner a third child is born and is living after two living children. Merely because the couple has parted with one child by giving the child away in adoption, the disqualification does not come to an end. While interpreting the scope of disqualification we shall have to keep in view the evil sought to be cured and purpose sought to be achieved by the enactment. If the person sought to be disqualified is responsible for or has given birth to children more than two who are living then merely because one or more of them are given in adoption the disqualification is not wiped out.

63. It was also submitted that the impugned disqualification would hit the women worst, inasmuch as in the Indian society they have no independence and they almost helplessly bear a third child if their husbands want them to do so. This contention need not detain us any longer. A male who compels his wife to bear a third child would disqualify not only his wife but himself as well. We do not think that with the awareness which is arising in Indian womenfolk, they are so helpless as to be compelled to bear a third child even though they do not wish to do so. At the end, suffice it to say that if the legislature chooses to carve out an exception in favour of females it is free to do so but merely because women are not excepted from the operation of the disqualification it does not render it unconstitutional.

64. Hypothetical examples were tried to be floated across the Bar by submitting that there may be cases where triplets are born or twins are born on the second pregnancy and consequently both of the parents would incur disqualification for reasons beyond their control or just by freak of divinity. Such are not normal cases and the validity of the law cannot be tested by applying it to abnormal situations. Exceptions do not make the rule nor render the rule irrelevant. One swallow does not make a summer; a single instance or indicator of something is not necessarily significant.

Conclusion

65. The challenge to the constitutional validity of Sections 175(1)(*q*) and 177(1) fails on all the counts. Both the provisions are held intra vires the Constitution. The provisions are salutary and in public interest. All the petitions which challenge the constitutional validity of the abovesaid provisions are held liable to be dismissed.

66. Certain consequential orders would be needed. The matters in this batch of hundreds of petitions can broadly be divided into a few categories. There are writ petitions under Article 32 of the Constitution directly filed in this Court wherein the only question arising for decision is the constitutional validity of the impugned provisions of the Haryana Act. There were many a writ petition filed in the High Court of Punjab and Haryana under

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Articles 226/227 of the Constitution which have been dismissed and appeals by special leave have been filed in this Court against the decisions of the High Court. The writ petitions, whether in this Court or in the High Court, were filed at different stages of the proceedings. In some of the matters the High Court had refused to stay by interim order the disqualification or the proceedings relating to disqualification pending before the Director under Section 177(2) of the Act. With the decision in these writ petitions and the appeals arising out of SLPs the proceedings shall stand revived at the stage at which they were, excepting in those matters where they stand already concluded. The proceedings under Section 177(2) of the Act before the Director or the hearing in the appeals, as the case may be, shall now be concluded. In such of the cases where the persons proceeded against have not filed their replies or have not appealed against the decision of the Director in view of the interim order of this Court or the High Court having been secured by them they would be entitled to file reply or appeal, as the case may be, within 15 days from the date of this judgment if the time had not already expired before their initiating proceedings in the High Court or this Court. Such of the cases where defence in the proceedings under Section 177(2) of the Act was raised on the ground that the disqualification was not attracted on account of a child or more having been given in adoption, need not be reopened as we have held that such a defence is not available.

67. Subject to the abovesaid directions all the writ petitions and civil appeals arising out of SLPs are dismissed.

[CONNECTED MATTER]

(2003) 8 Supreme Court Cases 396

(BEFORE B.N. KIRPAL, V.N. KHARE AND M.B. SHAH, JJ.)

(Record of Proceedings)

RAMESHWAR SINGH .. Petitioner;

Versus

STATE OF HARYANA AND OTHERS .. Respondents.

Writ Petition (C) No. 504 of 2000, decided on September 22, 2000

Panchayats and Zila Parishads — Haryana Panchayati Raj Act, 1994 (11 of 1994) — S. 175(1)(q) — Validity of — Condition of having more than two living children prescribed as a disqualification for a candidate desiring to stand for the office of Sarpanch or Panch of a Gram Panchayat or wanting to be a member of Panchayat Samiti or Zila Parishad — Held, is valid — Mere non-extension of said disqualification to other legislators and persons holding public offices would not be an infringement of Art. 14 of the Constitution — Constitution of India — Art. 14 — Discrimination

Writ petition dismissed W-M/24808/S

Advocates who appeared in this case :

B.S. Mor and Mahinder Singh Dahiya, Advocates, for the Petitioner.

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TWO CHILD NORM

State Governments Poised to Blunder

Colin Gonsalves

After the Supreme Court made mistaken observations in respect of the 'two child norm' in Javed v/s State of Haryana, several state governments have taken steps and are on the brink of enacting legislation to enforce a Two Child Norm. A blunder of epic proportions is about to be committed.

From 1951 to 2001, India's population grew from 360 million to 1020 million. This growth has been characterized as a 'population explosion'. The antidote, we are told is the punitive enforcement of the two child norm. To understand the folly of such a step one must, as Dr. Almas Ali explains in 'Population and Development', separate myth from reality in the population debate.

All nations typically go through three phases: the first of high birth rates and high death rates, the second of high birth rates and low death rates and the third of low birth rates and low death rates. After World War II, advances in health technology – including the discovery of antibiotics – caused a dramatic decline in the death rates. This caused population to grow at an unprecedented rate. 84% of India's population increase took place during this period. At the same time, and this is not commonly known, the Total Fertility Rate (TFR) i.e. the average number of children a woman would have, came down from 6 in 1951 to 3.2 in 2001. Yet the population continues to grow *not because of the family size* but because of, what is called, 'population momentum'. This is an accelerated in-built growth due to the high percentage of young people (60%) in the population who, even as they have fewer children, produce large quantum increases. This takes place despite the fact that family size is declining across the board for rural and urban families and for poor and middle class families alike.

The single most important factor that reduces momentum is the raising of the age of marriage. The strongest impact of this comes through increasing the years of schooling for girls. In Sri Lanka where this has been done fertility rates were quickly reduced without coercion.

Based on a misunderstanding that poorer people and particularly those in rural areas and slums are having too many children some were quick to suggest a two child norm with punitive disincentives. Superficial comparisons were made with China and its one child norm. A closer look shows precisely how wrong these comparisons were. China's TFR drop from 2.8 in 1979 to 2.0 in 1991 was comparable to Kerala's TFR drop from 3.0 in 1979 to 1.8 in 1991, the difference being that as compared to China's atrocious human rights record, in Kerala there was no coercion. Stress on education and development did the trick. However the Chinese decline also stemmed from the emphasis placed on education by the Chinese Communist Party during the prior decade - 1970-1979.

It was the realization that education, development and woman and child welfare was a better way to lower the family size rather than punitive disincentives that led to the paradigm shift from Population Control to Reproductive Health at the Cairo Conference in 1994. It was agreed that quality of life be emphasized and that there would be no force, coercion, incentives or disincentives. India too got out of its 'Emergency Model' family planning approach and introduced the Target Free Approach and followed this up with the National Population Policy (NPP) 2000.

NPP 2000 defined the overriding objective as the improvement in the quality of lives. One of the several immediate objectives was to address the unmet needs of contraception. 25% of poor families seek contraception but are unable to get it. There is no mention made in the Policy of the two-child norm, of targets or disincentives.

The two-child norm came in by a side wind. Persons who were disqualified from contesting Panchayat elections in Haryana filed a petition in the Supreme Court impugning the constitutionality of the State notifications laying down the norm. In these proceedings, the Central Government appears to have given the Supreme Court the impression that the two-child norm was indeed part of the National Population Policy. Nothing could be further from the truth. The consultations that took place prior show that the two child norm with its package of disincentives were emphatically opposed due to the anticipated adverse impact on poor women and hence omitted from the Policy altogether.

The decision of the Apex Court in Javed v/s. State of Haryana is a classic example of how a Court can make a terrible mistake while dealing with an intricate social issue merely because the parties before the court are unable or unwilling to properly explain the complexities involved. The court made several mistakes. First it relied on an obsolete 1960's Club of Rome framework and characterized "the torrential increase in the population....as more dangerous than a Hydrogen bomb" (Russel). It quotes with approval two obscure writers on the subject who say that "the rate of population growth has not moved one bit from 1979". Nothing could be more wrong. The truth is that India has experienced the sharpest fall in decadal growth from 23.81 in 1991 to 21.34 in 2001. This is the lowest population growth rate since independence!

Secondly, it refers to the Five Year Plans from the 1st to the 7th (ending 1991) with their emphasis on punitive disincentives and fails to notice the landmark departure in approach in the Cairo Conference (1994) with the emphasis on development, quality of life and women welfare and the rejection of disincentives.

Thirdly, it fails to notice that none of the grounds taken in the petition related to the impact on women. Towards the end of the judgment under the title "incidental questions" reference is made to the impact on women but even these are dismissed out of hand. The Court was not informed that population experts throughout the country were unanimous in their view that the impact on poor women would be immediate and severe.

What are the implications and fallout of the judgment? Dr. Ali points out that research conducted in Orissa, Rajasthan, Haryana and Madhya Pradesh indicates that the norm to disqualify candidates has led to the desertion of wives and families, seeking of abortions with the associated abortion related health risks, giving away of children for adoption and initiation of new marriages by male elected members. Women bear the brunt of the disqualification clause.

For breach of the two child norm several States have put together a package of punitive measures including exclusion from elections, exclusion from ration cards, kerosene and other BPL incentives, denial of education in government schools to the third child and withdrawal of welfare programmes for SC/STs.

These punitive measures will operate mainly against poor women. Total fertility is 3.47 among illiterate women as compared to 1.99 for the middle classes. The infant mortality rate among SCs, STs and OBCs is 83, 84 and 76 respectively as compared to 62 for others. These sections have a high wanted fertility rate due to the prevailing high infant mortality rate.

Clearly, to impose the two-child norm is to widen the inequality gap among the people as the disincentives would disproportionately impact on the already deprived population. More terrible, the two-child norm would provide an impetus for an increase in sex selective abortions and female foeticide, worsening the alarming decline in the child sex ratio noticed in the 2001 Census.

There is a lesson to be learnt from this. NGOs are the natural ally of the judiciary. In matters of general social significance they ought to be brought in to guide the Court and give it the larger picture, particularly, when the contesting parties have narrow vested interests.

To conclude: momentum will carry through for the next 30 years after which the falling TFR will assert itself and India will move into the third phase of low birth rate and low death rate. In the meanwhile, India must stop counting people and start counting on people, and invest in them, thus improving the quality of their lives.

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ICPD Issues And Us – Some Reflections

Dr. Mira Shiva

It was not just the emergency period that gave family planning a bad name, but it was the way the F.P. Programme had been planned with setting of 'targets' number wise and gender wise. Dr Ashish Bose had called this "Targetitis".

During the emergency as a post graduate in CMC. Ludhiana I heard from my senior doctor and teacher how on his way back from Delhi to Ludhiana, he had been stopped and marched to a F.P. camp for forced sterilization – and how he had escaped by the skin of his teeth when he demanded to talk to the collector whom he said he knew. If this could happen to a senior doctor, what would have been the fate of lesser mortals, many of whom were not even married nor had a living child. It was cruel. Equally cruel was the putting of IUCD/Copper T in women, even with blatant infection. Women complained of white discharge and all those involved in women's health were well aware of it. How could trained doctors and health personnel putting in IUCDs, in the numerous family planning camps not feel the need to address the other gynecological problems? Apparently there was no budget for treating infections, only for contraceptives. The entity called RTI's was born much later with the shift of family planning to reproductive child health programme passing through the other stages of programme planning, renaming i.e. family welfare, maternal and child health. RTI's initially were understood as Respiratory Tract Infections as was taught in medical education. The recognition of the obvious, as a significant reproductive health concern i.e. RTI's, STD's, earlier called V.D./venereal disease was a significant shift. Even though even today the efforts that needed to go in their prevention and management are inadequate and sometimes totally irrational.

It was the women's movement and some health groups including a few demographers, who raised their voices against coercive population control policies. Since the Family Planning Programme was a government programme and FP was a holy cow, any questioning of the policy, or of unethical clinical trials, of contraceptive technologies e.g. nor plant, net en, was considered as 'anti establishment' 'anti development' as well as 'anti national' activities.

Women's health movement was strong in India and similar voices were heard from other Asian countries Bangladesh, Philippines, Indonesia etc. Many groups come together as women resisting against hazardous technology and coercive population control policies and demanding right to quality reproductive health services and safe contraceptives.

The preparatory phase of ICPD saw several organisations working in women's health and community health become actively involved in the process besides many others. There was a spectrum and at one end, were population controllers, with their total faith in technology fixes, most of which were targeted at women, to decrease 'numbers' and at the other end were groups who believed in a woman's right to 'safe birth control', and her right over their body, her life and her reproduction.

Pre ICPD at VHAI we organised state level workshops in Himachal Pradesh, Madhya

Pradesh and Uttar Pradesh. We insisted that since the International Conference was on Population and Development, and therefore we would address 'development' issues besides 'population' concerns. The objective was to look at the diverse state level concerns on population as well as development.

High maternal and infant deaths, poor nutrition, non-availability of health services, specially emergency services, transport, resources, the negative impact of tourism in Himachal Pradesh with importing of 'city culture' and demand of 'wine and women', increased opening of liquor shops by state governments to raise revenue, asphyxiation of the rural economy, forced migration to towns for menial jobs, disruption of families, inadequate options for the youth in terms of livelihood and absence of vocational based education, were some of the issues discussed and concern expressed. Analytical papers, statistics along with heated discussions and debates ensured that the state VHA's and their member institutions were well informed and actively involved along with other government officials, socially conscious journalists, representatives of women's groups, PRIs etc. and grassroot workers.

ICPD prep com 3 in New York showed the difference in the perspective of the North and South, and also between those who were for 'population control at any cost' and those who saw 'family' planning, contraception as a reproductive health concern, involving both partners, as well as the state, which was expected to meet the need for safe contraceptive besides basic needs of its people, ensure the survival of the children, provide opportunities to women, prevent discrimination and violence against them so that they could make choices about their lives, which included having some say, in the choice of the father of their children, besides the number of children, and the spacing between them etc. etc.

The need for sensitivity at a human level to the partner was found to be one of the main areas of concern. The use of the word 'gender' tended to and still tends to provoke patriarchal reactions.

Talking of 'choice' of contraceptives as – 'technology fix' alone, when she had no choice to say 'no' to her partner, even when she was not well, or when, because of the rampant RTI's, the pleasure of one partner was 'pain' for the other – reflected the need for recognising and giving of real choices to women, beyond contraception. The need for health personnel, FP workers and society to look beyond the FP education brief, given routinely, where gender sensitivity and even fertility awareness – that ovulation takes place only once a month is not communicated.

It was articulated again and again that 'reproductive rights' alone were not possible without women's social and political rights, and their being respected as a human beings and not mere statistics in an increasingly patriarchal world.

ICPD Cairo saw massive debates on abortions, on structure of family, on inclusion of sex education in schools etc. Vatican and Islamic countries expressed their concern about the need to protect 'family values' and norms, as free availability of contraceptives would trivialize sacred relationship. Others saw access to contraception and abortion as their right. Many feminist groups saw family as an oppressive institution and some wanted definition of family to include, same sex partners. Many Islamic country representatives pointed out that the highest incidence of rapes, teenage pregnancies, pre marital sex was in these western countries, which wanted the rest of the world, to include sex education in schools, when apparently it was they who needed them the most and also some 'self control' in an era of increasing permissiveness trivialization of sex, of sexual relationships marriage as well as abortions. 'Freedom' and 'choice' had to be used with responsibility. Cairo saw entry of big time players in this field.

Financial commitments made by developed countries were 0.7% of GDP, with 20:20 initiative. The provision made by developed countries have not been met.

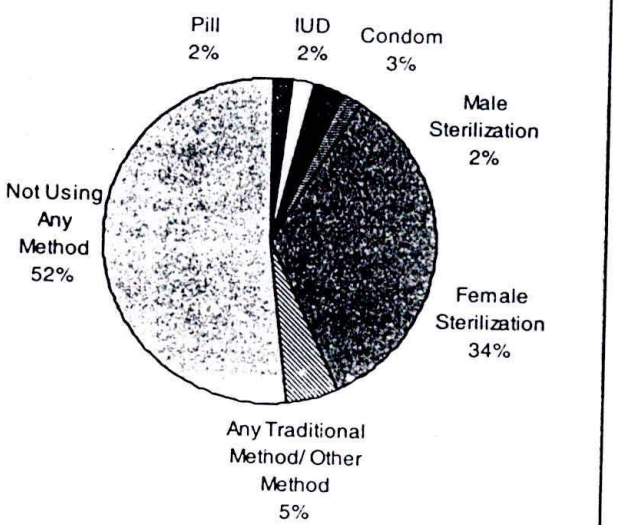
Where many of these are concerned some debates are relevant even today. Just as increasing age of marriage, increasing age of first pregnancy was seen to have a definite impact on decreasing birth rates, so also was the call to increase the age of 1st sexual encounter, faithfulness of partners and use of condoms to prevent STD, HIV/AIDS.

It is a pity that neither has gender sensitivity, nor gender responsibility increased as it should have. This would have reflected in decreased 'inflicted' pregnancies, decreased abortions, decreased STD's HIV/AIDS and decreased sexual violence.

It is a great pity that instead of building and using every possible defense and preventive measure, specially where male participation and male responsibility is concerned, talking about 'abstinence' and 'being faithful' is seen as abnormal – prudish and by dumb followers of

George Bush or the Vatican. The 'sex act' irrespective with whom, takes priority over relationships and 'condom' is the saviour. When it is known that manufacturing defect, storage defect and problems with proper and regular use of condom does not make condom, a 100% safe protection, in our social context. Recent reports have even indicated decline in condom sales, inspite of all the promotion of condoms. Prevention efforts of HIV/AIDS that relies only on condoms with "condombification" of the programme, without also pressing for greater responsibility in sexual behaviour, is a cause of concern not just for HIV/AIDS but also FP and reproductive health. Male responsibility is reflected in the number of male sterilization vasectomy (even with the easy 'no scalped vasectomy' being available) male contribution in family planning and contraception is grossly inadequate and decreasing, male contribution in permanent sterilization is merely 2% (Fig:1)

Figure 1: Current Use of Contraceptive Methods



Soruce: NFHS-2, India, 1998-99

The developing countries were concerned about the issue of migration, internal as well as international and also about the workers right of family reunification when workers stayed away for many many years from their families, to earn and send money to their families.

In the exhibition halls of the Conference in Cairo, the imagery of the population issue was created, with use of words like population bomb, population explosion, visuals and posters of people looking like ants falling off the earth and looking like huge garbage heaps with people piled on each other abounded. Pictures showing rows of pregnant women. Most of these 'people' were brown or black and many of these people were 'women', projected as the 'problem creators' the root of the population problem.

In the exhibition halls these images, undoubtedly created 'fear psychosis' as with 'nuclear war' and 'communism' evoking 'racist' feelings in general public and also greater 'victim blaming' with further removal of understanding of the gender and socio-economic aspects of the population issue. Most women have little or no say, where pregnancies are concerned and instead of strengthening them, they have been blamed and disempowered.

The stringent national immigration laws by these very countries demanded free movement of their products, yet restricting free movement of people was pointed out as double standards.

Chapter 3 on Equity Economic Growth and sustainable development was seen as the critical chapter by various women'' groups from the south.

The early 90s was the period when Uruguay Round of GATT had already been initiated and pressure on developed countries to open up their markets and decrease their import duties, tariff barrier had already started and in 1995 following the Dunkel Draft with only "take it or leave it" option given WTO literally as a supra national body came into existence.

Deep concern was felt then by the health movement and the women's movement and is felt much more now as unsustainable, exploitative, ecologically disastrous, self indulgent lifestyles, products and commodities are aggressively being marketed, to those 'with the purchasing power'. They are seen as the 'market' that must expand and the rest without the purchasing power, the poor majority are the 'population', with no rights and entitlements, and they must decrease. When 80% of the resources are consumed by 20% of the affluent, the issue of **consumption control** has to addressed as aggressively, as this level of consumption is UNSUSTAINABLE. More so in the developing countries with a significant % of people, below poverty line and the national governments in debt, or in the process of servicing debts, with further cuts in the already inadequate social sector budgets, in health, education and care of the elderly, disabled etc. is further eroding whatever little the people have had. The very concept of Alma Ata recognises, comprehensive health care is basic right for all, before the privileged care for few, at the cost of others.

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The 1995 World Health Report on 'Bridging the Gap' has highlighted the increasing inequalities between the rich and poor countries, and within the countries. This gap of increasing inequity is now in every sphere, and in many institutions. The international classification of diseases, Z595 was added as a new category and it stands for extreme poverty. The report says extreme poverty is on the increase (and obviously with it are the diseases of poverty). The Human Development Report says the same thing, so does the ILO about the erosion of livelihoods, erosion of the workers rights and entitlements, devaluation of human beings in a period where success is defined by the possession and control of money and decisions on the lives of others. Recent ILO report has pointed out that 50% of the youth are unemployed.

In such an environment devaluation of women, elderly, disabled, and the poor is much much more and if it has to be addressed, the question of rapidly increasing inequities must be addressed. It is also clear that the beneficiaries of the greatest privileges will never want to give them up, rather they would want more and more. If they are in position of policy making, programme planning, controlling resources. Further increase in inequities is to be expected with greater disempowerment and marginalization of the vulnerable if inequity creating policies are promoted.

The birth of WTO – the bilateral and multilateral pressures, lifting of quantitative restriction, change in patent laws, agriculture, economic industrial policies in compliance of international trade regimes, when it is clear they are not in the interest of the nation specially the poor majority – laying off of thousands of workers, closure of thousands of small scale sector units, conversion of thousands of artisans as daily wage labourers on the roads or in city slums, is the economic reality of many countries across the world.

Conflicts, wars in Iraq, Afghanistan, Sudan, Ivory Cost for oil, diamonds have taken place in the last decade. Peace is important for development as the price paid for war and conflicts is too heavy as priorities get distorted and arms and military spending, takes priority over medicines and health care.

Changes with the coming of the Bush administration and its unwillingness to support certain reproductive health programmes abortion related, has resulted in cutting of support to organizations (like UNFPA) which has resulted in many of the relevant reproductive health programmes in needy places being curtailed.

National Level

At the national level post ICPD Cairo, we saw the launching of new RCH programme in 1997 in keeping with ICPD's Programme of Action.

Against incentives disincentives and targets it saw their removal and initiation of the Target Free Approach (TFA). This has definitely been a major paradigm shift. The National Population Policy was evalued with a lot of discussions and debate.

The National Population Policy of 2000 was broad and incorporated issue of –

- Health services
- Girl child
- Male responsibility
- Female literacy and women's empowerment
- Decentralised Planning and Programme Implementation
- Convergence of Service Delivery at the Village Levels
- Empowering Women for Improved Health and Nutrition
- Child Health and Survival
- Meeting the Unmet Needs for Family Welfare Services
- Under Served Population Groups
- Diverse Health Care Providers
- Collaboration with and Commitments from

Non-government Organisations and the Private Sector

- Mainstreaming Indian Systems of Medicine and Homeopathy (ISMH)
- Contraceptive Technology and Research on Reproductive and Child Health
- Providing for the Older Population
- Information, Education and Communication
- Role of TSM in RCH
- Role of diverse health functionaries and

It has been a long process for building an understanding about what constitutes "reproductive health" within the national government's RCH programme, and within the women's health movement while the issue of-

- Family planning
- Safe pregnancy and child birth
- Safe abortion
- RTI, STI, HIV/AIDS
- Infertility
- Adolescent

have also been included priority is family planning. Unfortunately some of the other reproductive health concerns have not received the attention.

- Sexual violence
- Availability of essential medicines and their rational use in RCH must be ensured
- Male responsibility
- Teratogenic effect of drugs and chemicals taken in pregnancy where congenitally malformed babies are born to name a few
- Infertility due to genito urinary tuberculosis
- Abortions, still birth, low birth weight babies or even maternal death due to falciparum malaria
- RCH in medical education and medical practice

In 8 states Delhi, Punjab, Haryana, M.P., U.P., Karnataka, Gujarat, Tamil Nadu as part of sensitization effort about the RCH programme, we conducted workshops with faculty members of Obe gyne, paediatrics paid and community medicine on "RCH, women's health and gender concerns". It was clear that the medical colleges had not been involved in the process, the word 'gender' did not exist nor does it exist even today in medical education nor does reproductive health, or women's health, as obe gyne is not a substitute for this. The need for gender sensitivity in examining women patients, in not blaming them for pregnancies often inflicted, against their will, sensitivity in excluding possibility of pregnancy while prescribing medicines, in treating malaria, gender sensitivity, in treating cases of infertility, childlessness, as it is the women who are usually blamed and called Banjh (barren). There is a need for inclusion of talk to husband and in-laws, about xy chromosome, and role of 'y' chromosome from the father in determining male sex of the unborn foetus. This should be included in biology books in schools to stop victim blaming and making life of women hell for not producing a male child, and at the same time addressing sex selective abortion.

Several state level workshops were held to build an understanding about RCH and women's health, gender concern, the government RCH programmes, and efforts were made as well to build capacity.

There is no denying that in most places the coercive population control has gone. Yet it is present in some states and coming back in others.

Unfortunately many of the state policies have not been in keeping with the content and spirit of the National Population Policy, infact some are in blatant violations of NPP as well as ICPD.

The NHRC has been concerned about it. Keeping this the National Human Rights Commission declaration brought out following a national consultation by MOHFW, NHRC and UNFPA. It notes with great concern that population policies framed by some state governments reflect in certain aspect, respect for a coercive approach through use of incentives and disincentives, which in some cases are violative of human rights. This is not consistent with the spirit of the National Population Policy. The violation of human rights affects in particular the marginalized and the vulnerable sections of society, including women – NHRC 2003.

Due to steady decline of public health services in the past decade the access to and the quality of reproductive health services has also been affected. With significant gaps in ANMs, lab technician, doctors not in place, the RCH services are undoubtedly affected – even though the RCH budget has been increased.

Non-availability of referral services for emergency obstetric care and transport facilities other things were not worked out too well. This has unfortunately resulted in high maternal mortality, problems of availability of blood, when 85% of pregnant women are anemic and some have to undergo caesarian section with even 2-3 gm haemoglobin and, work till the time of delivery and resume work shortly after surgery. Non-availability of anesthesia and medicines have been identified as problem areas. Several attempts have been made by the ministry to address the major problem of non-availability of anesthetists by proposal to train medical doctors MBBS or nurses anesthetists. Resistance has come from Medical Association and FOGSI, as providing anesthesia and monitoring the patients requires technical competence and adequate training. Unfortunately the reality is that qualified, trained, skilled doctors whether they are obstetricians gynaecologists, paediatricians or anesthetists are not willing to go to the periphery. To address, the unacceptably high maternal mortality rate, provision of emergency obstetric care is crucial. Balance between 'quality and access' has to be made and ensured.

The MNGO scheme, which was launched in 1998, has resulted in around 100 MNGOs, 4000 FNGOs being selected for complementing the Government in the National RCH programme, and helping in improving the RCH services, in selected geographical areas. A new scheme to involve private practitioners is being made by the ministry to provide reproductive health services.

Since ICPD in Cairo the concept of RCH understanding wise is much clearer, unfortunately provision of quality RCH services to the women, is still not a reality for various reasons. Inadequate budget, absence of essential reproductive health commodities e.g. drugs, equipment, trained staff. Inadequate involvement of private practitioners, absence of clinical skills of health functionaries of public and private sector.

On the whole the status of women except for a privileged few has shown increasing devaluation, increasing discrimination and violence. This has been a cause of great concern.

It is clear that to ensure implementation of the National Policy of Empowerment of Women was brought in to facilitate intersectoral coordination. Several states brought out state policies. Women as health care providers at the bottom of the health hierarchy, as ANMs and as anganwadi workers they have shouldered the greatest work burden. Many of them face great insecurity and inadequate support.

Patriarchal mindset has rarely thought of their security difficulties in travelling their multiple roles as health care providers, as mothers, wives, daughters, in-laws and their poor health status and inadequate remuneration. As a nation there is so much that we can do for ourselves, and in many spheres we have managed to do.

To improve the health status of our women and children contribution has to come besides Health and Family Welfare from other ministries, health sector and from civil society. High birth rates are associated with low literacy and low work participation rate. Health and education budgets must be increased and livelihoods ensured.

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Reflections on ICPD and After

Ashish Bose

I had the privilege of participating at the International Conference on Population and Development (ICPD) , sponsored by United Nations at Cairo (September 5 – 13, 1994), as a member of the delegation sent by the International Union for the Scientific Study on Population (IUSSP with headquarters at Liege, Belgium and currently at Paris). We could attend both the official United Nations Conference as well as the Forum for NGOs and other non-official organisations. It was a huge conference. Such conferences have been held every ten years. I call these conferences *Kumbh Mela* which are held at sacred places in India every 12 years and *Ardh Kumbh Melas* every 6 years. I am happy that the United Nations is also following this style. There are 5 plus and 10 plus meetings and workshops. Without being cynical, I may say that Governments have got into the mode of *brahminical* rituals. Even when they are hibernating, they pretend to be extremely active and enthusiastically implementing all the recommendations of the ten yearly conferences. Have the objectives of ICPD 94 been attained?

Let me turn to India. The Department of Family Welfare of the Government of India was quick to endorse the philosophy and recommendations of the Cairo conference. It was quite hilarious for me to observe that while the bureaucrats had earlier ridiculed my plea for abandoning family planning targets (which I had made in my presidential address at the annual conference of the Indian Association for the Study of Population /IASP), they were quick to accept the recommendations of the ICPD conference which, inter alia, said :" **Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients".** (Para7.12 of Programme of Action of the United Nations International Conference on Populations and Development, reproduced by Ashish Bose in *India's Population Policy: Changing Paradigm*, B.R Publishers Delhi, 1996, p.279).

The theme of my presidential address at the 12th annual conference of IASP at Allahabad in 1987 was "For Whom the Target Tolls". I had challenged the whole strategy of target-setting, which led to body-snatching during the emergency (1975-77). I also challenged the use of money power and cash incentives to lure acceptors of sterilisation. Commenting on the target setting and incentive schemes I had said: "We are opposed to the giving of cash awards to different states in India for 'good' family planning work every year"(see Ashish Bose, *From Population to People*, Volume I, B.R Publishers, 1988,pp. 136-37). I had questioned the methodology of rating different states for giving cash awards. I was appalled when Uttar Pradesh, one of the worst states in India, got the first prize. I wrote to Prime Minister Rajiv Gandhi on this issue explaining in a technical note why this scheme should be abandoned and the tax payer's money saved. I must record with appreciation that at the instance of the Prime Minister this scheme was abandoned. (I think Rs 15 crores were involved in this unproductive exercise).

According to the Government of India's order, from 1st April 1996 the new scheme of Reproductive and Child Health (RCH) was introduced all over India. The term 'Family Welfare' was abandoned in favour of RCH. At this stage I must point out that ICPD did not use the expression RCH at all. The documents talked of Reproductive Health (RH) and Reproductive Rights. I had pointed out to my UN friends in Cairo that the concept of RH was nothing new to India. Our first Five Year Plan (1951-56) had talked of Maternal and Child Health (MCH). Perhaps our health Ministry was aware of this and they designated RH as RCH in India. So far so good. But what has been the record of RCH activities during the last 10 years? Is the programme a grand success or is our family planning administrators blaming UN agencies and academic scholars like me for suggesting that there should be no targets because the government cannot work without targets. The answer to this question will depend on the amount of fieldwork one has done in various parts of India to assess grassroots reality. My brief comments below are based on my limited exposure to field work in states like Punjab,

Haryana, Himachal Pradesh, Rajasthan, Uttar Pradesh and Orissa. I do not think the state of health or the implementation of the RCH programme has **improved qualitatively during the last ten years** in spite of the enormous funds from donor agencies like World Bank, UNFPA, USAID and so on. In fact, in several places, things have worsened.

I do not think that the lower level functionaries and the intended beneficiaries of the RCH programme have understood the implications of the paradigm shift from family welfare centred around sterilisation targets to RCH which is centred around improving the quality of service rendered in particular, to women and children and greater respect for 'informed choice' of contraceptives. The Government of India is also trying hard to promote male sterilisations (in particular, the NSV technique). But I do not think this has made any worthwhile impact on our male population **who has walked out of the family planning programme** ever since the emergency days were over. We are still paying a high price for the bungling on the family planning front because of Sanjay Gandhi's misguided enthusiasm and a subservient bureaucracy which basically fudged data on sterilisations and took recourse to unethical means to get as many people in the sterilisation net as possible. There is no point in blaming the department of family welfare for not succeeding in getting men into the family planning mode. This calls for an understanding of social psychology and how human minds work. The men have over the last 25 years, by and large ,convinced themselves that family planning concerns women only and they have no special responsibility except to take their wives to the sterilisation camps and collect some incentive money (which I found during my field work was often spent by the men on their drinks). So much so for reproductive rights! I do not think that budding scholars inspired by foreign grants who have worked on male responsibility and male intervention in the RCH programme have adequate understanding of Indian society. How can health and family planning administrators and surgeons using the NSV method bring about social transformation without which a paradigm shift is not possible? **Surgical intervention cannot bring about social transformation.**

It is my understanding based on fieldwork that women themselves all over the country (including Muslim women) do want family planning. Unfortunately, they have not received a fair deal in the sterilisation camps and the quality of service in terms of pre-operation checkup and post operation follow up has been appalling in most parts of India. Looking back, it would have been much better if the Department had concentrated its energy and money in improving the quality of RCH service rendered to women and children.

Why, for example, the progress of family welfare is so appalling in the BIMARU states (including their three new offshoots)? Why is the infant mortality rate so shockingly high in Orissa? The unfortunate reality is that ICPD 94 (and the subsequent rituals of 5 plus and 10 plus) have made very little difference to the actual implementation of the programme at the grassroots level.

A recent press report on the subject of sterilisation in Uttar Pradesh is both pathetic and hilarious: pathetic because the scheme is an insult to human dignity and hilarious because it exposes the idiocy (to use a mild expression) of the District Magistrates. I give below an excerpt from the *Indian Express*, Delhi dated 23 August, 2004:

"What's the link between getting sterilisation and owning a gun? Uttar Pradesh doesn't treat that as a joke..... some district magistrates in the state are now offering (incentives to a person wanting a gun license).....who opts for sterilisation. The incentive rises if you convince more people to go in for the procedure.

'Any person who opts for sterilisation will be given top most priority for granting a gun licence. We have done this as almost each application that comes to my office is for a gun licence. The family planning programme is lagging behind', Bareilly DM Dr. Moolchand told Indian Express. He goes on to lay down the rules: 'If you want a licence for a single barrel gun, you must get yourself sterilized first plus get one more person. For a double barrel gun, the applicant must bring two persons. For a rifle, the applicant should get three persons and for a revolver there should be four other than the licence seeker". He is confident that he will meet his district's sterilisation target with his plan."

What if a villager wants a canon? I understand from my sources in Bareilly that the crime rate has increased there and the DM wants to control the crime rate. Obviously he is a genius: he wants to control in one go both the crime rate and the population growth rate! I recall that in 1963, on the occasion of the first Asian Population Conference sponsored by United Nations in New Delhi, the Government of India had included in the Indian delegation Prof. Amartya Sen from the Delhi School of Economics. I had asked Amartya Sen for his views on the project of an American communications expert who had formed a Red Triangle Society, bought an elephant from donations collected from his friends in India and USA and paraded the elephant with a red triangle on it to impress on illiterate Indian villagers the enormity of India's population problem. Amartya Sen's reply was: **"I cannot think of a more asinine solution of an elephantine problem".** After so many years, one could make the same comment about the U.P District Magistrate's gun running scheme!

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Government of India
Ministry of Health and Family Welfare
Department of Family Welfare

STRATEGY IN 150 CMP DISTRICTS FOR FAMILY PLANNING

CMP Mandate

The Common Minimum Programme (CMP) of the United Progressive Alliance (UPA) Government states that "the UPA Government is committed to replicating all over the country the success that some Southern and other States have had in family planning. A sharply targeted Population Control Programme will be launched in the 150 odd high fertility districts". The Department of Family Welfare is initiating a CMP Programme accordingly in the identified 150 high fertility districts of the country. The strategy of the Department for the CMP Programme is as follows:

Selection of Districts

The districts were arranged in descending order of Total Fertility Rate (TFR) as per the Census 2001 data. By excluding better performing States with one or two districts from the list, like Haryana (Gurgaon), Uttaranchal (Hardwar), West Bengal (Uttar Dinajpur, Maldah), Gujarat (Dohad, Banas Kantha), Chhattisgarh (Sarguja) and Assam (Dhubri, Goalpara, Marigaon), a list of 150 districts has been arrived at. These districts belonging to the better off States will be taken care of by improved attention of the concerned States. These 150 districts are concentrated in the 5 EAG States of Bihar (36), U.P. (58), M.P. (24), Rajasthan (20) and Jharkhand (12), as at **Annexure-I**. *However, since it would be administratively inconvenient to limit the proposed initiatives to select districts within the State, it is proposed to cover all 209 districts in the 5 CMP States under the new Strategy.*

The Vision

The National Population Policy aims at achieving a National Total Fertility Rate (TFR) of 2.1 by 2010. It would still take another 35 years for the population to stabilize by 2045 at the expected level of 160 crore. However, the present trends indicate that if the present pace of reduction in growth rate continues, the TFR of 2.1 may at best, be attained by 2016. The population may touch 180 crore before stabilizing. It is, therefore, important to adopt strategy for addressing the high order births (above two children per family) in the identified high fertility districts, at a scale which will prevent at least 40 crore additional births by 2045 permitting the country's population to stabilize after peaking at about 135 crores. The plans arrived through Community Needs Assessment Approach (CNAA) in these districts also reflect a high level of unmet needs, basically due to weak service delivery mechanisms. Of the total 48 lakh sterilizations being reported in country, only around 13 lakhs are being reported in the CMP States where as their high order births in these States are in the range of 93 lakhs per annum (of the total 170 lakh high order births in the country). It is hoped to raise the level of sterilizations in these CMP States to 50 lakh per annum within the next four years. In fact, we should thereafter increase the scope of our programme and add another 150 high fertility districts to really tackle the

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unwanted births all across the country. It is also a fact that against the average annual growth rate of population of 1.7% in rural India, the same is 2.7% for urban India and 4% for urban slums. The high growth rate in urban slums is also largely due to the factor of immigration of BPL labour and families from high fertility and poor districts to urban areas, especially the metros. It would therefore be necessary to cover the urban slum pockets in the CMP strategy. Then only the systematic prevention of 40 crore unwanted births will actually happen.

Lessons from Southern States

Over the last 5 decades, the performance of the Family Welfare Programme has been distinctly better in the Southern States like Kerala, Tamil Nadu, and Karnataka as against the CMP States. Higher levels of literacy and women empowerment in these States contributed to the success of the programme. However, improved performance levels in these States also owe largely to the political will, administrative commitment and good governance in these States. A major lesson to be learnt from the Southern States is their success in involving the private sector in service delivery. In the State of Tamil Nadu, of the total 4 lakh sterilization being reported per annum, 1.5 lakh procedures are being reported through the private sector. In the State of Andhra Pradesh, the spectacular success in bringing down the growth rate of population in the last decade has been possible, despite the low level of literacy, due to the involvement of private sector and Self Help Groups, provision of insurance cover to family planning acceptors, and a higher Compensation package for sterilization in the State. Strong monitoring and the supervisory mechanisms in the Southern States have ensured better accountability of the service providers. Under the CMP Strategy, the lessons from the Southern States would be replicated in select States of U.P., M.P., Bihar, Rajasthan and Jharkhand.

Strategy in CMP Districts

The Thrust Areas in these districts would be family planning, immunization and safe delivery. Letters have been sent to Chief Ministers, Chief Secretaries and Secretaries (FW) of the selected States, and also to District Collectors of 150 CMP districts. Copies of the letters are enclosed at **Annexures II, III & IV**. The strategy aims at bringing back the District Administration into the Family Planning Programme. Detailed CMP Manual is being prepared for the District Collectors of the CMP districts, to provide them with a roadmap and suggested strategy. National/Regional Consultations with State Governments and District Magistrates of 150 CMP districts shall be held.

Emphasis on Family Planning services

The emphasis would be on targeting unmet need for family planning services in these districts. Additional funds would be provided for improved services for sterilization and IUD insertion. The Compensation package for sterilization is being revised, to adequately over the transaction costs of the procedures in public and private health facilities. Additionally, an imprest fund of Rs.10 lakhs would be provided to District Administration as a revolving fund for family planning. Professional Indemnity Insurance cover shall be extended to doctors conducting sterilization operations in both public sector and accredited private health facilities, so as to cover them against legal and financial costs of possible consumer cases. Detailed assessment of the requirement of drugs, equipments, contraceptives and laparoscopes is being done for CMP districts, and

a strategy shall be formalized for timely procurement and appropriate logistics arrangements.

Partnership with Private Sector

Partnerships with the private sector through accreditation, indemnity insurance coverage and suitable higher payment nearer to basic market cost are the major hope for attainment of the goals in the CMP districts. A revised Compensation package is being extended to accredited private/NGO health facilities for conducting sterilization/IUD insertion. A package of around Rs.1200 for sterilization in a private nursing home and Rs.600 in public health facility, inclusive of transactional cost to the Trained Birth Attendant (TBA), and the client to cover the expenses on travel, food, and access to the public/private hospitals for sterilization will energize the demand and supply chain in family planning. Availability of family planning services is thus hoped to increase through social marketing and social franchise of such services. It is aimed to provide quality assurance among such accredited facilities and to provide them with a logo so as to generate publicity of the availability of such family planning services in the private sector. Accrediting 15 to 20 private providers per district is an attainable task. Banks are being approached to announce a special package of loan of Rs.5 lakhs to Rs.10 lakhs to these accredited doctors in CMP districts to improve their infrastructure, space, equipment, Operation Theatre etc. These loans will be viable as an accredited clinic is expected to earn at least Rs.25,000 to Rs.30,000 extra per month and so repayment of the loan will be possible. This itself is likely to help achieve 25-35% extra family planning procedure. In Tamil Nadu, an average 30 to 40 private facilities have been accredited per district. In spite of a well functioning governmental system and low levels of fertility, 35% of all sterilization in the State are at accredited private clinics.

Promotion of maternal healthcare

The National Maternity Benefit Scheme is being revised as the proposed Janani Suraksha Yojana (JSY), with the aim of promotion of institutional delivery to bring down the high Maternal Mortality Rate (MMR) in these districts **(Annexure-V)**. It is hoped that the JSY would prevent female foeticide through raising consciousness for the girl child. It is aimed to provide an amount of Rs.1000/girl child and Rs.400/male child, if delivered in a health institution, by a BPL mother. Additionally, transport assistance upto Rs.150, and incentive to Dais @ Rs.200/150 for female/male child is also envisaged in lieu of appropriate antenatal and postnatal care and referral for institutional delivery. The scheme also aims at adoption of tubectomy by the pregnant women after the delivery. It is aimed to operationalize First Referral Units (FRUs) at district levels to ensure 24-hour service delivery for improved healthcare. Emphasis is also being laid on provision of health infrastructure in urban slums.

Engagement of TBAs

It is proposed to engage around 2.6 lakh Trained Birth Attendants (TBAs) at the rate of one per 500-1500 population aiming at one TBA for village under one AWW in the CMP States as the grass root level worker for the FW programme. The TBA would be the key to social mobilization in these districts. She would be recruited by the AWW, in consultation with the Women Self Help Group of the village, on payment of an honorarium of Rs. 100/- per month only. The ANM will countersign and confirm this appointment. The TBA will get IEC material and other support from District Health administration through the ANM.

