लोकाभिमुख
PEOPLE ORIENTED
ಜನಪರ

WHY CENSUS ?

To know the socio-economic and demographic health of the Nation

Census is a great national task. We owe it to the Nation to make the Census a success

Please co-operate during the Population Enumeration being conducted from 9 to 28th February, 2001

Provide accurate and complete information to the census enumerator

Information collected from you will be kept confidential

Director of Census Operations, Karnataka, Bangalore and Principal Census Officer (Deputy Commissioner, or Commissioner of City Municipal Corporation and Bangalore Development Authority and Officers of Local Bodies)

लोकाभिमुख
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ಜನಗಣತಿ ಏಕೆ ?

ದೇಶದ ಸಾಮಾಜಿಕ, ಆರ್ಥಿಕ ಮತ್ತು ಜನಾಂಗಗಳ

ಸ್ಥಿತಿಗತಿಗಳನ್ನು ತಿಳಿಯಲು ಜನಗಣತಿ ಅವಶ್ಯಕ

ಜನಗಣತಿ ಒಂದು ರಾಷ್ಟ್ರೀಯ ಮಹತ್ಕಾರ್ಯ.
ಅದನ್ನು ಯಶಸ್ವಿಯಾಗಿಸುವುದು ನಮ್ಮ ಕರ್ತವ್ಯ
ಮತ್ತು ಜವಾಬ್ದಾರಿ

2001ರ ಫೆಬ್ರವರಿ 9ರಿಂದ 28ರ ಅವಧಿಯಲ್ಲಿ
ನಡೆಯುವ ಜನಗಣತಿಯಲ್ಲಿ ದಯವಿಟ್ಟು ಸಹಕರಿಸಿ

ಗಣತಿದಾರರಿಗೆ ಸರಿಯಾದ ಮತ್ತು ಸಂಪೂರ್ಣವಾದ
ಮಾಹಿತಿಯನ್ನು ನೀಡಿ

ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಲಾದ
ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿಡಲಾಗುವುದು

ನಿರ್ದೇಶಕರು, ಜನಗಣತಿ ನಿರ್ದೇಶನಾಲಯ, ಕರ್ನಾಟಕ, ಬೆಂಗಳೂರು ಮತ್ತು
ಪ್ರಧಾನ ಜನಗಣತಿ ಅಧಿಕಾರಿಗಳು
(ಜಿಲ್ಲಾಧಿಕಾರಿಗಳು ಅಥವಾ
ನಗರಪಾಲಿಕೆಗಳ ಆಯುಕ್ತರು ಅಥವಾ
ಬೆಂಗಳೂರು ಅಭಿವೃದ್ಧಿ ಪ್ರಾಧಿಕಾರದ ಆಯುಕ್ತರು ಮತ್ತು
ಸ್ಥಳೀಯ ಆಡಳಿತ ಅಧಿಕಾರಿಗಳು)

ಇದರ ಮೌಲ್ಯವನ್ನು ಉಪಯೋಗಿಸಿಕೊಳ್ಳುವುದಿರಲಿ, ಇದರ ಮಹತ್ವವನ್ನು ನಾವು ಸಂಪೂರ್ಣವಾಗಿ ಅರಿತಿಲ್ಲವೆಂದೇ ಹೇಳಬೇಕು. ಇದನ್ನು ಸಂಪತ್ತಿನ ನಡುವೆ ಇರುವ ದಾರಿದ್ರ್ಯ ಎನ್ನದೇ ವಿಧಿ ಇಲ್ಲ.

ಭಾರತದಲ್ಲಿ ಮುಂದಿನ ಜನಗಣತಿ ಯಾವಾಗ ?

2001ರ ಫೆಬ್ರವರಿ 9ರಿಂದ ಮೊದಲ್ಗೊಂಡು ಮಾರ್ಚ್ 5ರ ವರೆಗಿನ ಅವಧಿಯಲ್ಲಿ ಭಾರತವು ತನ್ನ ಹದಿನಾಲ್ಕನೇ ಜನಗಣತಿಯನ್ನು ಕೈಗೊಳ್ಳಲಿದೆ. ಜನಗಣತಿಯ ಪೂರ್ವಭಾವಿಯಾಗಿ, 2000ನೇ ಇಸವಿಯ ಏಪ್ರಿಲ್ - ಜೂನ್ ತಿಂಗಳುಗಳ ಅವಧಿಯಲ್ಲಿ ಮನೆ ಪಟ್ಟಿ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಪೂರ್ಣಗೊಳಿಸಲಾಗಿದೆ. ಈ ಬಾರಿ ಜನಗಣತಿಯ ಸಮಯದಲ್ಲಿ ಸಾಂಪ್ರದಾಯಿಕವಾದ ವೈಯಕ್ತಿಕ ಚೀಟಿಯನ್ನು ಕೈಬಿಡಲಾಗಿದೆ ಮತ್ತು ವ್ಯಕ್ತಿಗತ ಮಾಹಿತಿಯನ್ನು ಕುಟುಂಬದ ಅನುಸೂಚಿಯಲ್ಲಿ ಸಂಗ್ರಹಿಸಲಾಗುವುದು. ಈ ಬಾರಿ ವಿಶೇಷವಾಗಿ ದೈಹಿಕ ಮತ್ತು ಮಾನಸಿಕ ವಿಕಲತೆಯ ಬಗ್ಗೆ ಪ್ರಶ್ನಿಸಲಾಗುವುದು. ಇದರಿಂದಾಗಿ ಸರ್ಕಾರ ಹಾಗೂ ಸಾರ್ವಜನಿಕ ಸೇವಾಸಂಸ್ಥೆಗಳು ವಿಕಲಾಂಗರ ಕಲ್ಯಾಣ ಯೋಜನೆಗಳನ್ನು ರೂಪಿಸಲು ಮೂಲಭೂತ ಮಾಹಿತಿಗಳು ದೊರಕಲಿವೆ. ಇದಲ್ಲದೆ ಪ್ರಪ್ರಥಮ ಬಾರಿಗೆ ಸಾಗುವಳಿದಾರರು, ಸಾಗುವಳಿ ಕಾರ್ಮಿಕರು ಮತ್ತು ಕುಟುಂಬ ಕೈಗಾರಿಕೆಯಲ್ಲಿನ ಕೆಲಸಗಾರರನ್ನು ಹೊರತುಪಡಿಸಿ ಉಳಿದ ಎಲ್ಲಾ ಇತರೆ ಕೆಲಸಗಾರರು ತಮ್ಮ ನಿವಾಸಸ್ಥಾನದಿಂದ ಕೆಲಸದ ಸ್ಥಳಕ್ಕೆ ಇರುವ ದೂರ ಮತ್ತು ಪ್ರಯಾಣಿಸುವ ಬಗೆಯ ಬಗೆಗಿನ ಮಾಹಿತಿಗಳನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುವುದಲ್ಲದೆ ಸಾಗುವಳಿ/ತೋಟಗಾರಿಕೆಯಲ್ಲಿ ತೊಡಗಿರುವ ಕುಟುಂಬಗಳ ಹಾಗೂ ಜಮೀನಿನ ವಿಸ್ತೀರ್ಣದ ಬಗೆಗಿನ ಮಾಹಿತಿಗಳನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುವುದು. ಇದರಿಂದಾಗಿ ರಾಷ್ಟ್ರದ ಕೃಷಿ ಯೋಜನೆಗಳಿಗೆ ಪೂರಕ ಮಾಹಿತಿಗಳು ದೊರಕಲಿವೆ.

ಜನಗಣತಿ ಸಮಯದಲ್ಲಿ ಸಂಗ್ರಹವಾಗುವ ಮಾಹಿತಿಗಳು ರಹಸ್ಯವೇ ?

ಜನಗಣತಿ ಕರ್ತವ್ಯದ ಜವಾಬ್ದಾರಿ ಹೊತ್ತುಕೊಂಡಿರುವ ಸಿಬ್ಬಂದಿಯು ಈ ಕಾರ್ಯವನ್ನು ವಿಶ್ವಾಸದಿಂದ ಮತ್ತು ಹೊಣೆಗಾರಿಕೆಯಿಂದ ಮಾಡಬೇಕಾಗಿರುವುದು ಜನಗಣತಿ ಕಾಯಿದೆ 1948ರ ರೀತ್ಯಾ ಕಡ್ಡಾಯವಾಗಿದೆ. ಇದೇ ರೀತಿ ಜನಗಣತಿಯ ಸಂದರ್ಭದಲ್ಲಿ ಕೇಳುವ ಪ್ರಶ್ನೆಗಳಿಗೆ ಸಂಬಂಧಿಸಿದ ವ್ಯಕ್ತಿಗಳು ಸರಿಯಾದ ಮತ್ತು ಪೂರ್ಣವಾದ ಮಾಹಿತಿ ಮತ್ತು ಉತ್ತರವನ್ನು ನೀಡುವುದು ಸಹಾ ಕಾಯಿದೆಯ ರೀತ್ಯಾ ಕಡ್ಡಾಯವಾಗಿದೆ. ಗಣತಿದಾರರಿಗೆ ಮಾಹಿತಿ ನೀಡುವಾಗ ಸಾರ್ವಜನಿಕರು ಯಾವುದೇ ರೀತಿಯ ಅನುಮಾನ ಮತ್ತು ಹಿಂಜರಿಕೆಗಳನ್ನು ಇಟ್ಟುಕೊಳ್ಳಕೊಡದು. ಸಾರ್ವಜನಿಕರು ನೀಡುವ ಮಾಹಿತಿಯ ರಹಸ್ಯವನ್ನು ಮತ್ತು ಮಾಹಿತಿ ನೀಡಿದ ವ್ಯಕ್ತಿಯ ಗುರುತನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ಕಾಪಾಡುವ ಸುರಕ್ಷತೆಯನ್ನು ಜನಗಣತಿ ಕಾಯಿದೆಯು ಒದಗಿಸಿದೆ.

ಒಟ್ಟಿನಲ್ಲಿ ಹೇಳುವುದಾದರೆ ಸಮಾಜದ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಮತ್ತು ಇತರೆ ಉನ್ನತಿಗಳಿಗಾಗಿ ರೂಪಿಸುವ ಎಲ್ಲಾ ಯೋಜನೆಗಳಿಗೆ ಜನಗಣತಿಯೇ ಆಧಾರ ಮತ್ತು ದೇಶದಲ್ಲಿ ಲಭ್ಯವಿರುವ ಮಾನವ ಸಂಪನ್ಮೂಲಗಳನ್ನು ಅರಿಯಲು ಏಕೈಕ ಮೂಲವಾಗಿದೆ.

ನಿಮ್ಮ ಪಾತ್ರ

2001ನೇ ಇಸವಿಯ ಫೆಬ್ರವರಿ 9- 28 ರ ಅವಧಿಯಲ್ಲಿ ಜನಗಣತಿಗಾಗಿ ಎಣಿಕೆದಾರರು ನಿಮ್ಮ ಮನೆಗಳಿಗೇ ಭೇಟಿ ನೀಡಿ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸಲಿದ್ದಾರೆ. ಅವರಿಗೆ ಸಂಪೂರ್ಣ ಸಹಕಾರ ಹಾಗೂ ಮಾಹಿತಿಗಳನ್ನು ನೀಡುವುದೇ ನಿಮ್ಮ ಪಾತ್ರ ಹಾಗೂ ಕರ್ತವ್ಯ

ಜನಗಣತಿ - ಫೆಬ್ರವರಿ 9ರಿಂದ 28, 2001
ವಸತಿರಹಿತರ ಜನಗಣತಿ - ಫೆಬ್ರವರಿ 28, 2001ರ ರಾತ್ರಿ
ಪುನಃ ಸಂದರ್ಶನದ ಸುತ್ತು - ಮಾರ್ಚ್ 1ರಿಂದ 5, 2001
ಜನಗಣತಿ ಸೂಚಿತ ದಿನಾಂಕ ಮತ್ತು ಘಳಿಗೆ -
2001ರ ಮಾರ್ಚ್ 1ರ 00.00 ಘಂಟೆ

ಸರ್ಕಾರಿ ಮುದ್ರಣಾಲಯ, ಬೆಂಗಳೂರು - 560 001

ಭಾರತ ಕೀ ಜನಗಣನಾ 2001 CENSUS OF INDIA
ಲೋಕಾಭಿಮುಖ
PEOPLE ORIENTED
ಜನಪರ

ಜನಗಣತಿ ಏಕೆ ?

ದೇಶದ ಸಾಮಾಜಿಕ, ಆರ್ಥಿಕ ಮತ್ತು ಜನಾಂಗಗಳ ಸ್ಥಿತಿಗತಿಗಳನ್ನು ತಿಳಿಯಲು

ಜನಗಣತಿ ಅವಶ್ಯಕ

ಜನಗಣತಿ ಒಂದು ರಾಷ್ಟ್ರೀಯ ಮಹತ್ಕಾರ್ಯ

ಅದನ್ನು ಯಶಸ್ವಿಯಾಗಿಸುವುದು ನಮ್ಮ ಕರ್ತವ್ಯ ಮತ್ತು ಜವಾಬ್ದಾರಿ

2001ರ ಫೆಬ್ರವರಿ 9ರಿಂದ 28ರ ಅವಧಿಯಲ್ಲಿ ನಡೆಯುವ ಜನಗಣತಿಯಲ್ಲಿ ದಯವಿಟ್ಟು ಸಹಕರಿಸಿ

ಜನಗಣತಿದಾರರಿಗೆ ಸರಿಯಾದ ಮತ್ತು ಸಂಪೂರ್ಣವಾದ ಮಾಹಿತಿಯನ್ನು ನೀಡಿ

ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಲಾದ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿಡಲಾಗುವುದು

ನಿರ್ದೇಶಕರು, ಜನಗಣತಿ ನಿರ್ದೇಶನಾಲಯ,
ಕರ್ನಾಟಕ, ಬೆಂಗಳೂರು ಮತ್ತು
ಪ್ರಧಾನ ಜನಗಣತಿ ಅಧಿಕಾರಿಗಳು
(ಜಿಲ್ಲಾಧಿಕಾರಿಗಳು ಅಥವಾ ನಗರಪಾಲಿಕೆಗಳ ಆಯುಕ್ತರು
ಅಥವಾ ಬೆಂಗಳೂರು ಅಭಿವೃದ್ಧಿ ಪ್ರಾಧಿಕಾರದ ಆಯುಕ್ತರು
ಮತ್ತು ಸ್ಥಳೀಯ ಆಡಳಿತ ಅಧಿಕಾರಿಗಳು

ಜನಗಣತಿ- 2001
ರಾಷ್ಟ್ರದ ಪ್ರಗತಿಯ ದಿಕ್ಸೂಚಿ

ಭಾರತದ ಜನಗಣತಿ 2001ರ ಕಾರ್ಯಾಚರಣೆಯ ಪ್ರಥಮ ಹಂತವಾದ ಮನೆಪಟ್ಟಿ ಕಾರ್ಯಾಚರಣೆಯು 2000 ಮೇ-ಜೂನ್ ತಿಂಗಳುಗಳ ಅವಧಿಯಲ್ಲಿ ಪೂರ್ಣಗೊಂಡಿದೆ. ಇದರ ಇನ್ನೊಂದು ಪ್ರಮುಖ ಹಂತವಾದ ವೈಯಕ್ತಿಕ ವಿವರಗಳ ಸಂಗ್ರಹಣೆ ಕಾರ್ಯವಾದ ಜನಗಣತಿಯನ್ನು 2001ರ ಫೆಬ್ರವರಿ 9ರಿಂದ 28ರವರೆಗೆ ಕೈಗೊಳ್ಳಲಾಗುವುದು. ಭಾರತದ ಜನಗಣತಿಯು ನಮ್ಮ ರಾಷ್ಟ್ರದ ಗಮನಾರ್ಹ ಘಟನೆಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ.

ಭಾರತದಲ್ಲಿ ಮೊಟ್ಟ ಮೊದಲಿಗೆ 1871ರಲ್ಲಿ ಜನಗಣತಿ ಆರಂಭವಾಯಿತು. ಅಲ್ಲಿಂದೀಚೆಗೆ ಯಾವುದೇ ಅಡೆತಡೆಯಿಲ್ಲದೆ ನಿರಾತಂಕವಾಗಿ ನಿಗದಿತ ಅವಧಿಗಳಲ್ಲಿ ಜನಗಣತಿಯನ್ನು ನಡೆಸಿಕೊಂಡು ಬಂದಿರುವ ಹೆಮ್ಮೆಯ ದಾಖಲೆ ಭಾರತಕ್ಕಿದೆ. ನಮ್ಮ ದೇಶ ಮತ್ತು ಜನತೆಯ ಬಗ್ಗೆ ಸಮಗ್ರವಾದ ಮತ್ತು ಅಧಿಕೃತವಾದ ಮಾಹಿತಿಯ ಮೂಲವೆಂದು ಇದನ್ನು ವಿಶ್ವದಾದ್ಯಂತ ಪರಿಗಣಿಸಲಾಗಿದೆ.

ಜನಗಣತಿಯು ರಾಷ್ಟ್ರ ವ್ಯಾಪಿಯಾದ ಒಂದು ಬೃಹತ್ ಕಾರ್ಯಾಚರಣೆ. ಕರ್ನಾಟಕ ರಾಜ್ಯದಲ್ಲಿರುವ 27 ಜಿಲ್ಲೆಗಳ 175 ತಾಲ್ಲೂಕುಗಳಲ್ಲಿನ 270 ಪಟ್ಟಣ ಪ್ರದೇಶಗಳು ಹಾಗೂ 29,480 ಗ್ರಾಮಗಳ ಉದ್ದಗಲಕ್ಕೂ ಅಂದರೆ ಯಾವುದೇ ಪ್ರದೇಶವನ್ನು ಗಣತಿಯಲ್ಲಿ ಕೈಬಿಡದೆ ಮತ್ತು ಒಂದಕ್ಕೂ ಹೆಚ್ಚು ಬಾರಿ ಎಣಿಕೆ ಆಗದಂತೆ ನೋಡಿಕೊಳ್ಳುವ ಸಲುವಾಗಿ ಸುಮಾರು 1,19,929 ಬ್ಲಾಕುಗಳಾಗಿ ವಿಂಗಡಿಸಲಾಗಿದೆ. ಈ ಬ್ಲಾಕುಗಳಲ್ಲಿ ವಾಸಿಸುತ್ತಿರುವ ಪ್ರತಿಯೊಬ್ಬ ಸ್ತ್ರೀ ಮತ್ತು ಪುರುಷರನ್ನು ಅವರ ಲಿಂಗ, ವಯೋಮಾನ ಹಾಗೂ ರಾಷ್ಟ್ರೀಯತೆಯ ಭೇದವಿಲ್ಲದೆ ಜನಗಣತಿಗೆ ಒಳಪಡಿಸಲಾಗುವುದು.

ಜನಗಣತಿ ಎಂದರೆ ಏನು ?

ವಿಶ್ವ ಸಂಸ್ಥೆಯು ಜನಸಂಖ್ಯಾ ಗಣತಿಯ ಆಧುನಿಕ ಪರಿಕಲ್ಪನೆಗಳನ್ನು ವಿವರವಾಗಿ ಹೇಳಿದೆ. ಅದರ ಪ್ರಕಾರ ಒಂದು ನಿಗದಿತ ಸಮಯದಲ್ಲಿ ನಿರ್ದಿಷ್ಟಗೊಳಿಸಿದ ವ್ಯಾಪ್ತಿಯ ಅಥವಾ ಒಂದು ದೇಶದಲ್ಲಿನ ಎಲ್ಲಾ ಜನರಿಗೆ ಸಂಬಂಧಿಸಿದ ಜನಾಂಗಸ್ಥಿತಿ ಹಾಗೂ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಅಂಕಿ ಅಂಶಗಳನ್ನು ಸಂಗ್ರಹಿಸುವ,ಸಂಕಲಿಸುವ ಮತ್ತು ಪ್ರಕಟಣೆಗೊಳಿಸುವ ಪ್ರಕ್ರಿಯೆಯನ್ನು ಜನಗಣತಿ ಎಂದು ಕರೆಯಲಾಗುತ್ತದೆ. ಭಾರತದ ಜನಗಣತಿಯು ಇದನ್ನು ಅಕ್ಷರಶಃ ಅಳವಡಿಸಿಕೊಂಡಿದೆ.

ಜನಗಣತಿಯಲ್ಲಿ ಸಂಗ್ರಹಿತವಾದ ಮಾಹಿತಿಗಳಿಂದ ಪ್ರಯೋಜನವೇನು ?

ಜನಸಂಖ್ಯಾ ದೃಷ್ಟಿಯಿಂದ ಭಾರತವು ಜಗತ್ತಿನಲ್ಲಿಯೇ ಎರಡನೆಯ ಅತಿದೊಡ್ಡ ರಾಷ್ಟ್ರ. ಕ್ರಿ.ಶ.2001ನೇ ಇಸವಿಯ ವೇಳೆಗೆ ಭಾರತದ ಜನಸಂಖ್ಯೆ ಒಂದು ಬಿಲಿಯನ್ ದಾಟುವ ನಿರೀಕ್ಷೆಯಿದೆ. ಭಾರತದ ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಗಳನ್ನು ಅರ್ಥ ಮಾಡಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಬಗೆಹರಿಸುವಲ್ಲಿ ಜನಗಣತಿಯ ಅಂಕಿ ಅಂಶಗಳು ಸಕಾಲಕ್ಕೆ ನಮ್ಮ ನೆರವಿಗೆ ಬರುತ್ತವೆ. ಆದ್ದರಿಂದ ನಮ್ಮ ರಾಷ್ಟ್ರದ ಜನಾಂಗ ಸ್ಥಿತಿ, ನಮ್ಮ ಜನರ ಆರ್ಥಿಕ ಹಾಗೂ ಸಾಮಾಜಿಕ ಸ್ಥಿತಿಗತಿಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳಬೇಕಾದ ಅವಶ್ಯಕತೆ ಇದೆ. ಜನಗಣತಿಯ ಪ್ರಾಮುಖ್ಯತೆ ಎಷ್ಟಿದೆಯೆಂದರೆ ಇಂದು ಜಗತ್ತಿನಲ್ಲಿ ಜನಸಂಖ್ಯಾ ಗಣತಿಯನ್ನು ಮಾಡದಿರುವ ಯಾವುದೇ ರಾಷ್ಟ್ರವೇ ಇಲ್ಲ.

ಭಾರತದಂತಹ ಬೃಹತ್ ಹಾಗೂ ವೈವಿಧ್ಯತೆ ಹೊಂದಿರುವ ರಾಷ್ಟ್ರದಲ್ಲಿ ಇದು ಒಂದು ಪ್ರಮುಖ ಅಡಳಿತಾತ್ಮಕ ಸಾಧನೆಯಷ್ಟೇ ಅಲ್ಲ, ಇದು ನಿರಂತರವಾಗಿ ಬದಲಾಗುತ್ತಿರುವ ನಮ್ಮ ರಾಷ್ಟ್ರದ ಆರ್ಥಿಕ ಹಾಗೂ ಸಾಮಾಜಿಕ ಪ್ರಶ್ನೆಗಳಿಗೆ, ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಗಳಿಗೆ ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಗಳಿಗೆ ಉತ್ತರ ಕಂಡುಕೊಳ್ಳಲು ಅಗತ್ಯವಾದ ಮಾಹಿತಿಯನ್ನು ನಮ್ಮ ಯೋಜಕರಿಗೆ, ನೀತಿರೂಪಕರಿಗೆ, ಆರ್ಥಿಕತಜ್ಞರಿಗೆ, ಸಂಖ್ಯಾ ಸಂಗ್ರಹಣಕಾರರಿಗೆ, ಸಂಶೋಧಕರಿಗೆ ಮತ್ತು ಅಡಳಿತಕಾರರಿಗೆ ಒದಗಿಸುತ್ತದೆ. ಕೆಳ ಹಂತದಲ್ಲಿ ನೀತಿ ನಿರೂಪಿಸಲು ಹಾಗೂ ರಾಷ್ಟ್ರದ ಆಹಾರ, ಆರೋಗ್ಯ, ವಸತಿ, ಶಿಕ್ಷಣ ಮತ್ತು ಉದ್ಯೋಗದ ಬೇಡಿಕೆಗಳ ಬಗ್ಗೆ ದೀರ್ಘಾವಧಿ ಮುನ್ನೋಟವನ್ನು ನೀಡಲು ಜನಗಣತಿ ಅತ್ಯವಶ್ಯಕವಾಗಿದೆ.

ಭಾರತಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಜನಗಣತಿಯು ಕೇವಲ ತಲೆ ಎಣಿಸುವ ಬೃಹತ್ ಕಾರ್ಯವಲ್ಲ. ಇದೊಂದು ರಾಷ್ಟ್ರವನ್ನು ಕಟ್ಟುವ ಪವಿತ್ರ ಕಾರ್ಯ. ಆದರೆ, ಸಾಮಾನ್ಯವಾಗಿ ಜನಗಣತಿಯು ರಾಷ್ಟ್ರೀಯ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಪ್ರಾಮುಖ್ಯ ಎಂದು ಭಾವಿಸದಿರುವ ಜನರೇ ಹೆಚ್ಚು. ಆದರೆ, ವಸ್ತು ಸ್ಥಿತಿ ಅದಲ್ಲ ಎನ್ನುವುದನ್ನು ನಾವು ನೀವೆಲ್ಲಾ ನೆನಪಿನಲ್ಲಿಟ್ಟುಕೊಳ್ಳಬೇಕು.

ಜನಗಣತಿಯ ಇತರ ಉದ್ದೇಶಗಳಲ್ಲಿ ಸರ್ಕಾರದ ನೀತಿ ನಿರೂಪಣೆ, ಆಡಳಿತ ಮತ್ತು ಮತದಾರರ ವಿಂಗಡಣೆ, ನಗರ ಮತ್ತು ಪಟ್ಟಣಗಳ ನ್ಯಾಯಿಕ ಅಥವಾ ಆಡಳಿತಾತ್ಮಕ ಸ್ಥಾನಮಾನ ಇವುಗಳನ್ನು ಗುರುತಿಸುವುದೂ ಸೇರಿದೆ. ಜನಗಣತಿಯು ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯ ವೈಜ್ಞಾನಿಕ ವಿಶ್ಲೇಷಣೆ, ಸಂಯೋಜನೆ, ವಿತರಣೆಯ ಬಗ್ಗೆ ಅಗತ್ಯವಾದ ಅಂಕಿ ಅಂಶಗಳನ್ನು ಒದಗಿಸುತ್ತದೆ. ಬದಲಾಗುತ್ತಿರುವ ನಗರ, ಗ್ರಾಮೀಣ ಜನಸಾಂದ್ರತೆ, ನಗರೀಕರಣಗೊಳ್ಳುತ್ತಿರುವ ಪ್ರದೇಶದ ಅಭಿವೃದ್ಧಿ, ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆ ಹಾಗೂ ವಿವಿಧ ಮಾರ್ಪಾಡುಗಳಿಗೆ ಅನುಗುಣವಾಗಿ ಜನಸಂಖ್ಯೆಯಲ್ಲಿ ಆಗುತ್ತಿರುವ ಜನಾಂಗ ವಿತರಣೆ ಇವೆಲ್ಲವೂ ವೈಜ್ಞಾನಿಕ ಅಧ್ಯಯನ ಮತ್ತು ಆಸಕ್ತಿಯ ಪ್ರಶ್ನೆಗಳಾಗಿವೆ. ಜನಗಣತಿಯು, ವಾಣಿಜ್ಯ ಮತ್ತು ಕೈಗಾರಿಕಾ ಯೋಜನೆಗಳಲ್ಲಿ ತೊಡಗಿರುವ ವ್ಯಕ್ತಿಗಳಿಗೆ ಮತ್ತು ಖಾಸಗಿ ಸಂಸ್ಥೆಗಳಿಗೆ ಹಲವು ರೀತಿಯಲ್ಲಿ ಉಪಯೋಗಕ್ಕೆ ಬರುತ್ತದೆ.

ಅಂಕಿ ಅಂಶಗಳಿಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಹೇಳುವುದಾದರೆ, ಭಾರತದ ಜನಗಣತಿ ಅಂಕಿ ಅಂಶಗಳ ತಳಹದಿಯು ತನ್ನ ವಿಷಯ ವ್ಯಾಪ್ತಿಯಲ್ಲಿ ಬಹುಮುಖಿಯಾಗಿದೆ. ಜನಾಂಗದ ಸ್ಥಿತಿ, ಆರ್ಥಿಕತೆ, ಸಾಮಾಜಿಕ ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕ ಗುಣಲಕ್ಷಣಗಳಾಗಿವೆ.

ಫಲವಂತಿಕೆ, ಶಿಶುಮರಣ, ಪರಿಶಿಷ್ಟ ಜಾತಿ, ಪಂಗಡ, ಭಾಷೆ, ಧರ್ಮ, ವಲಸೆ, ಶಿಕ್ಷಣ, ಆರೋಗ್ಯ, ಸಂಪರ್ಕ, ಬಾಲಕಾರ್ಮಿಕರು, ಉದ್ಯೋಗ, ವಯೋಮಾನ, ವಸತಿ, ಕೌಟುಂಬಿಕ ವ್ಯವಸ್ಥೆ, ನಗರೀಕರಣ, ಮೂಲಭೂತಸೌಲಭ್ಯ ಹೀಗೆ ಹತ್ತು ಹಲವು ವಿಷಯಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿ ನೀಡುತ್ತದೆ. ಇಷ್ಟರ ಮಟ್ಟಿಗೆ ಇದರ ವಿಷಯ ವ್ಯಾಪ್ತಿ ವಿಶಾಲವಾಗಿದೆ. ಒಟ್ಟಾರೆ ಹೇಳುವುದಾದರೆ, ಜನಗಣತಿಯು ಬೃಹತ್ ಅಂಕಿ ಅಂಶಗಳ ಮಾಹಿತಿಯ ಅಭೂತಪೂರ್ವಗಣಿಯಾಗಿದೆ.

ಭಾರತದ ಜನಗಣತಿ - ೨೦೦೧
ದೇಶದ ಜನಗಣತೆಯಲ್ಲಿ ಅಂಗವಿಕಲ ವ್ಯಕ್ತಿಗಳ ಸಮೀಕ್ಷೆಯ ಸೇರ್ಪಡೆ

೨೦೦೧ನೆಯ ಜನಗಣತಿ ಕಾರ್ಯವು ಫೆಬ್ರವರಿ ೫ ರಿಂದ ೨೮ನೆಯ ತಾರೀಖಿನವರೆಗೆ ನಡೆಯಲಿದೆ. ಭಾರತದ ಜನಗಣತಿಯು ಒಂದು ಬೃಹತ್ ಕಾರ್ಯವಾಗಿದ್ದು, ಅದರಿಂದ ಪಡೆದ ಮಾಹಿಯ ಆಧಾರದ ಮೇಲೆ, ಎಲ್ಲ ಅಭಿವೃದ್ಧಿ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ರೂಪಿಸಲಾಗುತ್ತದೆ. ರಾಷ್ಟ್ರೀಯ ಮಾದರಿ ಸಮೀಕ್ಷಾ ಸಂಸ್ಥೆಯು (NSSO), ೧೯೧೧ನೆಯ ಜನಗಣತಿಯ ಅಂಗವಾಗಿ, ಅಂಗವಿಕಲತೆಯುಳ್ಳವ್ಯಕ್ತಿಗಳ ಮಾದರಿ ಸಮೀಕ್ಷೆಯನ್ನು ದೇಶದಲ್ಲಿ ನಡೆಸಿದರು; ಇದಲ್ಲದೇ, ಕರ್ನಾಟಕ ಹಾಗೂ ಮಧ್ಯಪ್ರದೇಶದ ರಾಜ್ಯ ಸರ್ಕಾರಗಳು ಸಮೀಕ್ಷೆಗಳನ್ನು ತಮ್ಮ ತಮ್ಮ ರಾಜ್ಯಗಳಲ್ಲಿ ಪ್ರತ್ಯೇಕವಾಗಿ ನಡೆಸಿದರು. ಭಾರತದಲ್ಲಿ ಇಂದು ದೊರೆಯುವ ಅಂಗವಿಕಲತೆಯ ಬಗೆಗಿನ ಮಾಹಿತಿಯೆಲ್ಲವೂ, ಶೈಕ್ಷಣಿಕ / ಸಂಶೋಧನಾ ಸಂಸ್ಥೆಗಳು, ಸಮಗ್ರ ಶಿಶು ಅಭಿವೃದ್ಧಿ ಕಾರ್ಯಕ್ರಮ ICDS ಅಂಗವಾಗಿ ನಡೆಸಿದ ಸಮೀಕ್ಷೆಗಳು, ಪೊಲಿಯೋದಿಂದ ಉಂಟಾಗುವ ಕುಂಟುತನದ ಸಮೀಕ್ಷೆಗಳಿಂದ ಬಂದದ್ದೇ.

ಪ್ರಸ್ತುತ ಜನಗಣತಿಯ ಕಾರ್ಯಕ್ರಮದಡಿಯಲ್ಲಿ ಜನಗಣತಿ ಇಲಾಖೆ, ಭಾರತ ಸರ್ಕಾರ, ನಮ್ಮ ದೇಶದ ಜನರಲ್ಲಿ ಕಂಡುಬರುವ ಅಂಗವಿಕಲತೆಯ ಮಾಪನಾಕಾರ್ಯವನ್ನೂ ಸೇರಿಸಿರುವುದು ಶ್ಲಾಘನೀಯ. ಅಂಗವಿಕಲತೆಯಳ್ಳವರಿಗೆ ಉದ್ಯೋಗವಕಾಶಗಳನ್ನು ಕಲ್ಪಿಸುವ ಸಂಸ್ಥೆಯಾದNCPEDP ಮತ್ತು ಅಂಗವಿಕಲರ ಅಭಿವೃದ್ಧಿ / ಹಕ್ಕುಗಳಿಗಾಗಿ ಹೋರಾಡುವ ಹಲವು ಸಂಸ್ಥೆಗಳು - ಇವರೆಲ್ಲರ ಪರಿಶ್ರಮದ ಫಲವಾಗಿ ಸರ್ಕಾರವು ತನ್ನ ಗಮನವನ್ನು ಇತ್ತ ಕಡೆ ಹರಿಸಿ, ಅಂಗವಿಕಲ ವ್ಯಕ್ತಿಗಳ ಗಣತಿ - ಜನಗಣತಿ ೨೦೦೧ ಅಂಗವಾಗಿ ಸೇರ್ಪಡೆಯಾಗಿದೆ.

ಈ ಸಮೀಕ್ಷೆ ಫೆಬ್ರವರಿ ೨೦೦೧ ರಲ್ಲಿ ನಡೆಯುತ್ತಿವುದು ಬಹಳ ಸಂತೋಷದ ವಿಷಯ. ಈ - ಕಾರ್ಯವು ವ್ಯವಸ್ಥಿತವಾಗಿ, ಸರಿಯಾದ ರೀತಿಯಲ್ಲಿ ನಡೆಯುವಂತೆ ನೋಡಿಕೊಳ್ಳಬೇಕಾದುದು ಬಹಳ ಅವಶ್ಯಕ:

- ಜನರಿಗೆ, ಅಂಗವಿಕಲತೆಯುಳ್ಳ ವ್ಯಕ್ತಿಗಳ ಎಣಿಕೆಯೂ ಸಹ ಜನಗಣತಿಯ ಅಂಗವೆಂದು ತಿಳಿಸಬೇಕು.
- ಜನಗಣತಿಯನ್ನು ನಡೆಸುವ ಕಾರ್ಯಕರ್ತರಿಗೂ ಇದು ತಿಳಿದಿರಬೇಕು.
- ಕಾರ್ಯಕರ್ತರು ತಮ್ಮ ಮನೆಗಳಿಗೆ ಬಂದಾಗ, ಅಂಗವಿಕಲತೆಯುಳ್ಳ ವ್ಯಕ್ತಿಗಳು, ಅವರ ಸಂಬಂಧಿಕರು ಹಾಗೂ ಪರಿವಾರದವರಿಗೆ, ಅಂಗವಿಕಲತೆಯನ್ನು ಜನಗಣತಿಯಲ್ಲಿ ದಾಖಲಿಸಲಾಗುತ್ತದೆಂದು ತಿಳಿಸಿ ಹೇಳಬೇಕು.

ನಾವು ಈ ಸಮೀಕ್ಷೆಗೆ ಸಿದ್ಧವಾಗಿರುವೆವೇ ?