She will counsel the village women for adopting contraception, safe delivery and institutional delivery. She would also escort the client to the hospital, whether to a public or an accredited private facility, for family planning and institutional deliveries and be paid a transaction cost for each such procedure. She will also mobilize the children and expectant mothers on immunization days. She is expected to earn Rs. 7500 to Rs. 8000 per annum from her work. Additionally, she will be given products such as basic medicines, contraceptives and ORS etc. for social marketing in the village. She will also counsel for newborn care, breast feeding and adolescent hygiene and age of marriage. She will assist in registration of births. All these, she will do under the supervision of AWW and ANM among the women/girls of the community where she normally resides.

Strengthening Immunization Programme

Efforts shall also be made in these districts for improved immunization, including strengthening of cold-chain, induction of Auto Disposable Syringes and holding of Immunization Sessions on fixed days at village/habitation level, in convergence with the ICDS workers. A major strategy is to make the vaccine reach the immunization site on Vaccination Day so that the ANM can carry out longer sessions. It is proposed to bring in legislation to make it mandatory for all medical establishments, whether public or private, to render immunization services. Medium-term Plan for strengthening of Immunization has been moved to World Bank through Department of Expenditure. Copy of the same is enclosed at **Annexure-VI.**

Management Strengthening

The work in the CMP districts is proposed to be undertaken in a Mission mode. This would necessitate organizational restructuring of the Department of Family Welfare at the GoI level, and setting up of a National Resource Centre for providing Technical Assistance under different components of the Reproductive & Child Health Programme. It is also proposed to upgrade the management capacities at State and district levels for consolidation of the Programme Management Units through induction of key skilled professionals like MBAs, CAs, Inter Costs, MIS Specialists etc. under the leadership of an additional IAS Officer as Executive Director, SCOVA at State level, and ex-service men at district levels, to steer the programme. The strengthening of the financial and programme management would be a key input of the envisaged programme. Improvement of financial flows, improvement in accountability through better maintenance of accounts by induction of professional financial personnel, and use of e-technology to handle the huge number of transactions and sites efficiently is the management key to the CMP strategy.

Improved convergence, publicity and programme monitoring

A programme-specific IEC campaign shall be launched for the CMP districts, including wall writings, hoardings, posters, brochures, CDs and briefing kit for various stakeholders, informing the key players of the new initiatives and the public-private institutions partnering in this activity. Intersectoral convergence with related Departments would be strengthened and involvement of members of Panchayati Raj Institutions and Self Help Groups stressed to make the programme a people's programme. The monitoring of the Family Welfare Programme shall be improved through e-linking with video-conferencing in CMP districts and with the 5 EAG States' Secretaries. We also propose to use e-technology for social auditing, consumer suggestion/grievance monitoring,

handling fund flow and other related issues. A concept note on the subject is enclosed at **Annexure-VII**.

Financial Implications

Detailed costing has been done of all the additional activities proposed above. The Department of Family Welfare is of the view that it should be possible to undertake the additional activities in the current year by regrouping funds available under different Budget Heads of the Department. It should also be possible to accommodate the additional financial requirements for the remaining period of the 10th Plan within the Budget of the Department, if the officially indicated Outlays for the 10th Plan are fully funded. This would, however, require some intersectoral adjustments within the Budget Heads of this Department, for which orders of competent authorities would be obtained. It is possible to continue funding these new initiatives not only in these 150 CMP districts, but also in additional 100 to 150 districts in the 11th Plan with only a normal increase in the Budget, by 50%. The Common Minimum Programme already states that over a period, the Health Budget would be doubled. Also, from 9th Plan to 10th Plan, our Budget increased by 80%. We are thus looking at a very practical financial plan. The savings to the country, by way of avoiding 40 crore unwanted births would be far more.

Population Stabilization: The Case Against Coercion

A. K. Shiva Kumar

The Indian press and media have once again drawn attention to the urgent need for stabilizing India's population. That this should happen in the current context of the unnecessary controversy generated by the Census of India 2001 report giving religious totals is unfortunate. Also, it is equally disturbing that certain groups are calling for strict 'population control' measures, the imposition of a compulsory one-child or two-child norm, and the use of penalties and disincentives to forcibly restrict family size. It is even more disconcerting to find that a recent policy note from the Ministry of Health and Family Welfare outlines, as its strategy, monetary incentives and other measures for stepping up, over the next four years, the number of sterilization cases from around 18 lakhs to 50 lakhs a year in five high-fertility states.

There is no doubt that India should strive for rapid population stabilization. Apart from the unnecessary pressure on resources, infrastructure and the environment, a large number of unwanted births signals the lack of access that many people (especially women) have to basic education, family planning services and decent conditions of child survival. It also points significantly to the limited control that women often have over fertility decisions. Addressing these underlying causes for high fertility rates is urgently required, not only for advancing India's progress towards population stabilization but also for enhancing the quality of people's lives, for accelerating economic performance and for promoting human development. This is the proven path for achieving population stabilization. In contrast, those who advocate a compulsory one-child norm or two-child norm through use of coercion and penalties show complete disregard for human rights, for the dignity of women and for the sustainability of population policy interventions.

This paper presents arguments in favour of a humane approach to population stabilization and argues against taking an alarmist position on population especially at a time when birth rates are progressively declining and India is being lauded globally for some very effective population interventions. At some level, reiterating this position is unnecessary. India's National Population Policy 2000 – a document backed by political consensus formulated after considerable public debate and discussion – advocates and prescribes precisely these measures.

Some Common Myths

Many people tend to blame population per se for the low levels of income prevailing in different countries across the world. Such a perception or belief is highly misplaced. There is no automatic or predictable association between population size and economic well-being. China, the only country with a larger population than India, reports a per capita income that is almost 70 per cent higher than India's. Within India too, Andhra Pradesh (76 million) and Madhya Pradesh (80 million) reported similar levels of population in 2001. Yet, most recent estimates reveal that, in 1997-98, the per capita Net State Domestic Product in Madhya Pradesh was only Rs.8,114 – almost 30% lower than the per capita Net State Domestic Product (Rs. 10,590) in Andhra Pradesh.

Many also believe that a large population slows down economic growth. Once again, there

isn't any obviously predictable link between population growth and economic expansion. China and India, two of the world's most populous countries, grew at a much faster rate during the decade of the 1990s than most other countries. Within India, Kerala, the state with the lowest growth rate of population between 1981-91 recorded the lowest growth rate. On the other hand, Rajasthan's Gross State Domestic product grew the fastest in the 1980s despite the State recording the highest rate of population growth.

Many also wrongly interpret the association between high birth rates with high levels of income poverty. While a lower rate of population growth is conducive to poverty alleviation, reducing fertility rates by itself does not guarantee economic prosperity. In recent years, Bangladesh has recorded impressive reductions in fertility rates – from almost 7 in 1975 to 3.1 in 2001. Yet Bangladesh continues to remain one of the poorest countries in the world. Similarly, states like Goa, Kerala and Tamil Nadu that have lowered fertility to replacement levels have not done away with problems of human poverty. Also, it is interesting to note that Kerala and Haryana report very similar proportions of population living below the poverty line – around 24-25 per cent. Yet Kerala's birth rate is 18 whereas it is 27 per 1,000 population in Haryana.

Clearly, the linkages between population size, birth rates, economic well-being and economic growth are complex. Economic wellbeing is not a function of population size per se but is influenced significantly by a host of other factors including natural endowments, human resource capabilities, quality of governance and investment priorities of a region, state or country.

Key Influences

What are some of the factors that can explain fertility declines across societies? Four inter-connected factors are commonly associated with falling birth rates: women's empowerment, reduced child deaths, improved access to reproductive health care and services and a reduction in human poverty. Together, they exert many times more influence on lowering birth rates than any one of them acting alone.

Women get empowered when they begin to enjoy and exercise greater freedoms – economic, social, political and cultural. This occurs with higher levels of education, improved health and nutritional status, greater economic freedoms, improved access to employment and higher earnings, and more meaningful participation in decision making within and outside the family. More educated women tend to marry late and they also enjoy better health and nutritional status. These in turn have a positive impact on the health and survival of newborn babies and infants. And improvements in child survival, as discussed below, contribute in many ways to lowering birth rates.

A related concern, central to population debates, has to do with gender equality, and particularly the freedom and ability of women to exercise choices freely and without fear. The subordinate position of Indian women is well known. Most do not have the control they would like on their own fertility decisions. To the extent that fertility decisions are taken by a family, tackling the issue of gender equality necessarily implies addressing hard social realities that perpetuate male dominance, nurture unequal power relations within the family and in society, and obviate social constraints (or unfreedoms) that women face.

Improving child survival has a direct impact on birth rates. Public support for improving child survival conditions has sometimes been inhibited by the argument that, inasmuch as such efforts are successful, they are ultimately self-defeating because they serve only to aggravate the problem of rapid population growth. Such an argument is not only morally repugnant, but it is also demographically unsound.

Several mechanisms connect lower child death rates to lower birth rates. First, the physiological factor. An infant death means the end of breast feeding, an important 'natural contraceptive'. In the absence of any other method of birth planning, a new pregnancy becomes more likely. Second, the replacement factor. The death of a child prompts many couples to "replace" the loss by a new pregnancy sooner than would otherwise have been the case. Such families, which experience the death of a child, are also much less likely to use any method of family planning. Third, the insurance factor. When child death rates are high, many parents compensate for the anticipated loss of one or more of their children by giving birth to more children than they actually want. Compounded by such factors as son preference and the time lag between changes in death rates and changes in perceived risks, this 'insurance' factor is a major reason for the persistence of high birth rates. Fourth, the confidence factor. Empowering parents with today's child survival knowledge helps build confidence which is a crucial factor in the acceptance of family planning.

Three of the most important strategies for reducing child deaths – the education of women, the well-informed timing and spacing of births and breastfeeding – also happen to be the most direct methods of reducing child births. Reducing child deaths can help societies move towards family building by design than by chance. The interventions for improving child survival are well known – better education, improved access to health care, better nutrition, higher earnings, safe drinking water, and better sanitation. Not surprisingly, these are the same interventions that are needed for empowering women, for improving standards of living, and for stabilizing population.

High fertility rates are often a reflection of the extremely limited access that women have to decent health care and reproductive health services. Surveys repeatedly reveal that even poor women do not want to have many children. However, the lack of access to family planning interventions combined with poor knowledge and limited freedom to make choices leads to a situation of unwanted fertility. It is important to enlarge the contraception mix, expand the provisioning of quality health care and services, and simultaneously empower women and communities to make informed choices.

Finally, reducing human poverty is another factor that can have a direct impact on fertility rates. In discussing poverty, we need to look beyond income poverty to the poverty of opportunities – economic, social, cultural and political – that severely hampers progress. The State must ensure that jobs are created for the poor and that their incomes are enhanced. But it is also equally important to simultaneously ensure universal access to basic education and health, safe drinking water, adequate food and nutrition and so on – all of which are critical components of a decent quality of life.

A Matter of Rights

In recent years, human rights activists and women's groups have strongly influenced the approach to policy formulation for population stabilization. They have drawn attention to critical ethical principles of human dignity and women's freedoms when discussing population policies – a perspective globally endorsed at the 1994 International Conference on Population and Development held in Cairo. A rights-based approach to population policy formulation implies accepting certain fundamental premises about the position of women in society that: (1) women can and do make responsible decisions for themselves, their families, their communities, and increasingly, for the state of the world; (2) women have the right to determine when, whether, why, with whom, and how to express their sexuality; (3) women have the individual right and the social responsibility to decide whether, how, and when to have children and how many to have; and (4) sexual and social relationships between women and men must be governed by principles of equity, non-coercion, and mutual respect and responsibility. Adopting such a perspective implies requires abandoning fertility and demographic 'targets' and focusing on the quality of services. It entails promoting an essential package of reproductive and child health services that includes services for the prevention and management of unwanted pregnancy, the promotion of safe motherhood and child survival, nutritional services for vulnerable groups, services for the prevention and management of reproductive tract infections and sexually transmitted infections, as well as reproductive health services for adolescents.

The Senselessness of Coercion

There are still many advocates who favour 'controlling' population by forcibly limiting the number of children a woman can have. They argue that coercion and an authoritarian approach will yield the quickest results. Some even go to the extent of advocating that India should emulate China's one-child policy despite the many problems with the coercive approach. In China, for example, adoptions are reported to have risen sharply in the 1980s from around 200,000 before the one-child policy to almost 500,000 a year in 1987. A significantly higher proportion of girls is put up for adoption than boys. Others have pointed to the practice of forced abortions that jeopardizes the life of the mother. Some others have expressed concerns over the state of mental health of the population over time as society begins to deal with the specific problems of raising a single child – and that too a boy. Some fear that the shrinking child population will impose severe pressures on children who will have to care for aging parents. There are several other reasons why use of coercion is not necessary or justified.[1]

First, using coercive policies has little appeal especially when almost every other country in the world (including Bangladesh and Indonesia) has been able to lower birth rates and fertility levels without the use of force or compulsion. Within India, Tamil Nadu, Goa and Kerala, states with low fertility rates, have lowered birth rates without the use of any force or draconian measures. *Second,* imposing restrictions on the number of children violates people's freedoms and individual rights. *Third,* it makes little sense

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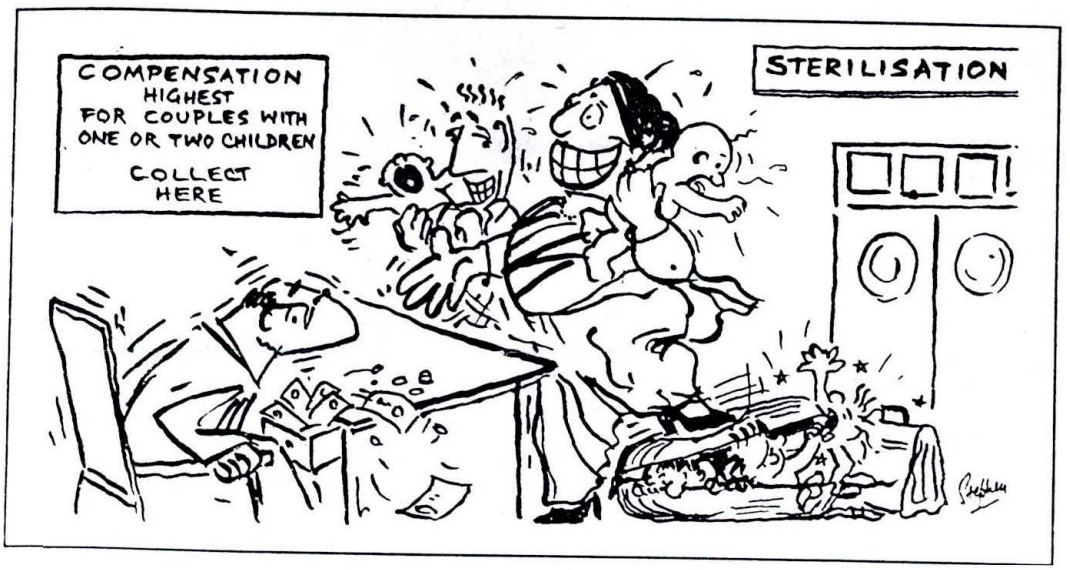

to impose penalties when people indeed want to have fewer children. Every survey points out that most people – even the poorest, those living in rural areas, and belonging to minority groups – want to have fewer children. At the same time, people's knowledge of family planning methods is also high. Why penalize people if the State is not able to fulfill its obligation of ensuring adequate provisioning of basic social services? *Fourth*, even in China, the coercive population policy was accompanied by a broad and equitable expansion of social and economic opportunities for women – the proven way to reduce population growth. *Fifth*, enforcing a one-child policy may be possible in an authoritarian country like China. But such measures are likely to have disastrous political consequences in any democracy. In India, the political and human wounds of the population 'control' measures initiated during the Emergency rule under Mrs. Indira Gandhi, some 25 years ago, are still to heal. *Sixth*, in countries of South Asia and even in China, with a strong son preference, such restrictions on family size will inevitably promote further discrimination against girl children and worsen the already prevalent discrimination against the girl child in India. In fact, it is a particularly serious concern given that the most alarming and disturbing result of the Census of India 2001 is the worsening female-to-male ratio in the child population aged 0-6 years. *Seventh*, a common argument in favour of a one-child policy is that it can *quickly* lower birth rates and speed up the process of population stabilization. There seems little evidence or justification for such a belief. China, with its one-child policy, was not able to lower its fertility rate any faster than Kerala that did it without coercion. In 1979, for instance, Kerala had a higher fertility than China. But by 1991, Kerala's fertility rate of 1.9 was lower than China's 2.0. Similarly, Bangladesh has shown that it is possible to reduce fertility rates rapidly without use of any coercion – by empowering women, educating people and improving access to reproductive health care.

There are other serious problems associated with the use of disincentives and penalties for reducing birth rates. Penalties tend to get reduced to tokenism, and they are difficult to implement. If anything, such a move is impractical and is full of loopholes. Also, imposing penalties has little ethical or moral justification. They tend to be unfair and inequitable in terms of how they affect different groups of people in society. Clearly, it will affect more adversely women in rural areas, those who are illiterate and those who belong to the disadvantaged communities. Clearly, these communities enjoy much less access to basic social services and opportunities than the rest of the society. The proposal, therefore, to impose penalties on people with more than two children is clearly biased against rural and tribal populations, against less educated persons, against those belonging to Scheduled Castes, Scheduled Tribes and Other Backward Castes, and the poor in general. Similarly, giving monetary incentives for sterilization is bound to lead to the exploitation of poor women. To begin with, fertility levels may not be drastically affected as many poor women, lured by the offer of money, may agree to undergo sterilization especially if they already have 3 or 4 or more children. At another level, the attraction of money can also force women to undergo sterilization even if they are reluctant to do so. In any case, the provisioning of counseling services or even medical services is so poor in many parts of the country that making it compulsory will imply exposing women to unnecessary health risks.[4]

The reality is that population stabilization is best achieved by seeking the cooperation of people, by treating women with respect, and by recognizing the human rights of individuals. It is critical for society to invest in its people - in their health, in their education, in expanding reproductive health choices and in enhancing their capabilities.

Concluding Remarks

India's National Population Policy 2000 spells out measures to achieve population stabilization. It rightly advocates and builds on a set of twelve themes: decentralised planning and programme implementation, convergence of service delivery at the village level, empowering women for improved health and nutrition, promoting child health and survival, meeting the unmet needs for family planning services, addressing as priority the needs of under-served groups such as those residing in urban slums, remote tribal and rural areas and adolescents. It also emphasizes the importance of collaborations between government and NGOs, research on contraceptive technologies, and strengthening legislation. The Action Plan accompanying the National Population Policy 2000 outlines in detail the many interventions that must be put in place. The challenge before India is to ensure proper implementation of the Action Plan.

There is absolutely no justification for enforcing penalties, or for introducing a compulsory one-child or two-child norm. Such measures not only tend to punish the poor and disadvantaged, the political and human consequences can be quite disastrous. It is also not true that only such draconian measures can arrest India's population expansion. India's population will continue to grow on account of the population momentum generated by an already large young age population – also predicted to be the source of economic buoyancy and comparative advantage in the years to come. Government of India's newly announced Common Minimum Programme (CMP) reiterates once again a strong political commitment to end human poverty. Many of the pro-poor interventions are likely to have a strong impact on reducing birth rates. Apart from these measures, any direct intervention to strengthen family planning services must be integrated with a more comprehensive effort to revamp the public health and health systems across the country. Ensuring adequate resources and political support for these interventions must become a national priority – born out of a genuine concern for accelerating population stabilization and advancing India's development.

A. K. Shiv Kumar is a development economist and adviser to UNICEF India. This paper is a condensed and modified version of an earlier article on population stabilization written by him for the National Human Rights Commission (2003).

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1 *Sen (1995) presents several philosophical and other arguments denouncing the use of coercion and arguing in favour of cooperation as the preferred and only way to achieve rapid population stabilization.*

2 *I have deliberately not referred to men as most family planning interventions in India target women. It is worth recalling that when men got targeted during the Emergency in India, it fuelled enormous public protest with serious political consequences. Sadly, women seem to have little support even on this matter of choice and health.*

Myths about Population growth among Muslims
Tilting at Windmills

Amit Sen Gupta

The BJP's shrill campaign, sparked off by the release of population and demographic characteristics based on religious communities, leverages on two pet projects of the party – population control and muslim bashing.

Hysteria Based on Falsehood

To be fair, the hysteria that the BJP tried to whip up, was partly fuelled by faulty presentation of statistics by the Census Department. This was further augmented by large sections of the print and visual media. Banner headlines in many prominent dailies "screamed" about the "huge" growth in muslim population between 1991 and 2001. Television channels, synonymous today with shallow and sensational reportage, joined in with gusto. Many channels had BJP and RSS spokespersons frothing at the mouth as they declaimed about Hindus in India being deluged by a burgeoning muslim population. Many "experts" lent their voice to this campaign – one prominent news channel featured a well known demographer who pontificated on the possible link with migration from Bangladesh.

Now that the Census Department has issued a clarification, and the Census data is open for examination, let us look at what the figures really say. The initial release from the Census Department said that the population in India had risen by 22.7% between 1991 and 2001. In this period the rate of growth among Hindus has been 20.3% and among Muslims it has been 36%. What the Census Department failed to highlight was the fact that in 1991, the state of J&K (the only muslim majority state in the country) had not been part of the census operations because of disturbed conditions. Thus, while the 2001 census figures include the population of J&K, the 1991 figures do not. In order to make any sort of comparison, the population of J&K should have been subtracted from the 2001 figures.

The total population of J&K, according to the 2001 census, is just above a crore, of which muslims constitute 67% of the population. Thus of the 13.8 crore muslim population in the country reported in the 2001 census, 0.68 crore – i.e. about 5% -- live in J&K. Because the 1991 Census did not include J&K we need to deduct this number from the 2001 census figures of muslim population. If we do so, we find that the growth rate for muslims between 1991 and 2001 is actually 29.3% -- 6.7% less than originally reported! The rate of growth among the Hindu population would also come down if we subtract the Hindu population of J&K, but marginally to 19.9% from the originally reported 20.3%. If we look at the new figures, we would see that the rate of population growth has declined in the last decade (from the previous decade) by 5.2 % among ***both*** Hindus and Muslims (from 25.1% and 34.5% respectively)!

The BJP and RSS owe an apology to the nation for foisting this falsehood on the country – a transparent ploy to sow communal discord. So do the media who sought to sensationalise the BJP's communal canard.

Bogey of Population Control

Having failed abjectly in its designs, the BJP is now trying to shift to another plank by resurrecting the bogey of population control. It now says that the issue is not just high growth in

muslim population, but also the larger issue of population growth. Why is the BJP saying this now? The 2001 census figures were available almost two years back – when its NDA Govt. was in power. The total figures for population growth between 1991 and 2001 haven't changed since then. The recent release by the Census Deptt. has only added disaggregated data based on religion. How has it suddenly become such a major issue? Clearly, for all its fancy footwork, the BJP has emerged as an irresponsible party that is willing to clutch on any straw in order to sow disharmony.

Let us, however, look a little more closely at the "population explosion" argument, not the least because it has many adherents even within the present dispensation. Let us, in fact, look at the reasons for the relatively high growth in muslim population. Blinkered vision, such as the BJP possesses, never makes for rational analysis of facts – because facts often inconvenience such bigots. The recent release by the Census Deptt. does not talk only about population growth. It gives detailed data about other socio-economic parameters, disaggregated on the basis of religious communities. This data is being presented by the Census Deptt. for the first time, and it is essential that we look closely at what it says. In its introduction while releasing the data the Census Deptt. says: *"In the past there has been a pressing demand from various agencies for the religion data cross-classified by socio-economic characteristics of the religious communities so as to assess the level of development achieved by them in the social and economic spheres of life. ... The National Minority Commission has been suggesting that religion data be cross-classified by various socio-economic characieristics of the religious minorities to assess the social and economic status attained by these groups. Their requirement is therefore being fulfilled by the Census Organization"*.

Conditions of Living among Muslims

This socio-economic data on the muslim community is startling – a sad commentary on the state of the nation 57 years after Independence. The data clearly shows that Muslims in this country area far behind in almost all socio-economic indicators. Literacy rate among muslims at 59.1% is way below the national average of 64.8% and lower than that of all other communities listed. Worse still, work participation rate among muslims is just 31.3%, again far below the national average of 39,1%. In other words a Muslim in India is 25% less likely to be working than the average citizen in the country. The picture is even more grim if we look at the disaggregated figures for work participation. Just 20.7% of muslims are listed as cultivators, as compared to an overall average of 31.7%. That is a muslim is 50% less likely to own and cultivate his own land, as compared to an average citizen of India. In contrast 8.1% of muslims -- almost twice the national average of 4.2% -- work in Household industries, that is in poor, ill paid, sweatshop conditions (see Table below).

Distribution of category of workers by religious communities, India - 2001

Category	All Religions	Hindus	Muslims	Christians	Sikhs	Buddhists	Jains	Others
Total	100	100	100	100	100	100	100	100
CL	31.7	33.1	20.7	29.2	32.4	20.4	11.7	49.9
AL	26.5	27.6	22.0	15.3	16.8	37.6	3.3	32.6
HHI	4.2	3.8	8.1	2.7	3.4	2.9	3.3	3.2
Others	37.6	35.5	49.1	52.8	47.3	39.2	81.7	14.3

CL: Cultivator; AL: Agricultural Labour; HHI: Household Industry

What the data shows is that the average muslim in the country is more likely to be illiterate, unemployed and landless. This is really the root cause of a relatively higher population growth among muslims. Numerous studies and experiences across the globe have shown that socio-economic development precedes population stabilization – not the other way round. It is foolhardy to believe that population growth can come down drastically without socio-economic development. If any body has been singularly responsible for pushing the muslim community further into the quagmire of poverty, unemployment and illiteracy, it is the BJP and its cohorts (while in Govt. as well as when in opposition). The BJP is actually responsible for a major part of the high population growth rate among muslims – by its discriminatory politics and hate campaigns.

Sex Ratio and the BJP's Silence

The muslim community, however, fares much better in respect to one indicator of socio-economic development. This is related to the sex ratio – both for the general population as well as for the 0-6 year age group. Declining sex ratio in the country is clearly indicative of discrimination towards women and girls and the prevalence of the heinous practice of sex-selective abortion and infanticide of girl children. It's a cause for national shame. Curiously Shri Venkiah Naidu and his friends have been totally silent about the fact that in this regard the muslim community fares better than the All India average and also better than Hindus. At 936. the sex ratio among muslims is better than the All India average of 933 and that of Hindus at 931. The child sex ratio (0-6 years group) which is indicative of the prevalence of female foeticide and infanticide, is 950 for muslims, 927 for the whole population and 925 for Hindus. Is the BJP's silence about this explained by the fact that the *manuvadi* core of the BJP's ideology would prefer to turn a blind eye to gender-discrimination and murder of girl children?

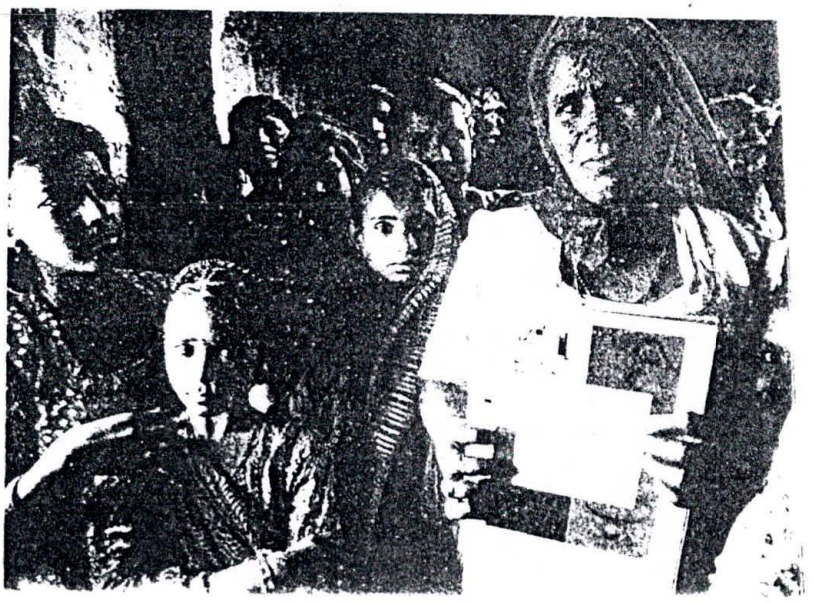
There are huge problems that face this country. If as a serious political party the BJP is looking for issues, it should not require it to tilt at windmills and resurrect imaginary monsters. The BJP's politics of falsehood and hate has been comprehensively rejected by the people of this country. But, as the saying goes: History repeats itself – the first time as tragedy, the second time as farce. In the ultimate analysis that is what the BJP's campaign is – a farce.

Voices From The Grassroots

Where have all the Services gone.....?

Lindsay Barnes

I promised to write this article for Health for the Millions, I learnt it was to be about ICPD + 10, and reproductive health services. I started to think, 'What services should I write about?' and then got sidetracked. Submerged in the little things that keep cropping up here in our village, in a backward part of the rich, steel plant district of Bokaro in Jharkhand.



Like the health camp that we'd started a couple of months ago in Chotitanr, a village 25 kms away. Some of the members of the 'mahila mandals' - women's groups - there had demanded immunisation for their children. None of their children had ever had anything other than polio drops in the 'Pulse Polio' programme. They were quite happy with this until they learnt other diseases could be immunised against through our health training programmes. Knowledge may be empowering, but it also means more work.

"You are providing immunisation for children of the 'mahila mandals' near the health centre, but what about us?" the group leaders had asked. We have been providing immunisation in our community health centre for the last five years, but their village was only 8 kms from the big city, couldn't they go to the government hospital there and get their children immunised, I tried to argue? After all less than 30% of the district's children are immunised, should a small NGO like ours really be getting into this?

"How to get there? There's no transport, we'd have to walk the whole way and back. And then they charge anyway, or they use the same needle for all the children. Then sometimes they don't come at all?" said one woman speaking from experience.

But now I'm wondering whether we should have agreed. To pick up the vaccines from Bokaro, and maintain the cold chain, is one big headache. There's no generator back up in the PHC, so we don't get our vaccines there. There's never any ice in the ice packs, and the voltage is too low to freeze. The vaccines from the PHC are picked up by the ANMs on Tuesdays, for immunising children on Wednesdays, without ice in the ice packs. "What can we do?" one of the ANM lamented, "if we pick up the vaccines on Wednesday, we can't reach the village before midday, and we have to leave by 1 o'clock. It takes 2 to 3 hours to get home."

Then last month there was no measles vaccine, and lots of children had to be returned unimmunised. We'd told them it would be available this month. And it isn't. The Jharkhand government had launched a special measles immunisation programme for the welfare of the children - in some districts of the state. So they had recalled all the measles vaccines from all the other districts, including Bokaro. Anticipating villagers might not understand that the government's measles drive was for their welfare, we decided to send our field coordinators to inform villagers of the measles-vaccine-less programme, and I finally started to think about the reproductive health programme.

But before I could pen my thoughts, Fulmoni Devi, from Mantanr, a village around 6 kms away, lands up in my courtyard. She has come on her own, though it's rice planting season, so it must be serious. Husbands rarely accompany their wives, having much more important social activities to do - playing cards or discussing matters of great importance in the teashops.

"Two moons have passed," she said, "can't you give me some injection or medicine to bring on my menses?" she asked.

At least three women a week come with such a request. She already had three children within five years, and she'd had enough. But hadn't she thought about prevention, or spacing, after all her village has a government health centre, I asked. Hadn't she heard of pills or 'Copper-T' or condoms?

"I've heard of pills, but villagers told me that it dries up the blood, and I don't have enough anyway, and 'Copper-T' they say causes cancer. And condoms! Don't ask about that!"

But doesn't the ANM provide all these services in the centre?

"How do I know? I've never been there. She comes to give our babies polio drops...Anyway never mind all this, what to do now?"

What indeed. The choices are limited. If Fulmoni agrees, she can get a safe, legal, free abortion at Bokaro General Hospital – if she agrees to undergo sterilisation. This hospital has a 'family welfare' programme, or popularly known as 'family planning' – which are the only free services made available to the public. Or she can get a safe, illegal, expensive abortion in a private nursing home in the city. Or the village 'doctor' provides a whole range of abortion services – injections, pills, and even conducts D&C in the village. Or there's the old woman in Kumirdoba who inserts medicine into the vagina with a stick. There's no dearth of choices. But abortion in a government health facility isn't one of them. This service is not available in any government hospital in the whole district.

I explained the 'choices' available to Fulmoni. She didn't realise that 'operations' (sterilisation) was available in the summer. Most villagers think that sterilisation operations can only be had during the winter. These operations were usually carried out in camps, held during the winter months. Women would be rounded up by touts, agents or ANMs and taken to the PHC, or Bokaro General Hospital, sterilised and taken home. With the announcement of the Target Free Approach (Or 'Trouble Free Approach' the doctors had chuckled when it was introduced) in 1997, 'operations' have not taken place in the PHC at all. They almost did this year, with the date being announced, and all arrangements were made. ANMs brought women from the villages. The gynaecologist turned up, coming all the way from Dhanbad, 80 kms away, and conducted one operation. Then she announced that she had been transferred and refused to do more. All the women were sent home.

So instead of operating at the PHC, during the month of March, women were rounded up and taken to the much more conveniently located district hospital, just 5kms away from the doctor's residence. Women paid a service charge to the agents that take them, for the vehicle that took them and for the injectable antibiotics that the doctors prescribed. Doctors advise injections to ensure the stitches didn't get infected, the women were told, since the medicines the government provides are substandard.

Fulmoni decided to go for abortion along with sterilisation, but then she pleaded, "How can we go alone to the big hospital? I've never been there before." So I had to think about who would accompany Fulmoni and her husband, before I could think about reproductive health matters. I'll think about this tomorrow, I tell myself, and put my notebook away.

Then, in the middle of the night Parvati Rai's husband comes and wakes us up. He's brought his wife on the back of his cycle. It wasn't unexpected; she'd been coming to our health centre for antenatal care from her third month. This was her eighth pregnancy – but only has three surviving children. All her children had been breech, and all born at home. Some survived, some didn't. The last one was born in our health centre, after the village 'doctor' had given huge doses of oxytocin in her seventh month, mistaking stomach cramps due to diarrhea for early labour pains.

Parvati's village is only 5 kms from the PHC, couldn't she go there? Last year the new Jharkhand administration helped promote 'safe motherhood' by building labour rooms in many PHCs. The government also ordered all PHCs should have one doctor available at all times. So now the doctor stays in the labour room, since no deliveries take place. The ANM there sometimes conducts home deliveries, for a fee. Parvati's husband had never seen the PHC.

In the early hours of the morning things weren't going well. Parvati's waters broke,

and down came a hand. A referral is always a cause for concern. Where to go, and how? There's nowhere in the Bokaro district where a poor villager can go for complications of childbirth, without selling his land. Caesarean sections do not take place in the district's government hospital. There's Bokaro General Hospital, I tell Parvati's husband, and he breaks out into a cold sweat. "We are poor, we can't go there. Try and save the mother..." he pleads. He cannot say, 'let the baby die, but.... For Bokaro General Hospital takes Rs.5000 at the time of admission. Other nursing homes take as much as they think you can pay, from Rs. 8000 to unlimited. Turn left at the junction, we tell patients, if you have Rs.5000 in your pocket, and turn right if you don't. 35kms down that road takes you to Purulia District Hospital, much further away, but cheaper. Parvati's husband arranges a taxi for Rs.500 and sets off.

After they have left I manage to get away, and sit with my notebook at last. Where to start? Where are the 'reproductive health services'? We need services in order to identify 'gaps'!

In editors note many years ago Prem Chand whose centenary is being celebrated wrote, 'Kafan' story of Budhiya and her slow painful death during childbirth. What today we would clearly recognize as obstructive labour, which needed emergency obstetric care to save the life of the baby and the mother. How many needless Kafans are needed to ensure mothers right to safe delivery. For a country giving high value to matratva motherhood, with MCH being an old programme and still a very important component of RCH, the priority the society, the NGOs and the government programmes are giving it is NOT ENOUGH.

It is because of the chronic poverty and neglect deep-rooted economic inequality born out of patriarchal mindset? Or is it because a pregnant woman is seen as population bomb, population increase in a demographically driven pregnancy prevention mandate, therefore further discriminated and derived access to proper care when it is well known or should be well known that women even now have very little say – in infliction of unwanted pregnancy. Empowerment of women for pregnancy prevention, AIDS prevention is important but not enough.

What are their entitlements? Where can they access health care services? Who must ensure this?

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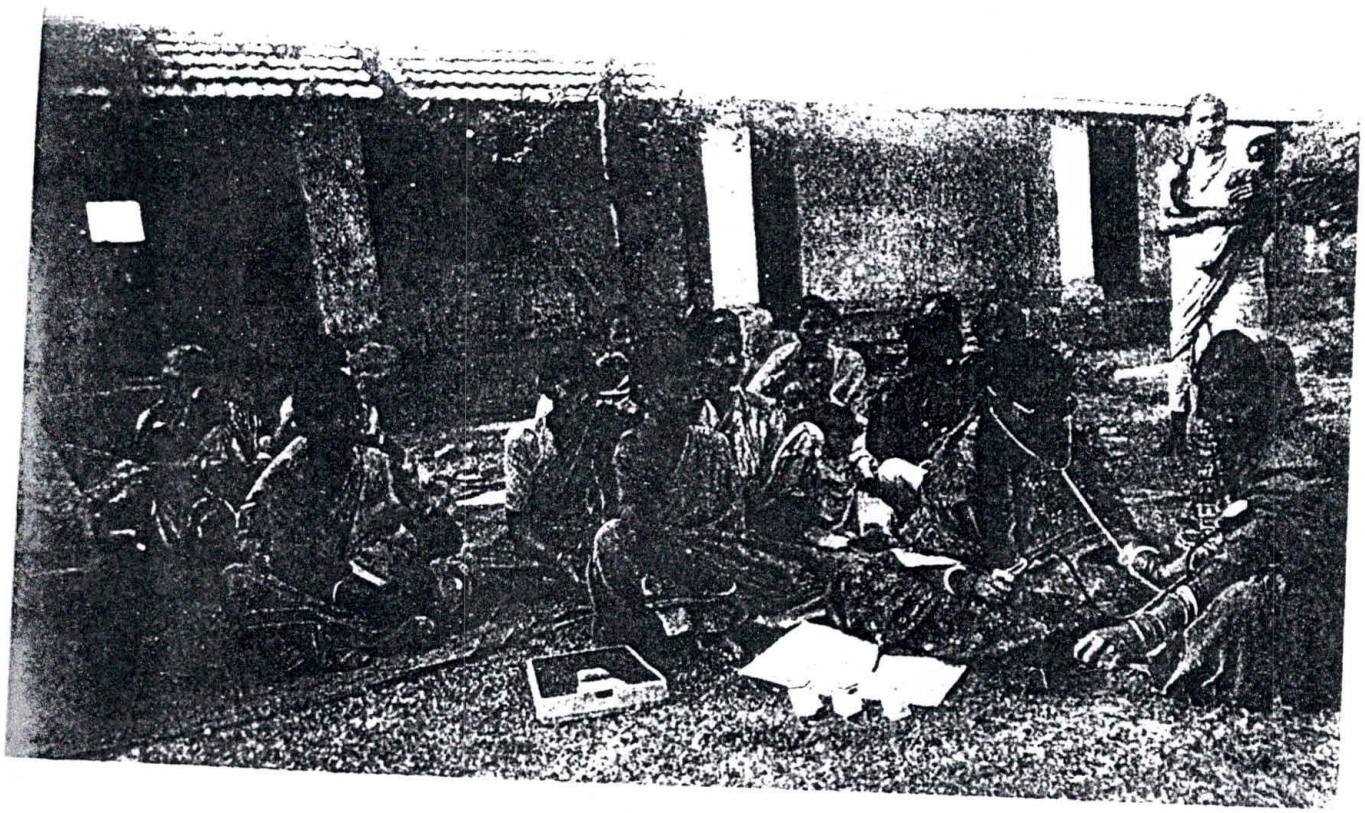

CONCEPT NOTE
(अवधारणा-पत्रक)

अंतराष्ट्रीय स्तर पर जनसंख्या वृद्धि को आमतौर पर भूख, गरीबी, अशिक्षा, बेरोजगारी पर्यावरण असंतुलन की समस्या का मूल कारण माना जाता है। जनसंख्या वृद्धि को नियंत्रित कर इन समस्याओं को समाप्त करने के लिए विभिन्न कार्यक्रमों पर ज़ोर दिया जा रहा है जनसंख्या नियंत्रण करने की दिशा में सन् 1952 में परिवार नियोजन कार्यक्रम सन् 1976 में राष्ट्रीय परिवार नीति विवरण एवं सन् 1983 में जनसंख्या स्थरीकरण हेतु संसद ने स्वास्थ्य नीति पारित करते समय अलग से जनसंख्या नीति की आवश्यकता पर जोर दिया था सन् 1991 में राष्ट्रीय विकास परिषद ने श्री करुणाकरण की अध्यक्षता में समिति गठित की इस समिति ने विकास जनसंख्या वृद्धि और पर्यावरण के प्रति समग्र दृष्टिकोण के लिए दीर्घ अवधि के लक्ष्य आधारित कार्यक्रम सहित राष्ट्रीय जनसंख्या नीति का प्रस्ताव दिया किन्तु संसदीय पटल पर कोई विचार विमर्श न हो पाने के कारण यह नीति पारित नहीं हो सकी तत्पश्चात यह सिफारिश की गई कि सरकार द्वारा जनसंख्या नीति बनाई जाये जो संसद में पारित हो। परिणाम स्वरुप सन् 1993 में डॉ. एम.एस. स्वामीनाथन् की अध्यक्षता में बने विशेषज्ञ दल ने राष्ट्रीय जनसंख्या नीति का मसौदा तैयार कर संसद सदस्यों को परिचालित कर केन्द्र और राज्य के अभिकरणों से टिप्पणीयां देने का अनुरोध किया। ताकि राष्ट्रीय विकास परिषद एवं संसद द्वारा अनुमोदित उपरोक्त नीति व्यापक राजनीतिक मतैक्य तैयार कर सकें। 1997 में विभिन्न प्रक्रिया के पश्चात संसद के किसी भी सदन में यह मसौदा नहीं रखा जा सका। मंत्रीमण्डल ने नीति के प्रारुप की जांच करने के लिए मंत्रियों के एक दल (उपाध्यक्ष योजना आयोग की अध्यक्षता में) की नियुक्ति की इस दल की विभिन्न दौरों में अनेक बैठके हुई जिसमें गहन विचार विमर्श हुआ मंत्रियों के दल ने इस नीति में अन्य सुझाव जोड़ने घटाने के साथ ही अंतिम रुप देने के लिए शिक्षाविदों, जनांकिकी विशेषज्ञों, समाजशास्त्री, जन स्वास्थ्य व्यवसायियों और महिला प्रतिनिधियों को आमंत्रित किया। और अंतिम रुप देकर 1999 में सुझावों सहित एक नया प्रारुप विचारार्थ प्रस्तुत किया।जनसंख्या नीति का अन्तिम स्वरूप सन 2000 मे पूरा हुआ जिसमे राष्टीय जनसंख्या नीति 2000 प्रजनन स्वास्थ्य परिचर्चा सेवाओं का लाभ उठाने मे नागरिको की स्वैच्छिक और समझदारी पूर्ण पसन्द सहमति के प्रति और परिवार नियोजन सेवाएं प्रदान करने के लक्ष्ययुक्त नीति को जारी रखने के प्रति सरकार की वचन बद्वता की पुष्टि करती है राष्टीय जनसंख्या नीति 2000 मे भारत के लोगों की प्रजनन और बाल स्वास्थय समबन्धी जरूरतों को पूरा करने और 2010 तक प्रति स्थापन स्तर को प्राप्त करने के लिए एक नीतिगत ढांचे की व्यवस्था है। यह साझेदारी मे कार्य कर रही सरकार उधोग स्वैच्छिक गैर शासकीय क्षेत्र द्वारा प्रजनन शिशु स्वास्थय सेवाओ के एक व्यापक पैकेज के विस्तार और कवरेज मे वृद्धि करते हुए बाल जीवन प्रत्याशा मातृत्व स्वास्थय और गर्भ निरोधक के मुददों पर साथ साथ ध्यान देने की आवश्यकता पर आधरित है। राष्टीय जनसंख्या नीति मे जनसंख्या स्थरीकरण हेतु पंचायत एंव स्थानीय निकाय की संस्थाओ के माध्यम से छोटे परिवार को प्रोत्साहन देने की बात कही गई है। प्रधानमंत्री की अध्यक्षता मे बना राष्टीय जनसंख्या नीति आयोग जिसके सदस्य सभी राज्यों के मुख्यमंत्री परिवार कल्याण विभाग के प्रभारी केन्द्रीय मंत्री और अन्य संबन्धित केन्द्रीय मंत्रालय और विभाग जन सांख्यकीय विशेषज्ञ जनस्वास्थय व्यवसायिक गैर सरकारी संगठन के सदस्य इस कमेटी के सदस्य होगें राष्ट्रीय स्तर पर बनी जनसंख्या नीति को राज्यों ने अपनी सुविधा अनुसार संशोधन कर लागू किया। पिछले कुछ वर्षो में लक्ष्य के आधार पर जनसंख्या नियंत्रण करने के लिए सरकारी तन्त्र, गैर सरकारी संस्था और अन्य ईकाईयों को माध्यम बनाया गया था और 1993 में घोषित नयी नीति में उपरोक्त कानून को पंचायत राज संस्था के माध्यम से लागू करने को अनिवार्य बनाया गया।