ಅಂಗವಿಕಲತೆಯ ವಿಷಯ ಜನಗಣತಿಯಲ್ಲಿ ಸೇರ್ಪಡೆಯಾಗಿರುವುದು ಇದೇ ಮೊದಲು. ಜನಗಣತಿಯ ಕಾರ್ಯಕರ್ತರೂ ಸಹ ಈ ವಿಷಯವನ್ನು ನೋಂದಾಯಿಸುತ್ತಿರುವುದು ಇದೇ ಮೊದಲು. ಆದ್ದರಿಂದ ಕಾರ್ಯಕರ್ತರಿಗೆ ತರಬೇತಿ ಕೊಡುವುದು ಅತ್ಯವಶ್ಯಕ. ಈ ತರಬೇತಿಯನ್ನು ರಾಜ್ಯ ಮಟ್ಟ, ಜಿಲ್ಲಾಮಟ್ಟ, ಉಪವಿಭಾಗ ಹಾಗೂ ತಾಲ್ಲೂಕು ಮಟ್ಟದಲ್ಲಿ ನಡೆಸಬೇಕು. ಇದನ್ನು ಕಾರ್ಯರೂಪಕ್ಕೆ ತರುವುದು ಹೇಗೆ? ಅದಕ್ಕಾಗಿ :

- ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರ / ಅವರ ಮೇಲಧಿಕಾರಿಗಳ ತರಬೇತಿಗಾಗಿ ಉಪಯುಕ್ತವಾದ ಕಲಿಕಾ ಸಾಮಾಗ್ರಿಗಳನ್ನು ರೂಪಿಸಬೇಕು.
- ಪ್ರಸಾರ ಮಾಧ್ಯಮಗಳಿಗಾಗಿ (ಟಿವಿ/ರೇಡಿಯೋ) ಉಪಯುಕ್ತವಾದ ಕಲಿಕಾ ಸಾಮಗ್ರಿಗಳು, ಅಂದರೆ ಭಿತ್ತಿ ಪತ್ರಗಳು, ಸಂದೇಶ ವಾಕ್ಯಗಳು, ಇತ್ಯಾದಿ - ಇವುಗಳನ್ನು ತಯಾರು ಮಾಡಬೇಕು.
- ಜನಗಣತಿಯಲ್ಲಿ ತೊಡಗಿರುವ ಎಲ್ಲ ಸರ್ಕಾರಿ ಅಧಿಕಾರಿಗಳಿಗೂ - ಅದರಲ್ಲೂ ಕಂದಾಯ, ಜನಗಣತಿ ಹಾಗೂ ಶಿಕ್ಷಣ ಇಲಾಖೆಗಳಿಗೆ - ಸರ್ಕಾರದ ಜ್ಞಾಪನಾ ಪತ್ರಗಳು ಮುಂಚಿತವಾಗಿಯೇ ತಲುಪಿಸಬೇಕು.
- ಈ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ, ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳಿಗೆ, ಅಂಗವಿಕಲರ ಅಭಿವೃದ್ಧಿ ಸಂಸ್ಥೆಗಳಿಗೆ ಹಾಗೂ ಅಂಗವಿಕಲ ವ್ಯಕ್ತಿಗಳಿಗೆ ಮುಂಚಿತವಾಗಿಯೇ ತಿಳಿಸಿರಬೇಕು.

ಸ್ವಯಂ ಸೇವಾ / ಅಂಗವಿಕಲರ ಅಭಿವೃದ್ಧಿ ಸಂಸ್ಥೆಗಳ ಪಾತ್ರ

ಜನಗಣತಿಯ ಕಾರ್ಯಕ್ರಮ ಕೇವಲ ಎರಡೇ ತಿಂಗಳುಗಳ ನಂತರ ಆರಂಭವಾಗುತ್ತದೆ. ಈ ಅಂಶಗಳೆಲ್ಲವನ್ನೂ ಕಾರ್ಯರೂಪಕ್ಕೆ ತರುವುದು ಹೇಗೆ? ಇದು ಒಂದು ಒಳ್ಳೆಯ ಅವಕಾಶ / ಕಾರ್ಯಕ್ರಮ. ಸ್ವಯಂ ಸಂಸ್ಥೆಗಳು / ಅಂಗವಿಕಲರ ಅಭಿವೃದ್ಧಿ ಸಂಸ್ಥೆಗಳು, ಇದನ್ನು ಆಂದೋಳನದ ಮಾದರಿಯಲ್ಲಿ ಅನುಷ್ಠಾನಕ್ಕೆ ತರಬೇಕು. ಕಾರ್ಯಕ್ರಮಕ್ಕಾಗಿ ಶೇಖರಿಸಿದ ಮಾಹಿತಿಯ ಮಹತ್ವವನ್ನು ಗುರುತಿಸಿ, ಈ ಸದವಕಾಶವನ್ನು ಯೋಜನೆಗಳನ್ನು ರೂಪಿಸುವುದಕ್ಕಾಗಿ ಬಳಸಿಕೊಳ್ಳಬೇಕು. (ಉದಾ: ಸಮುದಾಯ ಆಧಾರಿತ ಪುನರ್ವಸತಿ).

ಕಿವಿಮಾತು :

- ಅಂಗವಿಕಲರ ಅಭಿವೃದ್ಧಿ ಸಮೀಕ್ಷೆಯನ್ನು ರೂಪಿಸುವ ಜನಗಣತಿ ಇಲಾಖೆ - ಸ್ವಯಂ ಸೇವಾ ಸಂಸ್ಥೆಗಳೊಂದಿಗೆ ಅಂಗವಿಕಲರ ಕಲ್ಯಾಣ ಇಲಾಖೆ ಮತ್ತ ಇತರ ಇಲಾಖೆಗಳೊಂದಿಗೆ ನಿಕಟವಾದ ಸಂಪರ್ಕವನ್ನು ಸ್ಥಾಪಿಸಿಕೊಳ್ಳಬೇಕು. ಹೀಗೆ, ಸರ್ಕಾರಿ ಇಲಾಖೆ ಮತ್ತು ಸ್ವಯಂ ಸೇವಾ ಸಂಸ್ಥೆಗಳು ಜಂಟಿಯಾಗಿ ಕಾರ್ಯಯೋಜನೆಗಳನ್ನು ರೂಪಿಸಬೇಕು.

- ಈ ಯೋಜನೆಗಳು, ಸ್ಥಳೀಯ ಭಾಷೆಯಲ್ಲಿ ತರಬೇತಿ ಹಾಗೂ ಕಲಿಕಾ ಸಾಮಗ್ರಿಗಳನ್ನು ರೂಪಿಸಿ, ಅಭಿವೃದ್ಧಿಪಡಿಸುವಲ್ಲಿ ಕೇಂದ್ರಿಕೃತವಾಗಬೇಕು. ಹೀಗೆ ತಯಾರಾದ ತರಬೇತಿ/ ಕಲಿಕಾ ವಸ್ತುಗಳನ್ನು, ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರ ತರಬೇತಿ ಹಾಗೂ ಸಮುದಾಯ ಶಿಕ್ಷಣಕ್ಕಾಗಿ, ಪೂರ್ತಿ ಉಪಯೋಗವಾಗಬೇಕು.

- ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರ ತರಬೇತಿಯಲ್ಲಿ ಸಮುದಾಯಕ್ಕೆ ಶಿಕ್ಷಣ ನೀಡುವಲ್ಲಿ ಸ್ವಯಂ ಸೇವಾ ಸಂಸ್ಥೆಗಳು ಹಾಗೂ ಅಂಗವಿಕಲರ ಸಂಘ ಸಂಸ್ಥೆಗಳು ಸಕ್ರಿಯವಾಗಿ ಪಾಲ್ಗೊಳ್ಳುವಂತೆ ನೋಡಿಕೊಳ್ಳಬೇಕು.

- ಸ್ಥಳೀಯ ಗುಂಪುಗಳಾದ ಯುವಕ ಸಂಘಗಳು, ರೈತ ಸಂಘಗಳು, ಮಹಿಳಾ ಸಂಘ, ಹಾಲು ಉತ್ಪಾದಕರ ಸಹಕಾರಿ ಸಂಘಗಳು ಹಾಗೂ ಎಲಾ ಜನರಿಗೂ ಮುಂಚಿತವಾಗಿಯೇ ಇದರ ವಿಷಯ ತಿಳಿಸಿರಬೇಕು. ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರು, ಸಮುದಾಯಜನರು ಹಾಗೂ ಅಂಗವಿಕಲತೆಯಿರುವ ವ್ಯಕ್ತಿಗಳು ಆಂದೋಳನದಲ್ಲಿ ಭಾಗಿಗಳಾಗಲು ಸಾಧ್ಯವಾಗುತ್ತದೆ.

ಜನಗಣತಿ ಹಾಗೂ ಸರ್ಕಾರಿ ವ್ಯವಸ್ಥೆಯ ಪಾತ್ರ

ಮುಂಬರುವ ಜನಗಣತಿಯಲ್ಲಿ, ಅಂಗವಿಕಲರ ಮಾಹಿತಿ ಸಂಗ್ರಹಣೆ ಮಾಡುವುದರ ಬಗ್ಗೆ ತಿಳಿದುಕೊಂಡ ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರ ಹಾಗೂ ಸಮುದಾಯದಲ್ಲಿ ತಿಳುವಳಿಕೆ ಮೂಡಿಸುವುದು ಒಂದು ದೊಡ್ಡ ಸವಾಲೇ ಸರಿ.

ಕಿವಿಮಾತು :

- ಟಿವಿ ಹಾಗೂ ರೇಡಿಯೋದಲ್ಲಿ, ಸಂದೇಶ ವಾಕ್ಯಗಳನ್ನು ವಾರ್ತೆಗಳ ಮೊದಲು ಹಾಗೂ ನಂತರ; ರೇಡಿಯೋದಲ್ಲಿ ರೈತರ ಕಾರ್ಯಕ್ರಮದ ಮೊದಲು ಹಾಗೂ ನಂತರ, ಡಿಸೆಂಬರ್, ಜನವರಿ ಹಾಗೂ ಫೆಬ್ರವರಿ ಆರಂಭದಲ್ಲಿ ಪ್ರಸಾರ ಮಾಡಬೇಕು.

- ಸ್ವಯಂ ಸೇವಾ ಸಂಸ್ಥೆ ಹಾಗೂ ಅಂಗವಿಕಲ ವ್ಯಕ್ತಿಗಳ ಸಂಘ, ಸಂಸ್ಥೆಗಳನ್ನು ಮುಂಚಿತವಾಗಿಯೇ ಸಂಪರ್ಕಿಸಬೇಕು - ತರಬೇತಿ ಹಾಗೂ ಕಲಿಕಾ ಸಾಮಗ್ರಿಗಳನ್ನು ರೂಪಿಸಿ, ತಯಾರಿಸುವುದಕ್ಕಾಗಿ ಅವರ ಸಹಾಯವನ್ನು ಕೋರಬೇಕು. ಟಿವಿ ಹಾಗೂ ರೇಡಿಯೋದಲ್ಲಿ ಸಂದೇಶ ವಾಕ್ಯಗಳ ಪ್ರಸಾರಣೆಗಾಗಿ ಸಾಮಗ್ರಿಗಳನ್ನು ತಯರಿಸಬೇಕು; ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರು, ಅಂಗವಿಕಲರು ಹಾಗೂ ಅವರ ಪರಿವಾರದವರು, ಅಂಗವಿಕಲ ವ್ಯಕ್ತಿಗಳಿರುವ ಸಮುದಾಯಗಳು - ಇವರೆಲ್ಲರಿಗೂ ಇದನ್ನು ಅನುಷ್ಠಾನಕ್ಕೆ ತರುವ ತಿಳುವಳಿಕೆ ಕೊಡಬೇಕು.

Census 2001

DISABILITY STATUS OF PEOPLE OF INDIA

The Census exercise of 2001 is scheduled from 9 to 28 February. In India, the census forms a large exercise and data derived therein will form the basis of planning for all development programmes. The National Sample Survey Organization (NSSO) conducted sample surveys of people with disabilities across the country as part of census in 1991; and the Governments of Karnataka and Madhya Pradesh have conducted statewide surveys. Needless to say that these and other surveys conducted by research and academic institutions, surveys done as part of ICDS activity; polio lameness surveys – form the only data available in India today regarding disability.

The Census Directorate, Government of India and various groups working for People with Disabilities need to be congratulated for their efforts to include the enumeration of disabled people of our country. The National Council for Promotion of Employment of People with Disabilities, Disability Rights Group (DRG) and other disabled persons organisations have been instrumental in bringing the focus of the Government to this area, negotiating and ensuring its incorporation as part of the census activity in 2001.

The disability census taking place in February 2001 not without a challenge. The challenge being:

- People must be informed that disability status is part of Census 2001.
- Enumerators must be alert and record the disability status of people.
- People with disability, their kith and kin, their family members need to be informed that disability status is being recorded and that they should give accurate information to the enumerators when they visit the homes.

Let us take proactive measures . . .

Since disability census is part of the national census for the first time, the Enumerators will also be recording disability status for the first time. Hence the training is extremely important both for the Enumerators and their Supervisors, and has to be effective at all levels – District, sub-divisional and block. To facilitate this, we have to:

- ensure that a minimum of one day's training is conducted at the Mandal level;
- develop effective educational material like posters, handbills, flip charts, messages for AIR and Doordarshan, etc.
- ensure that government circulars reach all officers of the machinery involved in the Census – specially the revenue, and educational departments – all over the country it well in advance.
- ensure that the educational material used for training – be it messages telecast, broadcast or published in the print media – is uniform.
- ensure that all NGOs, disabled persons' organisations and people with disabilities are aware of the Census well in advance.

Role of NGOs, Disabled Persons' Organisations:

With two months left for the Census, it is a essential that all NGOs and disabled persons' organisations take up a campaign, use the data gathered and develop community based rehabilitation strategies.

Some tips:

It is essential that we:

- interact with the all departments like the Census Directorate, Department of Disabled Welfare, etc. handling disability, as well as the officials concerned such as the Commissioner for Disabilities, thereby ensuring that a collective plan is arrived at jointly by Government and NGOs.
- focus specifically on development and production of training and educational material in local languages and ensure its optimal use.

- ensure that NGOs and disabled persons' organisations participate in the training.
- ensure that local groups – youth groups, raitha sanghas, womens' groups, milk cooperatives and all community groups – are informed, well in advance and that they join in the campaign to assist the enumerators, the community and persons with disability.

Role of the Census Directorate and the Government Machinery:

To ensure training of enumerators and inform the community about enumeration of disabled people in the forthcoming census.

Some tips:

- Develop uniform messages for telecasting and broadcasting before and after the News and before the farmer's programme on AIR, every day during December, January and early February.
- Ensure that NGOs and disabled persons' organisations are involved in the design and production of training and educational material; development of materials for nationwide telecast and broadcast; training of enumerators, education of communities and persons with disabilities and their families.
- Contact corporate agencies and enlist their support for production of Information, Educational and Communication material on a large scale in local languages.
- Allocate additional budget for training of enumerators, personnel from publicity units like the print and electronic media.
- Ensure that revenue officers develop a communication and training strategy, well in advance for campaign activity over the next two months.
- Ensure that all state and central government machinery are informed and alerted through circulars and meetings that disability is part of census enumeration. This would involve all representatives, including panchayat representatives
- Hold meetings in all Panchayats all over the country regarding community education for total participation in enumeration of disability status during the first week of December to mark the International Day of Disabled Persons.
- Request the postal department to print messages about disability census on postcards, inland letters that will be distributed in January 2001 and early February.

Census 2001 is a great opportunity for people with disabilities. The exercise can be fruitful only if all the stakeholders – the community, the government, NGOs, disabled persons' organisations – are involved and make it accurate.

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2001ರ ಜನಗಣತಿ: ಒಂದು ಬಿಲಿಯನ್ ಎಣಿಕೆಯಿಂದಾಚೆಗೆ

ಎಚ್. ಶಶಿಧರ್, ಐ.ಎ.ಎಸ್.,
ಜನಗಣತಿ ಕಾರ್ಯಾಚರಣೆ ನಿರ್ದೇಶಕರು
ಕರ್ನಾಟಕ

ಕ್ರಿ.ಶ. 2001ರಲ್ಲಿ ನಡೆಯಲಿರುವ ಮುಂದಿನ ಜನಗಣತಿಗೆ ಕ್ಷಣಗಣನೆ ಆರಂಭವಾಗಿದೆ. ಇಪ್ಪತ್ತೊಂದನೆ ಶತಮಾನದ ಹಾಗೂ ಮೂರನೆ ಸಹಸ್ರಮಾನದ ಆರಂಭದಲ್ಲಿ ನಡೆಯುತ್ತಿರುವ 2001ರ ಜನಗಣತಿ ಭಾರತದ ಜನಸಂಖ್ಯೆಯನ್ನು ಸದ್ದುಗದ್ದಲವಿಲ್ಲದೆ ಒಂದು ಬಿಲಿಯನ್‌ಗೆ ಏರಿಸಲಿದೆ. ಭಾರತದ ಜನಸಂಖ್ಯಾ ರಂಗಪ್ರವೇಶವನ್ನು ಶೀಘ್ರದಲ್ಲಿಯೇ ತೆರೆ ಕಾಣಲಿದ್ದು ಜನಗಣತಿಯ ಅಂಕಿಸಂಖ್ಯೆಗಳನ್ನು ಹತ್ತು ವರ್ಷಗಳ ನಂತರ ಮತ್ತೊಮ್ಮೆ ಅನಾವರಣಗೊಳಿಸಲಿದೆ. ಇದು ಭಾರತದ ಜನಸಂಖ್ಯೆ ತನ್ನ ನೀತಿ ಮತ್ತು ಕಾರ್ಯಕ್ರಮಗಳ ಯಶಸ್ಸು ಮತ್ತು ವೈಫಲ್ಯಗಳನ್ನು ಪುನರ್‌ವಿಮರ್ಶಿಸಬೇಕೆಂದು ಎಚ್ಚರಿಕೆ ನೀಡಲಿದೆ. ಅಲ್ಲದೆ ಅಭಿವೃದ್ಧಿಶೀಲ ರಾಷ್ಟ್ರಗಳ ನಡುವೆ ಭಾರತದ ಸ್ಥಾನಮಾನವೇನು ಎಂಬುದರ ಬಗ್ಗೆ ಜಗತ್ತಿನಾದ್ಯಂತ ಕುತೂಹಲವನ್ನು ಸಹ ಕೆರಳಿಸಲಿದೆ. ಆದ್ದರಿಂದ ಒಂದು ಬಿಲಿಯನ್ = 100 ಮಿಲಿಯನ್ = 100 ಕೋಟಿ ಜನರನ್ನು ತಲುಪುವುದು ಅಥವಾ ಎಣಿಸುವುದು ಕೇವಲ ಸಂಖ್ಯೆಯಾಗುವುದಿಲ್ಲ. ಇದು ಅದಕ್ಕಿಂತ ಮಿಗಿಲಾದದ್ದು. ಅಂಕಿಗಳಿಂದ ಜನಸಂಖ್ಯೆಗೆ ಮತ್ತೆ ಅಲ್ಲಿಂದ ಜನತೆಯೆಡೆಗೆ ಸಾಗುವ ಬಹುಮುಖಿನಡೆ ಇದಾಗಿದೆ.