जनसंख्या नीति को देश के विभिन्न राज्यों आंध्रप्रदेश, मध्यप्रदेश महाराष्ट्र, उत्तरप्रदेश, राजस्थान, हरियाणा ने अलग अलग समय पर संशोधित कर लागू किया है।

कुछ राज्य की जनसंख्या नीति के ख़ास पहलू:-

1. पंचायत राज प्रणाली मे तीसरी संतान के कानून से प्रभावित जन-प्रतिनिधियों को पद से बर्खास्त करना एंव चुनाव लड़ने की पात्रता खत्म करना।
2. तीसरी संतान को सरकार के कल्याणकारी कार्यक्रमों से वंचित रखना।
3. परिवार नियोजन कार्यक्रम के अंतर्गत नये और टिकाऊ गर्भ-निरोधकों के इस्तेमाल को बढ़ावा देना।

राज्य जनसंख्या नीति के मुख्य उद्देश्य-

1. प्रजनन दर में कमी
2. मातृ मृत्यु दर में कमी
3. शिशु और बाल मृत्यु दर में कमी
4. अन्य सेवाओं का प्रावधान

जनसंख्या वृद्धि की तीव्रता उच्च जन्म दर और बाल मृत्यु दर की गंभीरता को देखते हुए मध्यप्रदेश सरकार ने 11 मई 2000 को एक समारोह में राज्य जनसंख्या नीति की घोषणा की। लक्ष्य आधारित कार्यक्रम के तौर पर राज्य सरकार ने जनसंख्या स्थरीकरण के लिए वर्तमान प्रजनन दर 4.0 से घटाकर 2011 तक 2.1 प्राप्त करने का लक्ष्य निर्धारित किया है। तो दूसरी ओर नीति में स्पष्ट कहा गया है कि 2011 तक शिशु मृत्यु दर 94 के वर्तमान स्तर से घटाकर 62 एवं वर्तमान मातृ मृत्यु दर को 498 प्रति लाख से घटाकर 220 करने का लक्ष्य निर्धारित किया गया है। इस लक्ष्य को प्राप्त करने के लिए राज्य सरकार ने विभिन्न विभागों शहरी स्थानीय निकायों पंचायत राज्य संस्थाओं गैर शासकीस संगठनों और निजी क्षेत्र की सहायता से प्रजनन दर एवं मृत्यु दर में कमी लाने का प्रयास निर्धारित किया है। नीति क्रियान्वयन की एक ईकाई पंचायत को सबसे सशक्त माध्यम मानते हुए जनसंख्या स्थरीकरण हेतु जनप्रतिनिधियों पर दो बच्चों का कानून लागू किया है।

मध्यप्रदेश मे मृत्यु दर

बाल मृत्यु दर	97	प्रति एक हजार जीवित बच्चों पर
मातृ मृत्यु दर	498	प्रति एक लाख जन्म पर

उपरोक्त जनसंख्या नीति के कियान्वयन हेतु अपनाई जानेवाली रणनीति।

रणनीति-

1. अनूकूल वातावरण तैयार करना।
2. राजनीतिक और सामाजिक समर्थन बढ़ाना।
3. महिलाओं का सशक्तिकरण करना।
4. किशोर शिक्षा और पारिवारिक जीवन शिक्षा शुरू करना।
5. समुदाय का समर्थन जुटाना।

उपरोक्त जनसंख्या नीति को विभिन्न संस्थाओं के माध्यम से कार्यान्वित किया जायेगा।

1. पंचायती राज संस्थाए एंव शहरी स्थानीय निकाय
2 जिला योजना समिति
3 निजी क्षेत्र
4 निगमित क्षेत्र
5 गैर–सरकारी संगठन
6 सहकारी और अन्य संस्थाए
7 विकास विभागों की भूमिका

स्थानीय निकाय और जनसंख्या नीति–

73 एवं 74 वां पंचायत राज संशोधित अधिनियम 1993 पारित करने वाला मध्यप्रदेश पहला अग्रणी राज्य रहा है। 1993 में लागू त्रिस्तरीय व्यवस्था के तहत् जिला जनपद और ग्राम पंचायत के माध्यम से 344424 प्रतिनिधियों ने सत्ता में शिरकत की इसमें एक तिहाई 116410 महिलाओं कों आरक्षण के माध्यम से पंचायत प्रतिनिधि के रूप मे सत्ता मे भागीदारी करने का मौका मिला। साथ ही 33 प्रतिशत दलित आदिवासियों को भी पंचायत मे भूमिका निभाने का अवसर मिला।

वर्तमान में मध्यप्रदेश में विक्रेन्द्रीकरण प्रणाली के तहत ग्राम स्वराज्य के माध्यम से ग्रामीण विकास का पूर्णतः कार्यभार पंचायतों को सौंप दिया गया है। सामूहिक भागीदारी के बल पर ग्रामीण विकास के लिए हर पंचायतों में आठ समितियां गठित की गई हैं जो स्वास्थ्य, शिक्षा, कृषि, सार्वजनिक संपदा, अधोसंरचना, सामाजिक सुरक्षा, न्याय, ग्राम विकास जैसे विभिन्न विषयों पर योजना बनाने से लेकर क्रियान्वित करने तक का काम करेंगी। इन समितियों में भी 33 % आरक्षण का प्रावधान रखा गया है। 73–74 वें संविधान संशोधन अधिनियम मे स्वास्थय परिवार कल्याण शिक्षा को ग्राम पंचायतों की एक जिम्मेवार बनाया गया है। राष्ट्रीय जनसंख्या नीति 2000 के संदर्भ मे पंचायती राज संस्थाएं विकेन्द्रिकृत नियोजन और कार्यक्रम को आगे बढाने का एक महत्वपूर्ण साधन है। तथापि उनकी क्षमता को साकार करने के लिए उन्हे संसाधन जुटाने की शक्तियों सहित प्रशासकीय और वित्तीय शक्तियों को और अधिक प्रत्यायोजन करके सुदृढ किये जाने की जरूरत है। इसके अतिरिक्त चूंकि निर्वाचित पंचायत स्थानों में 33 प्रतिशत स्थान महिलाओं के लिए आरक्षित है इसलिए जनसंख्या स्थिरीकरण हेतु एक लिंग संवेदी बहुक्षेत्रीय कार्यसूची को बढ़ावा देने के लिए पंचायत की प्रतिनिधि समितियां एक निर्वाचित महिला सदस्य की अध्यक्षता में बनाई जानी चाहिए जो स्थानीय स्तर पर चिंतन करेगी, योजना बनाएगी और कार्य करेगी। राष्ट्रीय स्तर पर समर्थन करेगी। परिवार कल्याण कार्यक्रम के कियान्वयन हेतु पंचायत राज संस्थाओं को उत्तरदायी मानते हुए राष्टीय स्तर पर छोटे परिवार की अवधारणा के मुताबिक दो बच्चो के कानून को नीति मे स्पष्टतः लागू किया गया है। जनसंख्या स्थिरीकरण कार्यकम हेतु गांव मे जनसंख्या पटल लगाने एंव ग्राम–पंचायतो मे जनसंख्या सम्बन्धी मुददों पर प्रत्येक वर्ष बैठकों और चर्चाओं का आयोजन करने कार्यक्रम का नियमित रूप से अनुश्रवण करने पर भी ज़ोर दिया गया है।

मध्यप्रदेश में लागू जनसंख्या नीति 2000 के मुताबिक पंचायत राज संशोधित अधिनियम 2001 की धारा 36 (डी) (1) के मुताबिक अब एसे प्रतिनिधि जिनकी दो से अधिक जीवित संतान है जिनमे से एक का जन्म 26 जनवरी 2001 को या उसके पश्चात् हुआ हो स्थानीय निकाय एवं पंचायत मंडल सहकारी सोसायटी के ऐसे निर्वाचित प्रतिनिधियों को उनके वर्तमान पदों से बर्ख़ास्त किया जायेगा। प्रभावित प्रतिनिधियों को चुनाव लडने

की पात्रता खत्म करने साथ ही कल्याणकारी योजनाओं से भी वंचित रखा जायेगा। इन प्रतिनिधियों को हटाने की प्रक्रिया इनके खिलाफ़ गांववासी सचिव एंव अन्य स्रोतों द्वारा आयी रिपोर्ट के आधार पर शुरु की जायेगी। रिपोर्ट के आधार पर जन्म प्रमाण पत्र, जन्म पंजीयन, संबंधित विभाग एवं अन्य स्रोतों के माध्यम से जानकारी एकत्र कर गहन जांच की जायेगी। कलेक्टर के अधीन न्यायालय मे जांच के दौरान सत्य घटना पाये जाने पर प्रतिनिधियों को पद से बर्खास्त किया जायेगा। उपरोक्त घटना पर कार्यवाही कलेक्टर न्यायालय में चलेगी और निर्णय देने का पूर्णतः अधिकार जिला कलेक्टर को दिया गया है। कलेक्टर के निर्णय के उपरांत प्रतिवादी चाहे तो हाईकोर्ट में अपील दायर कर सकता है। सन् 2001 से लागू दो बच्चों के इस कानून से फरवरी 2003 तक कुल 866 प्रतिनिधि प्रभावित हुए है (वर्तमान आंकड़ा बढ़ते क्रम में होगा) जिसमें 488 पंच, 357 सरपंच और 21 जनपद सदस्य शामिल हैं। प्रभावित प्रतिनिधियों के सर्वाधिक मामले 155 शिवपुरी जिले में दर्ज़ हुए हैं क़ानून से प्रभावित प्रतिनिधियों में कुछ पद से हटाये गये हैं, कुछ के खिलाफ़ जांच चल रही है और कुछ मामले कलेक्टर के न्यायालय एवं उच्च न्यायालय (जबलपुर) में विचाराधीन हैं।

मानव अधिकार विरोधी एंव महिलाओं के खिलाफ़ बने इस क़ानून से चयनित प्रतिनिधियों के समक्ष गंभीर समस्या खड़ी हो गई है जहां एक ओर पंचायत में महिला और दलित आदिवासियों को समान अधिकार देने के लिए 33 प्रतिशत आरक्षण लागू किया गया है तो दूसरी तरफ क़ानून का असर जातिगत और आर्थिक रुप से कमज़ोर इन वर्गों और ख़ासकर महिलाओं पर सबसे ज़्यादा पड़ रहा है। इस क़ानून के सभी अपात्र उम्मीदवारों में से 40 प्रतिशत महिलाएं है जिसमें 50 प्रतिशत महिलाएं अनुसूचित जाति एंव 38 प्रतिशत महिलाएं पिछड़े वर्ग की है। राष्ट्रीय जनसंख्या नीति समिति की आंशिक सदस्य रही देवकी जैन का मानना है कि यह जनसंख्या नीति गरीब अनुसूचित जाति, जनजाति और महिला विरोधी है और जनसंख्या नियंत्रण की ज़िम्मेवारी भी इन्हीं लोगों पर डाली गयी है। पंचायत में क़ानून लागू करने के पीछे सत्ता के ज़िम्मेवार लोगों का तर्क है कि स्थानीय निकाय के प्रतिनिधि पूरे समुदाय के लिए आदर्श मॉडल होते हैं इसलिए यह क़ानून आमजन को प्रभावित करने के लिए अवश्य कारगर साबित होगा। मध्यप्रदेश में सन् 2001 में लागू हुए क़ानून के कारण प्रभावित प्रतिनिधियों ख़ासतौर पर महिला प्रतिनिधियों को अनेक तरह की हिंसा का सामना करना पड़ रहा है क़ानून से प्रभावित इन प्रतिनिधियों को तलाक़, चारित्रिक दोष, बच्चा गोद दे देने जैसी मानसिक शारिरिक एंव आर्थिक हिंसा का सामना करना पड़ रहा है। क़ानून की पूर्व से जानकारी न होने के बाबजूद भी दलित आदिवासी ग़रीब अनपढ़ प्रतिनिधियो को पद से हटाया जा रहा है। जानकारी का अभाव और आर्थिक स्थिति कमज़ोर होने के कारण ये प्रतिनिधि क़ानूनी मदद से भी अपना बचाव नहीं कर पा रहे हैं। इन प्रतिनिधियों को क़ानून के चलते कई प्रकार की विसंगतियों का सामना करना पड़ रहा है।

इस क़ानून से बचने के लिए प्रभावित प्रतिनिधियों ने कई रास्ते अख़्तियार कर लिए हैं। जैसे–पत्नी को तलाक दे देना, तीसरा बच्चा गोद दे देना, अनचाहे गर्भपात (ख़ासकर कन्या भ्रूण को खत्म करने के लिए) आपरेशन (नसबंदी), ख़तरनाक गर्भ–निरोधकों का इस्तेमाल, तीसरी संतान को अपनी न मानना जैसी शंवास्पद बातें, चरित्रिक दोष जैसी गंभीर समस्याएं भी सामने आ रही हैं साथ ही पद को बचाने के लिए ये प्रतिनिधि रिकार्ड मे हेरा–फेरी कर रहे हैं जिससे भ्रष्टाचार को भी बढ़ावा मिल रहा है, और स्थानीय तनाव के कारण गलत रिपोर्ट

दर्ज करने की घटनाएं भी हो रही है, जिसके कारण हिंसा को बढ़ावा मिल रहा है।

कानून की पहली शिकार ओ.बी.सी. की महिला सरपंच....

मध्यप्रदेश के नीमच जिले के ग्राम पंचायत कनावटी की सरपंच शशि यादव ने 25 सितम्बर 2001 को दो बेटियों के बाद बेटे को जन्म दिया। उन्हें 26 जनवरी 2001 के पश्चात हुए तीसरी संतान के कानून लागू होने के कारण पद से बर्खास्त करने का नोटिस दिया। शशि यादव का कहना है कि मैंने पति, परिवार, जातिवालों के दबाब में पुत्र प्राप्ति के लिए तीसरे बच्चे को जन्म दिया। सरकार के इस फैसले से स्तब्ध शशि यादव कहती है कि भारतीय समाज में जब बच्चों का मामला आता है तो औरत की बहुत ही कम चलती है और मुझे नहीं लगता यह कोई अपराध है। शशि यादव उपरोक्त कानून की जानकारी से अनभिज्ञ थी।

उपरोक्त कानून के बारे में राज्यसभा सदस्य शबाना आजमी का कहना है कि यह कानून संतानोत्पत्ति अधिकारों का उल्लंघन करने वाला है।

स्त्री पुरुष अनुपात के मामले में कमजोर माने जाने वाले मध्यप्रदेश में प्रति 1000 पुरुषों पर 920 महिलाएं है जबकि राज्य के चम्बल संभाग के मुरैना जिले में 822 भिण्ड में 829, ग्वालियर में 847 और शिवपुरी, दतिया में मात्र 858 महिलाएं प्रति 1000 पुरुषों पर हैं। इन जिलों के औसत अनुपात का कम होना चिंतनीय विषय है। जबकि सन् 1991 की तुलना से 2001 में पूर्वी निमाड़, छिंदवाड़ा, नरसिंहपुर, दमोह जिले में स्त्रीयों का अनुपात लगातार घट रहा है। म.प्र. में साक्षरतादर कुल 64.1 प्रतिशत है जिसमें महिला साक्षरता 50.3 एवं पुरुषों की साक्षरता दर 76.80 है।

उपरोक्त स्त्री पुरुष अनुपात को देखते हुए यह विचारणीय प्रश्न है कि तीसरी संतान के कानून से स्त्रीयों की संख्या में और गिरावट आने की संभावना है।

2001 में लिंग अनुपात

मध्यप्रदेश	महिला	पुरुष
	920	1000
0 से 6 (आयु वर्ग)	929	1000

तीसरी संतान नाजायज़ है .....

जिला मुरैना ग्राम पंचायत खिरेटां के सरपंच जगराम कोरी को 26 जनवरी 2001 के पश्चात् तीसरी संतान होने के जुर्म में पद से हटाया गया जगराम कोरी ने अपने बचाव में कई तरह के हथकंडे अपनाये उसका कहना है गांव वालों ने गलत शिकायत की है। सरपंच ने अपने सात तर्को सहित एक आवेदन पत्र एस.डी.एम. तहसील अम्बाह को प्रेषित किया उसके एक तर्क में जगराम का कहना है कि उसकी पत्नी गुड्डी बाई (वास्तविक नाम पुष्पा) 5 नवम्बर 1999 से मेरा साथ छोड़कर अपने मायके उत्तरप्रदेश में रह रही है तब से आवेदक का उसके साथ कोई शारीरिक संबंध नहीं है इसलिए तीसरी संतान उसकी नहीं है जगराम कोरी ने तीसरी संतान को नाजायज ठहराते हुए पत्नी पर चरित्रहीनता का आरोप लगाकर तलाक दे दिया है।

अध्ययन की पहल.....

'समा' महिला स्वास्थ्य स्रोत समूह (दिल्ली) एक गैर शासकीय संस्था है "समा" आदिवासी दलित समुदायों के साथ स्वास्थ्य, प्रजनन अधिकार, हिंसा और महिलाओं व पिछड़े वर्ग के सामाजिक आर्थिक विकास से जुड़े मुद्दों पर सक्रिय रुप से कार्य कर रही है "समा" हर तरह के भेदभाव के खिलाफ समानता पर जोर देते हुए वंचित समुदाय की महिलाओं के सशक्तीकरण और उनके अधिकार के प्रति निष्ठा रखती है। "समा" का मुख्य काम महिला स्वास्थ्य के विभिन्न पहलुओं पर प्रशिक्षण के माध्यम से क्षमता विकसित करना स्रोत सामग्री तैयार करना, शोध समर्थन और इससे संबंधित संपर्क सूत्रों को विकसित करना है।

पिछले कुछ समय से "समा" जनसंख्या नीति के मुद्दे पर कार्यरत् है। "समा"एंव साथी संस्थाओं ने पंचायत में लागू हुए इस अप्रजातांत्रिक एवं मानव अधिकार विरोधी जनसंख्या नीति के खिलाफ राष्ट्रीय मानव अधिकार आयोग मे याचिका दायर की थी जिसके जबाब में आयोग ने राज्य मानव अधिकार आयोग को प्रश्नवादी और जिम्मेवार ठहराया। याचिका के साथ ही अभियान को मजबूत बनाने और गति देने के लिए अध्ययन की आवश्यकता भी महसूस की गई और तय किया कि अध्ययन उन प्रतिनिधियों के बीच हो जो कानून से प्रभावित हुए हैं ताकि प्रमाणित एवं ठोस तथ्यों के आधार पर आगामी कार्यक्रम की रुपरेखा बनायी जा सके।मध्यप्रदेशके 25 जिलों मे चल रहे इस अध्ययन कार्य मे भारत ज्ञान विज्ञान समिति एंव जन स्वास्थय अभियान समा के साथ मुख्य भूमिका निभा रहे है।

तीसरी संतान गोद दी .....

जिला छिंदवाड़ा तहसील परासिया की ग्राम पंचायत पलटवाड़ा की सरपंच सुदामा सरयाम और उनके पति पंच बसंत सरयाम ने अपने सरपंच, पंच पद बचाने हेतु 18.11.2001 को जन्मी तीसरी संतान को गोद दे दिया स्पष्टीकरण में सुदामा सरयाम का कहना है कि मैं 26 जनवरी 2001 के पूर्व ही गर्भवती हो चुकी थी और सरपंच पद बचाने के लिए भ्रूण हत्या नहीं करना चाहती थी जबकि उनके पति मानते हैं कि इस 5 साल के पंच, सरपंच पद के लिए संतान उत्पत्ति के इस ईश्वरीय और प्राकृतिक कार्य को नहीं रोका जा सकता वे साफ तौर पर स्वीकारते हैं कि पुत्र प्राप्ति के लिए तीसरी संतान के जन्म का संकल्प लिया था जबकि यह बच्चा भी बेटी हुई जिसे उन्होंने अपने परिचित दम्पति जिसके पूर्व से ही तीन बच्चे हैं उन्हें गोद दे दिया।

उपरोक्त कानून से प्रभावित प्रतिनिधि या तो न्यायालय की शरण में गये है या पद से हटाये जाने के पश्चात् वापिस अपनी परम्परागत भूमिका में।

अध्ययन के मुख्य उद्देश्य -

- उन पंचायत प्रतिनिधियों के अनुभवों का संकलन एवं विश्लेषण करना जिन्हें उपरोक्त कानून के तहत नोटिस दिया गया है/जांच चल रही है / हटायागया है या न्यायालय में मामला विचाराधीन है।
- उपरोक्त कानून का अध्ययन करना जिसके तहत इन्हें नोटिस जारी किया गया या पद मुक्त

किया गया है।

- प्रभावित प्रतिनिधियों खासकर महिला प्रतिनिधियों को किस तरह की कठिनाइयों का सामना करना पड़ रहा है।
- उपरोक्त कानून का असर, धर्म, जाति, लिंग, वर्ग के दृष्टिकोण से किस प्रकार हुआ है और पंचायत में इसका क्या महत्व है, का आंकलन करना।
- राजनीति की साझेदारी के मुद्दे का भारतीय संविधान के तहत अध्ययन और विश्लेषण करना।
- जनसंख्या नीति के खिलाफ न्याय के लिए इस मुद्दे को अभियान के रुप में आगे बढ़ाने के लिए प्रभावित प्रतिनिधि/क्षेत्रीय स्तर पर काम कर रही गैर–सरकारी संस्था/जनसंगठन/महिला समूह/आमजन/मीडिया को अभियान मे भागीदार बनाना।

अध्ययन के निष्कर्षो एवं साथियों के सुझाव के आधार पर अभियान को सतत् रुप से विभिन्न चरणों में चलाने के लिए लक्ष्य आधारित रुपरेखा तैयार की जायेगी।

अध्ययन के मुख्य आधार ....

- वे जिले जहां सबसे अधिक केस हुए हैं।
- हर क्षेत्रीय इकाईयों के प्रतिनिधि ज़िले।
- वे जिले जिनका स्त्री–पुरुष अनुपात तुलनात्मक रुप से अन्य ज़िलों से कम है।
- पूर्णतः आदिवासी गैर आदिवासी ज़िले।
- ग्रामीण सुदूर पिछड़े एवं शहरी क्षेत्र के अंतर्गत आने वाली पंचायतें।
- इसके अलावा उन प्रभावित प्रतिनिधियों को भी अध्ययन में शामिल किया जायेगा जिनके साथ विशेष घटनाएं घटी हैं।

अध्ययन क्षेत्र.....

पंचायत राज में लागू हुए तीसरी संतान के कानून का जनप्रतिधियों पर क्या असर पड़ रहा है का आंकलन करने के लिए दो राज्यों मध्यप्रदेश और राजस्थान को चुना गया है। उपरोक्त अध्ययन मध्यप्रदेश के भौगोलिक और सांस्कृतिक रुप से भिन्न क्षेत्र–बघेलखण्ड, बुंदेलखंड, महाकौशल मालवा, निमाड़ और चम्बल के जिलों में किया जायेगा।

अध्ययन के लिए मध्यप्रदेश के विभिन्न क्षेत्रों के 25 ज़िलों को चुना गया है हर जिले से 10 प्रतिनिधि । कुल 250 प्रतिनिधि एवं अन्य ईकाईयों जनपद, जिला पंचायत और नगर निगम के 25 प्रभावित प्रतिनिधि कुल 275 प्रतिनिधियों का दस्तावेजीकरण किया जायेगा।

रिकार्ड में हेराफेरी ....

तीसरी संतान के कानून से बचने के लिए रिकार्ड में हेराफेरी के मामले सबसे ज्यादा उजागर हो रहे हैं। इसमें पिछली तारीखों में जन्म प्रमाण पत्र बनवाना, रजिस्टर में पुराना रिकार्ड काटकर पुनः लिखना आदि।

एक घटना.....

"खण्डवा ज़िले की हरसूद तहसील की ग्राम पंचायत जोगीबेड़ा में कुछ ऐसा ही वाकया हुआ। सरपंच तोताराम के विरुद्ध ग्रामीणों ने शिकायत दर्ज की जिसमें कहा गया कि 7 जुलाई 2001 को सरपंच तोताराम को तीसरी संतान हुई है। सरपंच ने यह झूठ साबित करते हुए वास्तविक तारीख़ 08.11.2000 बताई और यह प्रसूति ज़िला अस्पताल खण्डवा में होना बताया। तोताराम की शंकास्पद बात से कलेक्टर ने गहन जांच करायी जांच के दौरान पाया कि उक्त तिथि पर किसी और महिला दुर्गाबाई निवासी खण्डवा को बच्चा हुआ था जिसका नाम रजिस्टर में पंजीकृत था जांच में स्पष्ट हुआ कि रजिस्टर में नाम काटकर ओवर राइटिंग की गई है साथ ही जन्म प्रमाण पत्र भी झूठा पाया गया।"

अध्ययन विधि.....

संपूर्ण अध्ययन सहभागी पद्धति से मध्यप्रदेश में क्षेत्रीय स्तर पर काम कर रही स्वयंसेवी संस्था/जनसंगठन एवं महिला समूह को भागीदार बनाकर किया जायेगा।

दस्तावेजीकरण का कार्य प्राथमिक और गहन सर्वे, समूह चर्चा और मुद्दे पर काम कर रहे व्यक्तियों विषय विशेषज्ञों से चर्चा के आधार कर किया जायेगा। अध्ययन के दौरान सरकारी गैर सरकारी दस्तावेजों, प्रेस कटिंग, नीतिगत दस्तावेजों का अध्ययन और विश्लेषण किया जायेगा।

आगामी कार्यक्रम.....

प्रभावित प्रतिनिधियों के अध्ययन से निकले निष्कर्षो एवं साथियों के सुझाव के आधार पर अभियान की आगामी रुपरेखा तय की जायेगी।

Rough Draft

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जनसंख्या : भ्रम और तथ्य

भ्रम - बढ़ती जनसंख्या के कारण ही भारत एक गरीब देश है। कम जनसंख्या वृद्धि होना, विकास की ओर पहला कदम है।

तथ्य - इस प्रकार के भ्रम हमें गलत निष्कर्ष पर पहुंचाते हैं, जैसे कि जन्मदर (जन्म प्रति 1000 जनसंख्या) कम होने पर भारत गरीबी को मिटाकर जीवन स्तर में सुधार ला सकता है। मगर सच यह है कि –

1998 में चीन की आबादी थी – 126 अरब, और उसका जी एन पी (GNP) यानि प्रति व्यक्ति कुल राष्ट्रीय आय (जो देश की आर्थिक स्थिति दर्शाता है) 750 यू एस डॉलर था। इसके मुकाबले भारत के आंकड़े 440 यू एस डॉलर थे, जबकि सन् 2000 में भी भारत की जनसंख्या (चीन से कहीं कम) केवल 1 अरब थी।

अगर भारत के अपने संदर्भ में ही देखा जाए तो मध्य प्रदेश और आंध्र प्रदेश दोनों राज्यों का 1998 में कुल जनसंख्या स्तर लगभग समान (78 लाख और 73 लाख) थी। फिर भी मध्य प्रदेश में प्रति व्यक्ति कुल राज्य घरेलू उत्पाद केवल 8,114 रुपये थी, जबकि आंध्र प्रदेश में यह 10,590 रुपये था।

इससे साफ जाहिर है कि विकास और जनसंख्या वृद्धि का सीधा एवं सरल रिश्ता नहीं है। विकास और आर्थिक वृद्धि इस बात पर निर्भर करती है कि जनता के स्वास्थ्य, शिक्षा और हित में कितना प्रभावशाली तरीके से निवेश किया गया है। जनता अपने को आर्थिक और सामाजिक रूप से जितना सुरक्षित महसूस करेगी उतना ही देश समृद्ध होगा।

भ्रम - आजादी के बाद भारत की खाद्य उत्पादनों की वृद्धि की अपेक्षा जनसंख्या वृद्धि अधिक हुई है।

तथ्य - आजादी के बाद से भारत की जनसंख्या 3 गुणा से थोड़ी कम बढ़ी है जबकि खाद्य उत्पादन में 4 गुणा से अधिक वृद्धि हुई है। इसलिए समय के माल्थस को गलत सिद्ध किया जिसके अनुसार गुणोत्तर श्रेणी से बढ़ती हुई जनसंख्या गुणात्मक रूप से बढ़ते हुए खाद्य उत्पादन से अधिक हो जायेगी, जो भूख और अकाल की अगुवाई करेगी। आज के हालात में समस्या पर्याप्त उत्पादन की नहीं, संसाधनों के वितरण की है, जिसके समान रूप से न होने के कारण देश में बड़े स्तर पर भुखमरी और मौत हो रही है।

भ्रम - भारत की जनसंख्या बढ़ने का मुख्य कारण आजादी के बाद से जन्म दर में तीव्र वृद्धि है।

तथ्य – इस प्रचलित धारणा के विपरीत, आजादी के बाद से, जन्म दर में कोई वृद्धि नहीं हुई है। वास्तव में मृत्यदर अच्छे पोषण, स्वास्थ्य सेवाओं, दवाइयों की उपलब्धता, चिकित्सा विज्ञान के विकास और स्वच्छता के कारण तीव्र गति से कम हुई है।

सामाजिक, आर्थिक उन्नति और आधुनीकरण से गुजरता प्रत्येक देश जनसंख्या वृद्धि के ऐसे चरण से गुजरता है, जो कि मुख्य रूप से (मध्य स्थित जनसंख्या अध्ययन परिवर्तन काल) तेजी से गिरती हुई मृत्यु दर और ऊंची जन्मदर के कारण होती है। फिर एक निश्चित समय के बाद ऐसी स्थिति आती है, जब मृत्युदर में कमी के साथ–साथ जन्म दर में भी कमी होने लगती है। भारत के कुछ राज्य केरल, तमिलनाडु और गोआ, कम जनसंख्या वृद्धि की इस स्थिति/चरण में पहुँच चुके हैं।

भ्रमः - सभी सामाजिक समस्याओं - जैसे कि पर्यावरण अवनति, बेरोज़गारी से लेकर शहरों में ट्रैफिक जाम तक की मुख्य जड़ जनसंख्या है।

तथ्य : ऊपर लिखित समस्याओं का मुख्य कारण संसाधनों का असमान वितरण है।

पर्यावरण अवनति का मुख्य कारण है औद्योगीकरण और शहरीकरण। इन के कारण जमीन की ऊपरी सतह का खिसकना (भूशरण), विद्युतशक्ति व संसाधनों की बढ़ती हुई मांग है।

शहरों में ट्रैफिक जाम - ट्रैफिक जाम का आरोप बढ़ती जनसंख्या पर नहीं लगाया जा सकता। यह तो मुट्ठीभर समृद्ध व अमीर वर्ग के लोगों की बढ़ते हुए आरामदायक जीवन स्तर की मांग के कारण है। जो परिवार पहले एक ही वाहन लेने में सक्षम थे, अब उनके पास कम से कम 3-4 वाहन है। समृद्ध क्षेत्रों में प्रति व्यक्ति उपभोग भयंकर रूप से बढ़ गया है और साधन एक तरफ अधिक केन्द्रित हो गये हैं।

बेरोजगारी - उपलब्ध रोजगार अवसरों में बिना हुनर और कम हुनर वाले श्रमिकों के लिए कोई जगह नहीं है। जैसे कि उभरते हुए उद्योगों में मूलतः हुनर वाला काम या वैश्वीकरण की ताकतों ने लघु उद्योगों को पूरी तरह से समाप्त कर दिया है और एक खास तरह के हुनर के लोगों को ही रोजगार के अवसर दिए हैं। लघु उद्योगों के अन्तरगत आने वाले बिना हुनर या कम हुनर वाले श्रमिक थे, जो आधुनिक तकनीकी जानकारियों से परिचित नहीं है इसलिए या तो उन्हें काम ही नहीं मिल रहा या फिर बहुत ही कम पैसे दिये जाते हैं।

समा

समा-महिलाओं और स्वास्थ्य के लिए संसाधन समूह

जे–59, पहली मंज़िल, नई दिल्ली – 110017

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- Primary Health Centers and subcentres with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from linkages;
- A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers;
- Enhanced content of Primary Health Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological and preventive measures.
- Surveillance centres at block level to monitor the local epedemiological situation and tertiary care with all speciality services, availaible in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based humanpower plan for the health sector be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend towards over-production of personnel trained in super-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. Steps

be taken forthwith to close down private medical colleges charging fees higher than state colleges or taking any form of donations, and to eliminate illegal private tuition by teachers in medical colleges. At least an year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education be made mandatory, without which license to practice not be issued. Similarly, three years of rural posting after post graduation be made compulsory.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:
   - ban all irrational and hazardous drugs;
   - introduce production quotas and price ceiling for essential drugs;
   - promote compulsory use of generic names;
   - regulate advertisements, promotion and marketing of all medications based on ethical criteria;
   - formulate guidelines for use of old and new vaccines;
   - control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology;
   - recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices;
   - promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:
    - integration of health impact assessment into all development projects;
    - decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners;
    - reorientation of measures to check STDs/AIDS through universal sex education, checking social disruption and displacement and commercialisation of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseaseslike diabetes, cancers, heart diseases, etc. to be available to all att appropriate levels of medical care.

14. Women-centered health initiatives that include:
    - awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in nutrition and health-care;
    - preventive and curative measures to deal with health consequences of womens' work and domestic violence;
    - complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector;
    - special support structures that focus on single, deserted, widowed women and commercial sex workers; gender sensitive services to deal with reproductive health including reproductive system illnesses, maternal health, abortion, and infertility;
    - vigorous public campaign accompanied by legal and administrative action against female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives which include:
    - a comprehensive child rights code, adequate budgetary allocation for universalisation of child care services, a expanded and revitalized ICDS programme and ensuring adequate support to working women to facilitate child care, especially breast feeding;

    - comprehensive measures to prevent child abuse and sexual abuse;
    - educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:
    - banning of hazardous technologies in industry and agriculture;
    - worker centered monitoring of working conditions with the onus of ensuring a safe workplace on the management;
    - reorientation of medical services for early detection of occupational disease;
    - special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. Measures towards mental health that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support and community based management of mental health problems be promoted. Services for early detection and integrated management of mental health problems be integrated with Primary Health Care.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising and sale of their products to the young, and provision of services for de-addiction.

जनसंख्या नीति

किसका फायदा? किसका नुकसान?

शमा

जनसंख्या नीति

किसका फायदा? किसका नुकसान?

समा – महिलाओं और स्वास्थ्य के लिए संसाधान समूह

इस पुस्तिका में दी गई जानकारी आवश्यक्तानुसार
उपयोग में लाई जा सकती है। स्त्रोत का उल्लेख अवश्य करें।

साभार – अभियान से जुड़े सभी साथी

प्रथम प्रकाशन : 2003

चित्रांकन : समा–महिलाओं और स्वास्थ्य के लिए संसाधन समूह
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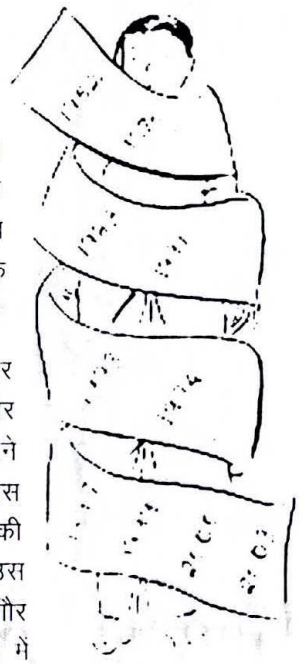
परिचय

जनसंख्या वृद्धि देश की तमाम समस्याओं – जैसे गरीबी, सामाजिक असमानतायें, पर्यावरण अवनति आदि को समझाने का एक आसान तरीका बनाया गया है। इसी तर्क पर आधारित है हमारे देश का जनसंख्या नियंत्रण कार्यक्रम जो गरीबों और खासकर औरतों को निशाना बनाता है। जनसंख्या नियंत्रण समर्थक इस भ्रम का प्रचार करते हैं कि जनसंख्या वृद्धि ही गरीबी की मुख्य जड़ है पर वह इस तथ्य को आसानी से नकारते हैं कि गरीबी का कारण जनसंख्या वृद्धि नहीं परन्तु संसाधनों का असमान बँटवारा है।

मानव विकास रिपोर्ट के अनुसार संसार के उन्नत आय देश के 20 प्रतिशत अमीरों का कुल निजी उपभोग 86 प्रतिशत है जबकि 20 प्रतिशत गरीब लोगों की निजी उपभोग 1.3 प्रतिशत है। आज भी आधी से ज्यादा जनसंख्या गरीबी में रह रही है जिसका मुख्य कारण है संसाधनों का असमान बँटवारा।

गरीबी को हटाना, मानव अधिकारों की सुरक्षा, पर्यावरण स्थायीकरण, महिलाओं को सशक्त करना, गरीबों और अमीरों के बीच अनौचित्य आर्थिक फासले को सुधारना आज के समय का सबसे अहम मुद्दा है। इन खास कारणों को नकारकर सरकार ने सिर्फ जनसंख्या 'नियंत्रण' को ही मुख्य मुद्दा बनाया है।

जनसंख्या नियंत्रण या परिवार नियोजन



भारत में पहला जनसंख्या नियंत्रण कार्यक्रम सन् 1952 में शुरू हुआ। तब उसे परिवार नियोजन कार्यक्रम कहा जाता था, जिसका ज़ोर बच्चों के बीच अन्तर रखने पर था। 1960 के दशक में कार्यक्रम का झुकाव लक्ष्य और प्रोत्साहन की तरफ हुआ जिसके अन्तरगत स्वास्थ्य कार्यक्रताओं को लक्ष्य पूर्ति पर आर्थिक रूप में पुरस्कार दिया जाने लगा।

70 के दशक में नसबंदी पर ज़ोर हुआ और पुरूषों को इसके लिए तैयार करने पर ज़ोर दिया गया। 1975 में आपातकाल लागू करने के साथ, गरीबों पर एक जंग सी छेड़ी गई। इस दौरान ज़ोर–जबरदस्ती से सैकड़ों पुरूषों की नसबंदी करवाई गई। यह एक कारण उस समय की केन्द्र सरकार गिरने का था। गौर करने की बात यह है कि इसके बाद भविष्य में किसी भी सरकार ने पुरूष नसबंदी पर ज़ोर नहीं दिया और औरतों को एक 'आसान और सुरक्षित' लक्ष्य मानते हुए उन्हें केन्द्रित किया। आज भी औरतों की नसबंदी पर तो ज़ोर है ही, लेकिन अब यह जबरदस्ती अन्य तरीकों से की जा रही है। उदाहरण के तहत आंध्र प्रदेश में औरत के दो से ज़्यादा बच्चे होने पर वह डवाक्रा (DWCRA) योजना या अन्य सामाजिक कल्याण योजनाओं का फ़ायदा नहीं उठा सकती। यदि हम इन बातों का मूल्यांकन करें तो पायेंगे कि हर मोड़ पर मानव अधिकारों का हनन हो रहा है।

इसी तरह 80 और 90 के दशक में महिलाओं को 'विस्तृत चयन' का अधिकार देते हुए उनके बहाने से हॉरमोनल गर्भनिरोधक जैसे 'इंजक्टेबल' (डैपो प्रोवेरा और नैट एन) आदि बिना परिक्षण किये बाजार में लाये गये।

इसी दौरान उदारीकरण और ढांचा समायोजन कार्यक्रमों के कारण जन स्वास्थ्य सेवाओं का निजीकरण बहुत तेजी से हो रहा है। मूल स्वास्थ्य सेवाओं और विशेष

राष्ट्रीय जनसंख्या नियंत्रण का कालानुक्रम	
1952	– भारत ने परिवार नियोजन कार्यक्रम को अपनाया।
1976	– राष्ट्रीय जनसंख्या नीति का कथन एवं विवरण किया गया।
1983	– राष्ट्रीय स्वास्थ्य नीति ने छोटे परिवारों को अपनाने पर जोर दिया गया।
1991	– जनसंख्या पर समिति बैठाई गई जिसने राष्ट्रीय जनसंख्या नीति को अपनाने पर दबाव डाला गया।
1993	– उस विशेषज्ञ समिति ने राष्ट्रीय जनसंख्या नीति की एक रूपरेखा बनाई जिसमें देश कि जनसंख्या एवं सामाजिक विकास पर जोर दिया।
1994	– मिस्र की राजधानी काईरो में 'जनसंख्या एवं विकास पर अन्तराष्ट्रीय सम्मेलन' (आई.सी.पी.डी.) आयोजित हुआ। इस मंच ने लक्ष्य मुक्त नजरिये को अपनाया और भारत सरकार भी एक हस्ताक्षरकर्ता बना।
1997	– प्रजनन एवं बाल स्वास्थ्य कार्यक्रम (आर.सी.एच.) शुरू किया गया।
1999	– राष्ट्रीय जनसंख्या नीति पर काफी चर्चा हुई।
2000	– संसद ने फरवरी 2000 में राष्ट्रीय जनसंख्या नीति को मंजूर किया।

दवाओं की कीमत अधिकतर जनसंख्या की पहुंच से बाहर होती जा रही है। आजादी के 55 साल बाद भी ज्यादातर लोग खासकर महिलायें – अनीमिया, दस्त, टी.बी./तपेदिक और मलेरिया जैसी बीमारियों से मर रहे हैं।

किन्तु गौर करने की बात है कि राष्ट्रीय जनसंख्या नीति केवल जनसंख्या को नियंत्रण करने पर ही ध्यान केन्द्रित कर पाई और सामाजिक विकास के लक्ष्य में उसने किसी भी तरह की भूमिका नहीं निभाई।

औरतों की मृत्यु के मुख्य कारण

क्र.म.	कारण	प्रतिशत
1.	प्रसव सम्बन्धी	2.93%
2.	दुर्घटना से	6.82%
3.	बुढ़ापे से सम्बन्धित तकलीफों से	25.61%
4.	संक्रमित बीमारिगों या तंत्र सम्बन्धित बीमारियों से	64.6%

स्रोत : भारत सरकार सर्वे 1982-83

यानि इन आंकड़ों से साफ जाहिर है कि औरतों में मृत्यु का कारण, प्रसव सम्बन्धी सिर्फ बच्चा पैदा होने से सम्बन्धित नहीं है। निम्न आंकड़ों के अनुसार मातृ मृत्यु की तुलना में संक्रमित बीमारियों से मरने वाली औरतों की संख्या दोगुनी है। नीचे दी गई तालिका में मातृ मृत्यु (प्रसव सम्बंधी कारणों से मौत)एवं संक्रमित बीमारियों से होने वाली मृत्यु के बीच एक तुलनात्मक अनुपात दर्शाया गया है–

वर्ष	मातृ मृत्यु	संक्रमित बीमारियों	कुल मृत्यु
1982	161 (2.24)	443 (6.21)	7129
1984	175 (2.21)	470 (5.95)	7902
1986	176 (2.15)	504 (6.16)	8187
1988	182 (1.77)	532 (5.74)	10283
1990	208 (2.26)	490 (5.34)	9180
1991	251 (2.50)	497 (4.96)	10025
1992	296 (2.36)	624 (5.49)	11373
1993	384 (2.98)	775 (5.83)	13291
स्त्रोतः Reproductive Health in Primary Health Care : CSMCH, JNU			

इन आंकड़ों की असलियत को नकारते हुए, सरकार कुछ दाता संस्थाओं से हाथ मिलाकर औरतों की मृत्यु के बाकि सभी कारणों को अनदेखा कर रही है और पूरा ध्यान जनसंख्या वृद्धि पर केन्द्रित करते हुये महंगे और खतरनाक गर्भनिरोधक तकनीकों का प्रचार कर रही है। परंतु अरबों रुपये खर्च करने के बावजूद एवं लक्ष्य मुक्त (टारगेट–फ्री अप्रोच) कार्य प्रणाली अपनाने के बाद भी हमें जन्म दर में किसी प्रकार का प्रभाव देखने को नहीं मिला। इसके बहुत से कारण हो सकते हैं जैसे कि –

पहला, नीति निरधारक एवं सामान्य मनुष्य के बीच में हित, समझ एवं प्राथमिकता का अंतर नीति निरधारक सामान्य जनता को एक–शिला जनसमूह की तरह देखता है जो भावहीन है और इन योजनाओं, नीति एवं कार्यक्रम को बिना सवाल किये अपना ले। इन दोनों के बीच में किसी भी तरह की बातचीत सम्भव नहीं है। ऐसी स्थिति में योजनाकर्ता जिनकी प्राथमिकता जन्म दर को केवल से रोकना है क्या ऐसे लोग भूमिहीन मजदूरों की पाँच या छः बच्चों कि जरूरतों को समझ सकेगें?