ಅಡೆತಡೆಯಿಲ್ಲದೆ ಹತ್ತು ವರ್ಷಗಳಿಗೊಮ್ಮೆ ಜನಗಣತಿ ಮಾಡಿರುವ ಸುಧೀರ್ಘ ಹೆಮ್ಮೆಯ ದಾಖಲೆ ಭಾರತಕ್ಕಿದೆ. ಕ್ರಿ.ಶ. 2001 ರಲ್ಲಿ ನಡೆಯುತ್ತಿರುವ ಜನಗಣತಿಯು 1871 ರಲ್ಲಿ ಪ್ರಥಮ ಜನಗಣತಿ ಆರಂಭವಾದ ನಂತರ ನಡೆಯುತ್ತಿರುವ 14ನೇ ದಶವಾರ್ಷಿಕ ಜನಗಣತಿ ಹಾಗೂ ಸ್ವಾತಂತ್ರ್ಯಾ ನಂತರ ನಡೆಯುತ್ತಿರುವ ಆರನೆಯ ಜನಗಣತಿ. ಭಾರತದ ಜನಗಣತಿ ರಾಷ್ಟ್ರದ ಪ್ರಮುಖ ಘಟನೆಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ. ನಿಖರ ಹಾಗೂ ಸಮಗ್ರ ಮಾಹಿತಿಯ ಮೂಲವೆಂದು ಜಗತ್ತಿನಾದ್ಯಂತ ಇದು ಮಾನ್ಯತೆ ಗಳಿಸಿದೆ. ಇದೊಂದು ಬೃಹತ್ ತಲೆ ಎಣಿಕೆ ಕಾರ್ಯವಲ್ಲ. ಇದು ನಮ್ಮ ನೆಲದ ಹಾಗೂ ಜನತೆಯ ಸಾಮಾಜಿಕ ಮತ್ತು ಆರ್ಥಿಕ ವಾಸ್ತವ ಸಂಗತಿಗಳನ್ನು ಹಾಗೂ ಜನಲಕ್ಷಣವನ್ನು ಸಂಗ್ರಹಿಸಿ, ಸಂಯೋಜಿಸಿ ದಾಖಲುಗೊಳಿಸುತ್ತದೆ. ಭಾರತದ ಜನಗಣತಿ ಒಂದು ಸ್ಮಾರಕದಂತಹ ಸಂಗತಿ: ಬೃಹತ್ತಾದ ರಾಷ್ಟ್ರೀಯ ಕಾರ್ಯಾಚರಣೆ. ರಾಷ್ಟ್ರದ ಮೂಲೆ, ಮೂಲೆಯನ್ನು ವ್ಯಾಪಿಸಿ ಯಾವೊಬ್ಬ ವ್ಯಕ್ತಿಯನ್ನು ಬಿಡದೆ ಹಾಗೂ ಯಾವುದನ್ನೂ ಪುನರಾವರ್ತಿಸದೆ ಎಲ್ಲರನ್ನು ಎಣಿಸುವ ಅಪೂರ್ವ ಸಾಹಸ ಕ್ರಿಯೆ.

ಜನಗಣತಿ ರಾಷ್ಟ್ರದ ಜನಸಂಖ್ಯೆಯ ಮೂಲ ಮಾಹಿತಿ. ಆಡಳಿತಕ್ಕೆ ಮತ್ತು ಸಾಮಾಜಿಕ ಹಾಗೂ ಆರ್ಥಿಕ ಯೋಜನೆಯ ಹಲವು ಹತ್ತು ಮಗ್ಗಲುಗಳಿಗೆ ಜನಗಣತಿಯೇ ಮೂಲ ಆಧಾರ. ಜನಗಣತಿಯಲ್ಲಿನ ವಿಶಾಲ ತಳಹದಿಯ ಅಂಕಿ ಅಂಶಗಳು ಮಾಹಿತಿಯ ಅತ್ಯದ್ಭುತ ಭಂಡಾರವಾಗಿದೆ. ಇವುಗಳನ್ನು ಉಪಯೋಗಿಸಿಕೊಳ್ಳುವುದಿರಲಿ ಈ ಮಾಹಿತಿಗಳ ಮೌಲ್ಯವನ್ನೇ ನಾವು

ಸರಿಯಾಗಿ ಅರಿತಿಲ್ಲ. ಇದನ್ನೇ ನಾವು ಸಂತತ್ತಿನ ನಡುವಿನ ದಾರಿದ್ರ್ಯವೆನ್ನಬಹುದು. ಭಾರತದ ಜನಗಣತಿಯ ಪ್ರಾಮುಖ್ಯತೆಗೆ ನಾವು ಹೆಚ್ಚು ಒತ್ತು ನೀಡಿಲ್ಲವೆಂದೇ ಹೇಳಬೇಕು. ಭಾರತದ ಜನಗಣತಿಯ ಅಂಕಿ ಅಂಶಗಳು ಶೀಘ್ರವಾಗಿ ಬದಲಾಗುತ್ತಿರುವ ನಮ್ಮ ಸಮಾಜದ ಜನಾಂಗೀಯ, ಸಾಮಾಜಿಕ ಮತ್ತು ಆರ್ಥಿಕ ಚಿತ್ರಣ ಮತ್ತು ಸಮಸ್ಯೆಗಳನ್ನು ಅರಿತುಕೊಳ್ಳುವಲ್ಲಿ ಹೇಗೆ ಸಹಕಾರಿಯಾಗುತ್ತಿವೆ ಎನ್ನುವುದನ್ನು ಪರಿಶೀಲಿಸೋಣ.

ವಿಸ್ತೀರ್ಣ ಮತ್ತು ಕಾಲದಲ್ಲಿ ನಾವು ಹೇಗೆ ಹಂಚಿಹೋಗಿದ್ದೇವೆ ?

ಭಾರತವು ಜಗತ್ತಿನ ಭೌಗೋಳಿಕ ವಿಸ್ತೀರ್ಣದಲ್ಲಿ ಕೇವಲ ಶೇ. 2.4 ರಷ್ಟು ಪ್ರದೇಶವನ್ನು ಆವರಿಸಿಕೊಂಡಿದೆ. ಆದರೆ ಜಗತ್ತಿನ ಜನಸಂಖ್ಯೆಯ ಶೇಕಡಾ 16.1 ರಷ್ಟು ಜನಸಂಖ್ಯೆ ಭಾರತದಲ್ಲಿದೆ. ಭಾರತದ ಭೌಗೋಳಿಕ ವಿಸ್ತೀರ್ಣದಲ್ಲಿನ ಮೂರು ಮಿಲಿಯನ್ ಚದರ ಕಿಲೋಮೀಟರ್ ಪ್ರದೇಶದಲ್ಲಿ ಭಾರತದ ಜನಸಂಖ್ಯೆಯ ಶೇ 30 ರಷ್ಟು ಜನರು 4600 ಪಟ್ಟಣ ಮತ್ತು ನಗರಗಳಲ್ಲಿ ವಾಸವಾಗಿದ್ದಾರೆ. ಉಳಿದ ಶೇ. 70 ರಷ್ಟು ಜನಸಂಖ್ಯೆ ಗ್ರಾಮೀಣ ಪ್ರದೇಶದಲ್ಲಿದೆ. 5,80,000ಕ್ಕೂ ಮಿಗಿಲಾದ ಹಳ್ಳಿಗಳು ; ಮೈದಾನ, ಅರಣ್ಯ, ದ್ವೀಪಗಳು, ಬೆಟ್ಟಗುಡ್ಡಗಳು ಇತ್ಯಾದಿ ಪ್ರದೇಶಗಳಲ್ಲಿ ಹರಡಿಕೊಂಡಿವೆ. ನಮ್ಮ ಸುತ್ತಲಿರುವ ಜಾಗ ಕಿರಿದಾಗುತ್ತಿದೆ. ಆದರೆ ಭಾರತದ ಜನಸಂಖ್ಯೆ 1901ರಲ್ಲಿದ್ದ ಚ.ಕಿ.ಮೀಗೆ 77 ಜನ ಸಾಂದ್ರತೆಯನ್ನು ದಾಟಿ 1951ರಲ್ಲಿ 117 ಕ್ಕೆ ಮತ್ತೆ 1991ರಲ್ಲಿ 267 ಕ್ಕೆ ಏರಿದೆ. ಭಾರತದ ಜನಸಾಂದ್ರತೆ ಬೇನಾದ ಜನಸಾಂದ್ರತೆಗಿಂತ ಹೆಚ್ಚಾಗಿದೆ. ಇಂದು, ಭಾರತದಲ್ಲಿ ಚದರ ಕಿಲೋ ಮೀಟರ್‌ಗೆ 305 ಜನರಿದ್ದರೆ ಬೇನಾದಲ್ಲಿ ಕೇವಲ 133 ಜನರಿದ್ದಾರೆ.

ಕಾಲಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ನಮ್ಮ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆ ಶರವೇಗದಲ್ಲಿದೆ. 1901ರಲ್ಲಿ ಭಾರತದಲ್ಲಿದ್ದ 236 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆ 1951ರಲ್ಲಿ 357 ಮಿಲಿಯನ್‌ಗೆ ತಲುಪಲು ಐದು ದಶಕಗಳನ್ನು (ಐವತ್ತು ವರ್ಷ)ತೆಗೆದುಕೊಂಡಿತು. ಆಗಿನ ಬೆಳವಣಿಗೆ ದರ ಶೇ 51.3 ರಷ್ಟಿತು. 2001ರ ವರೆಗಿನ ಇದೇ ಐದು ದಶಕದ ಅವಧಿಯಲ್ಲಿ ಭಾರತದ ಜನಸಂಖ್ಯೆ 1012 ಮಿಲಿಯನ್ ತಲುಪುವ ಸಾಧ್ಯತೆ ಇದೆ. ಇದನ್ನು ಜನಸಂಖ್ಯೆಯ ಮೂರು ಪಟ್ಟು ಏರಿಕೆ ಅಥವಾ ಶೇ 283.50ರ ಬೆಳವಣಿಗೆ ಎಂದು ಗುರುತಿಸಬಹುದು. ಈ ಬಿರುಸಿನ ಬೆಳವಣಿಗೆ 20ನೇ ಶತಮಾನದ ಅಂತ್ಯಕ್ಕೆ ಭಾರತದಲ್ಲಿ ಗಂಭೀರವಾದ ಮತ್ತು ಮಸುಕಾದ ಪರಿಸ್ಥಿತಿಯನ್ನು ಉಂಟು ಮಾಡಲಿದೆ.

ಇಪ್ಪತ್ತೊಂದನೆ ಶತಮಾನ ನಮಗೆ ಏನನ್ನು ಕಾದಿರಿಸಿದೆ ಎನ್ನುವುದನ್ನು ನೋಡೋಣ. 996 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಯುಳ್ಳ, ಭಾರತ (ಪುರುಷರು 515 ಮಿಲಿಯನ್, ಸ್ತ್ರೀಯರು 481 ಮಿಲಿಯನ್) ಬೇನಾವನ್ನು (1280 ಮಿಲಿಯನ್) ಬಿಟ್ಟಾರೆ ಜಗತ್ತಿನ ಅತಿ ಹೆಚ್ಚು ಜನಸಂಖ್ಯೆಯುಳ್ಳ ಎರಡನೆ ರಾಷ್ಟ್ರ. ಇವೆರಡೂ ಒಟ್ಟುಗೂಡಿ ಇಡೀ ಜಗತ್ತಿನ 6140 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಯ ಶೇ 37.50 ರಷ್ಟು ಜನಸಂಖ್ಯೆಯನ್ನು ನೀಡುತ್ತವೆ. ಕ್ರಿ.ಶ. 2015 ರ ವೇಳೆಗೆ ಬೇನಾದ 1452 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಗೆ ಪ್ರತಿಯಾಗಿ ಭಾರತವು 1263 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಯನ್ನು

ಹೊಂದಲಿದೆ. ಶೇ 20 ರ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯನ್ನು ಗಮನದಲ್ಲಿಟ್ಟುಕೊಂಡು ಲೆಕ್ಕ ಹಾಕಿದರೆ 2050ರ ವೇಳೆಗೆ ಭಾರತವೇ ಜಗತ್ತಿನ ಅತೀ ಹೆಚ್ಚು ಜನಸಂಖ್ಯಾ ರಾಷ್ಟ್ರವೆಂದು ಗುರುತಿಸಿಕೊಳ್ಳುವ ಅವಾಯವಿದೆ. ಅಂದಾಜುಗಳ ಪ್ರಕಾರ ಕ್ರಿ.ಶ. 2050ರ ವೇಳೆಗೆ ಚೀನಾದ 1765 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಗೆ ಹೋಲಿಸಿದರೆ ಭಾರತದ ಜನಸಂಖ್ಯೆ 1885 ಮಿಲಿಯನ್ ತಲುಪುವ ಸಾಧ್ಯತೆ ಇದೆ. ಭಾರತವು ನಿರೀಕ್ಷಿಸಿರುವ ಒಂದು ಬಿಲಿಯನ್ ಮೀರಿದ ಜನಸಂಖ್ಯೆ 21ನೇ ಶತಮಾನದ ಅಂತ್ಯಕ್ಕೆ ಎರಡು ಪಟ್ಟುಗಿಂತಲೂ ಹೆಚ್ಚಾಗುವ ನಿರೀಕ್ಷೆ ಇದೆ. ನಾವು ಬಿಂಬಿಸಿರುವ ಅಂಕಿ ಸಂಖ್ಯೆಗಳು ಏನಾದರೂ ಗುರುತುಗಳಾಗುವುದಾದರೆ ಪರಿಸ್ಥಿತಿ ಮತ್ತಷ್ಟು ಕರಾಳ ಮತ್ತು ನಿರಾಶದಾಯಕವಾಗಲಿದೆ.

" ಜನಸಂಖ್ಯಾ ತಜ್ಞರು ಜ್ಯೋತಿಷಿಗಳಲ್ಲ. ಹಾಗೆಯೇ ಬಿಂಬಿತ ಅಂದಾಜುಗಳು ಭವಿಷ್ಯವೂ ಅಲ್ಲ. ಕೆಲವು ನಂಬಿಕೆ ಅಧಾರಗಳನ್ನು ಅನುಸರಿಸಿ ಅಂದಾಜುಗಳನ್ನು ಬಿಂಬಿಸಲಾಗಿರುತ್ತದೆ. ಆಧಾರಗಳೇ ತಪ್ಪಾದರೆ ಅಂದಾಜುಗಳು ಸಹ ತಪ್ಪಾಗುತ್ತವೆ ". (ಆಶೀಷ್ ಬೋಸ್) ಈ ಬಿಂಬಿತ ಅಂದಾಜುಗಳು ತಪ್ಪಾಗುವಂತಾದರೆ ನಮಗೆ ಅದಕ್ಕಿಂತ ಸಂತೋಷದ ಸಂಗತಿ ಮತ್ತೊಂದಿಲ್ಲ.

ವಿಭಿನ್ನತೆ ಮತ್ತು ಬಡತನ

ಬಹುಶಃ ಜಗತ್ತಿನಲ್ಲೇ ಭಾರತದಷ್ಟು ಸಂಕೀರ್ಣವಾದ ವಿಭಿನ್ನತೆಯುಳ್ಳ ರಾಷ್ಟ್ರ (ಭಾರತೀಯ ಸಮಾಜ ಸಹ) ಇನ್ನೊಂದಿಲ್ಲ ಎನಿಸುತ್ತದೆ. ನಿರಂತರವಾಗಿ ಏರುತ್ತಿರುವ ಜನಸಂಖ್ಯೆ ,ಅನಿಶ್ಚಿತ ಮಾದರಿ ಮತ್ತು ಜನಸಂಖ್ಯೆಯ ಅಸಮತೋಲನವಾದ ಭೌಗೋಳಿಕ ಹಂಚಿಕೆ, ವಿವರೀತವಾದ ಪ್ರಾಂತೀಯ ಮತ್ತು ಉಪಪ್ರಾಂತೀಯ ಭಿನ್ನತೆ, ಇವೆಲ್ಲವನ್ನೂ ನಾವಿಲ್ಲಿ ನೋಡಬಹುದು. ಒಂದು ಡಜನ್‌ಗಿಂತಲೂ ಹೆಚ್ಚು ಪ್ರಮುಖ ಧರ್ಮಗಳು ಮತ್ತು 50 ಕ್ಕೂ ಹೆಚ್ಚು ಬಿಡಿಪಿಟ್ಟ ಧರ್ಮಗಳು ಹಾಗೂ ಮತೀಯ ನಂಬಿಕೆಗಳನ್ನು ಅನುಸರಿಸುವ ರಾಷ್ಟ್ರ ಜಗತ್ತಿನಲ್ಲಿ ಇರುವುದಾದರೆ ಅದು ಭಾರತ ಮಾತ್ರ. ಭಾರತದ ಒಟ್ಟು ಧಾರ್ಮಿಕ ಜನಸಂಖ್ಯೆಯಲ್ಲಿ ಹಿಂದುಗಳು (ಶೇ. 82) ಮುಸ್ಲಿಮರು (ಶೇ 12.12) ಕ್ರಿಶ್ಚಿಯನ್ನರು (ಶೇ. 1.94) ಜೈನರು (ಶೇ. 0.40) ಮತ್ತು 50 ಕ್ಕೂ ಮಿಗಿಲಾದ ಬಿಡಿಪಿಟ್ಟ ಧರ್ಮ ಮತ್ತು ಮತೀಯ ನಂಬಿಕೆಯುಳ್ಳವರು (ಶೇ. 0.39) ಇದ್ದಾರೆ. ಭಾರತ ಹಲವು ನಂಬಿಕೆಗಳನ್ನುಳ್ಳ ರಾಷ್ಟ್ರ. ಭಾರತವು ಯಾವುದೇ ಒಂದು ಧರ್ಮ ಅಥವಾ ನಂಬಿಕೆಯನ್ನು ಪೋಷಿಸುವುದಿಲ್ಲ. ಭಾರತದಲ್ಲಿ 3000 ಕ್ಕಿಂತಲೂ ಹೆಚ್ಚು ಜಾತಿ ಮತ್ತು ಉಪ- ಜಾತಿಗಳು ಅಸ್ತಿತ್ವದಲ್ಲಿವೆ. ಸುಮಾರು 200 ಭಾಷೆಗಳು ಮತ್ತು 800 ಕ್ಕೂ ಹೆಚ್ಚು ಉಪಭಾಷೆಗಳನ್ನು ಮಾತನಾಡಲಾಗುತ್ತದೆ. ಪುರಾತನ ಸಂಪ್ರದಾಯಗಳು ಮತ್ತು ವ್ಯಾಪಕವಾಗಿ ಹರಡಿರುವ ಪದ್ಧತಿಗಳನ್ನು ಆಚರಿಸಲಾಗುತ್ತದೆ. ಭಿನ್ನ ಭಿನ್ನ ಧಾರ್ಮಿಕ ಆಚರಣೆಗಳು ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕ ಮನೋಭಾವಗಳನ್ನು ಪ್ರದರ್ಶಿಸಲಾಗುತ್ತದೆ. ಉದ್ಯೋಗ, ವೃತ್ತಿ ಮತ್ತು ಕೆಲಸಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ವೃತ್ತಿಗೆ ಅಂಟಿಕೊಂಡಿರುವ ಮತ್ತು ಪ್ರಾದೇಶಿಕ ಆದ್ಯತೆಯನ್ನು ಅನುಸರಿಸುವ ವೈವಿಧ್ಯತೆ ನಮ್ಮ ಜನರಲ್ಲಿ ಬಹಳವಾಗಿದೆ. ಇವುಗಳ ಜೊತೆಗೆ ಕೇಂದ್ರ ಮತ್ತು ರಾಜ್ಯಗಳಲ್ಲಿ ಅಧಿಕಾರಕ್ಕೆ ಬರುವ

ಸರ್ಕಾರಗಳ ಬದಲಾಗುತ್ತಿರುವ ಆದ್ಯತೆಗಳೂ ಸಹ ಸೇರಿಕೊಳ್ಳುತ್ತವೆ. ಇವೆಲ್ಲಕ್ಕಿಂತ ಮಿಗಿಲಾಗಿ ನಮ್ಮ ನೆಲ ಮತ್ತು ಜನರ ಸಂಕೀರ್ಣತೆ, ವಿಭಿನ್ನತೆ ಮತ್ತು ವೈವಿಧ್ಯತೆ ಸ್ವಷ್ಟವಾಗಿ ಬಿಂಬಿತವಾಗುತ್ತಿದೆ.

"ಅಸಮಾನತೆ ಇಷ್ಟು , ಅನಿಷ್ಟಗಳು ಇನ್ನಷ್ಟು ". ಸಂಪತ್ತಿನ ಅಸಮತೋಲನ ಹಂಬಿಕೆಯ ಸಮಾಜದ ಕೆಳವರ್ಗದ ಜನರ ಬದುಕಿನ ಮೇಲೆ ಅಗಾಧ ಒತ್ತಡವನ್ನು ಹೇರಿದೆ. ಅಲ್ಲದೆ ಬಡವರು ಮತ್ತು ಶ್ರೀಮಂತರ ನಡುವೆ ಅಂತರವನ್ನು ಇನ್ನಷ್ಟು ಹೆಚ್ಚು ಮಾಡಿದೆ. ಗ್ರಾಮೀಣ ಬಡಜನರಂತೂ ಈ ಹೊಡೆತದಿಂದ ತತ್ತರಿಸಿ ಹೋಗಿದ್ದಾರೆ. ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನದ ಬೆಳವಣಿಗೆ ನಮ್ಮ ಅಸಹಾಯಕ ಜನರನ್ನು ಮುಖ್ಯವಾಹಿನಿಯಿಂದ ಬಹಳ ಹಿಂದಕ್ಕೆ ತಳ್ಳಿದ್ದು ಬಹುಪಾಲು ಜನರು ಹಿಂದುಳಿದಿದ್ದಾರೆ. ಶಿಕ್ಷಣ, ಸಾಮಾಜಿಕ ಸಾಂಸ್ಕೃತಿಕ ಇತರೆ ವಿಷಯಗಳಲ್ಲಿ ಉನ್ನತ ಮಟ್ಟ ತಲುಪಿದ್ದರೂ ಸಹ ತಮ್ಮ ಧಾರ್ಮಿಕ ಕಟ್ಟಾಚರಣೆ, ಭಾಷಾ ಧುರಭಿಮಾನ, ಜಾತಿ ಪೂರ್ವಾಗ್ರಹ, ಮೂಡನಂಬಿಕೆಯನ್ನು ಹೊಂದಿರುವ ಕೆಲಜನರಿಂದಾಗಿ ನಮ್ಮ ಜನರ ಸೌಹಾರ್ದಯುತ ಸಹಬಾಳ್ವೆಗೆ ಧಕ್ಕೆ ಬರುತ್ತಲಿದೆ. ನಮ್ಮ ಮಹಿಳೆ ಮತ್ತು ಮಕ್ಕಳು ಸಹಾ ತೀರಾ ನಿರ್ಲಕ್ಷ್ಯಕ್ಕೆ ಒಳಗಾಗಿರುವ ಗುಂಪಿಗೆ ಸೇರಿದ್ದಾರೆ. ಉದ್ಯೋಗವಕಾಶಗಳು ಕ್ಷೀಣಿಸುತ್ತಿವೆ. ಆದರೆ ಮತೀಯ ಸಾಮಾಜಿಕ ಘರ್ಷಣೆಗಳು ಬೆಟ್ಟದೆತ್ತರಕ್ಕೆ ಬೆಳೆಯುತ್ತಿವೆ.

ಶೀಘ್ರ ನಗರೀಕರಣ ಮತ್ತು ನಗರದೆಡೆಗಿನ ವಲಸೆಯಿಂದ ನಮ್ಮ ನಗರಗಳು ಸ್ಫೋಟಗೊಳ್ಳುತ್ತಿವೆ. ಸಂಪನ್ಮೂಲಗಳನ್ನು ನಾವು ಬೃಹತ್ ಪ್ರಮಾಣದಲ್ಲಿ ಉಪಯೋಗಿಸುತ್ತಿರುವುದು ಮತ್ತು ಹೆಚ್ಚಿನ ತ್ಯಾಜ್ಯ ವಸ್ತುಗಳನ್ನು ಬಿಸಾಡುತ್ತಿರುವುದು ಪರಿಸರವನ್ನು ಹಾಳುಗೆಡುವುತ್ತಿದೆ. ಒಂದೆಡೆ ನಮ್ಮ ಹಳ್ಳಿಗಳು ನಿರ್ಜೀವವಾಗುತ್ತಿವೆ. ಇನ್ನೊಂದೆಡೆಯಲ್ಲಿ ನಗರಗಳು ಭೂಮಿಯ ಮೇಲಿನ ನರಕಗಳಾಗುತ್ತಿವೆ. ಬಹುಪಾಲು ಜನರು ಅಸುರಕ್ಷತೆಯ ಭಾವನೆಯಿಂದ ಬಳಲುತ್ತಿದ್ದಾರೆ. ನಮ್ಮ ಸಮಾಜದ ವಿಭಿನ್ನತೆ ಮತ್ತು ಬಡತನಗಳ ನಡುವೆ ಪರಸ್ಪರ ಗಾಢಸಂಬಂಧ ಇದೆಯೆನ್ನುವುದನ್ನು ಇವುಗಳೆಲ್ಲವೂ ಸಾಬೀತುಗೊಳಿಸುತ್ತಿವೆ.

ದಾರಿದ್ರ್ಯ ಸಾಗರದ ನಡುವೆ ಅಭಿವೃದ್ಧಿಯ ಪುಟ್ಟ ನಡುಗಡ್ಡೆಗಳು :

ಇಂತಹ ಪರಿಸ್ಥಿತಿಯ ನಡುವೆ ಭಾರತದ ಜನಸಂಖ್ಯಾ ಸ್ಫೋಟದ ಪರಿಣಾಮವು ಸಮಾಜಕ್ಕೆ ಹೊರಲಾರದ ಹೊರೆಯಾಗಿದೆ. ನಮ್ಮಲ್ಲಿ ಜನಸಂಖ್ಯಾ ಮತ್ತು ಅಭಿವೃದ್ಧಿ ಸಮಸ್ಯೆಗಳಿಗೆ ಇದೇ ಮೂಲ ಕಾರಣವಾಗಿದೆ. ಜನಸಂಖ್ಯೆಯ ಶೀಘ್ರ ಬೆಳವಣಿಗೆ ಮತ್ತು ಸಂಪನ್ಮೂಲಗಳ ಅಸಮಪರ್ಕಕ ಲಭ್ಯತೆಯ ನಡುವೆ ಹೊಂದಾಣಿಕೆ ಆಗದಿರುವುದರಿಂದ ನಮ್ಮ ಜನರ ಜೀವನಮಟ್ಟ ಮತ್ತು ಗುಣಮಟ್ಟದ ಜೀವನಕ್ಕೆ ಧಕ್ಕೆ ತಂದೊಡ್ಡಿದೆ. ಈ ಅನಿಯಂತ್ರಿತ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯು ಸ್ವಾತಂತ್ರ್ಯಾನಂತರ ನಮ್ಮಲ್ಲಿ ಆಗಿರುವ ಅಲ್ಪಸ್ವಲ್ಪ ಅಭಿವೃದ್ಧಿಯ ಫಲವನ್ನು ನುಂಗಿ ನೊಣೆದು ಮತ್ತೆ ಬಾಯ್ದೆರೆದು ಕುಳಿತಿದೆ. ಇದರ ಫಲವಾಗಿಯೇ ನಾವಿಂದು ದಾರಿದ್ರ್ಯ ಸಾಗರದ ನಡುವೆ ಅಭಿವೃದ್ಧಿಯ ಪುಟ್ಟ ನಡುಗಡ್ಡೆಗಳನ್ನು ಕಾಣುತ್ತಿದ್ದೇವೆ.

ಕತ್ತರಿ ಪರಿಣಾಮಃ

ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಗೆ ಸಂಬಂಧಿಸಿದಂತೆ "ಕತ್ತರಿ ಪರಿಣಾಮ " ಎನ್ನುವ ಲಕ್ಷಣವೊಂದಿದೆ. ಇದರಲ್ಲಿ ಬಡತನ ಮತ್ತು ತೀವ್ರ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಗಳು ಅಭಿವೃದ್ಧಿಯ ಹಿನ್ನಡೆತಕ್ಕೆ ಮತ್ತು ಜೀವನಗುಣಮಟ್ಟದ ಸೂಚಕಗಳ ಇಳಿಕೆಗೆ ಕಾರಣವಾಗುತ್ತವೆ. ಇಂತಹ ನಿರುತ್ತೇಜಕ ವಾತಾವರಣವು ಮಾನವ ಅಂತಸ್ತಿಗೆ ಮತ್ತು ಮನುಷ್ಯರ ಉಳಿವಿಗೆ ಅಪಾಯ ತರುತ್ತವೆ.

ಪ್ರಸ್ತುತ ಭಾರತದಲ್ಲಿ 996 ಮಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಯಿದೆ. ಪ್ರತಿ ವರ್ಷ 17 ಮಿಲಿಯನ್‌ಗೂ ಹೆಚ್ಚು (ಶೇ 1.7) ಮಕ್ಕಳು ಹುಟ್ಟುತ್ತಿವೆ. ಭಾರತವು ಪ್ರತಿ ವರ್ಷ ಜಗತ್ತಿನ ಜನಸಂಖ್ಯೆಗೆ ಬೇರಾವುದೇ ರಾಷ್ಟ್ರಕ್ಕಿಂತ ಹೆಚ್ಚು ಜನರನ್ನು ಸೇರಿಸುತ್ತಿದೆ ಎನ್ನುವುದು, ಇದರ ಅರ್ಥ . ಇದನ್ನು ನೋಡಿದ ವಾಷಿಂಗ್ಟನ್ ಸಂಶೋಧಕ ತಂಡವೊಂದು " ಅರ್ಧಕ್ಕಿಂತಲೂ ಹೆಚ್ಚು ಅನಕ್ಷರಸ್ಥ ವಯಸ್ಕರು: ಅರ್ಧಕ್ಕಿಂತಲೂ ಮಿಗಿಲಾದ ಅಪೌಷ್ಟಿಕತೆಯ ಮಕ್ಕಳು ಹಾಗೂ ಬಡತನ ರೇಖೆಗಿಂತ ಕೆಳಗಿನ ಮೂರನೆ ಒಂದು ಭಾಗದಷ್ಟು ಜನಸಂಖ್ಯೆಯನ್ನು ಹೊಂದಿರುವ ದೇಶ ಒಂದು ಬಿಲಿಯನ್ ಜನಸಂಖ್ಯೆಯನ್ನು ತಲುಪುತ್ತಿರುವುದು ಸಂಭ್ರಮದ, ಆಚರಣೆಯ ಸಂಗತಿಯೇನಲ್ಲ. " ಎಂದು ಹೇಳಿದೆ. ನಾವು ಇಂತಹ ಖೋಟಾ ಸಾಧನೆಗಳ ಬಗ್ಗೆ ಹೆಮ್ಮೆ ಪಟ್ಟುಕೊಂಡು ಇದನ್ನೊಂದು ಸಂಭ್ರಮದ ವಿಷಯದಂತೆ ಆಚರಿಸುತ್ತೇವೆ ಎಂದು ಅವರು ಏಕೆ ಊಹಿಸಿಕೊಳ್ಳುತ್ತಾರೋ ತಿಳಿಯದು. ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಯ ದಿಗ್ಭ್ರಮೆಗೊಳಿಸುವ ಸಂಗತಿಗಳ ಬಗ್ಗೆ ಭಾರತಕ್ಕೆ ಸಂಪೂರ್ಣ ಅರಿವಿದೆ ಎನ್ನುವುದನ್ನು ಅವರು ಅರಿಯಬೇಕು.

ತೀವ್ರವಾದ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆ ಮತ್ತು ಬಡತನಗಳೆರಡೂ ಒಟ್ಟಿಗೆ ಸೇರಿದರೆ ಸಮಾಜದ ಒಟ್ಟಾರೆ ಹಂದರದಲ್ಲಿ ಜನಜೀವನದ ಗುಣಮಟ್ಟದ ಮೇಲೆ ಪ್ರತಿಕೂಲ ಪರಿಣಾಮ ಬೀರುತ್ತದೆ ಎನ್ನುವುದು ನಮಗೆ ತಿಳಿದಿದೆ. ಇದರ ಪರಿಣಾಮವಾಗಿ ಉದ್ಯೋಗವಕಾಶಗಳು ಕಡಿಮೆಯಾಗುತ್ತವೆ. ಆಹಾರದ ಪೂರೈಕೆಯಲ್ಲಿ ಕೊರತೆಯಾಗುತ್ತದೆ, ಶಿಕ್ಷಣ ಸೌಲಭ್ಯ ಕುಸಿಯುತ್ತದೆ. ಆರೋಗ್ಯ ಸೇವೆ ಮತ್ತು ನೈರ್ಮಲ್ಯದ ಗುಣಮಟ್ಟ ಕನಿಷ್ಟಗೊಳ್ಳುತ್ತದೆ. ಅಸಮರ್ಪಕ ವಸತಿ ಮತ್ತು ಪರಿಸರ ಕ್ಷೀಣಿಸುತ್ತದೆ. ಹೀಗೆಯೇ ಹತ್ತು ಹಲವು ವಿಷಯಗಳಲ್ಲಿ ಕೊರತೆ ಭಾದಿಸುತ್ತದೆ. ಸಮಾಜದ ಕೌಟುಂಬಿಕ ಹಂತದಲ್ಲಿ, ದೊಡ್ಡ ಪ್ರಮಾಣದ ಕುಟುಂಬಗಳನ್ನು ಶಕ್ತಗೊಳಿಸಿ ಅವಕಾಶಗಳ ಕೊರತೆ ಭಾದಿಸುತ್ತವೆ. ಕುಟುಂಬದಲ್ಲಿ ಅನಾರೋಗ್ಯದ ಪ್ರಮಾಣ ಹೆಚ್ಚಾಗುತ್ತದೆ, ಭೌತಿಕ ಮತ್ತು ಬೌದ್ಧಿಕ ಬೆಳವಣಿಗೆ ಕುಂಠಿತಗೊಳ್ಳುತ್ತದೆ. ಅಪೌಷ್ಟಿಕತೆ, ಮಾತೃ ಮರಣಸಂಖ್ಯೆ ಮತ್ತು ಶಿಶು ಮರಣ ಸಂಖ್ಯೆ ಹೆಚ್ಚಾಗುತ್ತದೆ. ಇವೆಲ್ಲವೂ ಸೇರಿ ಜೀವನ ಗುಣಮಟ್ಟದ ಸೂಚಕಗಳ ಇಳಿತಕ್ಕೆ ಕಾರಣವಾಗಿ ಜೀವನಮಟ್ಟ ಕುಸಿಯುತ್ತಿದೆ.

21 ನೇ ಶತಮಾನಕ್ಕೆ ಗುರಿಗಳು ಮತ್ತು ತಂತ್ರಗಳು

ಇಪ್ಪತ್ತೊಂದನೆ ಶತಮಾನದ ಆದಿಯಲ್ಲಿನ ಭಾರತದ ಚಿತ್ರಣ ನೋಡಲಿಕ್ಕೆ ಗಂಭೀರವಾಗಿದ್ದರೂ ತೀರಾ ಆತಂಕಕ್ಕೆ ಕಾರಣವಿಲ್ಲ. ಏಕೆಂದರೆ ಯಾವ ಸಮಸ್ಯೆಗಳಿಗೂ ತತ್‌ಕ್ಷಣದ ದಿಡೀರ್ ಪರಿಹಾರ ಇರುವುದಿಲ್ಲ. ಭಾರತದಂತಹ ಬೃಹತ್ ಪ್ರಮಾಣದ ಹಾಗೂ ಸಂಕೀರ್ಣ ವಿಭಿನ್ನ ರಾಷ್ಟ್ರದ ಸಮಸ್ಯೆಗಳನ್ನು ಬಗೆಹರಿಸುವುದು ಅಷ್ಟು ಸುಲಭದ ಕಾರ್ಯವೇನಲ್ಲ. ಅದರಲ್ಲೂ ವಿಶೇಷವಾಗಿ ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಯ ವಿಷಯದಲ್ಲಂತೂ ನಾವು ತಾಳ್ಮೆಯಿಂದ ದಶಕಗಳ ಕಾಲ ಕಾಯಬೇಕು. ಯಶಸ್ಸಿನ ಸಂಖ್ಯೆಗಿಂತ ವೈಫಲ್ಯಗಳ ಸಂಖ್ಯೆ ಹೆಚ್ಚಾಗಿದ್ದರೂ ಸಹ ನಾವು ನಿರಾಶೆಗೊಂಡು ಸಿನಿಕರಾಗಬೇಕಾದ ಅಗತ್ಯವಿಲ್ಲ. ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಯಿಂದಾಗಿ ನಮ್ಮೆಲ್ಲ ಅಭಿವೃದ್ಧಿ ಮತ್ತು ಯೋಜನೆಗಳು ಹಿಡಿತ ತಪ್ಪಿಹೋಗಿ ಫಲ್ಲವೂ ಕಳೆದುಹೋಗಿದೆ ಎನ್ನುವುದು ಸರಿಯಲ್ಲ. ಶಿಕ್ಷಣ ಮತ್ತು ಜೀವಿತಾವಧಿಯಲ್ಲಿ ಏರಿಕೆ :ಶಿಶುಮರಣ , ಜನನದರ, ಮರಣದರ, ಫಲವಂತಿಕೆ ದರ, ವಿವಾಹದ ವಯಸ್ಸು, ಗರ್ಭಿಣಿಯರ ಮರಣ, ಕುಟುಂಬ ಯೋಜನೆ, ಆರೋಗ್ಯ ರಕ್ಷಣೆ ಇತ್ಯಾದಿಕ್ಷೇತ್ರಗಳ ಸಾಧನೆಯಲ್ಲಿ ನಮ್ಮ ರಾಷ್ಟ್ರದ ಪ್ರಗತಿಯನ್ನು ಕಡೆಗಣಿಸುವಂತಿಲ್ಲ. ಈ ಕ್ಷೇತ್ರಗಳಲ್ಲಿ ನಾವು ಸಾಕಷ್ಟು ಸುಧಾರಣೆ ಕಂಡಿದ್ದೇವೆ.

ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯ ನಿಯಂತ್ರಣ, ಸಾಕ್ಷರತೆಯ ಪ್ರಮಾಣದಲ್ಲಿ ಏರಿಕೆ, ಶಿಶುಮರಣ ಸಂಖ್ಯೆಯಲ್ಲಿ ಇಳಿಕೆ, ಇವುಗಳಲ್ಲಿ ಭಾರತದ ಸಾಧನೆಯನ್ನು ನಾವು ಒಗ್ಗೂಡಿಸಿ ಫಲ ಪಡೆಯಬೇಕಿದೆ. ಭಾರತವು ಗಂಭೀರವಾಗಿ ಪ್ರಯತ್ನಿಸಬೇಕಾದ ಇನ್ನೂ ಹಲವಾರು ಬೃಹತ್ ಸಮಸ್ಯೆಗಳಿವೆ. ಅನಕ್ಷರತೆ, ಗ್ರಾಮೀಣಾಭಿವೃದ್ಧಿ, ಬಾಲ ಕಾರ್ಮಿಕರ ಸಮಸ್ಯೆ, ನಿರುದ್ಯೋಗ, 5-14 ವಯೋಮಾನದ ಮಕ್ಕಳ ಅದರಲ್ಲೂ ಹೆಣ್ಣು ಮಕ್ಕಳ ಶಿಕ್ಷಣಕ್ಕೆ ಒತ್ತಾಸೆ, ನಗರೀಕರಣ, ನಗರದೆಡೆಗೆ ವಲಸೆ, ಜೈವಿಕ ಮತ್ತು ಪರಿಸರ ಅಸಮತೋಲನ, ಪರಿಣಾಮಕಾರಿಯಲ್ಲದ ಕೃಷಿ ಮತ್ತು ಇದೆಲ್ಲಕ್ಕಿಂತಲೂ ಮಿಗಿಲಾಗಿ ರಾಜಕೀಯ, ಅಸ್ಥಿರತೆ, ಜನಸಂಖ್ಯಾ ನೀತಿ, ಅಭಿವೃದ್ಧಿಪರ ಯೋಜನೆ, ಮಾನವ ಸಂಪನ್ಮೂಲ ಅಭಿವೃದ್ಧಿ ಮತ್ತು ಇಳಿವಯಸ್ಸಿನ ಜನಸಂಖ್ಯೆ, ಇಳಿಮುಖವಾಗುತ್ತಿರುವ ಲಿಂಗ ಅನುಪಾತ, ಮಕ್ಕಳ ರಕ್ಷಣೆ, ಇವೆಲ್ಲವುಗಳಿಗೆ ಹೆಚ್ಚು ಗಮನ ಹರಿಸಬೇಕು. ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಸಾಕಷ್ಟು ಕಾರ್ಯ ಆಗಿದೆ. ಆದರೆ ಇನ್ನೂ ಮಾಡಬೇಕಾದ ಕಾರ್ಯ ಸಾಕಷ್ಟಿದೆ.

ಮುಂದುವರಿದ ರಾಷ್ಟ್ರಗಳ ಅನುಭವವನ್ನು ಪರಿಗಣನೆಗೆ ತೆಗೆದುಕೊಂಡರೆ, " ಯಾವುದೇ ಅಭಿವೃದ್ಧಿಯಾದಾಗ ಅದರಲ್ಲಿ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯಲ್ಲಿ ಇಳಿಕೆ ಆಗಿರುವುದು ಪ್ರಮುಖವಾಗಿರುತ್ತದೆ." ಭವಿಷ್ಯದಲ್ಲಿನ ಖರ್ಚು ವೆಚ್ಚಗಳು ಮತ್ತು ಗಂಭೀರ ಅಪಾಯಗಳನ್ನು ತಡೆಗಟ್ಟಬೇಕಾದರೆ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯನ್ನು ನಿಧಾನಗೊಳಿಸಲು ನಾವು ತುರ್ತು ಬೃಹತ್ ಪ್ರಯತ್ನಗಳನ್ನು ಕೈಗೊಳ್ಳಬೇಕಾಗಿದೆ. ಬೆಳವಣಿಗೆಯನ್ನು ಸ್ಥಗಿತಗೊಳಿಸುವುದಾದರೆ ಅದಕ್ಕಿಂತ ಸಂತಸದ ಸಂಗತಿ ಮತ್ತೊಂದಿಲ್ಲ. ಕ್ರಿ.ಶ. 2015ರ ವೇಳೆಗೆ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯನ್ನು ಋಣಾತ್ಮಕಗೊಳಿಸಿದರಂತೂ ಅದಕ್ಕೆ ಎಣೆಯೇ ಇಲ್ಲ. ಋಣಾತ್ಮಕ ಬೆಳವಣಿಗೆಯನ್ನು ಸಾಧಿಸುವುದು ಕೇವಲ ಕಾಲುಭಾಗ ಯುದ್ಧವನ್ನು ಗೆದ್ದಂತೆ. ಯಾಕೆಂದರೆ ಆ ವೇಳೆಗೆ ಭಾರತದ

ಜನಸಂಖ್ಯೆ 1263 ಮಿಲಿಯನ್‌ನವ್ಹಾಗಿರುತ್ತದೆ. ಇದು ಹಲವಾರು ಸಮಸ್ಯೆಗಳಿಗೆ ಕಾರಣವಾಗಿ ನಮ್ಮೆಲ್ಲ ಅಭಿವೃದ್ಧಿ ಪ್ರಯತ್ನಗಳನ್ನು ಸ್ಥಗಿತಗೊಳಿಸುತ್ತದೆ.

<u>ಸಮಸ್ಯಾತ್ಮಕ ರಾಜ್ಯಗಳು</u>

ಈ ಹಿಂದೆ ಇದ್ದಂತೆ ಹಾಗೂ ಮುಂದಿನ ದಶಕಗಳಲ್ಲಿ ಕೂಡ ನಮ್ಮ ರಾಷ್ಟ್ರದ ಸಾಮಾಜಿಕ, ಆರ್ಥಿಕ ಮತ್ತು ಜನಾಂಗೀಯ ಭವಿಷ್ಯ ಭಾರತದ ಅತಿ ಜನಸಾಂದ್ರತೆಯುಳ್ಳ ಒಂಬತ್ತು ರಾಜ್ಯಗಳ ಮೇಲೆ ನಿಂತಿದೆ. 1991ರ ಜನಗಣತಿಯ ಪ್ರಕಾರ ಈ ರಾಜ್ಯಗಳ ಜನಸಂಖ್ಯೆ ಹೀಗಿದೆ. ಉತ್ತರ ಪ್ರದೇಶ (ಶೇ 16.44) ಬಿಹಾರ (ಶೇ. 10.23) ಮಹಾರಾಷ್ಟ್ರ (ಶೇ. 9.33) ಪಶ್ಚಿಮ ಬಂಗಾಳ (ಶೇ. 8.06) ಆಂಧ್ರಪ್ರದೇಶ (ಶೇ. 7.86) ಮಧ್ಯಪ್ರದೇಶ (ಶೇ. 7.84) ತಮಿಳುನಾಡು (ಶೇ. 6.59) ಕರ್ನಾಟಕ (5.31) ಮತ್ತು ರಾಜಸ್ಥಾನ (ಶೇ 5.20) ಇವೆಲ್ಲವೂ ಸೇರಿ ಭಾರತದ ಒಟ್ಟು ಜನಸಂಖ್ಯೆಯ ಶೇ. 76.86 ರನ್ನು ಪ್ರತಿನಿಧಿಸುತ್ತವೆ. 1981-91ರ ದಶಕದಲ್ಲಿ ಈ ಒಂಬತ್ತು ರಾಜ್ಯಗಳ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯನ್ನು ಒಟ್ಟುಗೂಡಿಸಿದರೆ ಅದು ಸುಮಾರು ಶೇ.77.76ರಷ್ಟಾಗಿತ್ತು. ಈ ರಾಜ್ಯಗಳಲ್ಲಿನ ಸಮಸ್ಯೆಗಳ ಬಗ್ಗೆ ಗಮನಹರಿಸಿದರೆ ಭಾರತದ ಮುಕ್ಕಾಲು ಜನಸಂಖ್ಯೆಯ ಸಮಸ್ಯೆಯನ್ನು ಸರಿಪಡಿಸಿದಂತಾಗುತ್ತದೆ.

ಈ ಮೇಲಿನ ಒಂಬತ್ತು ರಾಜ್ಯಗಳಲ್ಲಿ " ಬಿ ಐ ಎಮ್ ಎ ಆರ್ ಯು " (ಭೀಮಾರ್) ರಾಜ್ಯಗಳ ಬಗ್ಗೆ (ಬಿಹಾರ, ಮಧ್ಯಪ್ರದೇಶ, ರಾಜಾಸ್ಥಾನ, ಮತ್ತು ಉತ್ತರ ಪ್ರದೇಶಗಳ ಹೆಸರಿನ ಮೊದಲ ಅಕ್ಷರಗಳನ್ನು ಸೇರಿಸಿ ಈ ಪದವನ್ನು ರಚಿಸಲಾಗಿದೆ) ವಿಶೇಷ ಗಮನಹರಿಸಬೇಕಾದ ಅಗತ್ಯವಿದೆ. ಭಾರತದ ಒಟ್ಟು ಜನಸಂಖ್ಯೆಯ ಶೇ 39.71ರಷ್ಟು ಜನಸಂಖ್ಯೆ ಈ ನಾಲ್ಕು ರಾಜ್ಯಗಳಲ್ಲಿಯೇ ಇದೆ. 1981-91ರ ದಶಕದಲ್ಲಿ ಭಾರತದ ಜನಸಂಖ್ಯೆಗೆ ಶೇ 42.28 ರಷ್ಟು ಜನಸಂಖ್ಯೆಯನ್ನು ಈ ರಾಜ್ಯಗಳು ಸೇರಿಸಿವೆ. ಉತ್ತರ ಪ್ರದೇಶ ಮತ್ತು ಬಿಹಾರ ಅತೀ ಹೆಚ್ಚು ಜನಸಾಂದ್ರತೆಯುಳ್ಳ ರಾಜ್ಯಗಳಾದರೆ ಮಧ್ಯಪ್ರದೇಶ ಮತ್ತು ರಾಜಾಸ್ಥಾನ ವಿಸ್ತೀರ್ಣದ ದೃಷ್ಟಿಯಲ್ಲಿ ವಿಶಾಲವಾದ ರಾಜ್ಯಗಳಾಗಿವೆ.

ಲಿಂಗ ಅನುಪಾತ ಎಂದರೆ 1000 ಮಂದಿ ಪುರುಷರಿಗೆ ಪ್ರತಿಯಾಗಿ ಇರುವ ಮಹಿಳೆಯರ ಸಂಖ್ಯೆ. ಇದು 1981ರಲ್ಲಿ 934 ಇದ್ದದ್ದು 1991ರಲ್ಲಿ ಆತಂಕಕಾರಿಯಾಗಿ 929 ಕ್ಕೆ ಇಳಿದುಹೋಗಿದೆ. ಈ ಮೂರು ರಾಜ್ಯಗಳಲ್ಲಿ ಲಿಂಗ ಅನುಪಾತವು ಮಧ್ಯಪ್ರದೇಶವನ್ನು ಹೊರತುಪಡಿಸಿ 882 ರಿಂದ 913ರ ವರೆಗೆ ಹರಡಿದ್ದು ಇದು ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿಯಾದ 929 ಕ್ಕಿಂತ ತೀರಾ ಕಡಿಮೆಯಾಗಿದೆ. ಕೇರಳ ರಾಜ್ಯದಲ್ಲಿ ಮಾತ್ರ ಈ ಲಿಂಗಅನುಪಾತದ ಸಂಖ್ಯೆ 1040 ಇದ್ದು ಇದು ಕೆಲ ಅಭಿವೃದ್ಧಿಹೊಂದಿದ ರಾಷ್ಟ್ರಗಳಾದ ಅಮೇರಿಕಾ ಸಂಯುಕ್ತ ಸಂಸ್ಥಾನ (1037) ಜರ್ಮನಿ, ಫ್ರಾನ್ಸ್ (1054) ಬ್ರಿಟನ್(1047) ಜಪಾನ್ (1037) ರಷ್ಯಾ ಒಕ್ಕೂಟಗಳು (1130) ಆಸ್ಟ್ರೇಲಿಯಾ (1003) ಇವುಗಳ ಜೊತೆ ಸಮಾನ ಹೋಲಿಕೆಯಿದೆ. ಇದು ಗಮನಾರ್ಹವಾದ ಸಂಗತಿ. ಭಾರತದ ಇತರೆ ಯಾವುದೇ ರಾಜ್ಯಗಳು 1000 ಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಲಿಂಗ ಅನುಪಾತವನ್ನು ಹೊಂದಿಲ್ಲ. ಕೇರಳ ಮತ್ತು ಭಾರತದ ಕೇಂದ್ರಾಡಳಿತ ಪ್ರದೇಶಗಳನ್ನು ಹೊರತುಪಡಿಸಿದರೆ ಉಳಿದ ರಾಜ್ಯಗಳ ಅನುಪಾತವನ್ನು

ಗಮನಿಸಿದರೆ ನಮ್ಮ ಸಮಾಜ ಹೆಣ್ಣುಮಗು ಮತ್ತು ಮಹಿಳೆಯರ ಸ್ಥಾನಮಾನದ ಬಗ್ಗೆ ಹೊಂದಿರುವ ಕೆಳ ಆದ್ಯತೆಯ ತಿಳಿಯುತ್ತದೆ. ಈ ಬಗ್ಗೆ ಇನ್ನೂ ಹೆಚ್ಚಿನ ವಿಶ್ಲೇಷಣೆ ಮತ್ತು ವಿವರಣೆ ನಡೆಸಿದರೆ ಹೆಣ್ಣು ಮಗುವಿನ ಮರಣದ ಪ್ರಮಾಣ ಮತ್ತು ತಾಯಂದಿರ ಮರಣ ಸಂಖ್ಯೆಯ ಬಗ್ಗೆ ಮತ್ತಷ್ಟು ಬೆಳಕು ಬೀಳುತ್ತದೆ.

ಕ್ರಿ.ಶ. 1991ರ ಸಾಕ್ಷರತೆ ಪ್ರಮಾಣವನ್ನು 7 ವರ್ಷ ಮತ್ತು ಅದಕ್ಕೂ ಮೇಲ್ಪಟ್ಟ ವಯೋಮಾನದ ಜನಸಂಖ್ಯೆಗೆ ಅನ್ವಯಿಸಿದರೆ ಕುತೂಹಲ ಸಂಗತಿಗಳು ಕಾಣಸಿಗುತ್ತವೆ. ಭಾರತದಲ್ಲಿನ ಅಕ್ಷರಸ್ಥರ ಸಂಖ್ಯೆ 1981ರಲ್ಲಿ ಶೇ 43.56 ಇದ್ದು 1981ರಲ್ಲಿ ಶೇ. 52.11ಕ್ಕೆ ಏರಿದೆ. ಈ ಮೂರು ರಾಜ್ಯಗಳಲ್ಲಿನ ಸಾಕ್ಷರತೆಯ ಪ್ರಮಾಣ ಗಾಬರಿ ಹುಟ್ಟಿಸುವಂತಿದೆ. ಬಿಹಾರ (ಶೇ.38.54) ಮಧ್ಯಪ್ರದೇಶ (ಶೇ 43.53) ರಾಜಾಸ್ಥಾನ (ಶೇ. 38.81) ಉತ್ತರ ಪ್ರದೇಶ (ಶೇ 41.71) ಇವು ಅತಿ ಕಡಿಮೆ ದರವನ್ನು (ಅರುಣಾಚಲಪ್ರದೇಶ, ದಾದರ್ ಮತ್ತು ನಗರ ಹವೇಲಿ ಹೊರತುಪಡಿಸಿ) ಹೊಂದಿವೆ. ಕೇರಳವು ಶೇ 100 ರ ಸಾಕ್ಷರತೆಯನ್ನು ಸಾಧಿಸಿದೆ. ನಾವೀಗ ಇತರೆ ಎಲ್ಲ ರಾಜ್ಯಗಳಲ್ಲಿ ಮತ್ತು ಕೇಂದ್ರಾಡಳಿತ ಪ್ರದೇಶಗಳಲ್ಲಿ ಅನಕ್ಷರತೆಯನ್ನು ತೊಡೆದುಹಾಕಲು ಅತ್ಯಾದ್ಯತೆಯನ್ನು ನೀಡಬೇಕಾಗಿದೆ.

ಶಿಶು ಮರಣ- ಇದು ಆರೋಗ್ಯದ ಸ್ಥಿತಿಗತಿಯ ಸೂಚಕ. ಪ್ರತಿ ಸಾವಿರ ಮಕ್ಕಳಲ್ಲಿ ತನ್ನ ಮೊದಲನೆ ವರ್ಷಕ್ಕೆ ಮುಂಚೆ ಮರಣವನ್ನಪ್ಪುವ ಮಕ್ಕಳ ಸಂಖ್ಯೆಯನ್ನು ಇದು ತೋರಿಸುತ್ತದೆ. 1995 ರಲ್ಲಿ ಈ ಕೆಳಕಂಡ ರಾಜ್ಯಗಳಲ್ಲಿ ಶಿಶುಮರಣ ದರ ಸಂಖ್ಯೆ ಹೀಗಿದೆ. ಒರಿಸ್ಸಾ (105) ಮಧ್ಯಪ್ರದೇಶ (101) ಉತ್ತರ ಪ್ರದೇಶ (89) ಬಿಹಾರ (78) ಮತ್ತು ರಾಜಾಸ್ಥಾನ (84) ಇವು ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿ (80) ಕ್ಕಿ ಹೆಚ್ಚಾಗಿದೆ. ಕೇರಳ (15) ಕರ್ನಾಟಕ (65) ಇಲ್ಲಿ ಶಿಶುಮರಣ ದರ ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿಗಿಂತ ತೀರಾ ಕಡಿಮೆಯಿದ್ದು ಉತ್ತಮ ಸಾಧನೆಯಾಗಿದೆ.