जब योजनाकर्ता गर्भ निरोधक तकनीकों के बारे में सोचता है तो वहीं उनके

सब सहायक कारणों से दूर कर देता है। उदाहरणतः कि संसार भर में सभी लोग छोटे परिवार को अपनाने के लिए तैयार हैं बशर्ते उनके जीवन स्तर में सुधार लाया जाये।

हैरियत की बात यह है कि धीरे–धीरे सरकार प्राथमिक स्वास्थ्य सेवाओं में बजट बढ़ा रही है मगर परिवार नियोजन को कहीं अधिक प्राथमिकता दे रही है। जैसे सन् 1998-1999 में स्वास्थ्य का बजट 1145.2 करोड़ था मगर परिवार कल्याण पर 2239.35 खर्च किया। विडम्बना यह है कि सारे विकास एक ऐसे देश में हो रहे हैं जहाँ कि 80 प्रतिशत जनसंख्या की सम्मान पूर्वक जीवन व्यापन के लिए मौलिक जरूरतों जैसे – भोजन, साफ पानी, स्वास्थ्य, घर और शिक्षा तक भी पहुँच नहीं है।

वार्षिक खर्चा (करोड़ों में)		
वर्ष	**स्वास्थ्य पर**	**परिवार कल्याण पर**
89-90	431	645.04
90-91	479.42	794.72
91-92	525.31	866.6
92-93	734.15	1051.41
93-94	843.94	1284.91
94-95	993.89	1442.03
97-98	920.2	1750.35
98-99	1145.2	2239.35
स्त्रोत : व्यय बजट 1989 से 99, भाग–2, भारत सरकार		

आज आधी से ज्यादा जनसंख्या को दो वक्त का खाना नसीब नहीं होता महिला रोज पानी एवं लकड़ी के लिए मीलों चलती हैं, अरबों की संख्या में लोग रोज़गार की तलाश में गांव से शहर की ओर जा रहे हैं और सड़कों पर रहते है। सन् 2000 के बाद भी संक्रमित बीमारियां जैसे कि टी.बी. मलेरिया से आज भी लाखों लोग मर रहे हैं इन सब का एक प्रमुख कारण है – देश के हर कोने तक स्वास्थ्य सेवायें पहुंचने की विफलतायें।

राष्ट्रीय जनसंख्या नीति - एक विचार और आलोचना

1994 के काइरो सम्मेलन से पहले 1993 में नई जनसंख्या नीति को अधिकारिता बनाने के लिए भारत सरकार ने एक समूह नियुक्त किया। यह समूह जो 'स्वामीनाथन समिति' के नाम से जाना जाता है, उन पर एक नीति प्रारूप तैयार करने की जिम्मेदारी सौंपी गई।

इस विशेषज्ञ समूह की सिफारिशों पर आधारित सरकार ने राष्ट्रीय जनसंख्या नीति, (गवर्नमैंट ऑफ इंडियाः 1996:13) पर एक प्रारुप कथन कि घोषणा की। 2000 के शुरू में इस प्रारूप में कायरो सम्मेलन की सिफारिशों के साथ फेरबदल किया गया और उसे संसद द्वारा स्वीकारा गया। सन् 2000 फरवरी में **राष्ट्रीय जनसंख्या नीति** लागू की गई।

राष्ट्रीय जनसंख्या नीति में क्या है?

इसका **तात्कालिक उद्देश्य** है गर्भ–निरोधक, स्वास्थ्य परिचर्या सम्बन्धी आधारभूत ढाँचे तथा स्वास्थ्य कार्मिकों की पूरी न हुई जरूरतों पर ध्यान देना तथा बुनियादी प्रजनन और बाल स्वास्थ्य परिचर्या के लिए एकीकृत सेवा प्रदानगी की व्यवस्था करना है। इसमें श्रम, उपकरण, दवाईयां और ढ़ांचा आदि सभी शामिल हैं।

मध्यकालिक उद्देश्य अन्तर्क्षेत्रीय प्रचालनात्मक (आपरेशनल) कार्यनीतियों को तेजी से कार्यान्वित करके 2010 तक कुल प्रजनन दर को प्रतिस्थापन स्तर तक लाना है। सभी विभाग जैसे कि मानव संसाधन विकास, महिला और शिशु, कृषि और ग्रामीण आपस में एक साथ जुड़कर उर्वरता को नीचे लाने की कोशिश करना।

दीर्घकालिक उद्देश्य सतत आर्थिक वृद्धि सामाजिक विकास और पर्यावरणिक संरक्षण की अपेक्षाओं के अनुरूप स्तर पर 2045 तक स्थिर जनसंख्या हासिल करना है।

2010 के लिए राष्ट्रीय सामाजिक जनांकिकीय लक्ष्य

1. बुनियादी प्रजनन और बाल स्वास्थ्य सम्बन्धी सेवाओं, आपूर्तियों और आधारभूत ढाँचे की पूरी न हुई जरूरतों पर ध्यान देना।

2. स्कूल शिक्षा को 14 वर्ष की आयु तक मुफ्त और अनिवार्य बनाना और प्राथमिक और माध्यमिक स्तरों पर बीच में स्कूल छोड देने वाले लड़कों और लड़कियों के प्रतिशत को कम करके 20 प्रतिशत से नीचे लाना।
3. शिशु मृत्यु दर को कम करके उसे प्रत्येक 1000 जीवित जन्मों पर 30 से नीचे लाना।
4. मातृ मृत्यु दर को कम करके प्रत्येक 1,00,000 जीवित जन्मों पर 100 से नीचे लाना।
5. सभी वैक्सीन निवारणीय रोगों की रोकथाम के लिए बच्चों का व्यापक रोग प्रतिरक्षण हासिल करना।
6. लड़कियों के विवाह देर से करने, 18 वर्ष से पहले नहीं और बेहतर रूप से 20 वर्ष की आयु के बाद करने को बढ़ावा देना।
7. 2016 तक 80 प्रतिशत सांस्थानिक प्रसव और प्रशिक्षित व्यक्तियों द्वारा 100 प्रतिशत प्रसव कराना।
8. सूचना/परामर्श की व्यापक सुलभता प्राप्त करना और ढेर सारे विकल्पों के साथ प्रजनन विनियमन और गर्भनिरोधन के लिए सेवायें प्रदान करना।
9. जन्म, मृत्यु, विवाह और गर्भ का 100 प्रतिशत पंजीकरण प्राप्त करवाना।
10. एड्स के फैलने को नियंत्रित करना और जनन–मार्गीय संक्रमणों और यौन संचारित संक्रमणों के उपचार और राष्ट्रीय एड्स नियंत्रण संगठन के बीच और अधिक एकीकरण को बढ़ावा देना।
11. संक्रामक रोगों का निवारण और नियंत्रण।
12. प्रजनन और बाल स्वास्थ्य सेवाओं की व्यवस्था करने और इन्हें परिवारों तक पहुंचाने में भारतीय चिकित्सा पद्धतियों को शामिल करना।
13. कुल प्रजनन दर के प्रतिस्थापन स्तरों को प्राप्त करने के लिए छोटे परिवार के मानदंड को जोरदार ढंग से प्रोत्साहित करना।
14. सम्बन्धित सामाजिक क्षेत्र के कार्यक्रमों को एक ही स्थान से कार्यान्वित करना ताकि परिवार कल्याण कार्यक्रम लोक संकेन्द्रित कार्यक्रम बन सकें।

इन लक्ष्यों की प्राप्ति के लिए 12 रणनीति चुने गये हैं जिसमें निम्नलिखित शामिल हैं -

❖ **योजना और कार्यक्रम कार्यान्वयन का पंचायती राज संस्था द्वारा विकेन्द्रीकरण -**

इसका मतलब कि जन्मों, मौतों, विवाहों और गर्भवस्थाओं के अनिवार्य पंजीकरण में छोटे परिवार के मानदंड को व्यापक बनाने में, सुरक्षित प्रसवों में वृद्धि करने में, नवजात और मातृ मृत्यु में कमी लाने में और 14 वर्ष की आयु तक अनिवार्य शिक्षा को बढ़ावा देने में अनुकरणीय कार्यनिष्पादन को दर्शाने वाली पंचायतों को राष्ट्रीय स्तर पर मान्यता दी जायेगी और सम्मानित किया जायेगा।

❖ **ग्रामीण स्तर पर स्वास्थ्य सेवाओं को एकीकृत कर प्रदान करना -**

अपर्याप्त स्वास्थ्य सेवाओं को ग्रामीण स्तर पर मोबाइल क्लीनिक, परामर्श केन्द्र, प्रजनन व शिशु स्वास्थ्य और जन्म व मृत्यु का पंजीकरण उपलब्ध करवाना।

❖ **बेहतर स्वास्थ्य और पोषण के लिए महिलाओं को अधिकार सम्पन्न बनाना।**

पंचायती राज द्वारा लड़कियों की शिक्षा, सुरक्षित मातृत्व एवं प्रजनन व शिशु स्वाथ्य की जिम्मेदारी उठाना चाहिये।

❖ **बाल स्वास्थ्य और जीवन रक्षा**

नवजात बाल मृत्यु दर में कमी लाना, उपकेन्द्रीय स्तर पर बाल अस्पताल खोलना, सुक्ष्म पोषक (Micro Nutrients) प्रदान करना।

❖ **परिवार कल्याण सेवाओं के लिए पूरी न हुई जरूरतों को पूरा करना -**

ग्रामीण तथा शहरी दोनों क्षेत्रों में गर्भ निरोधकों, एकीकृत सेवा प्रदानगी के लिए उपकरण, गर्भ निरोधक और परामर्श सेवायें, एम्बूलैंस सेवायें, अभिनव सामाजिक वितरण योजनाओं, उप–केंद्र तथा प्राथमिक स्वास्थ्य केन्द्र के स्तरों पर स्वास्थ्य सम्बन्धी आधारभूत ढांचे को मजबूत करना, बल प्रदान करना तथा उत्तरदायी बनाना महत्वपूर्ण है।

❖ **अल्प सेवित जनसंख्या समूह पर विशेष रूप से ध्यान केन्द्रित करना -**

शहरी झुग्गी झोपड़ियाँ, आदिवासी समुदायें, पहाड़ी क्षेत्र सेवायें उपलब्ध करना।

❖ **विविध स्वास्थ्य परिचर्या प्रदायक**

नीजि चिकित्सा व्यवसायियों एवं सरकारी चिकित्सकों को प्रचलित करना।

❖ **गैर-सरकारी संगठनों और निजी क्षेत्र के साथ सहयोग और प्रतिबद्धतायें -**

जहाँ सरकारी उपाय या क्षमता अपर्याप्त है और निजी क्षेत्र की सहभागिता अव्यवहार्य है वहाँ गैर–सरकारी संगठनों द्वारा सकेन्द्रित सेवा प्रदायगी प्रभावशाली ढंग से सरकारी प्रयासों की पूरक बनाना।

❖ **भारतीय चिकित्सा पद्धतियों एवं होम्योपैथी को मुख्य धारा में लाना-**

संस्थागत अईताप्राप्त भारतीय चिकित्सा पद्धति एवं होम्योपैथी चिकित्सा के व्यवसायियों को प्रजनन एवं शिशु स्वास्थ्य परिचर्या के सम्बन्ध में उपयुक्त प्रशिक्षण देने, उनमें जागरूकता बढ़ाने और उनके कौशल का विकास करने की व्यवस्था को शामिल करना।

❖ **गर्भनिरोधक प्रौद्योगिकी और प्रजनन एवं बाल स्वास्थ्य के सम्बन्ध में अनुसंधान -**

मातृ, शिशु और प्रजनन सेवा सुरक्षा के मुददे पर क्षेत्रिय खोज और क्लीनिक प्रयोगशाला कि प्रक्रिया की सीमा को बढ़ाना और प्रोत्साहित करना।

❖ **वयोवृद्ध लोगों के लिये व्यवस्था करना -**

वयोवृद्ध लोगों के लिए चिकित्सा स्वास्थ्य परिचर्या प्रदान हेतु ग्रामीण तथा शहरी केंद्रों और अस्पतालों को सुग्राही बनाना, प्रशिक्षण देना, वृद्धों को आर्थिक तौर पर आत्मनिर्भर बनाने वाली औपचारिक तथा अनौपचारिक को तैयार करना तथा प्राथमिक, द्वितीयक एवं तृतीयक स्तरों पर प्राथमिक स्वास्थ्य केन्द्रों, सामुदायिक स्वास्थ्य केन्द्रों और बड़े बच्चों को अपने वृद्ध माता–पिता की देखभाल करने के लिए उत्साहित करने हेतु प्रोत्साहन का पता लगाना शामिल है।

❖ **सूचना, शिक्षा तथा संप्रेषण**

परिवार कल्याण के सूचना, शिक्षा तथा संप्रेषण संदेश स्पष्ट होना और इन्हें देश के पूरे क्षेत्रों में साक्षर एवं निरक्षर तथा स्थानीय बोलियों में प्रचारित किया जाना।

राष्ट्रीय जनसंख्या नीति पर एक आलोचना

1. राष्ट्रीय जनसंख्या नीति विकास की धारणा को अपनाने में असमर्थ है। राष्ट्रीय जनसंख्या नीति के अन्दर कहीं भी रोज़गार, भोजन, स्वास्थ्य, आय जैसे अहम मुद्दों को शामिल नहीं किया गया है। यह नीति सिर्फ गरीबी और अविकास को जोड़ती है एवं जनसंख्या के अन्य निर्धारक को जोड़ने में असफल है।

   नीति ने जनसंख्या स्थायीकरण को सिर्फ आर्थिक विकास से जोड़ा है। लेकिन जनसंख्या को स्वास्थ्य, साफ पीने के पानी, रोजगार, आय जैसे मुददों से हटकर नहीं देख सकते। इस नीति को सिर्फ आर्थिक विकास पर ध्यान केन्द्रित न करके अन्य सामाजिक विकास पर भी ध्यान देना चाहिए।

2. राष्ट्रीय जनसंख्या नीति कहीं पर भी गर्भ-निरोधक, सामर्थक एवं प्राथमिक स्वास्थ्य सेवा की बात नहीं की। आज भी यदि हम देखें तो पायेगें संक्रमित बीमारियों से होने वाली मृत्यु ऊँचे दर पर है परन्तु इस नीति ने उनको कम करने के तरीकों पर अभी तक ध्यान केन्द्रित नहीं किया।

3. आज के समय में पंचायती राज संस्थाओं को गृह-शासन का अधिकार देना चाहिये। उनको योजना बनाने में, मानिटरिंग, वित्त सम्बन्धी योजनाओं को कार्यान्वित करने जैसी अहम भूमिका में नीति के अन्तरगत कोई भागीदारी नहीं दी गई।

4. जनसंख्या नीति का दावा है कि वह महिला सशक्तिकरण एवं उनकी जरूरतों पर ध्यान केन्द्रित करती है। लेकिन यदि हम गौर से इस नीति को देखें तो उसमें भेदभाव साफ झलकता हुआ पायेगें। इस नीति में महिलाओं को अपने शरीरिक समझ का सक्रिय अभिकर्ता मानने की जगह उन्हें गर्भनिरोधक और मातृ स्वास्थ्य सेवाओं के निष्क्रिय अभिकर्ता के रूप में देखा जाता है। इस तरह से यह बात साफ निकलकर आई कि महिलाओं को जानकारी और अपनी मर्जी के आधार पर अपने स्वास्थ्य को पहचानने का कोई मौका नहीं जाता। साथ ही साथ इस नीति ने गर्भ निरोधक अपनाने में पुरूष की भागीदारी पर भी जोर नहीं दिया जाता।

इसी प्रकार से पंचायती राज संस्था में देखें तो पायेगें की एक ओर तो महिला को पंचायती राज संस्था का मुख्य अंग माना गया है वही दूसरी ओर उसे योजना बनाने एवं फैसले लेने कि जिम्मेदारी से दूर रखा गया है।

5. समाज में महिलाओं को सिर्फ प्रजनन क्षमता के आधार पर देखा जाता है। महिलाओं का दर्जा सिर्फ बच्चा पैदा करना एवं उन्हें पालने तक ही सीमित रखा गया। किन्तु किशोरियों एवं प्रौढ महिला की तरफ ध्यान नहीं देते।

6. आज हमारे देश की एक और अहम समस्या जिस पर इस नीति ने ध्यान नहीं देती – वह है बढता हुआ 'निजीकरण'। पहले जहाँ स्वास्थ्य सेवायें निःशुल्क प्रदान की जाती थी वहीं शुल्क लेने की प्रथा निजी अस्पतालों में नहीं परन्तु सार्वजनिक एवं प्राथमिक स्वास्थ्य केन्द्र में भी शुरू की गई है। भारत में जहाँ पर 33 प्रतिशत से ज्यादा जनसंख्या गरीबी रेखा के नीचे रहती है जब उनके पास खाने के लिए पैसे नहीं होते तो जाँच, दवाइयों और शुल्क पर कहाँ से पैसे खर्चा करेंगे? कई अध्ययनों से साफ पता चलता है कि परिवार के पूरे खर्च में स्वास्थ्य को प्राथमिकता नहीं दी जाती है और अधिकतर परिवारों में गरीबी के कारण स्वास्थ्य के ऊपर खर्चे के लिए पैसे नहीं होते जिसके कारण उन्हें कर्जा लेना पडता है। यह कर्जा लेने की प्रथा और सही समय पर ब्याज नही चुका पाना गरीबों को और गरीब बना रही है। किन्तु निजीकरण से होने वाली परेशानियों पर यह नीति ने कुछ नहीं दर्शाया है।

7. राष्ट्रीय जनसंख्या नीति ने 2016 तक 80 प्रतिशत संस्थागत प्रसव का लक्ष्य रखा है। हमें इस बात पर गौर करना होगा कि हमारे देश कि 75 प्रतिशत जनसंख्या ग्रामीण है। आज भी हमारे देश में कुछ ऐसे गाँव हैं जहाँ पर बिजली पानी तक की सुविधा नहीं है। गाँव की महिलाओं को अपने घरेलू एवं स्वास्थ्य सम्बन्धी कार्यो के लिए बीस-बीस किलोमीटर पैदल चलना पड़ता है। जब उन गाँवों में अस्पताल ही नहीं है तो यह नीति संस्थागत प्रसव की बात कैसे कर सकती है? संस्थागत प्रसव की बात से पहले, अच्छी संख्या में अस्पताल एवं उनके अन्दर मिलने वाली सुविधायें होनी चाहिए ताकि महिलाओं की उन तक पहुँच हो।

   अस्पताल भर्ती या संस्थागतीकरण होने से 'स्वास्थ्य निजीकरण' की भी

राष्ट्रीय जनसंख्या नीति एंव राज्य जनसंख्या नीति

जैसे पहले ही बताया गया की हमारी राष्ट्रीय जनसंख्या नीति का मुख्य उद्देश्य स्वास्थ्य एवं विकास न होकर जनसंख्या स्थायीकरण पर जोर देती है। अफ़सोस की बात है कि राष्ट्रीय जनसंख्या नीति होने के बावजूद बहुत से राज्यों ने राज्य जनसंख्या नीति को अपनाया है। इन राज्य जनसंख्या नीतियों की अपनी विशेषतायें हैं जिसने कि राष्ट्रीय जनसंख्या नीति का पूर्ण उल्लंघन किया है। बहुत से राज्य जनसंख्या नीति ने इनाम एवं दण्ड देने कि नीति को अपनाया है। इन राज्य जनसंख्या नीति की मुख्य विशेषतायें इस प्रकार से हैं–

* तीसरी संतान के माता–पिता को विकास और कल्याणकारी कार्यक्रमों से वंचित रखना।
* पंचायती राज के अन्तरगत तीसरी संतान के जन्म लेने पर पंचायती पद–अधिकारियों को पद से हटाना एवं पंचायत के चुनाव में खड़े होने पर रोक लगाना।
* परिवार नियोजन कार्यक्रम के अन्तरगत नये एवं लम्बे गर्भ– निरोधक तरीकों का इस्तेमाल करना।

जनसंख्या नीति को देश के विभिन्न राज्यों आंध्रप्रदेश, मध्यप्रदेश, उत्तर प्रदेश, राजस्थान, महाराष्ट्र और हरियाणा ने अलग–अलग समय पर संशोधित कर लागू किया जिनके कुछ ख.स पहलू इस प्रकार से हैं –

राज्य	जनसंख्या नीति की कुछ विशेषतायें
उत्तर प्रदेश	* उन जोड़ों को सरकारी नौकरी से हटाना जो कि शादी कानूनी उम्र से पहले करते है। * इस नीति में लक्ष्य मुक्त दृष्टिकोण के विपरित योजना बनाई जिसमें इन्होंने 2005 तक का लक्ष्य 10 लाख नसबंदी एवं 30 लाख बच्चों के बीच दूरी रखने के तरीके पर जोर दिया।
आंध्र प्रदेश	* गाँवों के विकास कार्यक्रम स्कूल बनाना एवं अन्य कल्याणकारी योजनाओं पर आधारित है।
राजस्थान	* दो बच्चों की नीति के अन्तरगत सिर्फ पंचायती पद अधिकारियों को उनके पद से हटाना ही नहीं परन्तु सहकारी संस्था से भी पद अधिकारियों को हटाना।
मध्य प्रदेश	* तीसरी संतान को कल्याणकारी कार्यक्रमों से वंचित रखना * तीसरी संतान के जन्म लेने पर पंचायती पद–अधिकारियों को पद से हटाना एवं चुनाव में खड़े होने पर रोक लगाना
महाराष्ट्र	* दो बच्चों की नीति के तहत तीसरी संतान को 14 साल के मुफ्त शिक्षा के अधिकार से वंचित रखना। * अन्य कल्याणकारी योजनाओं से उस परिवार के सदस्यों को वंचित रखना। * दो बच्चों की नीति के तहत, उन परिवारों को जिनमे दो से अधिक बच्चे हैं उन्हें सरकार की 50 से अधिक कल्याणकारी योजनायें रखना। * पंचायती एवं जिला पद अधिकारियों को चुनाव लड़ने से वंचित रखना।

उत्तर प्रदेश राज्य जनसंख्या नीति (संक्षेप में)

11 जुलाई 2000 को उत्तर प्रदेश सरकार द्वारा नई जनसंख्या नीति की घोषणा की गयी। इसे फ्यूचरस ग्रुप इन्टरनेशनल एक अमेरिका की कंपनी के पॉलिसी प्रोजेक्ट द्वारा मुख्य रूप से तैयार किया गया तथा इसकी तैयारी में यू.एस.एड. ने 50 हजार यू.एस. डालर भुगतान किया। मुम्बई से विशेषज्ञ, सिफ्पसा (SIFPSA) के स्टाफ एवं चार गैर–सरकारी संस्थाओं से विचार कर विशेष निवेश लिया गया। राज्य के गैर–सरकारी संगठनों के सामने एक औपचारिक प्रस्तुति की गई परन्तु उन्हें ड्राफ्ट की कापी ले जाने की अनुमति नहीं थी।

ये नीति जनसंख्या के बढ़ते दबाव को प्राकृतिक संसाधनों एवं राज्य और सरकार द्वारा जीवन स्तर को बढ़ाने में असमर्थता से जोड़ती है। उत्तर प्रदेश जनसंख्या नीति ने लक्ष्य मुक्त दृष्टिकोण के विपरीत योजना बनाई जिसमें इन्होंने 2005 तक का लक्ष्य 10 लाख नसबंदी एवं 30 लाख बच्चों के बीच दूरी के तरीके पर जोर दिया।

इस नीति ने नई गर्भ–निरोधक तकनीकियों जैसे गर्भ–निरोधक सुई (डेप्रो प्रोवेरा आदि) को स्पष्ट रूप से सुझाया था। मगर इनके इस्तेमाल करने से औरतों के शरीर पर होने वाले हानिकारक प्रभाव पर बात नहीं की गई। यह नीति सुरक्षित गर्भपात सेवा प्रदान करने के मुद्दे पर भी चुप है।

इस नीति ने 2016 तक 80 प्रतिशत संस्थागत प्रसव पर ज़ोर डाला। ये नीति अपने उद्देश्यों को पूरा करने के लिए कुछ प्रोत्साहनों व हतोत्साहनों की भी सूची बताती है जैसे कि जो भी जोड़ा कानूनन उम्र से पहले शादी करते है वह सरकारी नौकरी से हटा दिये जाये इत्यादि।

मध्यप्रदेश राज्य जनसंख्या नीति में लागू "दो बच्चों की नीति"

मध्यप्रदेश में लागू जनसंख्या नीति के अन्तरगत में धारा 36(D)(1) के तहत 26 जनवरी 2001 के बाद तीसरी संतान होने पर प्रतिनिधियों को पद से बरखास्त किया जायेगा एवं बहुत–सी कल्याणकारी और विकास के योजनाओं से वंचित रखा जायेगा। सन् 2001 से लागू इस कानून से फरवरी 2003 तक 866 पंचायती पद अधिकारी प्रभावित हुए जिसमें 488 पंच, 357 सरपंच और 21 जनपद सदस्य शामिल है। अभी भी कुछ सरपंचों के खिलाफ जाँच चल रही है और कुछ मामले न्यायालय में विचारधीन है। यह आंकड़ा बढ़ते क्रम में है एवं मध्य प्रदेश में सर्वाधिक सांख्या पन्ना जिले में दर्ज हुए हैं।

इस कानून से बचने के लिए कुछ प्रभावित प्रतिनिधियों ने कई गलत रास्ते अख्तियार किये जैसे कि पत्नी को तलाक देना, तीसरे बच्चे को गोद दे देना, अनचाहे गर्भपात, चारित्रिक दोष इत्यादि। इस कानून का असर जातिगत और आर्थिक रूप से कमजोर वर्गों एवं महिलाओं पर सबसे ज्यादा पड़ रहा है।

सरपंच का पद बचाने के लिए पत्नी पर चरित्रहीन होने का आरोप, परिणाम पत्नी से तलाक ...

जिला भुरैना ग्राम पंचायत खिरेटां के सरपंच जे.के. को 26 जनवरी 2001 के बाद तीसरी संतान होने के जुर्म में पद से हटाने का नोटिस जारी किया गया। परन्तु अपने पद को बचाने के लिए उन्होंने तरह–तरह के तरीके अपनाये। उन्होंने अपने सात तर्क सहित एक आवेदन पत्र एस.डी.एम. को प्रेषित किया जिसमें उन्होंने लिखा कि उसकी पत्नी पी. 5 नवम्बर 1999 से उनका उन्हें साथ छोडकर अपने मायके उत्तरप्रदेश में रह रही है तब से आवेदक का उसके साथ कोई शारीरिक सम्बन्ध नहीं है इसलिए तीसरी सन्तान उनकी नहीं है। तीसरी संतान को नाजायज ठहराते हुए पत्नी पर चरित्रहीनता का आरोप लंगाकर तलाक दे दिया।

तीसरी संतान के कानून से बचने के लिए रिकॉर्ड में हेराफेरी के मामले सबसे ज्यादा उजागर हो रहे है। इसमें पिछली तारीखों में जन्म प्रमाण पत्र बनवाना, रजिस्टर में पुराना रिकार्ड काटकर पुनः लिखना आदि एक घटना ...

हरसूद के ग्राम पंचायत जोगीबडा के एक संरपच ने रिकार्ड में हेराफेरी की जिसके विरुद्ध कलेक्टर ने अपराधिक प्रकरण पंजीबद्ध करने के निर्देश पुलिस को दिये। इस तरह से प्रतिनिधियों ने दस्तावेजों में हेराफेरी कर अपने पद पर बने रहने के लिए नये तरीके ढूंढ लिये हैं।

जनसंख्या एवं विकास नीतियों के बीच संघर्ष

हालांकि जनसंख्या नीति जीवन स्तर में सुधार के विषय में चिंता व्यक्त करती है परन्तु अन्य मौलिक अधिकार के मुद्दों पर ध्यान केन्द्रित नहीं करती। जनसंख्या नीति का दस्तावेज़ी न तो जमीनी हक को सुधारने की बात करता है और न ही रोज़गार उत्पादन करने की। इसके विपरीत यह नीति सम्पूर्ण विकास के लिए जनसंख्या स्थायीकरण की जरूरत को एक–तरफा प्रक्रिया बताती हैं।

यह अवधारणा हमारे सामने यह प्रश्न रखती है कि जनसंख्या मुद्दे को लेकर यह माना जाता है कि मूल समस्या केवल बढ़ती जनसंख्या ही नहीं परन्तु इस जनसंख्या की सीमित संसाधनों की उपभोग क्षमता भी है। तब हमारे सामने यह प्रश्न उठता है कि छोटी जनसंख्या क्या है एवं हर व्यक्ति की संसाधन की उपभोग क्षमता कितनी होनी चाहिए। इस तरह से जनसंख्या के आकार को कौन–से आधार पर मापना चाहिए। अनाज की उत्पन्नता से, जमीन के आधार पर, संसाधन के आधार पर अथवा मानव–अनुपात के आधार पर?

यदि जनसंख्या को मापने में संसाधन उपलब्धता बाध्य हो रही है तो संसाधन उपभोगता का इस्तेमाल करना चाहिए। वसंत पेथे (भारतीय अर्थशास्त्री) के द्वारा तैयार किये गये एक नमूने के अनुसार जनसंख्या वृद्धि का कारण गरीबी है कि अन्यायी अन्तराष्ट्रीय आर्थिक अवस्था का कारण है। उन्होंने अनुमान लगाया कि यदि हम जनसंख्या को संसाधन उपभोग के तहत मापे तो जनगणना द्वारा मापे गये अमेरिका कि आबादी 250 मिलियन न होकर 25,000 मिलियन होनी चाहिए क्योंकि एक साधारण अमेरिका की संसाधन उपभोक्ता विश्व के उपभोक्ता से 100 गुना अच्छी है उसी तरह से भारत की जनसंख्या सिर्फ 300 मिलियन होनी चाहिए।

अमृत्य सेन ने यह तर्क सामने रखा है कि भारत में अन्न उत्पादन की बढ़ोत्तरी दर ने जनसंख्या वृद्धि को पीछे छोड दिया है। उन्होंने इस पर भी जोर दिया कि अन्न उत्पादन सबसे अच्छा वहाँ होता है जहां कि जनसंख्या ज्यादा हो।

परिवार नियोजन कार्यक्रम का मुख्य लक्ष्य गाँव है। शहर में लोगों के साथ "छोटे परिवार की नीति" अपनाने के लिए राज्य को इतना जोर–जबरदस्ती नहीं करनी पड़ती क्योंकि वह गर्भ–निरोधक तरीकों को अपनाने से हिचकिचाते

नहीं। किंतु जहाँ एक ओर गाँव के लोगों के लिए बच्चे सम्पत्ति है वहीं दूसरी ओर शहर के लोगों के लिए बच्चे दायित्व हैं।

हमारे देश की 75 प्रतिशत जनसंख्या गाँव में रहती है जिनमें से 80 प्रतिशत छोटे किसान एवं भूमिहीन मजदूर हैं। भारत के गाँव के लिए रोज़गार का मुख्य साधन खेती है जो कि साल के 5 से 6 महीने तक सीमित है (मौसमी रोज़गार)। इसलिए घर में जितने लोग होगें रोज़गार के साधन में उतने ज्यादा लोग हाथ बँटा सकेगें एवं इन कम दिनों के रोज़गार के मौके का ज्यादा फायदा उठा सकेगें। यदि परिवार की संख्या रोज़गार के इस दौरान ज्यादा होती तो उस समय काम करके घर की बचत में ज्यादा आमदनी जोड सकते हैं जो मौसमी रोजगार के समय खत्म होने पर उपयोग में लाया जा सके।

गरीब किसान के लिए परिवार का हर सदस्य उत्पादन के खर्च को कम करने में मदद करता है। यहाँ तक कि बच्चे भी परिवार को आमदानी में जोड़ने के अलावा घर के विभिन्न कार्यों में महिलाओं का हाथ भी बटाते है जैसे कि अपने छोटे भाई बहन की देखभाल करना, खाना बनाने में, पानी एवं लकड़ी लाने, जानवरों को चराने ले जाने में।

स्वस्थ होने का मानव अधिकार
सरकार की जिम्मेदारी

हर मानव को अपने एवं अपने परिवार के स्वास्थ्य और कल्याण का अधिकार है जिसमें रोटी, कपड़ा, मकान, स्वास्थ्य सम्बन्धी चिकित्सायें आदि का होना भी जुड़ा होता है। हर मनुष्य मातृत्व एवं शिशु विशेष देखरेख एवं सहायता के हकदार हैं।

(सार्वभौमिक विवरण का मानव अधिकार घोषणा-अनुच्छेद 25)

राज्य की यह भी जिम्मेदारी होती है कि वो हर मानव को सुरक्षित एवं स्वस्थ कार्य करने की व्यवस्था प्रदान करें एवं स्वस्थ शारीरिक और मानसिक स्तर प्रदान करे। इन अधिकारों को पूर्ण रूप से प्राप्त करने के लिए अनेक तरीकों को अपनाया गया जैसे कि – शिशु मृत्युदर में कमी लाना, शिशु के स्वास्थ्य पर ध्यान देना, हर प्रकार से पर्यावरण एवं औद्योगिक सम्बन्धी स्वास्थ्य में सुधार लाना, महामारी, स्थानिक, व्यवसायिक एवं अन्य सम्बन्धी रोगों के रोकथाम इलाज एवं नियंत्रण करना।

(आर्थिक, सामाजिक एवं सांस्कृतिक अधिकारों पर अंतराष्ट्रीय अधिवेशन - अनुच्छेद 7, 11 एवं 12)

राज्य महिलाओं के सुरक्षा के लिए शिक्षा एवं परिवार स्वास्थ्य सम्बन्धी जानकारी प्रदान करे जिसमें परिवार नियोजन एवं उनके अधिकारों पर सलाहे एवं जानकारी प्रदान करें जिससे कि महिलाओं एवं पुरूषों पर किसी भी प्रकार का लिंग विभेदीकरण न हो। राज्य (ग्रामीण महिला) के अधिकार पर भी ध्यान देता है कि उन्हें पर्याप्त स्वास्थ्य सुविधायें प्राप्त हो जिसमें परिवार नियोजन के बारे में जानकारी प्रदान करे।

(महिलाओं के विरुद्ध सभी प्रकार के भेदभाव पर रोक - अनुच्छेद 10-12 एवं 14)

राज्य जाति विभेदीकरण समाप्त करने पर भी ध्यान देता है और यह देखता है कि हर मानव पर कानून के सामने समान हो एवं उन्हें हर प्रकार की जन स्वास्थ्य एवं सामाजिक सेवाओं को प्रदान करना।

(सभी प्रकार के नस्लगत भेदभाव के उन्मुलन अनुच्छेद - 5)

राज्य बच्चों के अधिकारों के अन्तरगत उनको हर प्रकार के स्वास्थ्य सम्बन्धी बीमारियों के इलाज में सुधार लाने पर ध्यान देता है।

(बाल अधिकार - अनुच्छेद 24)

हमारी कुछ माँगें

यह नीतियाँ जो गरीबों और महिलाओं के अधिकारों का उल्लंघन करती है इनके खिलाफ हमारी कुछ माँगें हैं जो इनके अधिकारों की रक्षा करती है और इन्हें मज़बूत बनाती हैं–

हमारी माँगें इस प्रकार से है–

- जनता के लिए पर्याप्त रूप में मूल सुख–सुविधा संसाधनों को सुरक्षित करना और खाद्य एवं आवश्यक वस्तुओं को गरीबों तक उपलब्ध कराना।
- प्राथमिक स्वास्थ्य सेवाओं को मज़बूत करना और रोग–मुक्त एवं रोग–निरोधक दवाइयों के बीच संतुलन लाना। इन स्वास्थ्य केन्द्रों में परिक्षित स्वास्थ्य कर्मचारी का होना जरूरी है जो इन स्वास्थ्य सेवाओं का सही उपयोग करें और लोगों तक पहुँचाने की कोशिश करें।
- बिना किसी सामाजिक विभेदीकरण जैसे कि जाति, लिंग, जगह के आधार पर विभेदीकरण करना एवं हर प्रकार की स्वास्थ्य सेवायें उपलब्ध करवाना।
- साफ एवं सुरक्षित पेय जल की उपलब्धता।
- यदि हम ध्यान दें तो महिलाओं के प्रति हिंसा के बारे में किसी भी नीति के अन्तरगत बात नहीं की गई है फिर चाहे वह राष्ट्रीय जनसंख्या नीति हो अथवा स्वास्थ नीति हो हम चाहते है कि महिलाओं के प्रति हर तरह की हिंसा इन नीति में शामिल हो।

  उसके अलावा 'दो बच्चों की नीति' जिसके बारे में पहले भी हमने चर्चा की है एक अहम मुद्दा है एक तरफ तो राज्य जनसंख्या नीति जो दो बच्चों का प्रचार कर रही है वहीं दूसरी ओर महिलाओं के ऊपर हिंसा को बढ़ा दी है। हमें ऐसी नीतियों एवं कानून को शामिल होने से रोकना होगा।

- एक अच्छे मॉनीटरिंग प्रणाली को लांगू करना जो गर्भ–निरोधक तरीकों के लिए महिलाओं को निशाना नहीं बनाये परन्तु ऐसी सब चिक्त्सिा सम्बन्धी परिक्षण पर पाबंदी लगाना। इसके साथ–साथ गर्भ–जाँच तकनीकों पर भी पाबंदी कार्यन्वित करना और इससे होने वाली लिंग–अनुपात में गिरावट को रोकने की कोशिश करना।
- बच्चों को उनके विकास और अतिजीविता से वंचित रखना का मतलब अन्तराष्ट्रीय बाल अधिकारों का भी उल्लंघन करना हुआ जिसके साथ–साथ उच्चतम न्यायलय द्वारा बच्चों के शिक्षा के अधिकार का उल्लंघन करना भी शामिल है। इसके तहत् हमारी माँग है कि जनसंख्या एवं अन्य नीति के अन्तरगत जो बच्चों के अधिकारों का उल्लंघन करें उन्हें शामिल नहीं करना चाहिए क्योंकि इन नीतियों का जुड़ाव किसी भी तरह से बच्चों से नहीं होता है।
- भारतीय सविधान के अन्तरगत 73rd और 74th संशोधन ने पंचायती राज को और मज़बूत एवं बढ़ाने की कोशिश की है। यदि हम गौर से देखें तो पायेगें कि राज्य जनसंख्या नीति राष्ट्रीय जनसंख्या नीति के बिल्कुल विपरीत है। राष्ट्रीय जनसंख्या नीति ने कहीं पर भी दो बच्चों के कानून पर बात नहीं कि परन्तु राज्य जनसंख्या नीति ने दो बच्चों के कानून के तहत पंचों और सरपंचों को बरर्खास्त करने की बात की जो उन पंचों और सरपंचों के मानव अधिकारों का उल्लंघन करती है। इस से यह सवाल भी उठता है कि इस तरह के कानून विधान सभा और राज्य सभा प्रतिनिधित्व के लिए क्यों नहीं है? इस तरह के कानून एवं नीतियाँ मानव–अधिकारों का उल्लंघन करती है जो हमारे संविधान में शामिल नहीं होनी चाहिए।
- जैसा की राष्ट्रीय जनसंख्या नीति भी इस बात को मानती है कि आज भी भारत में स्वस्थ्य एवं सुरक्षित गर्भ–निरोधक सेवाओं की जरूरत है यदि हम आदिवासी एवं दलित वर्ग के अधिकारों को लें तो आज भी सामान्य जाति के लोगों के विपरीत मृत्युदर प्रतिशत ज्यादा पायेंगे। राष्ट्रीय परिवार स्वास्थ्य कल्याण सर्वो के अनुसार आदिवासी, दलित एवं अन्य पिछड़े वर्ग में बाल मृत्युदर की संख्या 83, 84 एवं 76 है जब कि सामान्य जाति में 62 प्रतिशत है। उसी तरह से पाँच वर्ष के अन्तरगत

होने वाली शिशु मृत्युदर 119, 126 और 103 है जो कि सामान्य जाति के लोगों में 82% प्रतिशत है। इस स्थिति में यदि हम दो बच्चों के कानून की बात करते हैं तो वो इन जातियों के बीच में दूरी बढ़ाने की कोशिश की गई है। ऐसी नीतियों को हमारे संविधान में शामिल नहीं होना चाहिए।

जनसंख्या नीति

गरीबों के खिलाफ है
औरतों के खिलाफ है
मानव अधिकार के खिलाफ है

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Targetted Negligence

India began its tryst with destiny half a century ago. Despite remarkable progress in many fields, the overall development indicator, the Human Development Index, continues to be poor with a low rank of 127 among 177 nations. One easy excuse has been the oft quoted 'population problem'. Politicians of different hues and persuasions, bureaucrats and even the middle class person in the streets finds the large number of poor an easy excuse for all forms of problems; from electricity to traffic problems, from inflation to sluggish economic growth. One tempting solution, has been has been the imposition of a target driven family planning programme, where everyone from district magistrate to the lowly anganwadi worker is given a number of sterilization cases she or he has to bring each month or year.

Uttar Pradesh is the state with the highest number of people living within her boundaries, and a population growth rate which is above the national average. It has also been the focus of population control and family planning programmes for a long time. It is interesting to examine the impact of a target oriented programme in contemporary times by looking at the example of Uttar Pradesh.

Mauli Devi of village Lohra Ahrora in Sonbhadra district lost her life during a sterilization operation on 7th February 2004. Nirmala Devi of village Belaparasa of Ambedkarnagar district died in similar circumstances just a week later. These are not isolated incidents. Women are coaxed, cajoled or coerced into agreeing for sterilization operations because they are easy 'targets'. However once they have signed on the dotted line and the operation is over they are forgotten. But for women the operation is often the beginning of a new ordeal. For many the operation table becomes the death bed. There are hardly any recorded deaths from sterilization, but community level observations are showing that these are not uncommon.

Parwati Devi of village Kodwari in Mirzapur district underwent her second sterilization operation in April 2003. Four years ago she had her first operation and then after having two more children she went in for her second sterilization operation. Failures are a common feature of sterilization operations. According to international standards the failure rate is roughly one in two hundred operations. However a study conducted by a state agency indicates that the failure rate could be a very high five percent which means that annually around 22,000 women have failed operations. But there is very little documentation of these failures and even less is done to support these women.

Besides failures and repeat pregnancies, infection of the stitches or the operation wound site is also common. These women hardly get any care for dressing of their wounds or receive extra other medicines. It is hardly surprising that women suffer from various complications after sterilization operations. The condition of sterilization camps is abysmal in the state. There has been more than one report in recent years of bicycle pumps being used for putting air into the abdomen before laparoscopic operations.

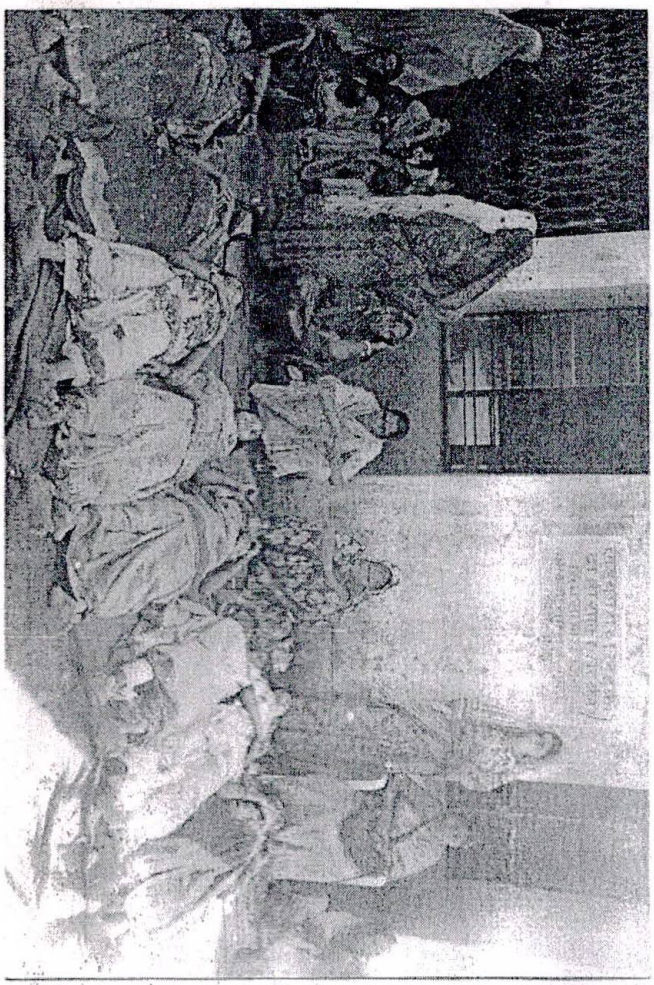
In addition to the hurry, and the concomitant risk of mistakes, there is hardly any attention paid to prevention and control of infection. Tubectomy operation of women, in contrast to the vasectomy operation of men, is a major operation. It requires that same care in terms of infection control as any major abdominal surgery for example removal gall bladder stones, or removal of the appendix. However such camps are found to take place in schools where classrooms become makeshift operation theatres. Surgeons don't remove their gloves after completing an operation (this can also add to the risk of HIV transmission) and instruments like the laparoscope are inadequately sterilized.

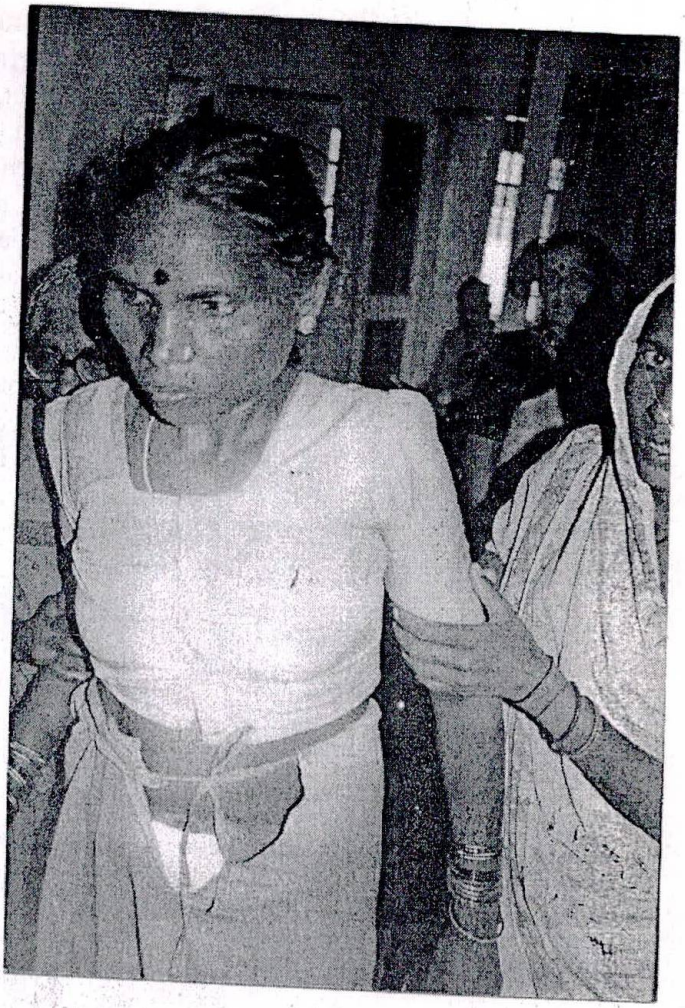
In August this year five young men were drugged and then vasectomised in the district of Lakhimpur Kheri. Two of them were under 21 and un-married. They were poor farm laborers and their landlord needed a licence to procure a gun. More than one district magistrate has started a scheme for giving licenses for guns against sterilization cases. They have justified it as being one easy way for meeting sterilization targets. There are reports that state has over 5 lakh pending applications for gun licences. It is easy to calculate the sterilization targets that can be met by applying the simple norm of two cases for a small gun and five for a big one!

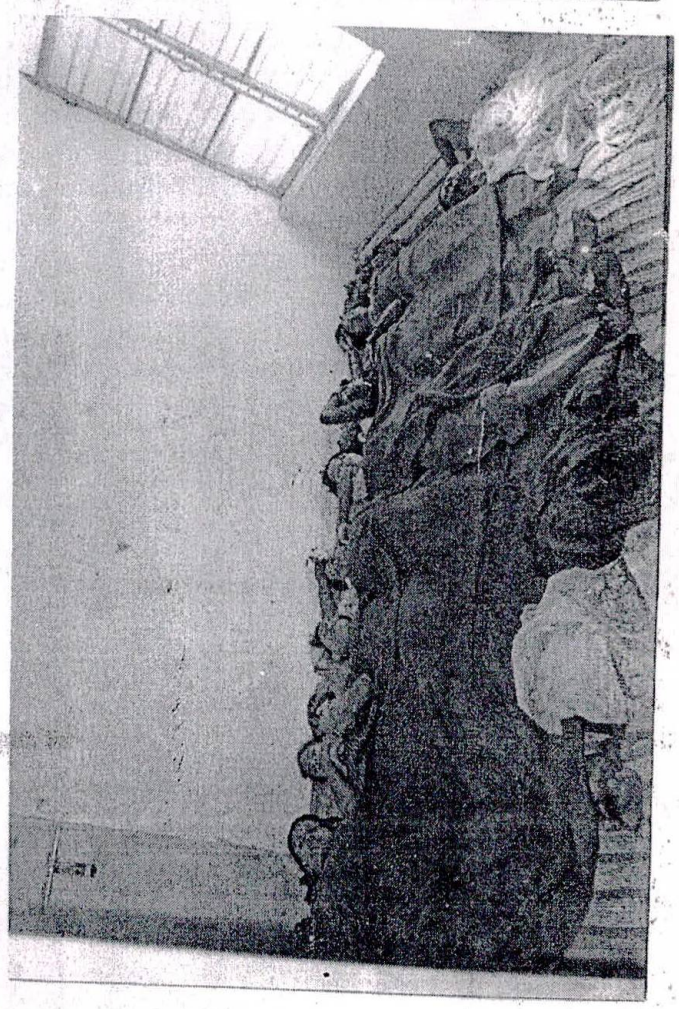
The case of Uttar Pradesh also highlights how 'targeted' population control program not only affects women who seek sterilization but any woman who needs government health care support. The whole health machinery in Uttar Pradesh is geared to implement the family planning program and there are no other services available for women. Every year nearly 40,000 women lose their lives to pregnancy or maternity. According to the last round of the National Family Health Survey only 4% of pregnant women received all the required check ups, immunization and tests. Nearly 80% of the five million births that take place in the state are unsupervised and the government nurse reaches a measly 7% of these women after her delivery within 2 months.

A little more than a quarter of a century ago a targeted and coercive approach to family planning programmes led to the downfall of a Congress Government. The Common Minimum Programme of the United Progressive Alliance, has once again mooted "a sharply targeted population control programme". The National Population Policy which was approved in 2000, recommends a target free, community needs centred approach which can go a long way in meeting the health needs of the community. This was also am affirmation of the commitment made at the International Conference on Population and Development in 1994. Experience from UP highlights the immense amount of medical negligence and the gross human rights violations that are committed in the name of targets. Unfortunately the impact of targets has most often been borne by women, and once men are involved, the political cost may prove to be too high once again.

Abhijit Das







HARYANA LIST OF PANCHES AND SARPANCHES FOR THE DISTRICT (1)

वर्ष 2000 से अब तक निलम्बित हुए सरपंचों/पंचों और सूचना (दोसे प्राचीक ब्योरों के केस में)

पंचों की रिपोर्ट

खण्ड नांगल चौधरी - जिला महेन्द्रगढ़

BLOCK - Nangal Chaudhary, Dist - Mahendragarh

क्रम सं०	खण्ड का नाम	अयोग्य/निलम्बित/नि० सरपंच/पंच का नाम	ग्राम पंचायत का नाम	क्रमांक/दिनांक	रिमार्कस
1	2	3	4	5	6
1	नां०चौधरी	रमेश चन्द पंच	मोहन पुर	1362-66/PA 24-4-02	
2	"	रोशन लाल पंच	मोहनपुर गुंगारका	1985-92 26/6/02	
3	"	राजबाला पंच	—do—	1993-97 26/6/02	
4	"	विजय कुमार पंच	कमानिया	886-88 7-3-02	
5.	"	तुलाराम पंच	गेरावतहला	2135-39/PA 12-7-02	
6	"	सविता पंच	रघोराम पुरा	2224-28 23-7-02	
7	"	वेद प्रकाश बनवारी पंच	मुलोदी	3214-18 5-11-02	
8	"	हनुमान पंच	—do—	—do—	
9	"	राजकुमार पंच	रवाजपुर	4150-55/PA 3-3-03	
10	"	सोमदत पंच	शहबाजपुर	4419-24/PA 14-3-03	
11		रतन लाल पंच	शहबाजपुर	—do—	
12	"	राधेश्याम पंच	नाङवी	752-56 17-7-04	

B.D.P.O.
Nangal Chaudhary

2

वर्ष 2000 से अब तक जिन जिस हुक सरपंचों / पंचों बारे सूचना (दो से अधिक सरपंचों के केस में सरपंचों की जिम्मेदारी)

	क्रमांक	खण्ड का नाम	अयोग्य घोषित किए गए सरपंच / पंच का नाम	ग्राम पंचायत का नाम	केस नंबर	
1	1	2	3	4	5	
	1	नोगल चौधरी	श्याम सुन्दर सरपंच	कमरधुरा	6143-46 / 6-12-01	माननीय चेयरमैन से रिवीजन / उच्च न्यायालय से stay order
	2	"	[illegible]	[illegible]	[illegible] / 14-3-07	[illegible]

खण्ड विकास एवं पंचायत अधिकारी
नोगल चौधरी

2000 से अब तक दिये गये कालोनियों/फर्मों की सूचना (हरियाणा शहरी विकास ... के बारे में) खण्ड - महेन्द्रगढ़ ! Block- Mahendergarh

3

	ब्लॉक का नाम	कालोनाइजर/डीलर/कम्पनी/फर्म का नाम	ग्राम/गांव का नाम	क्रमांक/दिनांक	विवरण
1.	महेन्द्रगढ़	श्री आत्मासिंह फर्म	खातोली	3980/PA दिनांक 30-3-2001	— दोषी कालोनाइजरों के खिलाफ
2.	"	" गजानन्द फर्म	सतनाली	4096-98/PA दिनांक 19-4-2001	—
3.	"	" लीलाराम फर्म	बूडीन	5869/PA दिनांक 2-11-2001	
4.	"	" श्रीनाथ चन्द्र फर्म	कोरोठ	6513-16/ दिनांक 27-3-2001	माननीय उच्च न्यायालय में दायर हुआ है
5.	"	" राजेन्द्र पुत्र रामस्वरूप फर्म	जुरेहरा	1223-27/PA दिनांक 9-4-2002	दोषी कालोनाइजरों के खिलाफ
6.	"	" श्रीनाथ चन्द्र फर्म	पाल	1981-87/PA दिनांक 26-6-2002	—
7.	"	" शेरसिंह फर्म	"	1981-87/PA दिनांक 26-6-2002	—
8.	"	" रणबीर व रामकुमार फर्म	खरखड़ा (कालोनी)	2145-50/PA दिनांक 12-7-2002	—
9.	"	" जगतसिंह फर्म	पाल	1981-87/PA दिनांक 26-6-2002	—
10.	"	" ~~नन्दूराम~~ नन्दूराम पुत्र लीलाराम फर्म	मालड़ा सराय	2132-34/PA दिनांक 12-7-2002	—

— क्रमांक 1590 [illegible]

Block - Kanina

खण्ड कार्यालय - कनीना

सूचना - प्रपत्र

क्र.सं.	खण्ड का नाम	अपदस्थ/निलम्बित/नि० सरपंच	पंच	ग्राम पंचायत का नाम	क्रमांक/दिनांक	नियम सं.
1	2	3		4	5	6.
1	कनीना	–	श्री [illegible] कुमार पंच वार्ड नं. 4 पुत्र श्री रामेश्वर दयाल	गोमला	D-C's order No. 15/ [illegible], दिनांक 14/4/2001	धारा 175(6) उपधारा - 1, 5, 6 - ह.प.रा.अ. - 1994.
2	"	–	श्री मातूराम पंच पुत्र कन्हैयाराम वार्ड नं. 5	[illegible]	D-C's order No. 47/P दिनांक 16-8-2001.	ऐसे अधिक बच्चो के कारण
3	"	–	श्री महावीर पंच पुत्र प्रभाती वार्ड नं. 2 (B-C)	[illegible]	D-C's order No. 32/P dt 24/7/2001.	-do-
4	"	–	श्री रमेश पंच वार्ड नं. 7 (B-C) पुत्र बिहारीलाल	[illegible]	3961-65/Panchayat dt 6-11-2001.	Under sec-177
5	"	–	श्री नन्दलाल पु० [illegible] W.N. 9 (S-C)	भड़फ	3388-92/P दिनांक 21-11-02.	Under sec. 173/177
6	"	–	श्री रमेश कुमार पु० [illegible] W-N-2 पंच (General)	-do-	1517/P dt 25-6-02	U/S-177

-2- Contd-

-2- Contd- खण्ड कार्यालय - कनीना

2	3	4	5	6
कनीना	— श्री गिरधारी पुत्र परसराम 15-11-2- पंच - सामान्य श्रेणी	गाछड़ा-	मुख्य उपायुक्त महोदय, नारनौल-	सफल कर्मचारी प्रस्ताव आदि अर्थदान चार्जित

6 (9)

BLOCK

क्र.सं.	ब्लाक का नाम	सम्बंधित पंच का नाम	ग्राम पंचायत का नाम	क्रमांक दिनांक	संगठन
1	अटेली नांगल	शम्भूप्रसाद पंच	तजपुर	10/2002	ओबिसिन कल्य
2.	अटेली नांगल	रोशन लाल पंच	नसीबपुर	1988-92 / 26/6/02	"
3	अटेली नांगल	बोधसिंह पंच	रतासहुद	1267-71 / 16/4/2002	"

BLOCK - Narnaul.

717

1	नारनौल	सुशीला देवी पंच	मेई वार्ड नं. 2	4754-57 PA / 27/12/001	1759/17 [illegible]
2	"	शीशराम पंच	रामबास वार्ड नं. 8	1321-24 PA / 1/4-2002	-Do-
3	"	बाबूलाल पंच	एनडेमा वार्ड 5	1737-40 PA / 28/5/2002	-Do-
4	"	संतोष देवी पंच	कुलताजपुर वार्ड 4	2140-44 PA / 12-7-2002	Do.
5	"	रणबीर सिंह पंच	फतहपुर वार्ड 8	2364-8 PA / 29/7/2002	-Do-
6.	"	आनसिंह पंच	डहर कला वार्ड 2	733-35 PA / 25/2/2002	Do
7.	"	हरिसिंह पंच	सिलारपुर महता वार्ड 6	734-38 PA / 29/7/2004	-Do-

ग्राम पाल के पंच — [3] तीनों :-

चुनाव — पंचों का कहना था कि हमारे गाँव में चुनाव के दौरान मीटिंग हुई उसमें ग्राम वासियों ने सर्वसम्मति पंचायत का चुनाव निर्विरोध किया गया तथा सभी वार्डों से पंच व सरपंच चुने गये। चुनाव के लगभग 2 साल बाद तीन बच्चों का मुद्दा 177 धारा के अन्तर्गत लेकर सुल्तान हरिजन ने जिला उपायुक्त महोदय को लिखित में तीनों पंच, जगत सिंह, राहुताश, सुभाषचन्द के खिलाफ शिकायत की। इसी विषय के अन्तर्गत लेकर तीनों पंचों को S.D.M के निर्देश अनुसार हटाया गया।

पद से अलग होने पर प्रभाव — जब हमें इस विषय हेतु नोटिस जिला उपायुक्त महोदय द्वारा मिले तब हमें काफी महसूस होने के साथ दुःख भी हुआ। लेकिन कानून के तहत होने के कारण हमें यह दिलासा मिली कि हमें इस पद से इसलिए हटाया गया है। हमारी पंचायत गाँव में विश्वास के कार्य निर्विवाद करती थी क्योंकि हमारी निर्विरोध पंचायत थी। फलतः पंचों ने बताया कि ग्राम वासियों ने हमारे ही को ... पद हेतु चुना।

पद से हटने पर प्रभाव — सभी पंचों एवं सरपंचों ने बताया कि पद से हटने के बाद दुःख हुआ। तथा ग्राम में शर्म भी महसूस की गयी। तथा हमारा सोचना यह था कि पंचायत में रहकर हम ग्राम विकास के कार्यों में अपनी भागीदारी करेंगे। लेकिन हमें समय का अभाव रहा।

पद का नाम = पंच

प्रार्थी का नाम = सन्तोष

पति का नाम = विजय

गांव का नाम = कुलतानपुर (Block - Nalwal)

वार्ड नं॰ = 4

शिक्षा = 8 पास

बच्चे = 4 लड़कियाँ

महिला को पंच का इस्तीफा देने पर मजबूर किया गया, क्या सरकार ने हमारे लिए ही नियम बनाया गया है। जब मैं पंच बनी हूं। यदि मेरे भी एक लड़का और एक लड़की होती तो मैं पंच पद से इस्तीफा न देती। तथा विकास कार्यों में बढ़-चढ़कर भाग लेती। हमारे पुराने सरपंच की वजह से मेरे बच्चों की रिपोर्ट लिखवाई तथा एप्लीकेशन लगाई गई जिसकी वजह से मुझे पद से हटाया गया। वह सरपंच हमारी पार्टी का न होने की वजह से मेरी दरख्वास्त लगाई गई जिससे हमारा इस्तीफा लिया गया मेरे हटने के बाद पंचे के चुनाव कराये गये तथा फिर हमारे वार्ड का पंच चुना गया। तथा वह महिला हमारे गली नं॰ से लड़ाई तथा आंगनबाड़ी केन्द्र में आना-जाना नहीं करेगा तथा महिला ने इच्छा जताई कि अब वो नहीं करेगा तो मैं भाग लेना चाहती हूं।

गाँव का नाम = सिलारपुर मठ्ठा
पंच का नाम = हरिसिंह
पिता का नाम = हलदूराम (Block Nalnaul)
वार्ड नं. = 6

यह पंच बिना चुनाव (अनपोल) बनाया गया था।
बच्चे = 5 = 3 लड़का 2 लड़कियाँ
शिक्षा = 8th पास

पड़ोसी आपसी झगड़े की वजह से इसको शिकायत की गई तथा एस.डी.ओ. 1997 में वापिस गया है लेकिन इसको पंच पद से हटने पर गलतफहमी समझी तथा बुरा लगा

पद का नाम - पंच

प्रार्थी का नाम = श्री रघबीरसिंह
पिता का नाम = श्री अमीलाल
गाँव का नाम = फूलतलपुर (Block - Nainwa)
वार्ड नं० = 8
जाति = लखेरा
शिक्षा = मैट्रिक पास
बच्चे = 9
लड़के = 2
लड़कियाँ = 7

1997 के बाद का एक, बनना था जिसकी कुल से पारा से, घरवालों ने विरोध किया तथा उसकी एप्लीकेशन लगाई थी। जो पंच पहले दो बार पंच रह चुका था उनका चुनाव कराया गया जिसमें हटाये गये पंच का छोटा भाई नित्यानन्द लखेरा ही पंच चुना गया। पंच का इस्तीफा देने से उस श्री रघबीर ने अपनी मान हानि समझी, क्योंकि गाँव में और भी दो पंचों हैं जिनके दो से ज्यादा बच्चे नहीं हैं तथा जिनका जन्म 1997 के बाद हुआ है। इसको बहुत बुरा लगा। इसलिए चुनाव में अपने भाई का प्रस्ताव डलवाया तथा वोटों में उसका भाई ही चुना गया। उस पंच ने कहा कि जब पंच का फार्म जमा कराया गया। उस समय हमें इस नियम का पता नहीं था।

(A)

1. 35 years old **Paso Devi**, belonging to scheduled caste community contested election for Zila Parishad Member. Paso Devi fought/ contested from ward no. 5 of ZP District Fatehabad. She is an illiterate woman from Nagpur Gram Panchayat of Fatehabad. When she contested for ZP membership, she was with the ruling party - Indian National Lok Dal. As Fatehabad has the highest scheduled caste population amongst other districts the post for chairperson ZP was reserved for scheduled caste woman. Out of 13 members elected for ZP, 7 were supporting her for the post of Chairperson.

The ruling party decided to elect **Smt. Kalo Devi** as Chairperson. This led to Paso Devi leaving the ruling party and joining hands with the opposition - Congress Party. As there were only two candidates eligible for the post the members of opposition supported Paso Devi whilst the ruling party supported Kalo Devi. This took a dramatic turn when the ruling party kidnapped Paso Devi whilst Kalo Devi, supported by the ruling party, was elected as ZP Chair.

Paso Devi currently is an elected member of Zila Parishad from ward no. 5. Her constituency had 44000 total votes at that time and covered 21 villages. Paso Devi won by 17500 votes.

At the time of election she had four children. Before election her sister adopted two of her children.

After one year, her own brother in law (Jeth), filed a case against her alleging her that she had more that two child which is disqualification as per Haryana Panchayati Raj Act. She obtained stay from Financial Commissioner and Secretary in this regard and continued as member Zila Parishad on the basis of that a similar case is pending with supreme court. When the judgment from Supreme Court came on 30.07.2004, Paso Devi also had to leave her seat. This shows that the constitutional Provision is used as weapon for political rivalry.

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2. **Mr. Devraj** s/o Sh. Phalli Ram is 35 years old belongs to scheduled caste got elected as Panchayat Samiti member. He contested from ward no.12 of Ratia Panchayat Samiti of Fatehabad District. He contested first time. He is educated up to 8th standard. His constituency comprised of five villages. He won the seat by 252 votes against her nearest rival. He belongs to SAINAL village. His rival candidate filed case against and challenged his qualification for the post. Devraj has three children (2 male and one female). The case was pending with deputy commissioner for one year and after one year he had been dismissed from the post as he had been declare disqualified. His third child was born on January 1996.

3. **Mr. Sher Singh**, Disqualified Sarpanch
Age -30 years, Caste-Valmiki (SC), Gram Panchayat- Lehariyan.
Education- Matric (10th)
Living Children- 5 (4 Female 1 male) Last child was born in 1999.
He contested election for the post of Sarpanch from the seat reserved for scheduled caste. Total votes in His Gram Panchayat at the time of election were 2300. He won the Election by 436 votes. His father had been member Panchayat for two terms. He was also a worker of ruling party. He was first suspended in 2001 on the basis of disqualification having more than two children. But he remained Sarpanch, as he was member of ruling party. He second time suspended in 2003, he again escaped himself. Finally he has been given notice on 05.07.2004, his arrears taken over on 00.07.2004 and dismissed 26.07.2004. He told that during his tenure of four year, administration never supported him in his work. Upper caste people (Panches) of his Panchayat influenced, JE, Secretary and BDPO. He was never provided all the funds. Development works done in his Panchayat some times without asking him. In parliament election he supported congress candidate as he belongs to his community, ruling party victimized him.

4. **Rajkumar**, Disqualified Sarpanch
Gram Panchayat –Bighar, Block & District Hatchabad, Total Votes: 6500
Age- 39 yrs
Education- 10+2
Caste- Scheduled Caste
Living children: 4 (2 Male 2 female) Last child born in 1996.
Rajkumar was elected unanimously as Sarpanch, as the post of Sarpanch in Bighar Gram Panchayat was reserved for scheduled caste. In 2002 there was a case of encroachment. Some upper caste people tried to influence him to take decision in their favour.But he refused saying that he cannot go against the will of majority of people. The same people are running a school. They offered free education to his children in their school. After having the proof of birth of his child, they filed case against Rajkumar. He declared disqualified and dismissed from the post on 26.05.2004.

5. **Mr. Billu**, Disqualified Sarpanch
Gram Panchayat- Bhundarwas Total Votes: 2800 won by 63
Age- 43 yrs, Scheduled caste, Education: 9th
Living Children: 5 (3 Female 2 male) Last Child Born in 1995 (female); Adopted by his brother in law.

Billu contested election on a reserved seat and won by 63 votes from his nearest rival Mr.Makhan Singh. After 39 days of Billu's election as Sarpanch, Mr.Makhan Singh filed case of disqualification against him. He fought the case up to B.D.Dhaliya, Secretary Department of Panchayats Govt. of Haryana and High Court. He finally dismissed on 28.01.2004

RAJASTHAN.

14

Women's experiences with the public health system

Testimony 1

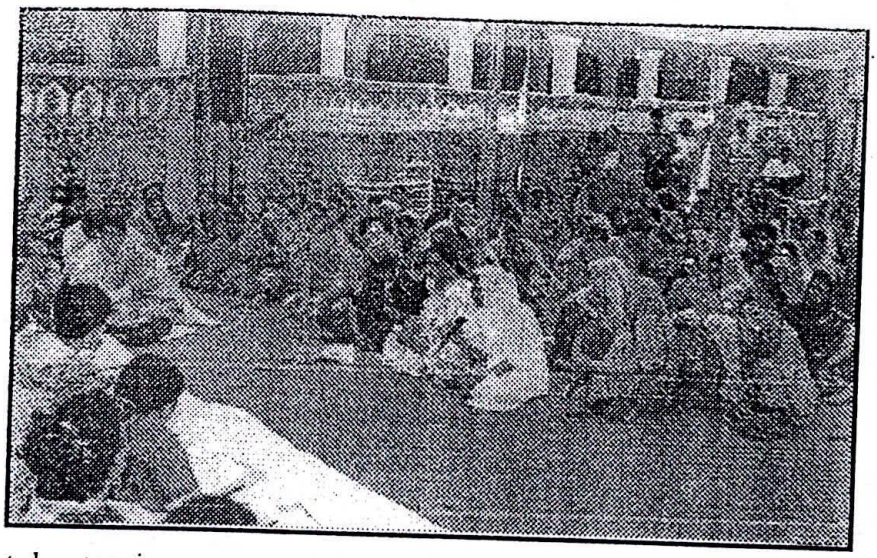
40 year old smt. mangibai W/o Ambalal Meena r/o village Manpura had tow children when she got tubectomy done 10 years ago in a sterilisation camp at Chhoti Sadri. But she continued to conceive even after the tubecomy and has given birth to three more children since then. In Mangibai's own words "....conceiving after getting tubectomy done makes it difficult to live in the village. Imagine my plight if instead of me my husband had got the operation done and then I would have conceived because of failure of his operation..."

Testimony 2

28 year old **Smt. Lacchibai w/o Sh. Fatehlal Meena r/o village Lalpura,** got tubectomy done earlier this year (after being encouraged by a multi purpose worker to do so) even though her family did not approve of it. She has been experiencing severe problems ever since the stitches were opened. She has been suffering from burning sensation while urinating, irregularity in menstruation as well as white discharge. Till now she has spent around 3000/- rupees in seeking tretment from both government and private doctors but with no respite. Since Smt lacchibai had got the operation done against the wishes of her family. Members of family do not take any responsibility for her situation and do not consider her problem seriously.

Testimony 3

35 year old **Smt. Ruplibai w/o. Sh. Narayan Meena r/o village Inton ka Talaab** got tubectomy done in the Chhoti Sadri camp after having three children. But she began to remain unwell after the operation with pain in stomach and during monsoon. season. One year after the operation she gave birth to another child. Smt. Lacchibai has this to say about her experience, "....



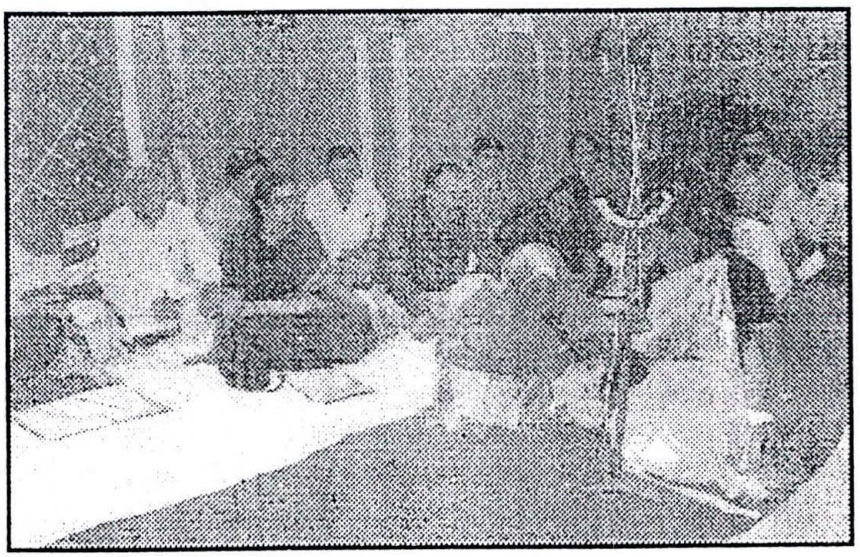
tubectomies are stressed upon and women are pursued to get tubectomies done but after that women are left on their own with no follow-up services." Her agony is that conceiving after tubectomy leads to ostracisation from the society.

Testimony 4

In the case of 30 year old **Smt. Kailashibai w/o Sh. Dama Meena r/o village Bhura** nobody ever told her about any method of family planning until her fifth child. After that also she was given information only about tubectomy and no other contraceptive option was given. One and a half year ago she got the tubectomy done and since then has been suffering from burning sensation while urinating and irregular menstruation. Due to unavailability of government services she has been seeking treatment from a private doctor but this has not been of any help and her problems still persist. Smt. Kailashibai also complains that none of her children were immunised. She feels that if she had got timely information about family planning methods she would not have had so many children and her life would have been somewhat better.

Testimony 5

18 year old Smt. **Dhamaribai** w/o Sh. Suitaram Meena r/o **village Mahidon ki Rail** conceived at the young age of 17 years. At the time of delivery even though she went to the government hospital yet the doctor sent her back home. At home ANM delivered her and the child died after two days. She says that no health care provider ever contacted her and informed her about the complications that could happen by conceiving at a young age. She says "...by conceiving at a young age I could neither take care of myself nor of my child. I not only lost my child but myself also feel very weak.



Testimony 6

42-year-old **Ratnibai w/o Sh. Laluram Meena r/o village Harmaron ki Rail** got married at the age of 18 years. Nobody told her about any methods of family planning until her fifth child. Ten years ago she got tubectomy done in a camp at Chhoti Sadri. But 6-7 months after the operation she started experiencing pain in abdomen, hands and feet, irregularity in

menstruation and white discharge. She consulted the ANM as well as PHC at Dhola Pani and took medication but with no relief. She has already spent about 3000/- rupees in the treatment so far. She says that she feels very weak after the tubectomy and is not able to do any heavy work, both agricultural as well as household. Having suffered so much she has lost faith in medicines and health care services.

Testimony 7

40 year old **Smt. Babri w/o Sh. Punjiya Meena r/o Harmaron ki Rail** got tubectomy done in a camp at Chhoti Sadri. During the operation she was aware of what was happening, which is to say that she had not been administered anaesthesia properly. 3 months after the operation she started experiencing pain in abdomen, burning sesation while urinating, irregular menstruation and white discharge. She sought treatment from the area ANM as well as private doctor but got no relief. She is very troubled by the illness and feels weak. Having spent about 800/- rupees already, she is not able to seek further treatment due to lack of money. Smt. Babri says"...I invited the problem on myself and am now looking upto god for some relief.

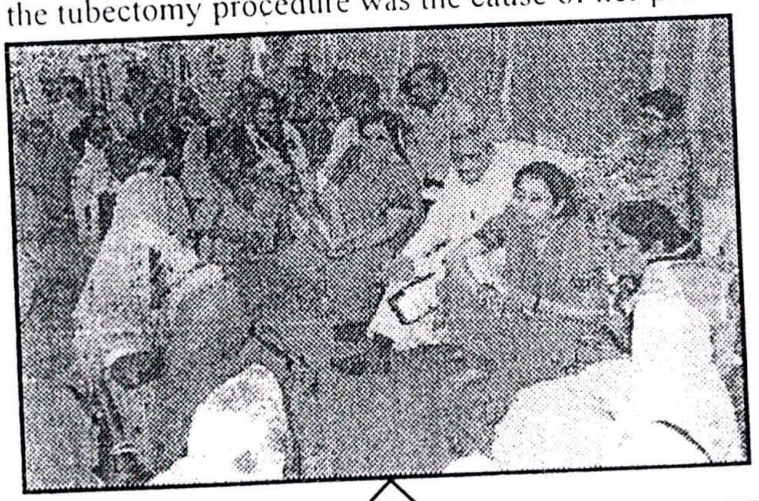
Testimony 8

27 year old **Smt. Bhulki Meena w/o Sh. Harji Meena r/o village Lavan Ki Khedi,** one day started having pain during her first pregnancy. Her husband called the compunder from the Chhoti Sadri CHC. The compounder administered an injection and a bottle of glucose which relieved her pain for a while. The compounder charged 200/- rupees and went back. After some time the woman again started having pain and also started vomiting. The family took her 8 kilometre away to Siyakhedi village in a bullock cart and from there hired a tractor to take her 30 kilometres away to Chhoti Sadri. The woman was administered a bottle of glucose in the hospital and asked to go to a private hospital in Neemach. The family hired a jeep and took her to

Neemach. She underwent caesarian there and was given two bottles of blood. In this way the family spent about 15000/- rupees in this entire treatment out of which 3500/- was the doctor's fees. The irony of the whole matter is that even after doing all this the newborn did not survive and the doctors also said that Smt. Bhulki Meena would not be able to conceive again.

Testimony 9

Smt. Bagdibai w/o Sh. Nanuram Ravat r/o village Barol got married at the age of 13 years. 4 years after the marriage she delivered her first son and two years after that another son was born to her. The third child she gave birth to, was a physically disabled girl. After her third delivery she got tubectomy done. But soon after the operation she started experiencing pain in abdomen and burning sesation while urinating. She sought treatment from the nearby government hospital. She was given a long list of medicines to buy from a medicine shop outside the hospital. As she did not have money for the medicines she mortgaged her land for 6000/- rupees. In addition to this she also had to borrow money from a money lender. Meanwhile she also started having the problem of white discharge. When she asked the doctor the reason for her problems she was told that the tubectomy procedure was the cause of her problems.