ಮತ್ತೊಂದು ಆರೋಗ್ಯ ಸೂಚಕ ಅಂಶವೆಂದರೆ ತಾಯಂದಿರ ಮರಣ ದರ. ಗರ್ಭಿಣಿ ಮತ್ತು ಶಿಶು ಜನನ ಸಂದರ್ಭದಲ್ಲಿ ಮರಣವನ್ನಪ್ಪುವ ತಾಯಂದಿರ ಸಂಖ್ಯೆ. ಈ ದರವನ್ನು ಪ್ರತಿ ಲಕ್ಷಕ್ಕೆ ಇಷ್ಟು ಎಂದು ಲೆಕ್ಕ ಹಾಕಲಾಗುತ್ತದೆ. ಇತರ ರಾಜ್ಯಗಳಿಗೆ ಹೋಲಿಸಿದರೆ ಕೇರಳದ ಸಾಧನೆ (87) ಪ್ರಶಂಶನೀಯವಾಗಿದೆ. ತಾಯಂದಿರ ಮರಣ ಸಂಖ್ಯೆ ಒರಿಸ್ಸಾದಲ್ಲಿ (738) ಮಧ್ಯಪ್ರದೇಶ (711) ಉತ್ತರ ಪ್ರದೇಶ (624) ರಾಜಾಸ್ಥಾನ (550) ಅಸ್ಸಾಂ (554) ಮತ್ತು ಬಿಹಾರ (470) ಇದ್ದು ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿಗಿಂತ (453) ಹೆಚ್ಚಾಗಿದೆ. ಕರ್ನಾಟಕದಲ್ಲಿನ ತಾಯಂದಿರ ಮರಣ ಸಂಖ್ಯೆ ದರ (450) ಇದ್ದು ಇದು ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿಗಿಂತ ಕಡಿಮೆ ಇದೆ.

ಜನನ ಸಂದರ್ಭದಲ್ಲಿ ಮಕ್ಕಳ ಜೀವಿತ ಶಕ್ತಿಯನ್ನು ಸಹ ಲೆಕ್ಕಹಾಕಲಾಗುತ್ತದೆ. ಇದು (59.1) ಮತ್ತು ಉತ್ತರ ಪ್ರದೇಶದಲ್ಲಿ (56.8) ಇದ್ದು ಇವುಗಳೆಲ್ಲವೂ ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿಗಿಂತ (60.3) ಕಡಿಮೆ ಇದೆ. ಇಲ್ಲಿ ಮತ್ತೆ ಕೇರಳ ರಾಜ್ಯವು ಇತರೆಲ್ಲ ರಾಜ್ಯಗಳನ್ನು ಬದಿಗೊತ್ತಿ ಶೇ 72.9 ರ ಸಾಧನೆ ಮಾಡಿದೆ. ಮಹಾರಾಷ್ಟ್ರ , ಹರಿಯಾಣ, ತಮಿಳುನಾಡು, ಮತ್ತು ಪಂಜಾಬು ರಾಜ್ಯಗಳು ಕರ್ನಾಟಕಕ್ಕಿಂತ (62.5) ಉತ್ತಮ ಸಾಧನೆ ಹೊಂದಿವೆ. ಶಿಶು ಮರಣ ಮತ್ತು ತಾಯಂದಿರ ಮರಣ

ಸಂಖ್ಯೆ ದರವನ್ನು ಕಡಿಮೆ ಮಾಡುವ ನಮ್ಮ ಪ್ರಯತ್ನಗಳು ಮುಂದುವರಿಸಬೇಕು ಹಾಗೂ ಅವುಗಳನ್ನು ಸದೃಢಗೊಳಿಸಬೇಕಾಗಿದೆ.

ನಾವು ಕಾಳಜಿ ವಹಿಸಬೇಕಾದ ಮತ್ತೊಂದು ಕ್ಷೇತ್ರವೆಂದರೆ 6-14 ರ ವಯೋಮಾನದ ಮಕ್ಕಳು ಶಾಲೆಗೆ ಹೋಗುತ್ತಿರುವ ಶೇಕಡಾವಾರು ಪ್ರಮಾಣ. ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಕೇರಳ (ಶೇ 95) ಇತರೆಲ್ಲ ರಾಜ್ಯಗಳಿಗಿಂತ ಮುಂದೆ ಇದೆ. 1993 ರಲ್ಲಿ ಈ ವಯೋಮಾನದ ಮಕ್ಕಳ ಶಾಲಾ ಹಾಜರಾತಿ: ವಿವಿಧ ರಾಜ್ಯಗಳಲ್ಲಿ ಹೀಗಿತ್ತು. ಅಸ್ಸಾಂ (ಶೇ 77.8) ಬಿಹಾರ (ಶೇ 66.8) ಮಧ್ಯಪ್ರದೇಶ (ಶೇ 69.5) ರಾಜಾಸ್ಥಾನ (ಶೇ 67) ಒರಿಸ್ಸಾ (ಶೇ 75.2) ಉತ್ತರ ಪ್ರದೇಶ (ಶೇ 65.8) ಪಶ್ಚಿಮಬಂಗಾಳ (ಶೇ 71) ಕರ್ನಾಟಕ (ಶೇ 73.8) ಇವುಗಳೆಲ್ಲವು ರಾಷ್ಟ್ರೀಯ ಸರಾಸರಿಗಿಂತ (ಶೇ 82) ಕಡಿಮೆಯಿದೆ. ಈ ನಿರಾಶಾದಾಯಕ ಪ್ರದರ್ಶನ ತಡೆಗಟ್ಟಲು ಒಗ್ಗೂಡುವಿಕೆಯ ಪ್ರಯತ್ನ ಅತ್ಯಗತ್ಯವಾಗಿದೆ.

ಸಾಮಾನ್ಯವಾಗಿ ಕೇರಳ ರಾಜ್ಯವನ್ನು " ಭಾರತದ ಜನಾಂಗ ಸ್ಥಿತಿಯ ಪ್ರಯೋಗಶಾಲೆ " ಎಂದೇ ಪರಿಗಣಿಸಲಾಗುತ್ತಿದೆ. ಜನಾಂಗ ಸ್ಥಿತಿಯಲ್ಲಿ ಕೇರಳ, ರಾಷ್ಟ್ರದಲ್ಲಿಯೇ ಅತ್ಯಾಧುನಿಕ ರಾಜ್ಯವಾಗಿದೆ. ಅತಿ ಹೆಚ್ಚು ನಿರುದ್ಯೋಗಿಗಳಿರುವ ಕಾರಣದಿಂದಾಗಿ ಕೇರಳ ಆರ್ಥಿಕವಾಗಿ ಭಾರತದ ಕೆಲವು ರಾಜ್ಯಗಳು ಮತ್ತು ಕೇಂದ್ರಾಡಳಿತ ಪ್ರದೇಶಗಳಿಗಿಂತಲೂ ಹಿಂದುಳಿದಿದೆ. ಜನಾಂಗ ಸ್ಥಿತಿಯಲ್ಲಿ ಆಧುನಿಕ ಸ್ಥಿತಿಯಲ್ಲಿರುವ ಮತ್ತು ಆರ್ಥಿಕ ಬೆಳವಣಿಗೆಯಲ್ಲಿ ಹಿಂದುಳಿದಿರುವ ಕೇರಳ ರಾಜ್ಯ ಚರ್ಚೆಗೆ ಮತ್ತು ಅಧ್ಯಯನಕ್ಕೆ ಕುತೂಹಲ ವಿಷಯವಾಗಿದೆ. ಹೀಗೆಂದರೆ, ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯೊಂದೇ ಆರ್ಥಿಕ ಬೆಳವಣಿಗೆಗೆ ಕಾರಣವಲ್ಲ ಎಂದು ಅರ್ಥವೆ?

ಮಹಿಳೆ ಮಾತ್ರವೆ ಭಾರತವನ್ನು ಉಳಿಸಬಲ್ಲಳು

ಹಲವಾರು ನೋಟಗಳಿಂದ ನೋಡಿದರೂ ಮಹಿಳೆ ಮಾತ್ರವೆ ಭಾರತವನ್ನು ಉಳಿಸಬಲ್ಲಳು. ಭವಿಷ್ಯದ ಅಭಿವೃದ್ಧಿಗೆ ಇವರೇ " ನಂಬಿಕೆಯ ಅಶಾರಿರಣ " ಎಂದು ಆರ್ಥಶಾಸ್ತ್ರಜ್ಞ ಅಮೀರ್ ಬೋಸ್ ಹೇಳಿದ್ದಾರೆ. ಈ ಸೂಚಕಗಳೆಂದರೆ

1) 10-14ರ ವಯೋಮಾನದ ಶಾಲೆಗೆ ಹೋಗುವ ಹೆಣ್ಣುಮಕ್ಕಳ ಸಂಖ್ಯೆ. ಭವಿಷ್ಯ ಅವರಿಗಾಗಿಯೇ ಇದೆ.

2) 15-19 ವಯೋಮಾನದಲ್ಲಿ ಮದುವೆಯಾಗುವ ಹೆಣ್ಣುಮಕ್ಕಳ ಸಂಖ್ಯೆ. ಈ ಅಂಕಿಗಳು ಸೊನ್ನೆ ಅಥವಾ ಸೊನ್ನೆಯ ಹತ್ತಿರಕ್ಕೆ ಬಂದರೆ ಮಹಿಳೆಯರಿಗೆ ಭವಿಷ್ಯವಿದೆ.

3) 20-24ರ ವಯೋಮಾನದ ಪ್ರತಿ ಮಹಿಳೆಯರಿಗೆ ಹುಟ್ಟುವ ಮಕ್ಕಳ ಸಂಖ್ಯೆ. ಈ ವಯೋಮಾನದ ಮಹಿಳೆಯರು ಕುಟುಂಬ ಯೋಜನೆಗೆ ಒಳಪಟ್ಟರೆ ಭವಿಷ್ಯದ ಬಗ್ಗೆ ಆಶಾವಾದ ಇಟ್ಟುಕೊಳ್ಳಬಹುದು.

ಈ ಸೂಚಕಗಳನ್ನು ತಜ್ಞರು ಬಹಳ ಮುಂದಾಲೋಚನೆ ಮಾಡಿ ಅಭಿವೃದ್ಧಿಯ

ಸೂಚಕಗಳೆಂದು ಪರಿಗಣಿಸಿದ್ದಾರೆ.

ಮಹಿಳಾ ಜನಸಂಖ್ಯೆಯ ಗಾತ್ರವನ್ನು ಪರಿಗಣಿಸಿದರೆ ಇದನ್ನು ಸುಲಭವಾಗಿ ಮೆಚ್ಚಿ ಒಪ್ಪಿಕೊಳ್ಳಬಹುದು. ನಮ್ಮ ರಾಷ್ಟ್ರದ ಒಟ್ಟು ಮಹಿಳಾ ಜನಸಂಖ್ಯೆಯಲ್ಲಿ ಶೇ 60 ಕ್ಕಿಂತ ತುಸು ಕಡಿಮೆ ಮಂದಿ ಶಿಶು ಉತ್ಪಾದನಾ ವಯೋಮಾನವಾದ 15-49 ವರ್ಷದಲ್ಲಿದ್ದಾರೆ. ಇದರಲ್ಲಿ ಸುಮಾರು ಶೇ 28 ರಷ್ಟು ಹೆಚ್ಚುಮಂದಿ 15-25 ವರ್ಷದ ವಯೋಮಾನದ ಗುಂಪಿನಲ್ಲಿ ಬರುತ್ತಾರೆ. ಇದರಿಂದ ಸ್ಪಷ್ಟವಾಗಿ ತಿಳಿಯುವುದೇನೆಂದರೆ ಶಿಕ್ಷಣದ ಮಟ್ಟ ಹೆಚ್ಚಿದಂತೆ ಮಕ್ಕಳ ಸಂಖ್ಯೆ ಕಡಿಮೆಯಾಗುತ್ತದೆ. ಏಳು ವರ್ಷದ ಶಿಕ್ಷಣವನ್ನು ಪಡೆದಿರುವ ಹೆಣ್ಣುಮಕ್ಕಳು ತಮ್ಮದೇ ವಯಸ್ಸಿನ ಅನಕ್ಷರಸ್ಥ ಸಹೋದರಿಯರು ಹೊಂದಿರುವ ಮಕ್ಕಳಿಗಿಂತ ಅರ್ಧದಷ್ಟು ಸಂಖ್ಯೆಯ ಮಕ್ಕಳನ್ನು ಹೊಂದಿರುತ್ತಾರೆ. ಭಾರತದ ಅನುಭವದಲ್ಲಿಯೇ ಹೇಳುವುದಾದರೆ, ವಿಶೇಷವಾಗಿ ಕೇರಳ ಮತ್ತಿತರ ರಾಜ್ಯಗಳಲ್ಲಿ ಹೆಣ್ಣುಮಕ್ಕಳ ಶಿಕ್ಷಣಮಟ್ಟ ಹೆಚ್ಚಿರುವುದರಿಂದ ಹೆಣ್ಣುಮಕ್ಕಳ ಸರಾಸರಿ ವಿವಾಹದ ವಯಸ್ಸು ಹೆಚ್ಚಾಗಿ ಕುಟುಂಬದ ಗಾತ್ರ ಕಡಿಮೆಯಾಗಿದೆ. ಇದರಿಂದ ಜೀವನಗುಣಮಟ್ಟದ ಸೂಚಕಗಳು ಸುಧಾರಿಸಿ ಜೀವನಮಟ್ಟವು ಉತ್ತಮಗೊಂಡಿದೆ.

ಒಂದೇ ಮಗುವಿನ ಕುಟುಂಬ : ಭವಿಷ್ಯದ ಅಲೆ

" ಚೀನಿಯರು ತಮ್ಮ ಜನಸಂಖ್ಯೆ ಮತ್ತು ಸಂಪನ್ಮೂಲಗಳನ್ನು ಮುಂದಾಲೋಚನೆಯಿಂದ ಊಹಿಸಿ ಸರಿಯಾಗಿ ಬಿಂಬಿಸುತ್ತಿದ್ದಾರೆ. ಅಲ್ಲದೆ ಇದರಿಂದ ಅವರು ಕಂಡುಕೊಂಡ ಸತ್ಯಗಳನ್ನು ನೀತಿಯನ್ನಾಗಿ ನಿರೂಪಿಸುವ ಧೈರ್ಯವನ್ನು ತೋರಿದ್ದಾರೆ." ಈ ಮಾತುಗಳ ಕಾರ್ಯರೂಪವಾಗಿ ಚೀನಿಯರು "ಒಂದೇ ಮಗುವಿನ ಕುಟುಂಬ " ಕಾರ್ಯಕ್ರಮವನ್ನು ಜಾರಿಗೊಳಿಸಿದ್ದಾರೆ. ಈ ಒಂದು ಮಗುವಿನ ಕುಟುಂಬದ ಕಾರ್ಯಕ್ರಮವನ್ನು ಚೀನಾ ಜಾರಿಗೊಳಿಸಿರುವುದಕ್ಕೆ ಕಾರಣ ಅವರ ಜೀವನಮಟ್ಟದಲ್ಲಿ ಕುಸಿತ ಮತ್ತು ಮರಣ ಸಂಖ್ಯೆಯಲ್ಲಿ ಏರಿಕೆಯಾಗಿದ್ದು ಎಂದು ಹೇಳಲಾಗುತ್ತಿದೆ. ಭಾರತದ ಪರಿಸ್ಥಿತಿ ಇದಕ್ಕಿಂತ ಉತ್ತಮವೇನಾಗಿಲ್ಲ. ನಿಜ ಹೇಳಬೇಕೆಂದರೆ ಇದು ಇನ್ನೂ ಕೆಟ್ಟದಾಗಿದೆ. " ಒಂದೇ ಮಗುವಿನ ಕುಟುಂಬ : ಭವಿಷ್ಯದ ಅಲೆ " ಈ ತಾರಕ ಮಂತ್ರವನ್ನು ಹಲವಾರು ಅಭಿವೃದ್ಧಿಶೀಲ ರಾಷ್ಟ್ರಗಳು ಒಪ್ಪಿಕೊಂಡಿವೆ. ಈಗೇನಿದ್ದರೂ ಇದನ್ನು ಅಪ್ಪಿಕೊಳ್ಳುವುದು ಮಾತ್ರ ಉಳಿದಿದೆ.

ಮುಂಬರುವ ಒಂದೆರಡು ವರ್ಷಗಳಲ್ಲಿ ಭಾರತವು ಒಂದು ಮಗುವಿನ ಕುಟುಂಬ ಕಾರ್ಯಕ್ರಮವನ್ನು ಅಳವಡಿಸಿಕೊಳ್ಳಲೇ ಬೇಕಾದ ಒತ್ತಡಕ್ಕೆ ಬೀಳುತ್ತದೆ. ಏಕೆಂದರೆ ಈಗಿರುವ ಬೃಹತ್ತಾದ ಸಂಖ್ಯೆಯ ಬಿಗುರು ಯುವಕರು ಮುಂದಿನ ಎರಡು ದಶಕಗಳಲ್ಲಿ ಶಿಶು ಉತ್ಪಾದನಾ ವಯೋಮಾನಕ್ಕೆ ಕಾಲಿಡಲಿದ್ದಾರೆ. ಈ ಕಾರ್ಯಕ್ರಮ ಮಾದರಿಯನ್ನು ಅಳವಡಿಸಿಕೊಳ್ಳುವುದರಿಂದ ಜೀವನಮಟ್ಟ ಸುಧಾರಿಸುವ ಖಾತ್ರಿಯಿದೆ. ಭಾರತದ ಪರಿಸ್ಥಿತಿಗೆ ಹೋಲಿಸಿ ಹೇಳುವುದಾದರೆ ರಾಜಕೀಯವಾಗಿ ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕವಾಗಿ ಇಂತಹ ನೀತಿಯನ್ನು ವಿಶೇಷವಾಗಿ ಒಪ್ಪಿಕೊಳ್ಳಬೇಕಾಗುವುದು ಅತ್ಯಗತ್ಯವಾಗಿದೆ. ಆದರೆ, ಭಾರತಕ್ಕೆ ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಅಲ್ಪ ಅವಕಾಶವಿದೆ. ರಾಷ್ಟ್ರದ ಭವಿಷ್ಯದ ಆಗು ಹೋಗುಗಳ ಹೊಣೆಯನ್ನು ಹೊತ್ತಿರುವ ನಮ್ಮ ಜನರು

ಎಬ್ಬೆತ್ತು ಈ ಪ್ರಸ್ತಾವನೆಯನ್ನು ಗಂಭೀರತೆಯಿಂದ ಪರಿಶೀಲಿಸುವ ತುರ್ತು ಸಮಯ ಬಂದೊದಗಿದೆ.