ग्राम पंचायत भोजनगर

(गीता देवी) वार्ड मेम्बर केस स्टडी–1

19

मेरा नाम गीता देवी पत्नी श्री बलवन्त सिंह गाँव भरोट डाकघर भोजनगर ब्लॉक सोलन, जिला सोलन की रहने वाली हूँ। मैं अनुसूचित जाति से सम्बन्ध रखती हूँ। जब मैं 20 साल की थी तो मेरी शादी इस गाँव में हुई। चुनाव से पहले मेरे पास तीन बच्चे 02 लड़कियां और एक लड़का था। अब मेरे पास चार बच्चे हैं। लड़का मेरे चुनाव लड़ने के बाद हुआ। 01 दिसम्बर 2000 को ग्राम पंचायत के चुनाव हुए। वार्ड भोजनगर के सभी ग्राम वासियों ने निर्णय लिया कि इस परिवार की महिला को वार्ड मेम्बर बनायेंगे। क्योंकि यह सीट अनुसूचित जाति की महिला के लिए आरक्षित थी। इस वार्ड से वार्ड मेंम्बर बनाने का जोर पण्डितों का रहा। इस वार्ड में सभी जातियों के लोग रहते हैं। हमारे वार्ड में पहली बार पंचायत में वार्ड मेंम्बर बनाई गयी। पूरे वार्ड के लोगों ने आपसी सलाह की और मुझे अनपोज विजय घोषित किया गया। वार्ड में 150 परिवार है। हमारी पंचायत में 05 वार्ड हैं। दो महिला, 03 पुरूष, प्रधान और उप–प्रधान भी महिला ही हैं।

वार्ड के लोगों की उम्मीद थी कि अगर इस परिवार की महिला को वार्ड मेंम्बर बनायेंगे तो सभी के लिए समान रूप से विकास कार्य इमानदारी तथा लगन से करवायेंगी लेकिन ऐसा नहीं हुआ।

मैं अपने वार्ड में 01 रास्ता और 01 बावड़ी बना पाई। जब मैं पंचायत में वार्ड मेंम्बर बनी तो मेरे परिवार वाले बहुत खुश थे मुझे बारह कहीं भी जाने से मना नहीं करते थे। मैंने ''सूत्र'' जगजीत नगर में तीन दिससीय आवासी प्रशिक्षण भी लिया। ब्लॉक सोलन में भी तीन दिन का प्रशिक्षण है। हर माह मैं पंचायत बैठक में जाती रही। पंचायत में सभी सदस्यों के साथ तालमेल था। वार्ड के लोग भी मुझ से खुश थे।

हिमाचल प्रदेश पंचायती राज (संशोधन) अधिनियम 2000 का अधिनियम संख्या 8 के अन्तर्गत मूल अधिनियम 1994 की संशोधित धारा 122 की उपधारा (1) के खण्ड ण के प्रावधान लागू होने के दिनांक 08.06.20001 के उपरान्त तीसरी सन्तान उत्पन्न हुई है, उन्हें इस पद से हटाया जाएगा, इस क़ानून के बारे में सूत्र की ट्रेनिंग में बताया था लेकिन मैंने इस पर कोई ध्यान नहीं दिया।

सन मार्च 2002 में चौथा बच्चा हुआ। ये बच्चा मेरे अचानक ही ठहर गया। मुझे माहवारी भी आती रही और बच्चा भी ठहर गया। जब मैंने अपना चैकअप करवाया तो मुझे पता चला कि पेट में बच्चा है। मैं ऑप्रेशन भी करवाती देती लेकिन डर के मारे नहीं करवाया क्योंकि कानून ही ऐसा बना है कि बच्चे को नहीं गिरा सकते। डॉक्टरों को भी डर है।

मार्च 2002 मे जब बच्चा पैदा हुआ तो तीन चार दिन बाद बच्चे का नाम पंचायत कार्यालय में दर्ज करवा दिया। कुछ दिन बाद मुझे उपायुक्त सोलन से कारण बताओ नोटिस प्राप्त हुआ कि आपके बच्चा हुआ है या नहीं, आप इसका जवाब दो नहीं तो आपके ऊपर कानून की धारा लगाई जाएगी। मैंने इस पत्र का कोई जवाब नहीं दिया क्योंकि ये बात सच्ची थी।

जब मुझे कारण बताओं नोटिस आया तो मैं सोचती रह गयी कि जो प्रधान बने है और वार्ड मेंम्बर बने हैं उनके तो 06–7 बच्चे हैं, उनको क्यों नहीं नोटिस आया।

दूबारा मुझे उपायुक्त सोलन से पत्र आया कि आप वार्ड मेंम्बर पद से त्यागपत्र दे दो लेकिन मैंने लिखित रूप से पंचायत को कुछ नहीं दिया। मैंने पंचायत में जाना छोड़ दिया।

जब मुझे त्याग पत्र देने का पत्र आया तो मुझे बहुत दुःख हुआ कि अब तो मेरी बेईज्जती हो गयी। दिल को बहुत बड़ा धक्का लगा। मैं सोचती रही कि प्रधान को क्यों नहीं निकाला। उसके पांच–छः बच्चे हैं। पंचायत के अन्य सदस्यों को भी मेरा बहुत दुःख हुआ। उन्हें भी इस बात का धक्का लगा। कि हमारे में से एक सदस्य को इस तरह से निकाला गया है।

सरकार ने यह अच्छा कानून नहीं बनाया। इससे महिलाओं और पुरूषों की बेईज्जती है। इस कानून को तोड़ना चाहिए। इस विषय पर गाँव से प्रस्ताव जाने चाहिए। क्योंकि आगामी चुनाव वही लड़ सकते हैं जिनके 4–5 बच्चे हैं। नई पीढ़ी वाले लोग पंचायत का चुनाव नहीं लड़ सकते। अगर बच्चा ठहर गया तो उस बच्चे को गिराना पड़ेगा या फिर पंचायत का पद छोड़ना पड़ेगा।

बच्चा पैदा करने के लिए सरकार का कोई दबाव नहीं होना चाहिए। क्योंकि सरकार हमारे बच्चों को खर्चा नहीं देती। वह बच्चों को पालती नहीं। हम दिन रात खेतों में काम करते हैं तब इन बच्चों को पालते हैं। इससे यह भी सिद्ध होता है कि काबिल आदमी चुनाव नहीं लड़ सकता।

मुझे पंचायत की तरफ से पूरा मानदेय मिल गया है। परिवार, पंचायत, गांव की तरफ से मेरी इज्जत में कोई फर्क नहीं है।

चुनावः जब मैंने पंचायत में जाना छोड़ दिया तो उसके बाद फिर से पंचायत वालों ने निर्णय लिया कि इस परिवार से किसी महिला को वार्ड मेम्बर का चुनाव किया जाए। जून 2002 में हमारे परिवार में से मेरी सास को वार्ड मेम्बर के पद पर चुना गया। इनको भी कोई वोट नहीं पड़ी। अनपोज़ ही पंचायत में लिया गया। जिस दिन मेरी सास को पंचायत में वार्ड मेंम्बर पद पर चुना गया। उस दिन पंचायत की तरफ से मुझे पार्टी दी गयी। गॉव के लोगों की जो उम्मीदें थी। मैं उनको पूरा नहीं कर पाई। उन उम्मीदों को मेरी सास श्रीमती लक्ष्मी देवी पूरा करेगी।

केस स्टडी

सुश्री मीना देवी–2

मेरा नाम मीना देवी पत्नी श्री लायक राम कश्यप गाँव खड़की डाकघर पट्टा बरावरी ब्लॉक सोलन जिला सोलन की रहने वाली हूँ। मेरी उम्र 25 वर्ष है। मेरी शिक्षा आठवीं तक है। मैं (कोली) अनुसूचित जाति से सम्बन्ध रखती हूँ। जब मैं उन्नीस वर्ष की थी तो मेरी मेरी शादी इस गाँव में हुई। मेरे पास चार बच्चे हैं। तीन लड़कियां तथा एक लड़का। लड़का तीन लड़कियों से छोटा है।

09 दिसम्बर 2000 को पंचायत के चुनाव हुए। जिस वार्ड में मैं रहती हूँ (पट्टा बरावरी) उससे दूसरा वार्ड जिसका नाम दोची है। इस वार्ड में हरिजन महिला के लिए सीट आरक्षित थी। दोची के स्वर्ण जाति के लोगों ने तथ ग्राम पंचायत प्रधान ने मुझे इस वार्ड से चुनाव लड़ने के लिए तैयार किया।

वार्ड दोची में सम्मिलित गांवः

इस वार्ड में 150 परिवार हैं।

01.दोची : स्वर्ण

02.घडयाण : स्वर्ण

03.धोडी : हरिजन– 19 परिवार

वार्ड के 150 परिवार 04 गाँव में बंटे हैं। वार्ड में हरिजनों के 19 परिवार है। ज्यादा परिवार स्वर्ण जाति के हैं। इस गाँव में स्वर्ण और हरिजन की आपसी गुटबन्दी के परिणामस्वरूप स्वर्णगुट द्वारा अपने प्रतिभय को बनाये रखने के लिए मुझे अपने वार्ड के लिए वार्ड मेंम्बर पद के लिए चयनित किया जबकि मेरा वार्ड पट्टा बरावरी है। मेरे मुकाबले में वार्ड दोची से दो महिलाएं चुनाव लड़ने के लिए तैयार कर दी। मगर उन्होंने अपने नामांकन पत्र वापिस ले लिए और मुझे अनपोज लेकर विजय घोषित कर दिया।

अपने वार्ड में मेंम्बर पद जनरल के लिए खुला था परन्तु मेरा इसमें कोई रूझान नहीं था। मैंने पहली बार वार्ड पंच का चुनाव लड़ा। मेरा विचार था कि अपने वार्ड में जो भी विकास के कार्य होंगे उन्हें मैं इमानदारी से करूंगी। वार्ड में बालवाड़ी हो, जनघर, महिलाओं के संगठन, स्वयं सहायता समूह हो, सभी रास्ते पक्के हो इत्यादि। मगर कुछ काम हुए। जैसे ग्राम पंचायत प्रधान के घर का पक्का रास्ता बना। मेरा इसमें कोई सहयोग, योगदान, प्रधान के दव, दबा व तानकसी से शून्य रहा। मैं इस पद पर तीन साल रही लेकिन ग्राम पंचायत प्रधान के कारण मै अपने वार्ड के लोगों की उम्मीदे पूरा नहीं कर पाई। इसके बावजूद भी लोग खुश रहे।

हिमाचल प्रदेश पंचायती राज (संशोधन) अधिनियम 2000 का अधिनियम संख्या 8 के अन्तर्गत मूल अधिनियम 1994 की संशोधित धारा 122 की उपधारा (1) के खण्ड ण के प्रावधान लागू होने के दिनांक 08.06.20001 के उपरान्त तीसरी सन्तान उत्पन्न हुई है, उन्हें इस पद से हटाया जाएगा, इस कानून की मुझे व मेरे परिवार वालों को कोई जानकारी नहीं थी।

चुनाव होने के एक साल उपरान्त मेरे एक लड़की हुई तथा तीन साल बाद फरवरी 2003 को लड़का पैदा हुआ। मैंने इस बच्चे का पंजीकरण ग्राम पंचायत पट्टा बरावरी में दर्ज करवा दिया। 05.03.2003 मुझे उपायुक्त सोलन से कारण बताओ नोटिस जारी हुआ जिसके परिणामस्वरूप 18.03.2003 को मैंने पंचायत में वार्ड मेंम्बर के पद से त्याग पत्र लिखकर पंचायत अधिकारी को प्रेषित किया। क्योंकि यह झूठ नहीं था। इसलिए मैंने इस पत्र का जिलाधीश महोदय को कोई जवाब नहीं दिया। मुझे 50 रूपये से 200 रूपये प्रतिमाह मानदेय मिलता रहा।

दिसम्बर 2002 से मार्च 2003 तक (चार माह) का मानदेय मुझे अभी प्राप्त नहीं हुआ है। मैंने इस विषय पर ग्राम पंचायत प्रधान से कोई बात नहीं की। जैसे मुझे जिलाधीश महोदय के द्वारा पत्र प्राप्त हुआ वैसे ही मैंने इस कानून का पालन करते हुए मैंने त्याग पत्र दे दिया तथा इसकी प्रतिलिपि ग्राम पंचायत प्रधान को भी दी, शून्य रही। जिलाधीश महोदय सोलन से जारी कारण बताओ नोटिस जब प्राप्त हुआ। इस कानून ज्ञात होते ही मुझे एक धक्का सा लगा कि मैं एक पंचायत में वार्ड मेंम्बर थी लेकिन अब मेरी क्या इज्जत रहेगी। ये मेरे साथ क्या हुआ? मेरे इस पद की अत्यन्त खुशी मेरे सास–ससुर को थी। जब मुझे नोटिस आया और मैंने अपने पद से त्याग पत्र दिया तो मेरे ससुर जी को बहुत गुस्सा आया और ससुर जी सीधे ही जिलाधीश का पत्र लेकर जिलाधीश कार्यालय सोलन पहुंचकर इस अधिनियम की जांचपड़ताल की। इन उन्हें इस कानून का पता चला और जिलाधीश ने समझाया तब शान्त हुए। परन्तु आज भी उन्हें अपनी बहू का पद छूट जाने से अति दुःख है। आगामी चुनाव की विपरित भावी योजना व विचार गठबन्धन की तैयारी मे हैं इस कानून का विरोध कर रहे हैं(कि हम दो बच्चों वालों को वोट नहीं देंगे।)

दो बच्चों का जो कानून बना है वह बिल्कुल सहीं नहीं है। महिलाओं और हरिजनों के लिए सीट आरक्षित की है। महिलाओं को बढ़ावा मिला तथा दूसरी तरफ मादाभ्रूणहत्या के लिए मजबूर कर रहे हैं जैसे दो बच्चों वाले ही चुनाव लड़ेंगे। अगर तीसरा बच्चा रह जाता है तो उसकी सफाई करवा देंगे क्योंकि इस कानून की तरफ किसी ने भी ध्यान नहीं दिया और न ही ही जानकारी थी।

इस कानून को पूर्णतया रद्द किया जाए क्योंकि इसका प्रभाव गरीब व विशेषकर महिला वर्ग तथा मादाभ्रूणहत्या पर वृद्धि। इस कानून का दूसरा प्रभाव यह भी है कि 07–08 बच्चों के माता–पिता फिर से पंचायत में आयेंगे और युवा पीढ़ी तथा गरीब समुदाय के लोग पंचायत राज में पूर्णतया वंचित रहेगी। इस पद के जाने से पारिवारिक स्तर पर मेरी इज्जत बरकरार है परन्तु सामाजिक स्तर पर मेरी इज्जत को ठेस पहुंची है। यह हादसा मेरी जिन्दगी का सबसे बड़ा है। जब से मैंने वार्ड मेम्पर का पद छोड़ा है तब से मैं गाँव में पंचायत की ओर नहीं गयी क्योंकि मुझे शर्म आती है।

परिवार वालों से जानकारीः

अब हमारे परिवार में कोई चुनाव नहीं लड़ेगा। अगर हमारे परिवार से बहू का वार्ड मेम्बर पद छीना नहीं जाता तो हम इसको आगे तक पहुंचाते। हम इस कानून का विरोध करते हैं और लिखा–पढ़ी भी करेंगे।

चुनावः

वार्ड पंच दोची में मई 2003 में दुबारा से धोड़ी गांव से महिला को चुना गया।

केस स्टडी

हरमेश चन्द–3

मेरा नाम हरमेश चन्द है। मेरी उम्र 37 वर्ष है। मेरी शिक्षा सातवीं तक है।। मेरा गाँव का नाम नालका है। मैं हरिजन परिवार से सम्बन्धित हूँ। मेरे चुनाव से पहले तीन लड़कियां थी। मैं बहुत ही गरीब हूँ। सन् 2000 में मुझे बी.डी.सी पद के लिए खड़ा किया गया। मैंने बहुत इन्कार किया लेकिन तीन चार गाँव के लिए लोगों ने मजबूर कर दिया और और अन्त में मुझ से बार–बार आग्रह करने पर मुझे चुनाव लडने लिए हाँ करनी पड़ी। मेरा मुकाबला गाँव खोखरा के मूलचन्द के साथ हुआ। चुनाव में मेरे गाँव के लोगों का पूरा सहयोग था। चुनाव में लगभग 10 दिन तक पूरे गाँव के लोग चुनाव प्रचार के लिए मेरे साथ गाँव–गाँव गये। जब शाम को सभी लोग वापिस आते तो उनके खाने–पीने की व्यवस्था करनी पड़ती थी। मेरी आर्थिक स्थिति खराब होने के बावजूद मुझे ये सभी व्यवस्था करनी पड़ी। मेरा 20,000/– रूपये चुनाव लड़ने के लिए खर्च हुआ।

उसके बाद 18 दिसम्बर 2001 को मैं पहली बार बी.डी.सी का मेम्बर बन कर अपनी ग्राम पंचायत स्नेड़ में आया। मुझे 1280 वोट तथा मूलचन्द को 720 वोट मिले। उसे दिन मेरी 14 पेटियां शराब की लगी

चुनाव के एक साल बाद मेरे एक बच्ची हुई। किसी भी सदस्य या अन्य लोगों ने इसका विरोध नहीं किया। चुनाव के अढाई साल बाद मेरे घर में लड़का हुआ। बच्चा होने के एक महीने बाद मुझे सोलन से एक पत्र प्राप्त हुआ जिसमें लिखा था कि आपके चुनाव के बाद 02 बच्चे पैदा हुए है इसलिए लोगों ने विरोध किया है कि इनको इस पद से निष्कासित किया जाए।

यह सुनकर मुझे बहुत दुःख हुआ। चुनाव के पहले मुझे इसके बारे में जानकारी नहीं दी गयी और जब 01 बच्ची हुई तब भी किसी ने विरोध नहीं किया। अब दो बच्चे होने के बाद विरोध कर रहे हैं। मुझे मार्च 2004 मे इस पद से त्याग पत्र देना पड़ा। इस बात का मेरे मन पर गहरा आघात पहुंचा कि जो गरीब बस्ती के लोगें के साथ जो मैनें जिम्मेदारी और विकास के वायदे किये थे वह सभी सपने अधूरे रह गये।

मैं गाँव के उन सभी लोगों के साथ नज़रे नहीं मिला पा रहा था क्योंकि उन्होंने मेरा पूरे चुनाव में साथ दिया वे कोई भी बात पूरी नहीं कर सका या यू समझें कि मैं झूठा साबित हुआ।

आज दिन तक हमारी हरिजन बस्ती के लोगों को ये अवसर नहीं मिला। हमारे गाँव में कभी भी किसी ने गाँव की तरफ विकास का ध्यान नहीं दिया। अब सुनहरा अवसर मिला और मैंने सोचा था कि जरूरी काम जो भी गाँव के विकास के हैं उनको पूरा करूंगा। गरीब लोगों का बहुत कम अवसर आने के लिए मिलता। बड़े–बडे वायदे करते हैं परन्तु चुनाव के बाद लोगों से मिलना या विकास के काम तो दूर शक्ल भी दिखाना पसन्द नहीं करते।

मेरा सरकार से अनुरोध है कि जो कानून सरकार ने बनाये हैं वह निराधार हैं क्योकि ये कानून सबके लिए बराबर होने चाहिए। ये कानून स्तर पर ही क्यों?

अन्य और को क्यों नहीं जैसे विधायकों व अन्य मन्त्रीमण्डल वालों को भी होना चाहिए या इस पंचायत स्तर के कानून को खारिज किया जाए।

केस स्टडी
मदन लाल (वार्ड पंच मटूली) – 4

मेरा नाम मदन लाल है। मैं गाँव मटूली डाकखाना मटूली तहसील नालागढ़ जिला सोलन हिमाचल प्रदेश का स्थाई निवासी हूँ। हरिजन साधारण परिवार से सम्बन्ध रखता हूँ। मेरी शादी 23 वर्ष की उम्र में 12 साल पहले हुई थी। शादी के एक साल बाद मेरी बड़ी बेटी का जन्म हुआ। उसके दो सल बाद दूसरी बेटी का जन्म हुआ। इस समय मेरी उम्र 35 वर्ष है। मेरी शिक्षा मिडल क्लास है। मेरी आय का कोई साधन नहीं है मैं खेतीबाड़ी तथा मजदूरी करके घर का गुजारा चलाता हूँ।

पिछले चुनाव सन् 2000 के चुनाव में मुझे सर्वसम्मति से वार्ड पंच चुनाव लड़ने के लिए मुझे तैयार किया।

गाँव की जनता मुझे मटूली पंचायत के वार्ड पंच पद के लिए मुझे अनपोज चुनना चाहती थी लेकिन कुछ विरोधी पार्टी ने मेरे मुकाबले रामभजन को चुनाव लड़ने के लिए खड़ा कर दिया। हम दोनों चुनाव मैदान में मुकाबले के लिए खड़े हुए जिसमें दोनों पक्षों का खर्चा भी हुआ। अन्त में मेरी विजय हुई।

कुल मिलाकर मेरे वार्ड में 180 वोटर थे जिसमें से मुझे 100 वोट मिले तथा मेरे विरोधी को 58 वोट प्राप्त हुए। मुझे 41 वोट से विजय घोषित किया गया। चुनाव के एक साल 05 महीने बाद फिर से मेरे दो जुड़वा बेटों ने जन्म लिया। मैं केवल डेढ़ वर्ष ही वार्ड पंच का प्रतिनिधित्व कर सका। मुझे उस समय काफी धक्का लगा जब मुझे हिमाचल प्रदेश पंचायतीराज (संसोधन) अधिनियम 2002 के नियमों के तहत मुझे मटूली पंचायत से त्याग पत्र देना पड़ा। क्योंकि जिलाधीश सोलन की ओर से तथा सचिव प्रधान ने मुझे त्याग पत्र लिखने को कहा जिसमें वार्ड पंच का पद छोड़ने को कहा गया और मुझे मार्च 2002 में पद छोड़ना पड़ा।

पद छोड़ते समय मुझे बहुत दुःख हुआ। मेरे वार्ड के लोगों को मुझे से काफी अपेक्षाएं थी। इसलिए उन्होंने चुनाव में बहुमत से वोट देकर जिताया था जिसके बदले मुझे भी अपनी जनता के लिए विकास के कार्य करवाने थे। मैंने अपने वार्ड के लिए थोड़ा ही काम कर पाया था जैसे कि अपने वार्ड के स्कूल के लिए 90 हजार, 80 हजार रूपये, खड़ौंजे के लिए मन्जूर करवाए। लेकिन मैंने मन में अपने वार्ड के लिए कार्य करवाने के लिए बहुत सारे सपने थे। जिसे मैं इमानदारी तथा लगन से करना चाहता था। लेकिन मैं बहस भी नहीं कर सकता था क्योंकि अधिनियम वर्ष 2002 के बाद दो से अधिक बच्चे होने पर कोई भी व्यक्ति पद पर बना नहीं रह सकता। यह नियम बनने से मुझे बहुत दुःख हुआ। इस नियम के बनने से हमें बहुत अपमान सहन करना पड़ा। सब की नज़रों में एक बच्चा पैदा करने से गिर गये। तब हमें महसूस हुआ कि हमें इलैक्शन नहीं लड़ना चाहिए या मेरे साथ उन लोगों को भी शर्मिन्दा होना पड़ा। जिन्होंने दूसरे पक्ष के खिलाफ वोट देकर मुझे जिताया था।

साथ ही जिन सदस्यों ने हमें जिताने के बाद मुझ से विकास कार्य की उम्मीद लगाई थी उसमें पानी फिर गया। मैं एक साल सात महीने ही वार्ड पंच का प्रतिनिधित्व कर सका।

सोमा देवी केसस्टडी–5

मेरा नाम सोमा देवी है। गाँव खोल बेली की रहने वाली हूँ। मैं गुज्जर जाति से सम्बन्ध रखती हूँ। मैं एक गरीब परिवार से सम्बन्ध रखती हूँ। हमारा मुख्य व्यवसाय पशु पालन और खेती बाड़ी करना है। मेरे दो देवर एक जेठानी और सास–ससुर जी है। खेती का काम अधिकतर महिलाएं ही करती है। मेरा पति दिहाड़ी का काम करके घर का गुजारा चलाते है।। मैं शिक्षा आठवीं पास है। मेरे पास दो लड़कियां है। जिनकी उम्र 7–09 वर्ष है। इस समय मेरी आयु 28 वर्ष है।

दिसम्बर 2002 में मेरे ससुर और गाँव के सभी लोगो ने वार्ड मेम्बर का चुनाव के लिए मेरा नाम परपोज किया। जब मुझे पता चला कि मुझे वार्ड पंच के लिए चुनना चाहते है तो मैने इन्कार किया कि मैं चुना नहीं लड़ना चाहती लेकिन मेरे परिवार वालों ने कहा कि तुझे डरने की बात नहीं हम सब लोग तेरे साथ हैं।

काफी इन्कार करने पर भी जब कोई नहीं माना और मुझे फार्म भरना पड़ा। फार्म भरते समय मुझे बहुत डर लग रहा था। और दिल में था कि अगर मैं चुनाव हार गयी तो मेरी बेईज्जती होगी

मेरा मुकाबला नयी कलौनी की लज्जो देवी के साथ हुआ। हमने काफी मेहनत की दिन–रात गाँव में जाते थे। जब हम गाँव में जाते थे तो कहीं सुनने को मिलता था कि बेटी चिन्ता मत करना तुम्हारी जीत अवश्य होगी। परन्तु मेरे पति से गाँव के लोग शराब पीने को मांगते थे। हमारे घर की स्थिति बहुत खराब थी। शाम को लोगो को खाना और शराब पीने को देनी पड़ती थी। चुनाव लड़ने लिए 15–20 हजार रूपये की जरूरत थी। इतना पैसा कहाँ से लाना था। मेरे चाचा जी ने इसकी जिम्मेवारी ली।

15 वोट से मैने वार्ड पंच का पद चुनाव जीत लिया। जिस दिन मैंने चुनाव जीता घर में खुशी की लहर आई। सभी लोगों ने खुशी मनाई और मैं भी बहुत खुश हुई और 2001 में हम पहली बार अपनी पंचायत की बैठक में गयी। कभी घर से बाहर नहीं निकली थी। थोड़ा डर लग रहा था। मैंने अपने पति को साथ चलने के लिए कहा। जिस दिन पंचायत की बैठक थी मैं अपने पति को साथ लेकर गयी। शर्म और झिझक के मारे किसी से बात नहीं कर सकती थी। बुजुर्ग लोगों के सामने कुर्सी पर बैठने में शर्म महसूस होती थी।। लेकिन मैंने धीरे–धीरे सबसे पहले शर्म छोड़ी और पंचायत बैठक में अकेली आने लगी। अपने वार्ड के विकास कार्यों को करवाना और गाँव वालो की समस्या को सुनना मेरा फर्ज बन गया। मुझे अब पंचायत के कार्य को करवाने में रूची होने लगी।

लेकिन बहुत दुःख हुआ कि चुनाव जीतने के अढ़ाई साल बाद जब मुझे बेटा पैदा हुआ तो सचिव से हमारी पंचायत को पत्र आया कि दो बच्चों के बाद तीसरा बच्चा होने कोई भी पंचायत प्रतिनिधि पद पर नहीं रह सकता और मुझे पंच पद से त्याग पत्र देना पड़ा। इसका मुझे बहत दुःख हुआ। क्योंकि हमारी जाति में ही एक महिला थी जो वार्ड पंच बनी थी। हमारी जाति में महिला को घर से बाहर नहीं जाने दिया जाता है। बड़ी मुश्किल से मुझे वार्ड पंच के लिए खड़ा किया गया था। यह जो कानून बना है, यह हम महिलाओं के लिए अच्छा नहीं है। अगर मेरे पहले बेटा होता तो मुझे

तीसरा बच्चा पैदा करने की जरूरत नहीं थी। अगर मेरे पास लड़का न होता तो मेरे परिवार वाले मेरा जीना मुश्किल कर देते। हमेशा लड़का न होने पर ताना देते। हम महिलाओं को घर, समाज को देखकर चलना पड़ता है। यह कानून महिलाओं के हित के लिए नहीं हैं। मुझे बहुत दुःख हुआ कि मुझे वार्ड पंच का पद छोड़ना पड़ा। बड़ी मुश्किल से तो महिलाओं को यह हक मिलता है उसे भी छीन लिया जाता है।

मुझे अपने जीवन में सबसे बड़ी खुशी मिली थी जब मुझे चुनाव में सफलता मिली थी उतना ही दुःख मुझे आज पद छोड़ने का था। मैं सोचती हूं कि काश मैंने चुनाव न लड़ा होता। तो अच्छा होता। अपना पंच पद छोड़ने से आसपास समाज में लोगों के ताने सुनने को तो न मिलते। जो महिला मेरे मुकाबले में खड़ी थी वह मुझे ताने देती है। जिन सदस्यों ने मेरा साथ दिया व वोट डालकर बहुमत से जिताया उनके सामने मुझे शर्मिन्दा होना पड़ता है। इस कानून के बनने से नई पीढ़ियों को बहुत कम भाग लेने में रूची लेंगे। उन्हें लगेगा कि हमारे बच्चे हो गये तो हमें भी इसी तरह पद छोड़ना पड़ेगा।

केस स्टडी - 6
हेमराज

पंचायत मण्डली नेर ग्राम पंचायत रामशहर में सदस्यों को पंचातय के प्रतिनिधि वार्ड पंच के बारे में चर्चा के दौरान सहभागियों को हिमाचल प्रदेश पंचायती राज (संशोधन) अधिनियम 2000 का अधिनियम संख्या 8 के अन्तर्गत मूल अधिनियम 1994 की संशोधित धारा 122 की उपधारा (1) के खण्ड–ण के प्रावधान लागू होने के दिनांक 08.06.20001 के उपरान्त तीसरी सन्तान उत्पन्न हुई है, उन्हें इस पद से हटाया जाएगा, की जानकारी दी गयी तथ यह भी जानकारी दी कि अन्य पंचायतों के कौन–कौन से वार्ड पंचों को अपने पदों से त्याग पत्र देना पड़ा।

उपरोक्त विषय पर चर्चा करते समय पंचायत मण्डली सदस्यों ने अपने वार्ड पंच हेमराज के बारे में बताया कि दिसम्बर 2000 को पंचायतों को चुनाव आये तो हम सब ने निर्णय लिया कि श्री हेमराज को पंच बनायेंगे। इसे हम अनपोज चुनना चाहते थे लेकिन विपक्षी पार्टी ने हेमराज के खिलाफ श्री तारा चन्द को खड़ा कर दिया। जिसमें दोनों पार्टी का खर्चा भी हुआ।

अन्त में हेमराज की विजय हुई। हेमराज को 160 वोट मिले और ताराचन्द को 32 वोट मिले। हमें बड़ी खुशी हुई कि जिसे हमने चुनाव में खड़ा किया था उसकी विजय हुई।

श्री हेमराज क पास पहले दो बेटियां थी। फिर से उनकी पत्नी को बच्चा ठहर गया। बेटे के इन्तजार में हपले ही तीन बेटियां थी जब चौथा बच्चा ठहरा तो हेमराज की पत्नी लिंग जांच करवाने के लिए नालागढ़ भी नहीं जा सकती थी क्योकि सुनीता पंचायत मण्डली से जुड़ी थी। मादाभ्रणहत्य के अन्तर्गत यह निर्णय लिया गया था कि कोई भी महिला लिंग जांच नहीं करवाने देगी और न ही लिंग जांच करवायेगी। अगर कोई महिला ऐसा करती हुई पाई गयी तो उसके खिलाफ कार्यवाही की जाएगी तथा उसे समूह से निकाल देंगे। इसी कारण सुनीता लिंग जांच करवा कर गर्भपात भी नहीं करवा सकती थी।

दिनांक 20.03.2003 को फिर से चौथी बेटी ने जन्म लिया। जब चौथी बेटी के बारे में हेमराज को पता चला तो उन्होंने अपनी बेटी भाई के नाम लिखवा दिया कि मेरे भाई के दो जुड़वा बच्चे हुए हैं ताकि उसके पद पर कोई असर न हो और अपने पंच पद को बरकरार रखा।

साथ वाड पंच को कायम रखने के लिए पंचायत प्रधान, सचिव ने पूरा सहयोग दिया जबकि विरोधी पार्टी ने इसकी छानबीन करने की मांग भी रखी थी।

दिनांक 05.03.2004 को छानबीन की गयी लेकिन कोई सबूत न मिलने के कारण छानबीन करने वाले देखते ही रह गये। हर बार प्रधान का पति इस वार्ड पंच को बचा जाते हैं जबकि लिंग अनुपात का डाटा लेते समय हेमराज की मां व परिवार वालो ने उस बेटी का नाम सुनीता वार्ड पंच की पत्नी को दो बच्चों की संख्या में लिखवाया है। यह सब वार्ड पंचों को नये काननू बनने के कारण करना पड़ा। जिसके लिए उन्हें इतनी हदें तय करने पडी। उसने अपनी बेटी को दूसरे के नाम करना पड़ा ताकि वह अपने वार्ड पंच पद को बचा सके।

केस–स्टडी

देवीदयाल–7

वार्ड मेम्बर देवीदयाल पुत्र श्री जीतराम गाँव टिपरा डाकघर सुजरपूर तहसील कसौली जिला सोलन में वार्ड न0.4 का स्थाई निवासी है। वह हरिजन जाति से सम्बन्ध रखता है। उसकी उम्र 35 वर्ष है तथा उसकी शिक्षा आठवीं पास है। वह गरीब परिवार का सदस्य है। उसके वार्ड मेम्बर बनने से पहले दो लड़कियां तथा एक लड़का था। लेकिन लड़का नपुंसक है। ।

उसका नामांकन वार्ड मेम्बर में ग्राम वासियों ने दिनांक 27 नवम्बर 2000 को सर्वसम्मति से चयनित किया था। उसमें उसके मुकाबले में गाँव का कोई भी व्यक्ति खड़ा नहीं हुआ और वह सर्वसम्मति के साथ चुना गया। उससे पहले भी हरिजन जाति का ही उस वार्ड का वार्ड पंच था। लेकिन देवीदयाल के मुकाबले में कोई भी खडा नहीं हुआ।

उसके लड़के की उम्र 10 साल है। लड़के के नपुंसक होने के कारण उसे दो लड़कियों के बाद लड़के का इन्तजार करना पड़ा। चुनाव लड़ने के बाद उसके पास तीसरी सन्तान लड़की हो गयी। वार्ड मेंम्बर बनने के के बाद गाँव पिपली वाला में दो ग्राम वासियों श्री आसाराम व रतन का पेड़ों के पीछे झगड़ा हो गया था। उस दौरान मौका वारदात के दौरान जिसका पेड़ था उसी का गवाहत के समक्ष जमीन मालिक जिसके पेड़ अपने थे उसके पेड़ों को उसी का बताया गया और उनका आपसी समझौता करवाया गया तो इस फैसले से जिस का पेड़ था वह खुश नहीं हुआ उसके गाँव की वर्षों पुरानी मांग दो पुलियों की थी। इन पुलियों के बारे में मैंने बहुत पत्राचार किया जिसके परिणाम स्वरूप जिला परिषद् और ब्लॉक समिति के मेम्बर ने इकट्ठा पैसा दिया। लेकिन पुलियों का वजट अधिक था जिसके कारण उनका काम अधूरा रह गया।

उसने गाँव में कुछ और कार्य भी करवाए जो निम्न प्रकार से है:–

01. गाँव की बावड़ी का पक्का करवाना

02. गाँव की गली का काम करवाना

03. गाँव में एक डंगे का निर्माण करवाना

उपरोक्त कार्य करवाने के बाद गाँव के लोग काफी खुश थे लेकिन शरारती तत्वों ने जो कि उसके काम को देखकर खुश नहीं हुए जिनका झगड़ा पेड़ों का था उनमें से एक व्यक्ति ने मेरे खिलाफ जिला उपायुक्त को पत्र लिखा कि हमारे वार्ड मेम्बर के चार बच्चे हैं। धारा 122 के तहत दो बच्चों से ज्यादा वाला उम्मीदवार चुनाव नहीं लड़ सकता। जिसका आरोप देवीदयाल पर लगाया गया। जबकि उसके सारे बच्चे पंचायत रिकॉर्ड के मुताबिक दर्ज थे। फिर उसके चौथे बच्चे का नाम पंचायत रिकॉर्ड में दर्ज है कि नहीं। शिकायतकर्ता ने सैक्टरी से पूछा सैक्टरी ने उत्तर दिया कि हाँ बिल्कुल दर्ज है। उसके बाद भी शिकायत कर्ता ने उपयायुक्त को बार–बार पत्राचार किया।

जबकि सभी ग्रामवासी मेरे कार्य से खुश थे। लेकिन शिकायत कर्ता ने उपयायुक्त को बार–बार पत्रा लिखने के बाद उपायुक्त ने वार्ड मेम्बर को पत्र मिला कि आप अपने बच्चों का ब्यौरा दें तो उसने इसका कोई उत्तर नहीं दिया क्योंकि 06.12.02.2002 को उसके पास चौथा बच्चा हो गया था।

उपायुक्त के पत्र मिलने के बाद वार्ड मेम्बर को 15 दिन बाद बाद मेम्बरशीप से रद्द करने का पत्र दिया गया। जिसके उपरान्त देवीदयाल को वार्ड पंच पद से निलम्बित कर दिया गया।

गाँव के विकास कार्यों में वार्ड मेम्बर की बहत दिलचस्पी थी। इसलिए इसलिए वार्ड मैंम्बर को उचित न्याय दिलाया जाए।

पद से बरखास्त करने के बाद बहुत से गाँव के लोगों को धक्का लगा क्योंकि उकना कहना था कि हमारे गाँव में पहले भी पंच बने थे लेकिन हमारे गाँव को जाने के लिए दो बड़े–बड़े नाले पड़ते है जिससे किसी ने भी पुलियों की मांग नहीं की व पुलियों का कार्य नहीं करवाया था।

लेकिन देवीदयाल ने दोनो पुलियां बनवा दी थी। लेकिन गाँव के एक ही आदमी ने शिकायत करके पंचायत से निकलवा दिया जिसका असर घरवालों पर भी बहुत बुरा पड़ा जो पुलियों का कार्य वार्ड मेंम्बर देवीदयाल ने करवाया था वह वहीं तक सीमित है। इसके आगे कोई कार्य नहीं हुआ। वह कार्य अभी अधूरा पड़ा है।

केस–स्टडी

जगत राम – 8

मेरा नाम जगत राम ठाकुर पुत्र श्री गोपाल राम ठाकुर है। मैं गाँव नवगांव, डाकघर नवगांव, ब्लॉक कुनिहार, जिला सोलन का स्थाई निवासी हूँ। मेरी उम्र 38 वर्ष है। मैं राजपूत जाति से सम्बन्ध रखता हूँ। मेरी शादी 24 वर्ष की उम्र में हुई थी। मेरी शिक्षा बी.ए पास है। मेरे पांच बच्चे हैं। चार लड़कियां और एक लड़का।

दिसम्बर 2000 में पंचायत के चुनाव हुए तथा इस चुनाव में मैंन स्वयं वार्ड मेम्बर बनने का निर्णय लिया क्योंकि कुछ साल पहले मेरे मकान गिर गये थे। मैंने पंचायत के प्रधान तथा वार्ड मेम्बर से कहा कि मेरी मदद करो लेकिन किसी ने भी मेरी मदद नहीं की। इसलिए मुझे गुस्सा था। हमारे रिश्तेदार एम.एल.ए धर्मपाल भी है लेकिन कोई सुनवाई नहीं करता।

मैंने वार्ड न0.2 नवगांव से चुनाव लड़ा जो दूसरा वार्ड था जब मैंने फार्म भरा तो किसी ने भी एतराज नहीं किया। मैंने पहली बार चुनाव लड़ा। मेरे मुकाबले में एक सदस्य खड़ा हुआ और मैं 68 वोटों से जीत गया। जब मैं जीता तो मुझे खुशी हुई कि अब मैं अपने वार्ड के लिए कुछ करूंगा।

पंचायत में जिसके साथ अन्याय हो रहा हो उसको न्याय दिलाना तथा जिसका हक है उसी पात्तर को हक मिलना चाहिए, इमानदारी से लोगों का काम करना तथा संघर्ष करना, ये मेरी उम्मीदें थी। हमारे वार्ड के लिए सीट ओपन हुई थी। मुझे पंचायत का कार्य करने के लिए एक साल मिला जो मेरी उम्मीदें थी, मैं कुछ कार्य नहीं कर पाया। अपने वार्ड में एक रास्ता बनाया। वार्ड के लोग मुझ से खुश है। चुनाव से पहले मेरे चार लड़कियां थी। चुनाव से पहले मेरी पत्नी को तीन–चार बार गर्भ ठहरा एक बार तो सफाई करवा दी लेकिन जब दूसरी तीसरी बार जब गर्भ ठहरा तो शिमला में अल्ट्रसांउड करवा तो पता चला कि लड़की है तो उसकी सफाई करवा दी। उसके बाद जब गर्भ ठहरा तो चैक नहीं करवाया और लड़का हुआ।

27 फरवरी 2004 को बच्चा पैदा हुआ और 05 दिन बाद बच्चे को पंचायत में दर्ज करवा दिया। फिर 20–25 दिन बाद मुझे कारण बताओ नोटिस मेरे नाम से आया। मैंने कोई कार्यवाही नहीं की और पंचायत में जाकर त्यागपत्र दे दिया। उसके बाद ग्राम पंचायत को कारण बताओ नोटिस आया। इसके लिए प्रधान ने मेरी कोई मदद नहीं की।

मुझे इस कानून का कोई पता नहीं था। जब कारण बताओ नोटिस जिला कार्यालय से प्राप्त हुआ तब पता चला तो मुझे बहुत दुःख हुआ। मेरे वार्ड के लोगों को भी दुःख हुआ। सरकार ने ये जो कानून बनाया, ये कानून गलत है या तो सब के लिए लागू होना चाहिए, नहीं तो किसी के लिए नहीं होना चाहिए।

अगर ये कानून रहा तो काबिल आदमी पंचायत के चुनाव नहीं लड़ सकता दूसरे नई पीढ़ी के लोग ग्राम पंचायत का चुनाव नहीं लड़ सकते क्योंकि अगर गर्भ ठहर जाता है

तो कानून के डर से बच्चे को गिरा देंगे। अगर बच्चा हो गया तो पद छोड़ना पड़ेगा। ये कानून गलत है, उसको तोड़ना चाहिए।

अप्रैल 2003 को वार्ड न0.2 को दूबारा से चुनाव हुआ तथा मेरे परिवार से मेरे चाचा जी को वार्ड मेंम्बर बनाया गया जिनका नाम हीरा सिंह है तथा इनकी शिक्षा आठवीं पास है। अभी तक इन्होंने वार्ड के लिए कोई कार्य नहीं किया।

केस–स्टडी हिमा देवी – 9
ग्राम पंचायत संघोई

मेरा नाम हिमा देवी पत्नी श्री परस राम ग्राम घरैल डाकघर मांजू, तहसील अर्की, ब्लॉक कुनिहार जिला सोलन की स्थाई निवासी हूँ। मेरी उम्र 26 वर्ष है। मैं अनुसूचित जाति (कोली) से सम्बन्ध रखती हूँ। मेरी शादी 19 वर्ष में हुई थी। मेरी शिक्षा आठवीं पास है। मेरे चार बच्चे हैं। (तीन लड़कियां और एक लड़का)

दिसम्बर 2000 मे ग्राम पंचायत के चुनाव हुए। जिसमें मुझे गाँव के लोगों द्वारा प्रोत्साहित किया गया। मैंने पहली बार चुनाव लड़ा। मैंने वार्ड न03 से चुनाव लड़ा। मुझे पूरे वार्ड से विजय घोषित किया गया। मेरे मुकाबले मे कोई भी अन्य सदस्य नहीं थी। जब मैं वार्ड मेम्बर बनी तो लोगों की मेरे से बहुत से उम्मीदें थी कि हमारे वार्ड में सड़के, बावड़ी का निर्माण और अन्य सुधार की अपेक्षा थी। मेरी सीट अनुसूचित महिला के लिए आरक्षित थी। जब तक मैं वार्ड मेम्बर के पद पर रही उस समय मैंने गाँव संघोई के लिए जो कार्य किये जैसे–हवाघर का बनाना, बावड़ी बनाना, रास्ते का निर्माण करना आदि कार्य किये।

लोग मेरे कार्य से खुश थे। चुनाव से पहले मेरी 02 लड़कियां थी और चुनाव से एक साल बाद भी एक लड़की पैदा हुई थी और फिर बाद में लड़का पैदा हुआ।

हिमाचल प्रदेश पंचायती राज (संशोधन) अधिनियम 2000 का अधिनियम संख्या 8 के अन्तर्गत मूल अधिनियम 1994 की संशोधित धारा 122 की उपधारा (1) के खण्ड ण के प्रावधान लागू होने के दिनांक 08.06.20001 के उपरान्त तीसरी सन्तान उत्पन्न हुई है, उन्हें इस पद से हटाया जाएगा, इस कानून की मुझे व मेरे परिवार वालों को कोई जानकारी नहीं थी। बच्चा पैदा होने के बाद मैंने पंचायत में बच्चों के नाम दर्ज करवाए थे और कुछ महीने बाद पंचायत समिति की सदस्या हमारी ग्राम पंचायत की बैठक में आई और पंचायत से पूरा रिकॉर्ड ले गयी। उन्होंने बी.डी.सी ऑफिस में (विकास खण्ड अधिकारी) को सूचना दी और कुछ दिन बाद मुझे जिलाधीश सोलन से कारण बताओ नोटिस का पत्र आया लेकिन मैंने उसका कोई जवाब नहीं दिया और मुझे बी.डी.ओ. सोलन से कारण बताओ नोटिस का पत्र आया। लेकिन मैंने इसका कोई जवाब नहीं दिया। मुझे वी.डी.ओ. द्वारा कहा गया कि आप वार्ड मेम्बर पद से त्याग पत्र दे दो। लेकिन ग्राम पंचायत प्रधान ने मना किया कि अभी आप रहने दो। फिर दूसरा पत्र आया कि आप अपने पद से त्याग पत्र दे दो नहीं तो आपके ऊपर धारा लगाई जाएगी। जब मुझे कारण बताओ नोटिस का पत्र आया तो मैं डर गयी कि ये कौन सा पत्र आया है और अब क्या होगा? मैंने अपने परिवार वालों को बताया तो उन्होंने मुझे हिम्मत दी कि इसका कुछ नहीं होगा फिर मैंने गाँव वालों को बताया तथा फिर पंचायत में लेकिन सब को हैरानी हुई और दुःख भी हुआ लेकिन मुझे हिम्मत देते रहे। मैंने वार्ड के लोगों की जो मरे से उम्मीदें थी वह मैं पूरी नहीं कर पाई क्योंकि ये जो कानून है, गलत है कि दो बच्चों वाले ही चुनाव लड़ सकते हैं। इस में काबिल आदमी पंचायत के चुनाव से वंचित रह जायेंगे। नई पीढ़ी के लोग पंचायत के चुनाव नहीं लड़ सकते क्योंकि नई पीढ़ी के लोगों की उम्र 24

साल से 40 साल तक चुनाव में भाग नहीं ले सकते क्योंकि अगर बीच में गर्भ ठहर जाता है तो उस बच्चे की सफाई की जाएगी या फिर बच्चे को दूसरे के नाम पर पंचायत में लिखा जाएगा। जिसमें लड़ाई झगड़ा होने की सम्भावना है और बाद में बच्चे को जायदाद से वंचित रहना पड़ेगा। परिवार में मेरी इज्जत वैसी ही है जो पहले थी और गाँव वालों में भी इज्जत वैसी ही है।

आगामी चुनाव के लिए हमारे परिवार से चुनाव लड़ने के लिए तैयार हैं और वह चुनाव लड़ेगे। बच्चे पैदा करने के लिए सरकार का कोई दबाव नहीं होना चाहिए। अपनी इच्छा से बच्चे पैदा करने का अधिकार स्वयं का होना चाहिए।

मैं ग्राम पंचायत की हर बैठक में भाग लेती थी। मुझे शुरू से 50 रूपये मिलता था और बाद में 100 रूपये। मेरे वार्ड से एक महिला को दूबारा से अनपोज चुना गया। जिसका नाम हीरादेई है।

केस–स्टडी देवेन्द्र कुमार – 10
ग्राम पंचायत बखालग

मेरा नाम देवेन्द्र कुमार सुपुत्र स्वर्गीय श्री कृष्ण लाल गाँव चन्दपूर डाकघर बखालग जिला सोलन ब्लॉक कुनिहार का स्थाई निवासी हूँ। मेरी उम्र 33 साल है। मैं स्वर्ण जाति (खतरी से सम्बन्ध रखता हूँ। मेरी शिक्षा बी.ए तक है। मेरी शादी 21 वर्ष में हुई थी मेरे तीन बच्चे (दो लडकियां तथा एक लड़का) है।

मेरे पास चुनाव से पहले दो लड़कियां थी। दिसम्बर 2000 में ग्राम पंचायत के चुनाव हुए। वार्ड के सभी लोगों ने मुझे चुनाव लड़ने के लिए प्रेरित किया और मुझे अनपोज ही वार्ड मेम्बर घोषित कर दिया गया। हमारे वार्ड की सीट ओपन थी। मैंने पहली बार ग्राम पंचायत का चुनाव लड़ा। मुझे से लोगों को उम्मीदें थी कि हमारे वार्ड में जितने भी विकास के कार्य हो, वह सही हो, जैसे– गाँव के रास्ते पक्के बनाना।

बावडी का पक्का करवाना। हमारे गाँव में 37 साल पुराना प्राथमिक पाठशाला को मिडल स्कूल बनाना और मेरे पढ़े–लिखे होने से पंचायत के कार्य में बदलाव लाना।

जब तक मुझे पंचायत के कार्य करने का मौका मिला। उस दौरान मैं अपने वार्ड में एक रास्ता पक्का और एक पीने के पानी की बावड़ी बनवाई। प्राथमिक पाठशाला को आठवीं तक बनवाया। मेरे पंचायत के सदस्य तथा वार्ड के लोग मेरे कार्य से खुश थे। यह चुनाव सन 2003 में हुआ।हिमाचल प्रदेश पंचायती राज (संशोधन) अधिनियम 2000 का अधिनियम संख्या 8 के अन्तर्गत मूल अधिनियम 1994 की संशोधित धारा 122 की उपधारा (1) के खण्ड ण के प्रावधान लागू होने के दिनांक 08.06.20001 के उपरान्त तीसरी सन्तान उत्पन्न हुई है, उन्हें इस पद से हटाया जाएगा, इस कानून की मुझे व मेरे परिवार वालों को कोई जानकारी नहीं थी।

08.06.2001 को कानून लागू हुआ और 18.06.2001 को लड़का पैदा हुआ। मैंने तीन–चार दिन बाद पंचायत में बच्चा दर्ज करवा दिया। पंचायत सचिव द्वारा विकास खण्ड अधिकारी को रिपोर्ट दी गयी। कुछ दिन बाद मुझे जिलाधीश सोलन से कारण बताओं नोटिस का पत्र आया। इसका मैंने कोई जवाब नहीं दिया। मैं पंचायत की बैठक में जाता रहा लेकिन मैंने वहां हंस्ताक्षर नहीं किये। हस्ताक्षर करने के लिए मुझे पंचायत सचिव ने मना कर दी। कुछ दिन बाद मुझे आदेश जारी किया गया कि आपको त्याग पत्र देना पड़ेगा लेकिन मैंने कोई भी त्याग पत्र नहीं दिया और न ही पंचायत को लिखकर दिया है। ग्राम पंचायत के प्रधान ने मेरी कोई सहायता नहीं की।

जब कारण बताओ नोटिस आया तो मुझे बहुत दुःख हुआ तथा रोना भी आया कि अब मैं आगे नहीं बढ़ सकता तथा लोगों की उम्मीदों को पूरा नहीं कर सकता। मेरे वार्ड के लोगों/परिवार को भी इस बात का दुःख हुआ लेकिन सरकार का कानून है। इसलिए मैं चुप रहा। जो इज्जत मेरी वार्ड मेम्बर पद से बनी थी उसमें भी फर्क आया। अगर सरकार ने जनसंख्या कम करनी है तो ये कानून नीचे स्तर से ऊंचे स्तर के तक होना चाहिए।

पढ़े–लिखे, कम उम्र, काबिल आदमी पंचायत के चुनाव से वंचित रह सकते है क्योंकि अगर किसी के गर्भ ठहर गया या लिंग जांच करवायेंगे अगर लड़की हुई तो गिरा देंगे। इससे मादाभ्रूणहत्या बढ़ेगी या फिर बच्चा और किसी के नाम से दर्ज किया जाएगा। जायदाद के पीछे झगड़ा होगा। अगर महिला के बार–बार बच्चे होंगे तो महिला को बीमारी भी लग सकती है।

हमारे परिवार से अब कोई भी पंचायत का चुनाव नहीं लड़ेगा क्योंकि अब इसमें कोई रूची नहीं रही। बच्चे पैदा करने के लिए सरकार का दबाव नहीं होना चाहिए। अपनी इच्छा होनी चाहिए कि कितने बच्चे पैदा करने हैं। मुझे मानदेय हर माह मिलता रहा।

मेरे वार्ड में 2003 में दूबारा से चुनाव किया गया जिसका नाम पदम चन्द है। इनको भी अनपोज ही विजय घोषित किया गया।

MADHYA PRADESH

Case Study -1

Sarpanch	-	**Mrs. Geeta Madan Pandole**
Village	-	**Valni**
Panchayat	-	**Valni**
Development Block	-	**Prabhatpattan**
District	-	**Betul (M.P.)**

Geeta Pandole was elected to the post of Sarpanch for the first time. She has four daughters. Her fourth daughter was born on 26th January 2001 and after one and half months later she came to know about this law. Prior to this, no one had told her that there had been an amendment in the Panchayat Raj system. The unexpected information staggered all, her and the villagers as well, who had elected her. The villagers thought what kind of a democratic system was it that a person they had chosen with their votes would be removed from her post in such a manner. They gave a written letter objecting to this step. They promised her every help, but due to economic constraints, she couldn't fight.

Geeta has received formal education up to eighth standard. The woman representative who has replaced Geeta, happens to be illiterate.

Geetabai says that giving birth to a male child is a social demand. It is not her fault that she delivered four girls? Geetabai is a wise and active woman who, apart from increasing her interaction with her fellow villagers, has also got roads and a well constructed in her village. She has also brought the benefits of the Indira Awas Yojna to the eligible villagers and led in constituting a women's group.

Case Study -2

Sarpanch	-	**Mrs. Prenvati SunderSailu**
Village	-	**Handipani**
Panchayat	-	**Handipani**
Developmental Block	-	**Shahpur**
District	-	**Betul**

Mrs. Premvati Sailu, aged 28, got elected to the post of Sarpanch for the first time. Her husband was also a Panch. He too has been removed. They have four girls. Sunder Sailu is the only child (son) in his family. He is worried that his family's name would be wiped out if he did not have any son.

Premvatibai came to know about the law in March 2004, when she was carrying the fourth baby in her womb. They were advised to terminate the pregnancy, but it being the eighth month, it was not medically possible. She delivered a female child. Premvati is carrying another baby presently and is in her ninth month. Population control and the post of Sarpanch are secondary priorities compared to the yearning for a male child.

Premvati Bai has undertaken several development works during her tenure. She got a road, a pond, a school building constructed; constituted three Self-help Groups that are still functioning with her guidance. She says politics is secondary priority in her life. She needs a male child to carry on the family name. But she regrets that her removal has brought to halt several development works like issuing the children of the village caste certificates.

'We were sent a copy of the court decision in English. We've written to the District Collector that we don't know English; hence we may be sent its Hindi translation. Changing laws so frequently affects the village community adversely.'

N.B.:- The Sarpanch can't come to Delhi, being in the ninth month of pregnancy.

Case Study – 3

Sarpanch	-	**Mrs. Ramkali Panse**
Village	-	**Naharpur**
Panchayat	-	**Kamod**
Development Block	-	**Bhimpur**
District	-	**Betul (M.P.)**

'The Government talks of promoting women and yet puts them in trouble,' says the ex-Sarpanch, Ramkali Panse, removed from her post because of a complaint that she has more than two children. She was removed from her post on 01/06/2004. Earlier, she was dismissed on 29/11/00 and she got a stay order on 16/01/2003. Regarding her third child, she says her family experience tells her she must have at least two male children for looking after them in old age as the son of her elder brother-in-law fell sick at the age of 8 and eventually died.

"Fighting this case caused us economic loss at first. We had to appear in the SDM's court and then, before the Collector, leaving all our other work. We did fight it in the High Court, but that too was a costly affair. But, we do want that a poor tribal should get justice and laws that adversely affect women and make a poor family retrogressive in its thinking should better not be passed.'

Ramkali likes her work as a Sarpanch and has undertaken several development works during her tenure. She was responsible for getting constructed two school buildings, three wells, five community centers, an aanganwadi building, a road, a check dam and a stop dam with the help of voluntary community labor. 'I do want to bring development to my village, but have no say in this matter. My opponents made a complaint after I gave birth to my third child and I had to give up my post. There are lots of Sarpanches whose third child was born after 26th January 2001, but they have not been removed as no complaint has been made against them. Such double standards confound our thinking and foster mutual hostility amongst people.

Case Study – 4

Panch	-	**Mrs. Indravati/Lakhan Kasde**
Village	-	**Chapra Raiyat**
Panchayat	-	**Pahavadi**
Developmental Block	-	**Sahapur**
District	-	**Betul (M.P.)**

'The law of the Government, introduced in 2001, stipulating removal of Panchayat representatives having more than three children is violating the rights of the people like us belonging to the lower sections. This is a law, we don't endorse.

I was elected unanimously from Ward 11 and devoted myself fully to village development. 'During my tenure, I got roads constructed in my ward, houses for three villagers under the Indira Awas Yojna, a *chaupal* and a school building. I also got the existing roads mended.

'The villagers elected me of their own will. I was elected unanimously. My father-in-law is also an ex-Panch from the same ward. I'm not educated, but I do help people in development work.

'I encouraged women's participation in village development work; constituted women Self-help Group and am its member still. I didn't know I'd be removed from my post under this law; otherwise I'd not have been in the fray. The law has hurt my honor. The decision of the Government is utterly wrong. Had I known it earlier, I'd have certainly resigned from my post of my own will.'

Case Study -5

Panch	-	**Mrs. Ramvati/Sarvan Lal Parkade**
Village	-	**Pather**
Panchayat	-	**Pather**
Development Block	-	**Ghoradongri**
District	-	**Betul (M.P.)**

Ramvati Bai was elected to the post of Panch for the first time. She has three children. The third girl was born to her after 26th January 2001. By then, no body had told her that there had been an amendment in the Panchayat Raj system. Thus, the unexpected news saddened her and the villagers as well who had elected her. They wondered - 'What sort of news is this? How can the person elected by our votes in a democratic system be removed like this! Our vote has gone waste.'

Ramvati Bai is illiterate, but does know what the development of the village means. It was for this reason the villagers elected her. She undertook village development works like road construction, installation of hand pumps and tube wells etc.

Ramvati Bai says the whole thing is wrong. Had she known before, she wouldn't have contested the election. Wrong kind of persons would get elected due to such laws.

Case Study – 6

Panch	-	**Mrs. Surgati Bai/Harishankar Aahok**
Village	-	**Khari (Jamundhanar)**
Panchayat	-	**Khari**
Development Block	-	**Ghoradongri**
District	-	**Betul (M.P.)**

Surgati Bai Aahok had been elected to the post of Panch for the first time from Ward no. 2 of Khari Panchayat. She was removed from her post after 26th January 2001, when she gave birth to her third child.

'Had I known earlier, I wouldn't have contested the election. I came to know about this law when I was pregnant. The law is all wrong. The Government is doing injustice with the Panchayat representatives.'

Surgati Bai has done village development works like road construction and Indira Awas Yojna etc in her ward. She is of the opinion that this law has hurt her honor. Suragati Bai is a wise and active woman.

Case Study – 7

Panch	-	**Mrs. Phoolvati/Mauzi Dhurve**
Village	-	**Chapra**
Panchayat	-	**Pahawadi**
Development Block	-	**Shahpur**
District	-	**Betul (M.P.)**

Phoolvati Bai got elected as Panch for the first time and unanimously. She has six children. The third child was born in March 2001.

'The Sarpanch, the Up-sarpanch and the Secretary tell us nothing. I have taken keen interest in development work since I got elected. Though, I couldn't do much for I didn't get much information about Panchayat work. I want to learn and do something.

I didn't know about this rule. I was not given even a notice. I was dismissed straight away.'

केस स्टेडी नं. 1

सरपंच	–	श्रीमति गीता मदन पंडोले
ग्राम	–	वलनी
पंचायत	–	वलनी
विकास खण्ड	–	प्रभातपट्टन
जिला	–	बैतूल (म.प्र.)

गीता पंडोले पहली बार पंचायत में सरपंच पद पर चुनकर आई उनकी चार लड़कियां है, 26 जनवरी 2001 के बाद चौथी लड़की पैदा हुई उसके डेढ़ माह बाद गीता को इस कानून की जानकारी हुई इसके पूर्व उसे किसी ने नहीं बताया था कि पंचायती राज व्यवस्था में संशोधन हुआ है । इस अचानक आई जानकारी पर वह स्वयं एवं गावं वाले जिन्होने चुना था, उन्हे अचंभित कर दिया, यह क्या खबर है इस लोक तांत्रिक व्यवस्था में हमने अपना मत देकर जिसे चुना था, उसे इस तरह कैसे हटाया जा सकता है । ग्राम पंचायत के लोगों ने लिखित में जिलाधीश को आपत्ति पत्र दिया एवं हर संभव प्रयास हेतु तैयार थे, परन्तु आर्थिक परेशानी के कारण यह संभव नहीं हो सका ।

गीता बाई आठवी कक्षा तक शिक्षित है । वर्तमान में जिस महिला को प्रभार दिया गया वह अशिक्षित है ।

गीता बाई का कहना है की यह सामाजिक व्यवस्था है कि एक लड़का होना चाहिए । चार लड़कियां हो गई, इसमें मेरी क्या गलती है । गीता बाई समझदार एवं सक्रिय महिला है, जिन्होने गांव के साथ संवाद बढ़ाने के साथ ही सड़क निर्माण, कुआं निर्माण, इन्दिरा आवास महिला समूह गठन इत्यादि कार्य भी अपने गांव के लिए किये है ।

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केस स्टेडी नं. 2

सरपंच	–	श्रीमति प्रेमवती सुंदर सैलू
ग्राम	–	हांडीपानी
पंचायत	–	हांडीपानी
विकास खण्ड	–	शाहपुर
जिला	–	बैतूल (म.प्र.)

श्रीमति प्रेमवती सैलू (28 साल) प्रथम बार सरपंच के पद पर चुनकर आई इनके पति श्री सुन्दर सैलू भी पंच थे, उन्हें भी निष्काषित कर दिया गया । प्रेमवती बाई पंचायत चुनाव में महिला आरक्षण के तहत चुनकर आई थी । प्रेमवति बाई को चार लड़कियां है । सुन्दर सैलू अपने परिवार में एकलोता है। अत : सुन्दर का कहना है कि यदि मेरा बैटा नहीं हुआ तो में मेरा भी नामोनिशान मिट जायेगा ।

प्रमवति बाई को इस कानून की खबर जब चौथा बच्चा पेट में था (सुनकर आने के बाद) मार्च 2004 में पता लगी, उन्हे सलाह दी गई की अबार्शन करवा लो परन्तु आठ माह का गर्भ था, अतः यह संभव नहीं था, लड़की पैदा हुई, इस माह तक प्रेमवति नौ माह से गर्भवती है । लड़के की चाह में जनसंख्या नियंत्रण या सरपंच का पद दोनो ही प्राथमिक नहीं है ।

प्रेमवति बाई ने अपने कार्यकाल में कई कार्य करवायें जैसे सड़क, तलाब, शाला, भवन, तीन स्वयं सहायता समूह बनवाये जो की आपके मार्ग दर्शन से सक्रिय है, प्रेमवति बाई का कहना है कि राजनिति करना हमारे लिए साधाराण कार्य हैं । हमें लड़का चाहिए जो भविष्य में देखेगा । परन्तु मुझे हटाने से कई विकास कार्य रूक गये, जैसे बच्चो के जाति प्रमाण पत्र इत्यादि ।

हमें आदेश के साथ कोर्ट के फैसले कि अंग्रेजी प्रति भेजी गई, हमनें जिला कलेक्टर को लिखकर भेजा है, हमें अंग्रेजी समझ में नहीं आती इसे हिन्दी में अनुवाद करके भेजे । सरकार के बार बार नियम कानून के बदलने से गावं समाज के उपर विपरीत असर पड़ता है ।

नोट :– यह सरपंच 9 माह से गर्भवती है, अतः दिल्ली नहीं जापायेगी ।

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केस स्टेडी नं. 3

सरपंच – श्रीमति रामकली पांसे
ग्राम – नहरपुर
पंचायत – कामोद
विकास खण्ड – भीमपुर
जिला – बैतूल (म.प्र.)

सरकार महिलाओं को आगें बढ़ने की बात कहती है, परन्तु महिलाओं को ही परेशानी में डालती है, यह कहना है तीसरी संतान होने की शिकायत पर हटाई गई पूर्व सरपंच रामकली पांसे का ।

रामकली बाई का 01/06/2004 को पद से हटाया गया इससे पूर्व 29/11/0 को पद से हटाया गया था हाईकोर्ट से 16/1/2003 को स्टे आर्डर मिल गया था ।

रामकली का तीसरी संतान के बारे में कहना है कि हमारे परिवार का अनुभव है कि मेरे जैठ का लड़का 8 साल का होने पर बीमार होकर मर गया था । मेरा परिवार चहाता है कि मेरे दो बेटे हो जिससे वृदावस्था में हमारा सहारा बने ।

इस केस में हमें आर्थिक हानि होती है, सभी कार्य को छोड़कर एम.डी. एम कोर्ट में पेशी पर जाना पड़ा, फिर कलेक्टर के पास जाना पड़ा । हाईकोर्ट में केस लड़ा उससे भी आर्थिक हानि उठानी पड़ी परन्तु हम चहाते है कि गरिब आदिवासी को उनका न्याय मिलें एवं इस तरह के नियम कानून न बनाये जिसका प्रभाव महिला एवं गरीब परिवार के सोच में ठहराव लाये ।

श्रीमति रामकली बाई को सरपंच का कार्य करना अच्छा लगता है, उनके कार्यकाल में कई विकास कार्य हुए है जैसे दो शाला भवन, तीन कुंए, पांच सामुदायिक भवन, एक आंगनवाड़ी भवन, सड़क निर्माण, चैक डेम, स्टाप डेम श्रमदान निर्माण से बनाया गया । मैं गांव का विकास करना चाहती हूँ, परन्तु पद से हटने पर कोई अधिकार नहीं है । मेरी तीसरी संतान पैदा होने पर विरोधि ायों ने शिकायत कर दी और मुझे पद से हटना पड़ा था, अभि जिले में बहुत से ऐसे सरपंच आज भी पद पर बने हुये, जिनके 26 जनवरी 2001 के बाद संतान होने पर शिकायत नहीं हुई, यह दोहरापन हमारी सोच को पेचिदा बनाता है एवं व्यक्तिगत दुराव भी बनता है ।

केस स्टेडी नं. 4

पंच – श्रीमति इन्द्रावति / लखन कसदे

ग्राम – चापड़ा रैयत

पंचायत – पहावाड़ी

विकास खण्ड – शाहपुर

जिला – बैतूल (म.प्र.)

सरकार का 2001 के बाद तीन संतान वालो को (पंचायत सदस्य गण) निकालने का कानून हमें नीचें दर्जे के लोगों के अधिकारों का हनन हो रहा है । यह कानून गलत है, में वार्ड क्र. 11 से पहली बार निर्विरोध चुनाव जीत कर आई और ग्राम विकास के कार्य में तन मन से जुट गई ।

मैंने अपने कार्य काल में तीन लोगों को इन्दिरा आवास, और वार्उ में सड़क निर्माण, सड़को की मरम्मत, चौपाल निर्माण, शाला भवन निर्माण आदि कार्य किये ।

मुझे गांव के लोगों ने अपनी स्वेच्छा से चुनाव में खड़ा किया और में उस वार्ड से निर्विरोध ा जीती मेरे ससुर भी पूर्व में पंच थे, इसके बाद मैं पंच बनी मैं पढ़ी लिखी नहीं हूँ, पर विकास कार्य में लोगो की मदद करती हूँ ।

मैंने महिला की भागीदारी ग्राम विकास कार्यो में एवं स्वयं विकास के लिए महिला स्व सहायता समूह का निर्माण किया जिसमें मैं भी सदस्य हूँ, हमें पूर्व में ऐसा मालूम नहीं था, कि तीन बच्चों के कानून में मुझे निकाल दिया जायेगा, नहीं तो मैं पंच नहीं बनती, इससे मेरे सम्मान को ठेस पहुचीं है, सरकार का यह निर्णय गलत है, पहलें पता होता तो मैं स्वेच्छा से इस्तीफा दें देती ।

केस स्टेडी नं. 5

श्रीमति रामवती / सरवन लाल परकड़े

ग्राम – पाठर

पंचायत – पाठर

विकास खण्ड – घोड़ाडोंगरी

जिला – बैतूल (म.प्र.)

रामवती बाई परकड़े पहली बार पंच पद पर चुनकर आई उनके तीन बच्चे है, 26 जनवरी 2001 के बाद तीसरी लड़की पैदा हुई, उससे पहले उसे किसी ने नहीं बताया था की पंचायती राज व्यवस्था में संशोधन हुआ है । इस प्रकार की अचानक आई जानकारी पर वह खंड एवं गांव वाले जिन्होंने चुना था वे खुद दुखी हो गये कि यह क्या खबर है ।

लोकतांत्रिक व्यवस्था में हमने अपना मत देकर जिसे चुना था, उसे इस तरह कैसे हटाया जा सकता है, हमारा वोट व्यर्थ गया । रामवती बाई अशिक्षित है, परन्तु गांव के (वार्ड) विकास की समझ रखती है, इसलिये लोगों में अपना नेता चुना था । ग्राम विकास कामों में सड़क निर्माण, हैण्डपंप खनन, ट्युबवेल आदि कार्य किये ।

रामवती बाई का कहना है कि यह गलत कानून है, पहले पता होता तो चुनाव नहीं लड़ती ऐसा कहना है, ऐसे कानून होने से गलत व्यक्ति प्रतिनिधि चुनकर आयेंगे ।

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केस स्टेडी नं. 6

श्रीमति सुगरती ँध्व हरिशंकर आहेक

ग्राम — खारी (जामुनढानर)

पंचायत — खारी

विकास खण्ड — घोड़ाडोंगरी।

जिला — बैतूल (म.प्र.)

सुगरती बाई आहेक पहली बार गांव में पंच पद पर वार्ड नं. 2 खारी से चुनकर आई 26 जनवरी 2001 के बाद तीसरी संतान पैदा होने से पद से हटाई गई ।

मुझे पहले से पता होता तो मैं चुनाव में खड़ी नहीं होती मेरे पेट में बच्चा था, तब मुझे ये ज्ञात हुआ कि ऐसा कानून है, यह गलत है, जनप्रति निधियों के साथ सरकार अन्याय कर रहीं है ।

सुगरती बाई ने ग्राम विकास हेतु वार्ड में सड़क निर्माण इंदिरा आवास इत्यादि काम अपने वार्ड के लिए किये है । सरकार के इस कानून से हमारे सम्मान पर ठेस पहुंची । सुगरती बाई समझदार एवं सक्रिय महिला है ।

केस स्टेडी नं. 7

श्रीमति फुलवती मौजी धुर्वे

ग्राम — चापड़ा

पंचायत — पहावाड़ी

विकास खण्ड — शाहपुर

जिला — बैतूल (म.प्र.)

फुलवती बाई पहली बार पंच पद पर निर्विरोध चुनाव जीतकर आयी । मेरे 6 बच्चे है, छटवा बच्चा मार्च 2001 में हुआ ।

सरपंच उपसरपंच सचिव हमें काई जानकारी नहीं बताते चुनाव के बाद से मैंने विकास के कार्य करने में रूचि दी, परन्तु जानकारी ना होने के कारण मैं अपने वार्ड के लिए ज्यादा कुछ नहीं कर सकी । परन्तु मैं सीखकर कुछ करना चाहती हूँ । मुझे इस नियम के बारे में पता नहीं था, मुझे नोटिस नहीं मिला सिधे निकाल दिया ।

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Five Case Studies on Sterilization in Different District of UP

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Case Study 1

Case: Female Sterilization

Name: Bitti

Age: 32

Caste: Cole

Children: 5

Village: Maarkundi

District: Chitrakoot-Karvi

State: Uttar Pradesh

Source: News Paper

Date: 23rd September. 03

On 23rd September a sterilization camp was organized in Community Health Centre of Manikpur. Bitti had got first appointment and doctor called her to operation room initially. First, doctor gave an injection to her. While operating doctor cut wrong vein. For that her condition got complicated. She started bleeding. When doctor realized that her condition got out of control then, CMO and doctor took her in Rooprani Hospital in Allahabad. But her condition becomes more and more complicated because of bleeding. That time she needed blood. Doctor asked her husband and he gave one bottle blood. After receiving blood her condition got better. In spite of this, her treatment not happened in Allahabad, she had to come Manikpur. Her treatment was going on in CHC of Manikpur. According to doctor (Who came from Lucknow) "victim woman was ill, if she could not come for operation, definitely she would be die". But victimize woman's condition proofed that doctor statement was totally wrong.

Case identified by VANANGNA, Chitrakoot

Case – 2

Case: Female Sterilization
Name: Shimla Devi
Age: 35
Caste: Lohar
Children: 5
Village: Aidilpur
District: Azamgarh
State: Uttar Pradesh
Date: 12th February.04
Source: Grameen Punarnirman Sansthan, Bellari, Azamgarh

Shanti Devi (ANM) suggested Shimla Devi to do sterilization. ANM decided that on 12th February, she would take her in CHC, Atraulia. On that day ANM's husband came to her (victimize) home and told her that today they cannot go CHC because they cannot arrange any transportation. But after some time, Urai Nishad (ration shop owner), Mahantu Nishad and Rampareet came to victimize home and told her that they have arranged transport so come with them. When she reached at CHC, she did not find ANM. She told that before operating, doctor did not do any check-up. First a person put an injection and after half an hour she called in operation room. During operation, surgeon got very much irritate because he was not finding the vein. It took half an hour of operation. Before leaving CHC, she got vomiting four or five times. But no health worker came with her. When she came back at home, she met with ANM, she told her everything, ANM got angered, then she wrote a medicine and after eight days she again come and cut her stitch. After cutting the stitch, she did not feel any relief. She got pain and swelling. Then she went to CHC, Atraulia, that time surgeon was not there, another doctor saw her and told that once again she has to do operation because internally stitch got brake. For that operation she has to pay 500/-Rs. According to her doctor's behaviour was very bad that is why she did not go CHC again. But day by day her condition become complicated then she went to Shahganj, Jaunpur. Firstly doctor did her

ultrasound and told her she got hernia. But she was little bit confused. She went to another doctor, but he also told same thing. Then she had to do another operation on 26th June 04. That time she got 14 stitches and doctor took 5000/-Rs. During all these process she faced mental, physical and economic harassment. Now she wanted to like that health department should reimbursement her.

Case identified by Grameen Punarnirman Sansthan, Bellari, Azamgarh

Case – 3

Case: Female Sterilization
Name: Sudha Singh
Age: 27
Children: 2
Address: 123/9 Shastri Nagar, Kanpur
State: Uttar Pradesh
Date: 8th June.03
Source: Local News Paper

On 28th May Mrs. Sudha Singh went to government hospital for sterilization. Her sister-in-law was with her. Doctor told her she is pregnant of 6 week, so she has to come tomorrow and after abortion she will do sterilization. On 23rd May, again she went over there; firstly doctor did abortion and then did sterilization. Next day again Shuda went there and told the nurse she has a problem. Nurse checked her and said she has gastric. Nurse gave medicine and told everything will be all right. But she did not get relief. Next day doctor said that once again they have to do operation. On 1st June Sudha had one more operation but she did not fine. Next Eight days after operation she was senseless. As a result, she died on 8th June.

Case identified by Savita Misra

Case – 4

Case: Failure of Female Sterilization

Name: Manti Devi

Age: 30

Caste: Yadav

Children: 3

Village: Bhawanipur, Cunaar

District: Mirzapur

State: Uttar Pradesh

Date: 13th January.04

Source: Shikhar Prashikshan Sansthan, Chunaar.

Manto Devi has three children and all three are boys. So both have decided to family planning. This case was happened in 1997. Manto devi went to Dhorawal, Primary Health Centre for sterilization. Initially health worker did all check-up like; blood, urine test and pregnancy test. Then doctor did sterilization. After sterilization again she became a mother of two children. In February 2001, again she did sterilization. She has all evidence regarding sterilization and she wanted to file her case.

Case identified by Sadafal, associated with Shikhar Prashikshan Sansthan, Chunaar.

Case – 5

Case: Female Sterilization
Name: Heerawati Devi
Age: 35
Caste:
Children: 5
Village: Shobhol, Cunaar
District: Mirzapur
State: Uttar Pradesh
Date: 2003
Source: Shikhar Prashikshan Sansthan, Chunaar.

This case is based on basically temptation. One-day gram pradhan and his supporter came to Heerawati's house and started alluring. They said to her if she gets sterilization they would give her land on lease. So, she got sterilization but after that her stitches become an acute condition. She did not get any facility in government hospital then she had to go private hospital. However, gram pradhan also ditch her and did not give anything.

Case identified by Shikhar Prashikshan Sansthan, Chunaar.

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पीड़िता का परिचय

नाम - निर्मला देवी (मृतका)
पति - अगरद्दी
उम्र - 30 वर्ष
शिक्षा - अशिक्षित

परिवार का परिचय

बच्चों की संख्या - 3
सबसे छोटे बच्चे की उम्र - 2 वर्ष 6 माह
मलगीराम (ससुर)
धर्म - हिन्दू
जाति - चमार (अनुसूचित जाति)
पूरा पता -
ग्रा०+पो० - बेलापरसा
जिला - अम्बेडकर नगर फैजाबाद

° मुख्य व्यवस्याय / आमदनी के स्रोत
- मजदूरी
- खेती 3 बिश्वा

आर्थिक स्थित
- कमजोर (रोज कमाओ रोज खाओ)

सामाजिक स्थित -
- निम्न (कोई राजनैतिक पहुँच नहीं है)

घटना का मुख्य अपराधी
- डा० गंगाराम गौतम M.B.BS (M.S.)
P.H.C. बसखारी अम्बेडकर नगर, फैजाबाद
- दुर्गावती (आगनबाड़ी कार्यकर्ती)
बेलापरसा अम्बेडकर नगर फैजाबाद

घटना की प्रक्रिया -

दिनांक 14-2-004 को दुर्गावती देवी कार्यकर्ती आगनवाड़ी बेलापरसा ने निर्मला देवी से सम्पर्क करके उसे अपना नसबंदी आपरेशन कराने के लिए प्रेरित किया, निर्मला देवी के समझ में आ गया कि, मुझे आपरेशन करा लेना चाहिए।

दुर्गावती देवी द्वारा बतायी गयी तारीख दिनांक 17.2.04 को निर्मला तथा उसके पड़ोस की पुष्पादेवी w/o वासुदेव आपरेशन हेतु दुर्गावती के साथ P.H.C. बसखारी जाने हेतु तैयार हुई। निर्मला देवी की सास को जब यह मालूम हुआ कि वह नसबंदी कराने जा रही है तो उन्होंने उसके साथ चलने को कहा लेकिन दुर्गावती देवी ने कहा कि "आप क्या जायेंगी हम तो खुद गार्जियन हैं दो तीन घण्टे में हम लोग वापस आ जायेंगे"। साथ में आपरेशन हेतु गई पुष्पा देवी ने बताया कि अस्पताल पहुँचने पर नसबंदी हेतु आयीं चार महिलाओं को एक ही सिरिंज और सूई से तीन-तीन इंजेक्शन लगाये गए। तथा किसी कागज पर हम लोगों के अंगूठे भी लगवाये गए। उस कागज में क्या लिखा था यह हम नहीं जानते। केवल पेशाब की जाँच की गई थी। सूई लगने के तुरन्त बाद ए.एन.एम. ने बताया कि तुम लोग पेशाब करके आ जाओ अब आपरेशन होगा। निर्मला ने पहले आपरेशन कराने की इच्छा व्यक्त की। डा० गंगाराम सर्जन उसे 2 बजे आपरेशन कक्ष में ले गए। कुछ देर बाद निर्मला देवी की हालत बिगड़ने के कारण अन्य तीन महिलाओं को कहा कि तुम लोग भाग जाओ क्योंकि निर्मला की हालत खराब है, इसे लेकर हम टाण्डा जा रहे हैं। (अपनी निजी कार से डा० निर्मला को लेकर सामुदायिक स्वास्थ्य केन्द्र टाण्डा चले गए। इधर इसकी सूचना पुष्पा देवी ने निर्मला के घर वालों को दिया। घर से उसके ससुर और पति आदि C.H.C. टाण्डा गये। C.H.C. टाण्डा पर निर्मला देवी का इलाज संभव न होने के कारण उसे वहाँ के डाक्टरों ने सदर अस्पताल फैजाबाद ले जाने को कहा। भलगीराम करीब 3:30 पर C.H.C टाण्डा जब पहुँचे तो उन्हें बताया गया कि तुम्हारा मरीज फैजाबाद भेज दिया गया है। भलगीराम वापस बेलापरसा आया और कुछ पैसों की व्यवस्था करके भलगी, अगरदी, प्रदीप, रामवृक्ष, सभाजीत, रामसहारा रात के 11 बजे सदर अस्पताल फैजाबाद पहुँचे। सदर पहुचने पर वहा अस्पताल के बाहर डा० व फोर्स की गाड़ी खड़ी थी। भलगीराम ने बताया कि मेरे पहुँचने पर पंचनामा पर जबरदस्ती अँगूठा लगवा लिया गया। लाश को पोस्टमार्टम हेतु रात में ही भेज दिया गया। लाश को हटाने के बाद लाश के नीचे का कपड़ा खून से पूरी तरह लतपत था जिसको देखकर भलगी को शक है कि निर्मला की मौत P.H.C. बसखारी में ही हो गई होगी। करीब रात 2:30 पर पोस्टमार्टम के बाद लाश बाहर निकाली गई तथा लाश के दाहसंस्कार हेतु मुख्यचिकित्सा अधिकारी डा० ओ०पी० पाठक ने 10,000 रु नकद

मृतका के ससुर मलंगीराम को दिया। एम्बुलेंश में लाश रखी गयी। उसके साथ में उपजिलाधिकारी व क्षेत्राधिकारी टाण्डा के, अतिरिक्त 7 गाड़ी फोर्स के साथ लाश मृतका के निवास ग्राम बेलापरसा दिनांक 18.2.2004 को 5 बजे प्रातः पहुँची। फोर्स भी उनके घर पर ही रुकी तथा फोर्स ने लाश के आते ही परिवार वालों की के ऊपर लाश का दाह संस्कार करने के लिए दबाव बनाया। मृतका के परिवार वालों की तरफ से स्थानीय सांसद श्री विभूतदत्त व विधायक श्री लालजी वर्मा को फोन से घटना की सूचना दी गयी। परिणामतः ये दोनों जनप्रतिनिधि करीब 11 बजे दिन को बेलापरसा आये इन्हीं के साथ ही डा० गंगाराम गौतम ने मृतका के परिवार वालो के यहाँ आये थे। सभी लोगो के सामने ही डा० गंगाराम गौतम ने मृतका के परिवार वालो से कहा कि तुम लोगों की गरीबी देखकर हम तुम्हे 15000 रूपये का सहयोग कर रहे हैं तथा तुरन्त उन्होंने 15000 रुपये नकद मलंगीराम को दिया। क्षेत्रीय विधायक श्री लालजी वर्मा ने 1000 रुपये अपनी तरफ दिया। सांसद महोदय ने कहा कि इनके परिवार को सहयोग दिलाने हेतु शासन को लिखा जायेगा। सांसद महोदय बराबर अधिकारियों, डाक्टर एवं फोर्स के हाँ में हाँ मिलाते दिखे। उपजिलाधिकारी टाण्डा ने मृतका के परिवार के लोगों को 1 बीघा जमीन पट्टा देने की घोषणा की। मृतका की सास ने बताया कि निर्मला जब आपरेशन हेतु जा रही थी तो उसके हाथ में दो चाँदी की अंगूठी, पैरों में दो मीना, गले में एक चाँदी का चेन, पैर में एक जोड़ी पायल, नाक में सोना की एक बड़ी कील थी। जिसमें से परिवार वालों को केवल मीना, चेन और पायल ही वापस मिला। इसके बाद टाण्डा स्थित गंगादेव घाट पर मृतका की लाश को ले जाकर दाह संस्कार किया गया। शव यात्रा एवं दाहसंस्कार के समय उपजिलाधिकारी, क्षेत्राधिकारी, टाण्डा तथा बरियारी थाने के एस. ओ. पुलिस पुलिस बल के साथ मौजूद रहे।

प्रत्यक्ष साक्षी

- पुष्पादेवी w/o वासुदेव ग्राम बेलापरसा अम्बेडकरनगर फैजाबाद

अपनी नसबंदी आपरेशन कराने निर्मला के साथ गई थी।

- अखबारों की कतरन

समुदाय का विचार

समुदाय के लोग चाहते थे D.M., S.P. आए तथा घटना की पूरी प्रक्रिया को देखते हुए पीड़िता के परिवार के लोगों को कुछ राहत की घोषणा तथा दोषी डा० के विरुद्ध कार्यवाही के बाद दाहसंस्कार किया जाए परन्तु अधिकारियों व फोर्स के लोग तुरन्त दाह संस्कार करने के लिए दबाव डाले। ग्राम प्रधान ने भी फोर्स व अधिकारियों के हाँ में हाँ मिलाया। पुलिस गाँव को खाली करने में ही लगी रही। पुलिस ने F.I.R. दर्ज किया है या नहीं यह परिवार के लोगों को नहीं मालूम।

मीडिया की भूमिका

परिवार के सदस्यों ने बताया कि अभी तक कोई पत्रकार हमलोगों से संपर्क नहीं किया है। जबकि स्थानीय समाचार पत्र दैनिक जागरण, हिन्दुस्तान एवं जनमोर्चा में घटना से संबंधित समाचारों को प्रकाशित किया गया है।

18.2.2004 को उपजिलाधिकारी टाण्डा ने बेलापस्सा में घोषणा किया था कि मृतका निर्मला देवी के परिवार को खेती के लिए 1 बीघा जमीन पट्टा की जायेगी लेकिन अभी तक इस संबंध में कोई कार्यवाही नहीं हुई, और न ही अभी तक कोई लेखपाल, कानूनगो, तहसीलदार या प्रधान आदि ने परिवार से संपर्क नहीं किया।

मृतका के परिवार के लोगो को ऐसी स्थिति में उनके क्या अधिकार हैं और क्या-क्या सहायता मिल सकती है कुछ भी मालूम नहीं है। गरीब व अज्ञान होने के कारण वे इस समस्या के समाधान के लिए क्या करें कुछ समझ में नहीं आया। घटना के संबंध में शुरू में गाँव के लोगों को कोई जानकारी नहीं थी।

पीड़ित परिवार क्या चाहता है

- बच्चों के जीवन निर्वाह हेतु सहायता की आवश्यकता
- पट्टे की घोषणा पर कार्यवाही
- अपराधी डा० गंगाराम गौतम को कटघरे में खड़ा किया जाए तथा भरपूर मुआवजा देते हुए दण्डित किया जाए।

केस स्टडी

नसबंदी के दौरान महिला की मृत्यु

- दस्तावेजी करण करने वाली टीम / व्यक्ति का नाम व संस्था का पता

सुश्री संध्या श्री मिथिलेश श्री सुनील	: : :	शिखर प्रशिक्षण संस्थान टेकउर, चुनार मिर्जापुर
सुश्री शकुन्तला	:	कृति संदर्भ केन्द्र लखनऊ

- घटना की पहली जानकारी :–

  9 फरवरी 04 को अमर उजाला, हिन्दुस्तान पेपर में छपी सामाचार के माध्यम से जानकारी मिली।

- दस्तावेजीकरण के दौरान मिले व्यक्ति का नाम व पता

  दस्तावेजीकरण के दौरान निम्न व्यक्तियों से सम्पर्क व बातचीत की गयी।

श्री बुधिराम	:	मृतिका का भाई
सुश्री चन्दा देवी	:	भाभी
श्री दशमी	:	भाई (मृतिका का)
चटनी (विदेशी)	:	बड़ा बेटा
सुश्री तारा	:	बड़ी बेटी
गोबिन्दा	:	बेटा
श्री राधेश्याम	:	पति
पड़ोसी 7	:	3 महिला 4 पुरुष

- साक्षात्कार / भ्रमण की तारिख

  24 फरवरी 2004

- देखे हुए दस्तावेजों के नाम

1. अखबार की कतरन
2. राष्ट्रीय पारिवारिक लाभ योजना में अनुदान हेतु आवेदन पत्र की कापी
3. पोस्टमार्टम रिपोर्ट
4. मेडिकल रिपोर्ट
5. आर्थिक सहायता हेतु आवेदन पत्र की कापी
6. परिवार रजिस्टर की कापी
7. प्रधान द्वारा दिया गया प्रमाण पत्र

परिचय :–

मृतिका का नाम	:	सुश्री मौली देवी
उम्र	:	30 वर्ष
जाति	:	मुसहर (आदिवासी)
शैक्षिक स्तर	:	अशिक्षित

परिवार का परिचय :–

मौली देवी का पारिवारिक स्थिति बहुत दयनीय है रहने के लिए अपना मकान नहीं है अपने भाई के मकान में रहती थी मृतिका का सबसे छोटा लड़का दोनों ऑख का अंधा है जिसकी उम्र लगभग 1वर्ष हे। मौली देवी के पति मजदुरी करते है। मृतिका स्वयं भी मजदुरी करती थी।

धर्म	:	हिन्दू
पूरा पता	:	ग्राम लोहरा
थाना	:	अहरौरा
जिला	:	सोनभद्र

बच्चों की संख्या कुल 6 बच्चें
4 लड़का, 2 लड़की
बड़ा लड़का 15 वर्ष का और सबसे छोटा लड़का 1 वर्ष का है जो जन्म से अंधा है।

घटना की प्रक्रिया :–

दिनांक 7 फरवरी 04 को सुबह 8 बजे मौली देवी अपने 9 वर्षीय पुत्र गोविन्दा को लेकर अहरौरा प्राथमिक स्वास्थ्य केन्द्र पर नसबंदी आप्रेशन कराने गयी। उसके साथ में पड़ोस में रहने वाली ए.एन.एम. केवला देवी भी गयी। मौली देवी के पति उस समय घर पर नहीं थे, काम करने के लिए बाहर गये थे। जाते समय मौली देवी अपनी 14 वर्षीय लड़की तारा से बोली कि खाना बनाकर रखना वह थोड़ी देर में आएगी। लगभग शाम 4 बजे ए.एन.एम. के पति झुम्मन ने उसके लड़के को बताया कि फोन आया है तुम्हारी मॉ की तबियत खराब हो गयी है ये खबर सुनकर मौली का लड़का अपने पिता को बुलाने गया। ए.एन.एम. का प्रधान जी के यहॉ दुबारा फोन आया कि मौली देवी की इलाज के लिए मिर्जापुर ले जाया गया है इसलिए उनके पति मिर्जापुर पहुॅचे प्रधान के घर से कोई आकर बताया कि मौली को मिर्जापुर ले जाया गया है जब सब लोग जाने के लिए तैयार हुए तो उनसे कहा गया कि बच्चों को लेकर मत चलो केवल 4 बड़े लोग (सरकार) चलो। ए.एन.एम. एवं डाक्टर सभी लोग पोस्टमार्टम के लिए उसे लेकर चुनार आये मौली देवी ने कैम्प में ही दम तोड़ दिया था। उसके पति को मिर्जापुर बुलाया गया था इसलिए उसका पति राधेश्याम रात भर मिर्जापुर अस्पताल में मौली देवी को

ढूँढता रहा, इधर चुनार में उसका साला भी अपने बहनोई को ढूँढ रहा था राधे को ढूँढने के लिए प्रधान ने उसे एक गाड़ी दिलवायी थी। जब मृतिका का भाई उसके पति को ढूँढने गया था, (बहाँ पर उपस्थित सभी लोगों जिसकें सी. एम. ओ., प्रधान, ए.एन.एम. तथा अन्य डाक्टर थे) ने मौली देवी के 15 वर्षीय पुत्र से एक कागज पर दस्तखत करवाये थे जबकि उसके पुत्र ने अपने पिता की गैर हाजरी में साइन करने से मना किया, लेकिन उससे जबरन साइन कराकर मृतिका का पोस्टमार्टम कर दिया। अपनी पत्नी को ढूँढता हुआ राधे दुसरे दिन सुबह वहाँ पहुँचा तो उससे एक पेपर पर राधे के शब्दों में "हम पढ़ा लिखा नहीं है हमें पागल बनाकर सब दस्तखत ले लिया।" अंगुठा लगवाकर सी.एम.ओ. ने उसे 10,000 (दस हजार) रुपये दिये उसे बताया गया कि तुम्हारी पत्नी को आप्रेशन से पूर्व सुई लगाया गया, जिससे उसकी हालत बिगड़ गयी जब उसे इलाज के लिए मिर्जापुर ला रहे थे तो रास्ते में उसने दम तोड़ दिया उसे हार्ट अटैक हो गया, साथ ही उसके पति को आश्वासन दिया गया कि उसे 10,000 (दस हजार) रुपये और दिये जाएगे, साथ ही एक कालोली, तीन बीघा जमीन, बिजली दी जाएगी।

वहाँ पर उपस्थित सभी सरकारी साहब लोगों ने कहा कि लाश घर मत ले जाओं और यही फूँक दो और सभी लोग (जिसमें C.M.O. प्रधान, मिडवाइफ तथा अन्य डाक्टरी के लोग) लाश फूकने की जल्दी करने लगे अंत में बालूघाट चुनार में ही उसका अंतिम संस्कार कर दिया गया। उस समय वहाँ पर तीन सरकारी गाड़ी थी जिसमें डी.एम., सी. एम. ओ. तथा अस्तपताल के डाक्टर आदि शामिल थे। इसके बाद मृतिका के परिवार वाले घर लौट आये। आज तक उन्हें अन्य कही गयी सहायता नहीं दी गयी है ए.एन.एम. का कहना है कि प्रयास हो रहा है इसमें समय लगेगा, जब कि प्रधान उन्हे कोई तब्बजू नही दे रहा है। "प्रधान जी को पैसा चाहिए मैं गरीब आदमी पैसा कहाँ से दूगा" (राधे के शब्दों में) दिनांक 23 फरवरी को मै (राधे) अपने बच्चों को लेकर मिडवाइफ के घर गया और कहा कि मैं सारे बच्चों को यही छोड़ दूगाँ आपकों ही इसे देखना होगा तभी वहाँ पर सुकत पुलिस चौकी प्रभारी (सर्वेस सिंह) वहाँ आये और थप्पड़ मारते हुए बोले कि वहाँ पर बच्चों को लेकर क्यो आये हो जाकर डी. एम. से बात करो इसे क्यों परेशान कर रहे हो और गंदी गालियां भी दी। मृतिका के भाई के शब्दो मे बहनोई की उपस्थिति में लाश का पोस्टमार्टम हो गया था, लाश हम लोगों को देखने नहीं दिया गया।

मृतिका का 9 वर्षीय गोबिन्दा पुत्र के शब्दों में – "माँ को जब अहरौरा अस्तपताल से बाहर लाया गया तो वह हिल–डुल नही रही थी"

आप क्या करना चाहते है यह पूछने पर राधे ने कहा कि हमें मदद चाहिए प्रधान और मिडवाइफ के खिलाफ रिपोर्ट होना चाहिए। प्रधान जी यहाँ आकर बोले कि तुम लोगों के लिए 5 लाख की मांग कर रहे थे लेकिन मौके पर कुछ नहीं बोले।

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नसबन्दी शिविर में ऑपरेशन के दौरान महिला की मृत्यु

घटना

दिनांक 30 जनवरी, 2003 को जिला गोंडा की हलघरमऊ पी. एच. सी. में परिवार नियोजन शिविर के दौरान चिकित्सकीय लापरवाही से ग्राम कुंवरपुर अमरोहा टोला निर्जनपुर की एक 26 वर्षीय महिला मृदा कुमारी (तीन बच्चों की मॉ 7 वर्ष, 6 वर्ष तथा 5 वर्ष) की मौत हो गयी। मृदा कुमारी के परिवार वालों का कहना है कि उसने ऑपरेशन से पहले ही डॉक्टर को बोला था कि उसका दिल घबरा रहा है। उसे दो इन्जेक्शन लगाये गये और ऑपरेशन शुरू कर दिया गया, और इसी बीच (3 बजकर 30 मिनट पर) महिला ने दम तोड़ दिया।

महिला की मृत्यु होते ही पी. एच. सी. में कार्यरत सभी लोग डॉक्टर समेत उसे छोड़कर इधर–उधर भाग गये। जब उसके घर वाले पी. एच. सी. पहुंचे, (5 बजकर 30 मिनट पर) महिला की लाश स्ट्रेचर में ओ. टी. के बाहर दरवाजे पर पड़ी थी, और वहाँ कोई मौजूद नहीं था। पी. एच. सी. में उस दिन कोई रेफरल तथा एम्बूलैंस की कोई व्यवस्था नहीं थी, और न ही ऑक्सीजन सिलेण्डर । घटना होने के 15 दिन बाद भी मृतका के परिवार को न तो पोस्टमार्टम रिर्पोट दी गयी है और न ही कोई मुआवजा।

हमारे द्वारा तुरन्त उठाया गया कदम : अखबार में (इंडियन एक्सप्रेस, दिनॉक 7 फरवरी, 03) ख़बर देखते ही इंडियन एक्सप्रेस के ऑफिस में फोन किया गया। पता चला कि यह न्यूज़ एजेन्सी से निकली थी। अतः गोंडा ज़िला अस्पताल में सी. एम. ओ को फोन किया गया। उन्होंने कहा कि आप हलघरमऊ पी. एच. सी. से पता करें क्योंकि यह घटना वहाँ पर हुयी थी। साथ ही उन्होंने कहा कि इस केस में अभी 15 दिन लग जायेंगे, आप पन्द्रह दिन बात बात करें।

अतः दूसरे दिन दिनांक 8 फरवरी, 03 को बनारस में उत्तर प्रदेश की कुछ स्वैच्छिक संस्थाओं (हैल्थवॉच उ0 प्र0 के सदस्यों) की एक बैठक थी। *हैल्थवॉच एक राष्ट्रीय नेटवर्क है जों महिला स्वास्थ्य सम्बन्धी मुद्दों पर पर कार्य करने के लिए 1994 में आई. सी. पी. डी (जनसंख्या एवं विकास पर अर्न्राष्ट्रीय सम्मेलन) के दौरान बनाया गया था। यह इस बात पर निगरानी रखता है कि देशभर में हर व्यक्ति प्रजनन एवं यौनिक स्वास्थ्य एवं अधिकार हासिल कर पा रहा है या नहीं।*

अतः इस ख़बर पर चर्चा की गयी और तय किया गया कि इस घटना की जॉच हेतु तीन लोगों की एक टीम (जिसमें डॉ0 दिनेश सिंह, **चौपाल, गोरखपुर**, सुश्री रेनू, **ऑली, लखनऊ** तथा सुश्री शकुन्तला **कृति रिसोर्स सेन्टर, लखनऊ**) बनाई गयी। सुश्री रेनू का स्वास्थ्य खराब होने के कारण उनके स्थान पर सुश्री आशा, **कृति रिर्सोस सेन्टर**, लखनऊ को इस टीम में शामिल किया गया।

(13)

इन्टरव्यू

दिनॉकः 14.02.03

डॉ0 आर. आर. भारती (सी. एम. ओ., जिला अस्पताल, गोंडा)

इस घटना के बारे में अभी कुछ नहीं कह सकते, मामला under process है।

श्री अतुल कुलश्रेष्ठ : पी.एम., डिफ्सा, गोंडा

हॉ मौत हो गयी। उसके तो पेट में चीरा भी नहीं लगाया था, टेबल पर लिटाते ही हार्ट अटैक हो गया। डॉ अग्रवाल बहुत अच्छा डॉक्टर है। वो तो हजार से ऊपर केस कर चुका है। उस दिन तो वह छुट्टी पर था, ट्रेन छूट गयी थी, इसलिए वापस आ गये और कैम्प करने चले गये। आप बताइये छुट्टी पर होकर भी कोई सरकारी डॉक्टर काम पर जायेगा। ये आखिरी केस था। डॉक्टर बहुत अच्छा है, पहले पूरी चैकिंक करता है सुई लगी कि नहीं, अपने सामने लगवाता है। कुछ किस्मत ही ऐसी हो गयी। बहुत ही बेहतर (qualitative) काम करता है। सुबह 10 बजे वो कैम्प में पहुंच जाते हैं और पॉच बजे ही लौटते हैं जितने भी केस हों।

परिवार कल्याण कार्यक्रम इतना अच्छा चल रहा था, हमारे 13,324 टारगेट हैं इस साल के जिसमें से 5000 पूरे हो गये। इस केस के कारण सब ठप्प पड़ा है। परिवार कल्याण तो राष्ट्रीय कार्यक्रम है। ऐसे कार्यक्रमों का राजनीतिक़रण करेगें तो कैसे होगा, देश में ऐसे ही भूखमरी है, बेकारी है।

पोस्टमार्टम रिपोट तो निकल गयी है वह तो गुप्त (confidential) रहती है। कमेटी बैठती है फिर गर्वनमैंट ऑफ यू. पी. को जायेगी। वैसे डॉक्टर के बचाव में सरकारी वकील, डी.एम., सी. एम. ओ. सभी लगे हैं यदि कोर्ट केस होता है तो! पहले तो परिवार सर्पोट कर रहा था लेकिन राजनीति के चलते ऐसा हो गया है। डॉ-आलोक लेप्रोस्कोपिक ट्रेन्ड हैं।

इसके बाद हमारी टीम पहुंची ए. डी, गोंडा जिला अस्पताल से मिलने, लेकिन कार्यालय से पता चला कि ए. डी. साहब कहीं गये हैं। सो हमनें वहॉ के लिपिक से बातचीत की। उनसे हमें जो जानकारी मिली वह इस प्रकार से थी –

हॉ 30 तारीख को एक महिला की मौत हो गयी थी नसबन्दी के दौरान। डॉक्टर तो भाग आये, वहॉ तो काफी हल्ला हो गया था, सब ट्रेक्टर–ट्राली लेकर आ गये थे। रोज़ अख़बारों में निकल रहा है। हम तो ज्यादा नहीं बता सकते, हमको इतना ही बताया गया है। बांकि जानकारी अभी गुप्त (confidential) है।

श्री आर. डी. गुप्ता, कम्प्यूटर, हलघरमऊ, पी. एच. सी

मृतका (द्रव्या कुमारी) किसी और एक महिला के साथ आयी थी। उस दिन 13 केस रजिस्टर्ड थे। ये ए.एन.एम. शकुन्तला सिंह का केस था। 4 केस हो चुके थे, यह पॉचवा केस था। डॉक्टर ने चीरा लगा लिया था, ट्रोकार घुसाने वाले थे, पता चला कि मर गयी। अन्दर डॉक्टर मौजूद था, ये तो वही बता सकता है कि क्या हुआ, हम नॉन टैक्नीकल लोग क्या बता सकते हैं। एफ.आई.आर. घर वालों ने ही की किसी के कहने पर ही की होगी। उस दिन 5.15 पर गॉव वालों की भीड़ ट्रैक्टर–ट्राली लेकर जमा हो गयी थी।ये सब नेतागिरी पब्लिक करवाती है। हम सब लोग एक–एक करके निकल गये थे, दो स्थानीय लोग थे उन्होंने ही पब्लिक को कन्ट्रोल किया होगा। बांकि केस वापस कर दिये। हमारी तो अब हिम्मत ही नहीं हो रही है कि कैम्प आगे करें। हम तो पल्स पोलियो प्रोग्राम के लिए भी चिन्तित हैं, डर रहे थे। लाश पोस्टमार्टम के लिए उसी दिन चली गयी थी। पोस्टमार्टम दूसरे दिन हुआ।

ऑपरेशन के समय पूरी टीम रहती है, डॉक्टर, नर्स, सुन्न करने वाला आदि। इतनी स्मूदली प्रोग्राम चल रहा था, केश गाड़ी से घर पहुंचा दिये जाते हैं। इस वर्ष हमारा लक्ष्य 687 का है । 265 केस पूरे हो गये है। हमारा विश्वास था कि मार्च तक 400 केस पूरे हो जायेंगे।

बी. एच. टी. फार्म पहले नहीं थे, यहीं जनवरी से आये हैं। इस महिला का बी. एच. टी. डॉक्टर वर्मा के पास है। अब सिफ्सा के अलावा नहीं चल रहे हैं। कर्नलगंज (सी.एच.सी.) में भी ऑपरेशन होते हैं। बृहस्पतिवार को ही अधिकतर ऑपरेशन होते हैं। अभी सिफ्सा के चार कैम्प चल रहे हैं, चारों की फंडिग सिफ्सा से ही होती है। परिवार नियोजन के अलावा गर्भवती देखभाल, बच्चे आदि के लिए भी प्रोग्राम भी चलते है। डॉ रेहाना खातून लेडी डॉक्टर और स्टॉफ नर्स भी आती हैं। हमारे डॉक्टर एम ओ आई सी नहीं हैं।

पति श्री रामभवन गोस्वामी, उम्र– 28 साल, तीन बच्चे– बेटी 7 साल, बेटा 6 साल, बेटा 5 साल
ग्राम– कुवंरपुर अमरोहा टोला निर्जनपुर, फोन नं. (पी.पी.) 05261– 245166

हम क्या बतायें, हम डॉक्टर आलोक अग्रवाल व डॉ रेहाना खातून को नहीं छोड़ेंगे। हम तो बर्बाद हो गये। बच्चों का भविष्य खराब हो गया। हमारे गाँव से और कोई तैयार नहीं हुआ, एक वही तैयार हुयी और वापस ही नहीं आयी। (रोते हुए) मेरा फैसला तो नहीं था, मुझसे किसी कागज पर भी दस्तखत नहीं करवाये न ही ए.एन.एम. ने कुछ मुझसे कहा। उसी से बात हुयी थी, मैंने सोचा कोई बात नहीं। मेरे घर वालों ने भी कुछ नहीं कहा, क्या बताये समय खराब था। ये सब डॉक्टर की लापरवाही से हो गया। **जब केस करते हैं तो क्या एम्बूलेंस नहीं रखनी चाहिए अस्पताल में ?**

जब हम लोग रो–पीट रहे थे। उसी में मेरे छोटे भाई चन्द्रभवन से एक कागज पर दस्तख़त करवाया और सी.एम.ओ. ऑफिस में दस हजार रूपये देने लगे। **कहा कि यह नियम है अगर ऑपरेशन होता है तो एक हजार तथा मर जाने पर दस हजार दिया जाता है। यह रात के 9.30 बजे की बात है। कहा कि ये ले लो और पोस्टमार्टम अभी हो जायेगा। ये लोग हमें डी. एम. के पास भी लेकर गये कि पोस्टमार्टम का आर्डर दें दे, मज़बूरी है, डी. एम. ने आदेश नहीं दिया।** विधायक जी को फोन करके पूछा दस हजार के बारे में तो उन्होंने आकर देखा तो मेरे भाई से जिस कागज पर दस्तख़त करवाये थे उस पर लिखा था कि मृदा कुमारी अपनी स्वेच्छा से आयी थी और स्ट्रेचर पर लेटाते ही मर गयी। फिर वह कागज हमने लेकर फाड़ दिया। पैसा हमनें नहीं लिया। हमने डॉक्टर से कहा कि वह सुबह चार किमी. चल कर आयी थी और लिटाते ही कैसे मर गयी ? हम तुम्हें एक लाख रूपये देते हैं तुम हमारी मृदा हमको दे दो।

उर्मिला देवी (मृतका की जेठानी)

उसने डॉक्टर से कहा था मेरा दिल घबरा रहा है। चार लोगों का हो गया था, उसका पांचवा नम्बर था। उसको दो सूई लगायी थी। जब शकुन्तला, ए.एन.एम. रोते हुए आयी तो मैने पूछा क्या हुआ, उसने कहा जो छोटी मोटी थी वह उस पार हो गयी है, और एक औरत ने मुझसे कहा कि तू घर जा, फिर मैं घर आयी। **वहाँ 20 मिनट में चार ऑपरेशन हुए थे।**

मृतका के जेठ, देवर तथा अन्य

जब ये (उर्मिला देवी) घर पहुंची तो हम लोग ट्रैक्टर, साइकिल लेकर अस्पताल पहुंचे। उन लोगों ने इसे (जेठानी) को भी नहीं बताया। **सब एक–एक करके भाग गये। जब हम वहाँ पहुंचे तो देखा लाश दरवाज़े के बाहर स्ट्रेचर पर पड़ी थी, स्ट्रेचर पर खून लगा था।** हमारे पहुंचते ही (5.30 बजे) तुरन्त एस.डी.एम. और सी. ओ., कर्नलगंज तथा एस. ओ., कटरा वहाँ पहुंचे। जब हमने लाश घर ले जाने के लिए पूछा तो एस.डी. एम. साहब ने कहा कि हम जानना चाहते हैं कि मौत क्यों हुई इसलिए पोस्टमार्टम करवाना होगा। फिर पुलिस पहुंची तो पंचनामा बनाकर लाश पोस्टमार्टम के लिए गोंडा को निकलवा दी। हम तो दुःख से बौरा रहे थे। **साढे तीन बजे उसकी मौत हो गयी थी और सात बजे लाश को गोंडा को रवाना किया गया और दूसरे दिन 1.30 बजे पोस्टमार्टम हुआ, ये लापरवाही है। स्वास्थ्य विभाग की लापरवाही नहीं तो क्या है सब छोड़कर चले गये, मुझे संतोष हो जाता अगर इन्होंने उसको मरने के बाद भी गाड़ी में रखकर कर्नलगंज या गोंडा पहुंचा दिया होता, हमे लगता कि इन्होंने कोशिश तो की। सी. ओ. साहब कह रहे थे कि सबको भागने की क्या ज़रूरत थी, उन्हें हमें बताना चाहिए था। यहाँ कर्नलगंज छोड़कर ये लोग गोंडा चले गये। सी. ओ. साहब ने हमारा बहुत साथ दिया। सी. एम. ओ. साहब के लिए तो मामूली बात है, वे कहते हैं ऐसा तो कई बार हो जाता है, कोई नई बात नहीं है।**

पूर्व विधायक जी की मॉ ब्लॉक प्रमुख हैं। उनके कहने पर ही उन्होंने रिपोर्ट दर्ज की। 31 जनवरी को हमने रिर्पोट लिखवाई। हमनें रिर्पोट के लिए डी. एम. को भी काग़ज़ दिया, उन्होंने कहा एस. पी. को दे दो। लेकिन 5 तारीख को जब एस. पी. ने सी. ओ. साहब को वॉयरलेस किया, और डॉक्टरों के बयान हुए तब जाकर रिर्पोट दर्ज की गयी।

पोस्टमार्टम रिर्पोट सी. ओ. साहब के पास है, हमें नहीं देंगे। जब हमनें रिर्पोट मांगी तो उन्होंने कहा कि देने का नियम नहीं है, एस. पी. ऑफिस से पॉच रूपये के स्टैम्प पेपर पर मिलेगी। रिर्पोट सी. ओ. ने पढ़ायी थी उसमें मृत्यु का कारण स्पष्ट नहीं है। आगे कारवाई (बिजरा) के लिए भेजी गयी है।

वहॉ पर कोई व्यवस्था नहीं थी। न कोई गाड़ी (एम्बुलेंस) थी न ऑक्सीजन सिलैण्डर। हमने लाश की अन्तयेष्ठी कर दी। द्रव्या के अंगूठे में स्याही लगी थी। ये सब स्वास्थ्य विभाग की लापरवाही से हुआ। कर्नलगंज में दो एम्बुंलेंस हैं । सब कुछ होने के बाद भी एक भी एम्बुंलेंस वहॉ नही पहुंची।

हम आपको एक और केस और बताते हैं साहब। गोंसाईपुर (भमुवा से दक्खिन) हमारे रिश्तेदार ही हैं। सफाई कराने एक महिला गयी थी। सफाई करने में घाव कर दिया। तब उसे बच्चेदानी का ऑपरेशन कराना पड़ा और अस्पताल में ऑपरेशन करते समय ही मर गयी। छोटा सा बच्चा है उसका। ये सब लापरवाही नहीं तो क्या है। डॉ रेहाना खातून की कई बार बीच में तन्ख्वाह भी रूकी थी, कुछ केस खराब की होगी, ये तो बैक डेट में साइन करके पैसा लेती है।

हमारा तो नुकसान हो गया । ये हमारे साथ ही नही पूरे देश के लिए अन्याय है, पूरे देश में ये अन्याय हो रहा है। हमारी मॉग क्षतिपूर्ति और दोषी को दण्ड देना है। हम लोगों को स्वास्थ्य विभाग की तरफ से किसी ने सांत्वना भी नहीं दी। आप ही पहले हैं जो हमारे पास आये।

डॉ आलोक अग्रवाल, एम. एस. (सर्जन)

हॉ, हर बृहस्पतिवार को कैम्प लगते हैं। उस दिन भी मैं गया था। चार ऑपरेशन कर चुके थे, पॉचवा उसका नम्बर था। इन्जैक्शन लग चुके थे। सारी जॉच भी हो चुकी थी। मैं तो अपने सामने ही सब करवाता हूँ सफाई भी, मुझे विश्वास नहीं होता, इसलिए सामने ही सब कुछ करवाता हूँ। ये तो मैं आपको पूरे विश्वास से बताता हूँ हमारे केस में कोई इन्फैक्शन नहीं होता । पहले मैं इमरजैंसी दवा भी अपने पास एक किट रखता था साथ में ऑक्सीजन भी। क्योकिं हमारे कोई रिस्तेदार यहॉ पर रहते थे, उनको कभी भी रात–बेरात ज़रूरत पड़ जाती थी। मैनें तीन बार उनको बचाया लेकिन चौथी बार नहीं बचा सका। पहले मै कैम्प में भी अपनी किट लेकर जाता था, किसी डॉक्टर ने मुझसे कहा

भी आप क्यों लेकर आते है। मैं उससे बातें कर रहा था कि आपके कितने बच्चे हैं आदि–आदि। चीरा लगा लिया था लेकिन लेप्रोस्कोप नहीं घुसाया था। तभी बस, वो तो अच्छा था कि स्ट्रेचर रिंग वाला था, मैंने जल्दी उसे नीचे किया, सॉस भी दी, इन्जेक्शन भी दिया, हार्ट पर हाथ रखा तो बीट्स नहीं थी। फिर मैं वहॉ क्या करता, मैं वापस गोंडा आ गया, मुझे तो सी.एम.ओं को इन्फॉम करना था। आप ही बताइये कौन डॉक्टर वहॉ पर रहता। उसको वहीं हिस्टीरीकल हार्ट अटैक हुआ था।

अब स्टैन्डर्ड तो बना हुआ है। उसे फॉलो करना मुश्किल है। उसे फॉलो करके तो एक भी केस संभव नहीं हो सकता। हिमोग्लोबिन तो अधिकतर का 8–9 के बीच मे रहता है। बड़ी मुश्किल से वो तैयार होती है। एक बार लौटाने का मतलब है कि दोबारा उनका न आना। फिर ए. एन. एम. कहती है कर दो, उसका अलग दबाव रहता है, असल में टॉरगेट पूरा करना होता है। स्टैन्डर्ड तो कहता है कि दो लेप्रोस्कोप से एक दिन में सिर्फ 16 से 20 ऑपरेशन होने चाहिए और उसके लिए चार घण्टे रखे गये हैं। लेकिन ऐसा कहॉ संभव है यहॉ तो 40–45 केस एक दिन में भी आ जाते हैं आप तो जानते ही हैं कि बड़ी मुश्किल से केस आते हैं। वैसे तो केस रोज भी कैम्प करें तो रोज ही केस मिलेंगे। अब हमारे पास एक लेप्रोस्कोप है, और बीस मिनट तक उसे ऑटोक्लेव करने का होता है, ये तो मुश्किल हैं। बांकि चीज़े तो हम ऑटोक्लेव करते हैं।

ऑक्सीजन सिलेण्डर तो हैं लेकिन रिफिलिंग की व्यवस्था नहीं है , उन्हें लखनऊ भेजना होता है। रेफरल की व्यवस्था नहीं है। उस दिन जीप तो गयी थी। उसी में गद्दा डाल दिया था अगर कुछ ज़रूरत पड़ती है तो। मैडिकल एक्जामिन पूरा नहीं कर पाते, जितनी जॉच हो सकती हैं पूरी करते हैं अब जितने साधन मौजूद हैं। ए. एन. एम. पर सी. एम. ओ. का दबाव रहता है। उसे अपना टारगेट पूरा करना होता है। कई बार तो माहवारी के दौरान भी महिलाएं आ जाती है। अब क्या करें, ए. एन. एम. बड़ी मुश्किल से तैयार कर पाती है। लगभग 90 प्रतिशत महिलाएं पी. आई. डी. हैं। हम तो राष्ट्र हित में काम कर रहे हैं। मै तो उसके बाद भी कैम्प करने गया। मैं तो अपने काम में लगा था क्योंकि मुझे कुछ ऐसा नहीं था। जितने भी केस होते हैं करता हूँ। एक बार तो ऐसा हुआ मैं कैम्प करके (30–35 केस) यहाँ पहुंचा तो देखा दूसरी गाड़ी पर मेरा इन्तज़ार हो रहा था कि आप दूसरी जगह चलना होगा, वहॉ पर 17 केस अभी बांकि हैं दूसरे डॉक्टर साहब उतने नहीं कर पायेंगे। यहॉ तक कि कभी–कभी रविवार व बुधवार को भी जाना पड़ता है। वैसे तो मैं सी. एच. सी. में पोस्टेड हूं लेकिन एक दिन भी नहीं जा पाता।

जी. ओ. तो हमनें पढ़ा नहीं है। लेकिन सुना है कि जी. ओ. है डाक्टरों की सुरक्षा का ..... अब क्या करें प्राइवेट वकील करना पड़ेगा। हम भी क्या कर सकते हैं, साधन पूरे उपलब्ध नहीं है।

15-02-03

डॉ0 आर. आर. भारती, सी. एम. ओ (प्रातः 11 बजे)

टीमः यह जो महिला की हलघरमऊ में नसबन्दी के समय मृत्यु हो गयी थी हमें उसकी रिपोर्ट देखनी थी ।

सी.एम.ओः रिर्पोट आपको नहीं दिखायी जायेगी। यह कोई नियम नहीं है। वह गुप्त रखा गया है। आपने कुछ दिन पहले फोन किया था न।

टीमः हमको रिर्पोट सिर्फ देखनी थी, यह तो अधिकार है कि रिर्पोट देखी जा सकती है। हम जानना चाहते हैं कि उसकी मृत्यु क्यों हुई?

सी. एम. ओः आप क्या मुझसे ज्यादा जानती है। हम कह रहे हैं ऐसा कोई नियम नहीं है। वह तो गर्वमैन्ट के पास जायेगी। कोर्ट में ही देखी जा सकती है।

टीमः मुआवज़े की क्या कोई व्यवस्था है?

सी. एम. ओ.: हॉ दस हजार रूपये दिये जायेगें स्वास्थ्य विभाग से। बांकि अगर सरकार देना चाहती है तो देगी।

टीमः अगर कोई दोषी पाया जाता है तो उसके लिए क्या प्रावधान है?

सी. एम. ओः दोषी को दण्डित किया जायेगा।

डॉ विवेक मिश्रा, सर्जन, एम.बी.बी.एस., जिला अस्पताल, गोंडा

पोस्टमार्टम तो हो गया है, बिजरा के लिए गयी है। व्यवस्था में कमी हैं। हम लोगों पर भी ऊपर से दबाव रहता है। पूरी जिम्मेदारी तो डॉक्टर के ऊपर ही आ जाती हैं आखिर में। कौन साथ देता है। अब व्यवस्था में इतनी कमियां है। क्या बतायें। हम लोगों का तो कोई बचाव ही नहीं है। पोस्टमार्टम रिपोर्ट का भी ऐसा ही है। 24 घण्टे बाद लाश पोस्टमार्टम के लिए मिलती है, तब तक पुलिस कस्टडी में रहती है। इतनी देर बाद लाश का पोस्टमार्टम होगा तेा बताइये क्या रिपोर्ट होगी। व्यवस्थाओं में ही सब गड़बड़ है। एक बाक्या बताता हूं एक बार कहीं से आ रहा था जीप ऐसी दी गयी थी जिसमें आगे से सीसा भी नहीं था, एक उल्लू कहीं से आया और मेरे मुंह पर टकराया, पूरी ऑख दूसरे दिन काली हो गयी। हॉ हार्टअटैक हो गया थां। ऐसा हो जाने पर डॉक्टर को ही भुगतना पड़ता है। साधनों की कमी है।

नसबन्दी शिविर टीम दिनांक 14.02.03 : डॉ आलोक अग्रवाल, डॉ. रेहाना खातून, स्टाफ नर्स, एनैस्थैसिस्ट, ए.एन.एम. (शकुन्ता सिंह)

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महिला हिंसा केस
लापरवाह स्वास्थ्य सेवाओं के चलते नसबन्दी मृत्यु

स्रोत

रेहाना अदीब
त्रहचा रस्तौगी
सुरेशो सैनी
दिशा सामाजिक संगठन
सुलतानपुर चिलकाना
जिला सहारनपुर (उ0 प्र0)

घटना की पहली जानकारी– अखबारों के द्वारा (अमर उजाला, शाह टाइम्स व दैनिक जागरण)

साक्ष्य व्यक्ति – पीड़िता का पति व चाची सास
जिनके नाम इस प्रकार हैं–
जयपाल पुत्र श्री रवि
रानी पत्नी मेनपाल

दस्तावेज – अखबारों की कतरन

परिचय

सुनीता पत्नी जयपाल	पीड़िता
उम्र	28 वर्ष
जाति	दलित
शिक्षा	अनपढ़
ग्राम	कौरी माजरा
जिला	सहारनपुर
राज्य	उत्तर प्रदेश
अस्पताल	जिला महिला रेडकास चिकित्सालय
पति	जयपाल
बच्चे	चार दो लड़के अनिकेत उम्र 4 वर्ष, दूसरे का नाम नही रखा गया उम्र 15 दिन दो लड़कियां – रीतू उम्र 8 वर्ष व ओमारानी उम्र 6 वर्ष
पति का व्यवसाय	मजदूरी (रिक्शा चालक)
परिवार की स्थिति	खराब
वर्तमान स्थिति	मानसिक रूप से पति परेशान क्योंकि सुनीता की मृत्यु हो गयी है।

इतिहास

शहर से 5 किमी. दूर दलितों का एक गांव कौरीमाजरा है। यह लोग शहर मे मजदूरी करके गुजारा करते हैं।

गांव के लोगों के द्वारा प्रदर्शन

सूचना मिलने पर घटना स्थल पर गांव के लोगों ने आक्रोश जताया।

अपराधियों का नाम – डा0 मधु सक्सेना, डा. सुजाता ढल, एएनएम शकुन्तला
जिला महिला रेडक्रास चिकित्सालय – जिला सहारनपुर

घटना की प्रकिया

पीड़िता सुनीता के ग्राम मे एएनएम शकुन्तला आती है। शकुन्तला ने ही सुनीता को नसबन्दी कराने की सलाह दी। सुनीता ने 12 दिन पूर्व ही एक शिशु को जन्म दिया था। जब ये बात सुनीता ने शकुन्तला को बतायी तो उसने कहा कि इसमे खतरे की कोई बात नही है। और सब कुछ ठीक होगा यह आश्वासन मिलने पर सुनीता अपने पति जयपाल तथा चाची सास रानी के साथ जिला महिला रेडक्रास चिकित्सालय, सहारनपुर गयी। उस दिन अस्पताल में नसबन्दी शिविर लगा था, जहां 50 केस आये थे। इनमे से 24 वां नम्बर सुनीता का था। डा. मधु सक्सेना ने सुनीता को पेन्सिलीन तथा जैकोलिन के इन्जेक्शन टेस्ट के लिए लगाये। उसके लगभग 3 घण्टे के बाद डा. ने सुनीता का आप्रेशन शुरू किया। डा. एक ट्यूब ही डाल पायी थी और दूसरी डालने वाली थी तभी सुनीता की हालत बिगड़ने लगी। डाक्टरों ने उसे उपलब्ध जीवन दायक दवाइयां दी तथा आक्सीजन भी दी फिर भी सुनीता को नही बचा पायी और सुनीता ने आपरेशन टेबल पर ही दम तोड़ दिया। सुनीता के पति जयपाल के अनुसार सुनीता के आपरेशन के लिए जाने के थोड़ी देर बाद ही वहां उपस्थित डाक्टर तथा ए.एन.एम. कुछ परेशान सी घूमने लगी। सुनीता के पति को कुछ आशंका हुई उसने पूछा कि ऑपरेशन किसका हो रहा है ? इस पर ए.एन.एम. शकुन्तला ने कहा कि ऑपरेशन किसी और का हो रहा है, तुम्हारी पत्नी का नही। जब जयपाल ऑपरेशन थियेटर की ओर गया तो उसने डाक्टरों तथा ए.एन.एम. को बातें करते देखा वे सभी बहुत ही परेशान दिख रहे थे जिससे उससे किसी अनिष्ट की आशंका हुई। कुछ ही देर बाद वहां सी.एम.ओ. डा. डी.सी. सक्सेना तथा सिटी मजिस्ट्रेट विमल दुबे पहुंचें। उन्हे डाक्टरों ने फोन करके बुलाया था। उन्होने जयपाल से कहा कि वह अपनी पत्नी की लाश को वहां से ले जाये। जयपाल के मना करने तथा आक्रोश जताने पर उन्होने कहा कि यदि अभी लाश नही लेकर गये तो इसकी और दुर्गति होगी और लाश का पोस्टमार्टम भी होगा। वहां मौजूद लोगों के आक्रोश जताने पर सिटी मजिस्ट्रेट तथा डाक्टरों ने थाना कोतवाली से पुलिस फोर्स बुला ली तथा सुनीता की लाश को पोस्टामार्टम के लिए भेज दिया।

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घटना का ब्यौरा

- 21–05–2004 को शाम तीन बजे यह घटना हुई।
- शाम को लगभग 4 बजे सुनीता की लाश को पोस्टमार्टम के लिए भेजा गया।
- पोस्टमार्टम रात के लगभग 9 बजे हुआ।
- एफ.आई. आर. दर्ज नही की गयी।
- डाक्टरों ने सुनीता के पति को दस हजार रूपये अन्तिम संस्कार के लिए दिये।

अन्य घटक

- ग्राम प्रधान के द्वारा पीड़िता के परिवार को किसी भी प्रकार की मदद नही मिली।
- मीडिया का प्रयास सराहनीय रहा।
- प्रशासनिक अधिकारियों ने पीड़ित परिवार की ओर से मुँह मोड़ा।
- उपचिकित्साअधिकारी डा. पी. के. जैन ने बताया कि इस महिला की मृत्यु हार्ट फेल की वजह से हुई और इस विषय में कोई भी जानकारी डा. ए. के. गुप्ता ही दे सकते है।

बाधाएं

- उच्च प्रशासनिक अधिकारियों द्वारा पीड़िता के पति को धमकी।
- डाक्टरों के द्वारा धमकी।
- पुलिस के द्वारा पीड़िता के परिजनों को धमकी।
- डाक्टरों द्वारा दस हजार रूपये देकर पीड़िता के परिजनों का मुँह बन्द करने का प्रयास।

पीड़िता के परिवार का कहना है कि –

- मेरी पत्नी की मृत्यु के बाद मेरे बच्चों का क्या होगा ? मेरा भी जीना बेकार है।
- मै और मेरी पत्नी दोनो मिलकर परिवार को चलाते थे अब मेरे घर की आर्थिक स्थिति बिगड़ जायेगी।
- मेरे 12 दिन का शिशु पूरी तरह से अपनी माँ पर आश्रित था। अब उसका पालन–पोषण कौन करेगा ?

समाधान के प्रयास

- गॉव के लोगों तथा सम्बन्धियों ने हिम्मत बंधायी।

- दलित सेना उत्तर प्रदेश के द्वारा मुख्य मंत्री को एक ज्ञापन दिया गया जिसमे इस घटना की जांच करने की मांग की गयी तथा लापरवाही बरतने वाले स्वास्थ्यकर्मियों के खिलाफ दण्डात्मक कार्यवाही किये जाने की मांग की गयी।

आवश्यक सलंग्नक

- अखबारों की कटिंग
- पीड़िता के परिवार का फोटो ग्राफ
- जिला महिला रेडक्रास चिकित्सालय के फोटोग्राफ

धन्यवाद

BIHAR

NAME OF STATE: BIHAR

	Name of the Victim/member accompanying (please specify)	Contact	Case description(Brief)	Accommodation Venue / days	Travel (Train)	
					Arr: Date & Time	Dep: Date & Tir
1.	Ms Geeta Kumari	W/o Mr. Rajeshwar Singh, Hanuman Nagar, Chemni Chak, Block Phulwarisharif, Thana – Gaurichak, Patna.	Tubectomy done by Mary Stoves Clinic, Dak Bangla Road, Patna in the month of December 2002. Abortion was also done along with tubectomy. Problem faced: Septic infection, blood clotted in the uterus. Ultrasound done and medicines given for relief. On May 15, 2004-the expected date of menstruation but didn't take place. She again became pregnant. Went to PMCH, Patna and get aborted in the second phase of pregnancy and again got tubectomy in PMCH in the month of August 2004. Treatment going on.	Indian Social Institute, New Delhi / 3 days	9.10.2004 in the morning.	11.10.2004 the evening
2.	Ms Somi Gupta	W/o Mr. Ashok Gupta, Akhiyarpur, Thana – Bikram, Block – Bikram, Patna	Did her tubectomy just after delivery of child in the year 1989. The child died within a month. In the year 1996, she conceived and she aborted. In the year 2001, she again conceived, she got tubectomy as well as abortion in the first phase of the pregnancy. Now she got her menopause.	Indian Social Institute, New Delhi / 3 days	9.10.2004 in the morning.	11.10.2004 the evening

3.	Ms. Kusum Devi	W/o Mr. Budhadev Dubey, Vinampura, P.S. – Mahendei, Jehanabad	Got tubectomy ion the year 1995 when she had three children. After that she conceived twice after tubectomy and gave birth to 2-girl child. Again tubectomy was done in the year 2000.	Indian Social Institute, New Delhi / 3 days	9.10.2004 in the morning.	11.10.2004 the evening
4.				Indian Social Institute, New Delhi		
5.				Indian Social Institute, New Delhi		
6.				Indian Social Institute, New Delhi		

State Organisers / Experts:

	Name of person expert/organizer	Contact address / tel. no.	Accommodation Venue / days	Travel (Train)	
1.	Sapan Majumdar	Bihar VHA	Indian Social Institute	Arrival Date & time	Departure Date and time

Sapan Majumdar (Bihar VHA)

ORISSA

Testimonies
Orissa, BGVS/PHA

To shicdelhi @ vsnl.net To abhijit @ u.washington.edu
To hrlndel@ vsnl.net

Sl. No.	Detailed		Case in brief
01	Name of the Village	Godida	Sterilization failure. 3rd child borne. Green card facilities denied.
	Name of the women	Charulata Sahu	
	Father/Husband name	Banamber Sahu	
	Age	30	
	Educational status	Nonliterate	
	Marital status	Married	
	Marital condition	Good	
	Year of marriage	15 years	
	No. of female child	*	
	No. of male child	*	
	Age/month of the last child	3 years	
	Whether given free consent to be interviewed	yes	
02	Name of the Village	Garama	Sterilization not conducted in the pretext of prevalence of other internal disorder with the women. Medical personnel do not entertain. Clams money, as they would be taking the risk Third child borne. Deprived from the benefits of the green card.
	Name of the women	Mania Bhoi	
	Father/Husband name	Bipin Bhoi	
	Age	24	
	Educational status	Illiterate	
	Marital status	Married	
	Marital condition	Good	
	Year of marriage	8 years	
	No. of female child	2	
	No. of male child	*	
	Age/month of the last child	7 months	
	Whether given free consent to be interviewed	Yes	
03	Name of the Village	Garama	Sterilization not possible as doctors returned the patient 4 times. Local hospital not equipped with necessary infrastructure. Doctor insists for supply of kits by patient to make it happen.
	Name of the women	Pratima Bhoi	
	Father/Husband name	Prasant Bhoi	
	Age	24	
	Educational status	Literate	
	Marital status	Married	
	Marital condition	Bad	
	Year of marriage	5 years	
	No. of female child	1	

	No. of male child	1	
	Age/month of the last child	1 year	
	Whether given free consent to be interviewed	yes	
04	Name of the Village	Tarasahi	Approached for sterilization. Doctors denied and consumed time. Then found Problem in menstruation. Menstruation stopped. Women conceived. PHC and CHC denied for abortion. The next child came.
	Name of the women	Swarnalata Behera	
	Father/Husband name	Ramesh Behera	
	Age	35	
	Educational status	Class-II	
	Marital status	Married	
	Marital condition	Good	
	Year of marriage	12 years	
	No. of female child	3	
	No. of male child	1	
	Age/month of the last child	2	
	Whether given free consent to be interviewed	yes	
			Nov. – 2001 Sterilization unsuccessful. Menstruation stopped. ANM says it is usual. Woman becomes pregnant. Approached for abortion. Doctor demands Rs. 1000/ for that. Advice to again come so that they can do the same after the 3rd child.
05	Name of the Village	Paschimadia	
	Name of the women	Lochana Behera	
	Father/Husband name	Rabi Behera	
	Age	35	
	Educational status	Nonliterate	
	Marital status	Married	
	Marital condition	Good	
	Year of marriage	19 years	
	No. of female child	4	
	No. of male child	1	
	Age/month of the last child	2	
	Whether given free consent to be interviewed	yes	
			2001 – Nov. Sterilization done in camp. Dec –2001 menstruation stopped ANM says – it is usual!! After 4 months approached to the doctor. Doctor says it is a 5 months pregnancy case. Too late and riskful for abortion. The woman gave birth to a 3rd child. Now she is used to take contraceptives (oral pills) for prevention.
06	Name of the Village	Paschmadia	
	Name of the women	Kumari Behera	
	Father/Husband name	Kartik Behera	
	Age	35	
	Educational status	Class-II	
	Marital status	Married	
	Marital condition	Good	
	Year of marriage	12 years	
	No. of female child	*	
	No. of male child	3	
	Age/month of the last child	2	

	Whether given free consent to be interviewed	Yes	

(*) Data unexhibited

Mr. Gourang Mohapatra
Mr. Blorin Mohanty
BGVS – Orissa

Contact Tel. No. – Mr. G.Mohapatra – 094370 36305 (m)
Mr. B. Mohanty - 094371 11204 (m)
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