ನಿರಂತರ ಅಭಿವೃದ್ಧಿ:

ಭಾರತ ಪ್ರಜಾಸತ್ತೆಯ ಗುಣಮಟ್ಟ ಉತ್ತಮಗೊಳ್ಳಬೇಕೆನ್ನುವುದನ್ನು ಬಿಟ್ಟರೆ ಭಾರತೀಯ ಸಮಾಜದ ಪ್ರಜಾಪ್ರಭುತ್ವ
ಮತ್ತು ಜಾತ್ಯಾತೀತೆಯ ಬಗ್ಗೆ ವಿಶ್ವಾಸ ಇನ್ನೂ ಉಳಿದುಕೊಂಡಿದೆ. ಭಾರತದ ನಿಜವಾದ ಶಕ್ತಿಯ ಮೂಲವೇ ಅದು. ನಮ್ಮ ಸಮಾಜದ ಜಾತ್ಯಾತೀತ ವಿಶ್ವಾಸಾರ್ಹತೆ ಕೆಲವೊಮ್ಮೆ ಅಲ್ಲಲ್ಲಿ ಅಲುಗಾಡಿದರೂ ಒಟ್ಟಾರೆಯಾಗಿ ಅದು ಗಟ್ಟಿಯಾಗಿಯೇ ಉಳಿದಿದೆ. ರಾಜಕೀಯ ಅಸ್ಥಿರತೆಯ ಹೊರತಾಗಿಯೂ ಸಹ ನಮ್ಮ ಜನರು ಸಾರ್ವತ್ರಿಕ ಚುನಾವಣೆಗಳಲ್ಲಿ ಆಗಾಗ್ಗೆ ಪ್ರಜಾಪ್ರಭುತ್ವ ಅಳ್ವಿಕೆಯ ಬಗ್ಗೆ ತಮಗಿರುವ ವಿಶ್ವಾಸವನ್ನು ಪ್ರದರ್ಶಿಸುತ್ತಲೇ ಬಂದಿದ್ದಾರೆ. ಇದನ್ನು ನಾವು ಮರೆಯುವಂತಿಲ್ಲ. ರಾಜಕೀಯ ಸ್ಥಿರತೆ ಮತ್ತು ಸರಿಯಾದ ಅಳ್ವಿಕೆಯ ವ್ಯವಸ್ಥೆಗಳು ಜೊತೆಗೂಡಿದರೆ ಅವು ಅಭಿವೃದ್ಧಿ ಪ್ರಕ್ರಿಯೆಗೆ ಮತ್ತು ಬಹುಮುಖ ಸತ್ಪರಿಣಾಮಗಳಿಗೆ ಒಂದು ರೀತಿಯ ವೇಗವರ್ಧಕವಾಗಿ ಕೆಲಸ ಮಾಡುತ್ತವೆ.

ಭವಿಷ್ಯದ ಅಭಿವೃದ್ಧಿಯೆಂದರೆ ಭವಿಷ್ಯವನ್ನು ಸಂರಕ್ಷಿಸುವ ನಿರಂತರ ಅಭಿವೃದ್ಧಿಯೆಂದೇ ಅರ್ಥ. ಅಭಿವೃದ್ಧಿಯೆಂದರೆ ಈಗ ಕೇವಲ ತಲಾವಾರು ಆದಾಯ, ರಾಷ್ಟ್ರೀಯ ಆದಾಯ, ಋಣಸಾಲ, ಜಗತ್ತಿನಲ್ಲಿ ರಾಷ್ಟ್ರದ ಸ್ಥಾನಮಾನ, ಹಣದುಬ್ಬರ, ಜಿಡಿಪಿ ಮತ್ತು ಇನ್ನೂ ಏನೇನೋ ಅಲ್ಲ. ಇದರಲ್ಲಿ ಆಹಾರ, ವಸತಿ, ಆರೋಗ್ಯ, ಉದ್ಯೋಗ, ಸಾಕ್ಷರತೆ, ಶಿಕ್ಷಣ, ಸಂಸ್ಕೃತಿ, ಮೌಲ್ಯಗಳು, ರಕ್ಷಣೆ ಮತ್ತು ಎಲ್ಲಕ್ಕಿಂತ ಮಿಗಿಲಾಗಿ ಮಾನವ ಘನತೆ ಇವುಗಳೂ ಸೇರುತ್ತವೆ. ಎಲ್ಲಿಯವರೆಗೆ ನಮ್ಮ ಬಿರುಸಿನ ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯನ್ನು ನಾವು ನಿಯಂತ್ರಿಸುವುದಿಲ್ಲವೋ ಅಲ್ಲಿಯವರೆಗೆ ನಮ್ಮ ನಿರಂತರ ಅಭವೃದ್ಧಿಯ ಬಗೆಗಿನ ಚರ್ಚೆ, ಅದರ ಬಗೆಗಿನ ಕಾಳಜಿ ಇವೆಲ್ಲವು ಕಾರ್ಯಾಚರಣೆಗಿಳಿಯದ ಕೇವಲ ಬರೀ ಒಣ ಸಲಹೆಗಳಾಗುತ್ತವೆ.

ನಮಗುಳಿದಿರುವ ಅತ್ಯಲ್ಪ ಸಮಯದಲ್ಲಿ ನಾವು ನಮ್ಮೆಲ್ಲ ಪ್ರಯತ್ನಗಳನ್ನು ಮಾಡಬೇಕಾಗಿದೆ " ಮುನ್ನೆಚ್ಚರಿಸುವುದೆಂದರೆ – ಮುನ್ಸೂಚಿಸುವುದು." ಎಚ್ಚರಿಕೆ, ಈಗ ಹಿಂದೆಂದಿಗಿಂತಲೂ ಗಟ್ಟಿಯಾಗಿದೆ ಮತ್ತು ಸ್ಪಷ್ಟವಾಗಿದೆ. ಯೋಜಕರಿಗೆ, ನೀತಿ ನಿರೂಪಕರಿಗೆ, ಆಡಳಿತಗಾರರಿಗೆ, ತಜ್ಞರಿಗೆ, ಶಿಕ್ಷಣ ತಜ್ಞರಿಗೆ,ವೃತ್ತಿವಂತರಿಗೆ, ಮತ್ತು ಸಾಮಾನ್ಯ ಜನರಿಗೆ, ಮಹಿಳೆಯರಿಗೆ ಇದು ಸಕಾಲವಾಗಿದೆ. ಭೂತಕಾಲವನ್ನು ನೋಡುತ್ತಲೆ ಮುಂದಿರುವ ಭವಿಷ್ಯದ ಸವಾಲುಗಳನ್ನು ಪುನರ್‌ಸ್ವೀಕರಿಸಲು ಕಾಲ ಪರಿಪಕ್ವವಾಗಿದೆ.

ನಮ್ಮ ಸಾಮಾಜಿಕ ಕಾಳಜಿಯನ್ನು ಜಾಗೃತಗೊಳಿಸಿಕೊಂಡು ಸಮಾನ ನೀತಿಗಳು, ನಂಬಿಕೆಗಳನ್ನು ಒಗ್ಗೂಡಿಸಿಕೊಂಡು ದೃಢನಿಶ್ಚಯದಿಂದ ಸಮಗ್ರವಾಗಿ ದುಡಿಯೋಣ. ಸವಾಲುಗಳನ್ನು ಎದುರಿಸಲು ನಾವು ಸಮರ್ಥರಾಗಿದ್ದೇವೆ, ಭಾರತವನ್ನು ಸಂರಕ್ಷಿಸಲು, ಶುದ್ಧಗೊಳಿಸಲು, ಸಮರ್ಥಗೊಳಿಸಲು, ಸಮೃದ್ಧಗೊಳಿಸಲು ನಾವು ಶಕ್ತರಿದ್ದೇವೆ. ಇದು ಸುದೀರ್ಘ ಹೋರಾಟ

ಎನ್ನುವುದು ನಮ್ಮೆಲ್ಲರಿಗೂ ತಿಳಿದಿದೆ. ಆದರೂ ಛಲ ಬಿಡದೆ ಹೋರಾಡುವ ಸಂಕಲ್ಪವನ್ನು ತಳೆಯೋಣ. ಬನ್ನಿ ಜೊತೆಗೂಡಿ ಹೋರಾಡೋಣ.

ಇಂಗ್ಲೀಷ್ ಲೇಖನದ ಅನುವಾದ : ಎನ್.ಆರ್. ವಿಶುಕುಮಾರ್

కీలక ప్రమాణికాంశాల్లో భారత సాధనలను తెలిపే పట్టిక

STATEMENT SHOWING THE ACHIEVEMENTS OF INDIA IN CERTAIN KEY AREAS

1	LITERACY అక్షరాస్యత	1901	1951 Age 5+ years only	1981 Age 5+ years only	1991 Age 7+ years only
	Literates అక్షరాస్యులు Persons వ్యక్తులు	5.40	18.33	41.42	52.71
	Males పురుషులు	9.83	27.16	53.45	63.86
	Females మహిళలు	0.60	8.86	28.46	39.42
	Illiterates అనక్షరాస్యులు Persons వ్యక్తులు	94.6	81.67	58.58	47.89
	Males పురుషులు	90.17	72.84	46.55	36.14
	Females మహిళలు	99.40	91.14	71.54	60.58

2	LIFE EXPECTANCY AT BIRTH జనన సమయంలో ఉండే ఆయుర్దాయం	1901-1911	1951-1961	1981-1985	1987-1991	2001 (Expected)
	Males పురుషులు	22.59	41.89	55.40	58.10	62.36
	Females మహిళలు	23.31	40.55	55.70	58.60	63.39

3	INFANT శిశు మరణాల్లో MORTALITY RATE PER 1000 వెయ్యి POPULATION	దశాబ్ది Decade 1901-11	1951 (Specific) నిర్దిష్ట	1981 (Specific) నిర్దిష్ట	1991 (Total) మొత్తం	2001 (Expected)
	Males పురుషులు	290.0	235	86	80	63
	Females మహిళలు	284.6	218	82		64
4	(ESTIMATED)(అంచనా) BIRTH RATE జననాల్లో PER 1000 జనాభా POPULATION	49.2	41.7	33.9	29.5	24.10
5	DEATH RATE మరణాల్లో PER 1000 వెయ్యి POPULATION మరణాలు	42.6	22.8	12.5	9.8	8.99
6	FERTILITY RATE PER 1000 ప్రతి వెయ్యి POPULATION సంతానోత్పత్తి	-	-	4.5	3.6	3.05

AGE AT MARRIAGE	1891-1901	1901-1911	1911-1921	1921-1931	1931-1941	1941-1951	1951-1961	1971	1981
Mean age at marriage of females Married upto age 35	12.77	13.04	13.52	12.50	14.00	15.38	15.43	17.1*	18.3*
Mean age at marriage of males married upto age 50	21.01	20.44	20.74	18.45	20.34	19.93	21.76	22.3*	23.3*

8	MORTALITY OF PREGNANT WOMAN (PER THOUSAND POPULATION IN RURAL AREAS)	1994	1995
	Child birth & pregnancy ప్రసవ సమయంలో మరణాలు	388	353
	Percentage to the total మొత్తం శాతాలు	12.1	9.8

Source : Census Publications of India.

ಜನಗಣತಿ 2001ರ ಮಹತ್ವ ಮತ್ತು ಹೊಸ ಲಕ್ಷಣಗಳು

ಎಚ್. ಶಶಿಧರ್, ಐ.ಎ.ಎಸ್.,
ಜನಗಣತಿ ಕಾರ್ಯಾಚರಣೆ ನಿರ್ದೇಶಕರು
ಕರ್ನಾಟಕ

ನೂರ ಮೂವತ್ತೈದು ವರ್ಷಗಳ ಭವ್ಯ ಹಿನ್ನೆಲೆಯಿರುವ ಭಾರತ ಜನಗಣತಿ ಹತ್ತು ವರ್ಷಗಳ ನಂತರ ಮತ್ತೊಮ್ಮೆ ಬರುತ್ತಿದೆ. ಭಾರತ ಜನಗಣತಿ ಸಂಸ್ಥೆಯು ತನ್ನೆಲ್ಲ ಜನಶಕ್ತಿ, ಸಾಮಗ್ರಿ ಮತ್ತು ಹಣಕಾಸು ವ್ಯವಸ್ಥೆಯನ್ನು ಸಜ್ಜುಗೊಳಿಸಿಕೊಂಡು ಜಗತ್ತಿನಲ್ಲೇ ಅತೀ ದೊಡ್ಡದಾದ ಆಡಳಿತಾತ್ಮಕ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಕೈಗೆತ್ತಿಕೊಳ್ಳುತ್ತಿದೆ. ಭಾರತ ಜನಗಣತಿ 2001 ಫೆಬ್ರವರಿ 9 ರಿಂದ 28ರ ವರೆಗೆ ನಡೆಯಲಿದೆ. ಇದು ಇಪ್ಪತ್ತೊಂದನೆ ಶತಮಾನದ ಮತ್ತು ಮೂರನೆ ಸಹಸ್ರಮಾನದ ಮೊಟ್ಟ ಮೊದಲ ಜನಗಣತಿಯೆನ್ನುವ ಹೆಗ್ಗಳಿಕೆಯನ್ನು ಹೊಂದಿರುವುದು ಈ ಸಲದ ವಿಶೇಷ. ನಿರಂತರವಾಗಿ ಬೆಳೆಯುತ್ತಿರುವ ಭಾರತ ಜನಸಂಖ್ಯೆಯ ಜನಾಂಗೀಯ ಸ್ವಾಸ್ಥ್ಯವನ್ನು; ಭಾರತದ, ಸಾಮಾಜಿಕ, ಆರ್ಥಿಕ ವ್ಯವಸ್ಥೆಯ ಸಮಗ್ರ ಚಿತ್ರಣವನ್ನು ಈ ಜನಗಣತಿ ನೀಡಲಿದೆ. ಮುಂಬರುವ ದಶಕಗಳಿಗೆ ಇದೊಂದು ಐತಿಹಾಸಿಕ ದಾಖಲೆಯಾಗಿ ಉಳಿಯಲಿದೆ. 1874 ರಲ್ಲಿ ಪ್ರಪ್ರಥಮವಾಗಿ ಭಾರತದ ಜನಗಣತಿ ಆರಂಭವಾದ ನಂತರ ಇದು 14ನೇ ದಶವಾರ್ಷಿಕ ಜನಗಣತಿ ಹಾಗೂ ಸ್ವಾತಂತ್ರ್ಯಾನಂತರದ ಆರನೇ ಜನಗಣತಿಯಾಗಿದೆ.

ಕ್ರಿ.ಶ. 2001ದ ಜನಗಣತಿ ಹಲವು ಪ್ರಥಮಗಳನ್ನು ತನ್ನ ತೆಕ್ಕೆಯಲ್ಲಿಟ್ಟುಕೊಂಡಿದೆ. ಪ್ರಪ್ರಥಮ ಬಾರಿಗೆ ಎರಡು ಮಿಲಿಯನ್‌ಗೂ ಹೆಚ್ಚು ಜನರನ್ನು ಜನಗಣತಿ ಕಾರ್ಯಾಚರಣೆಗಾಗಿ ನೇಮಿಸಿಕೊಂಡು ತರಬೇತಿ ನೀಡಲಾಗುತ್ತಿದೆ. ಇವರು ಕ್ರಿ.ಶ. 2001ರ ಮಾರ್ಚ್ 1ನೇ ತಾರೀಖಿನಂದು ಭಾರತದಲ್ಲಿದ್ದ ಸುಮಾರು ಒಂದು ಬಿಲಿಯನ್ ಅಥವಾ ನೂರು ಕೋಟಿಗೂ ಹೆಚ್ಚಿನ ಜನರನ್ನು ತಲುಪಿ ಅವರಿಂದ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸಬೇಕಾಗಿದೆ. ಈ ಭಾರಿ ಜನಸಂಖ್ಯೆಯು 25 ರಾಜ್ಯಗಳಲ್ಲಿ ಆರು ಕೇಂದ್ರಾಡಳಿತ ಪ್ರದೇಶಗಳಲ್ಲಿ, 593 ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಸುಮಾರು 5,500 ತಾಲ್ಲೂಕುಗಳಲ್ಲಿ 5100 ನಗರ ಮತ್ತು ಪಟ್ಟಣಗಳಲ್ಲಿ ಮತ್ತು 6,87,000 ಹಳ್ಳಿಗಳಲ್ಲಿ ವಾಸವಾಗಿದ್ದು ಇವರೆಲ್ಲರನ್ನೂ ಎಣಿಸಬೇಕಾಗಿದೆ. ವಯಸ್ಸು, ಲಿಂಗ ಮತ್ತು ರಾಷ್ಟ್ರೀಯತೆಯನ್ನು ಪರಿಗಣಿಸದೆ ಪ್ರತಿಯೊಂದು ಮಗು,ಮಹಿಳೆ,ಪುರುಷ, ನಪುಂಸಕರು ಹೀಗೆ ಎಲ್ಲರನ್ನು ಎಣಿಸಬೇಕು. ಯಾರನ್ನೂ ಬಿಡುವಂತಿಲ್ಲ ಹಾಗೂ ಪುನರಾವರ್ತಿಸುವಂತಿಲ್ಲ. ನಿಜಕ್ಕೂ ಇದೊಂದು ದೈತ್ಯಕಾರ್ಯ. ಈ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಕೈಗೊತ್ತಿಕೊಳ್ಳುವ ಸಾಮರ್ಥ್ಯ ಪರಿಣತಿ ಮತ್ತು ಅನುಭವ ಭಾರತ ಜನಗಣತಿ ಇಲಾಖೆಗಿದೆ.

ಭಾರತ ಜನಗಣತಿಗೆ ಎರಡು ಹಂತಗಳಿವೆ. ಮೊದಲ ಅಥವಾ ಪ್ರಾಥಮಿಕ ಹಂತ ಮನೆಪಟ್ಟಿ ಕಾರ್ಯಾಚರಣೆಗೆ ಸಂಬಂಧಿಸಿದೆ. ಈ ಕಾರ್ಯಾಚರಣೆಯಲ್ಲಿ ವಸತಿ ಮತ್ತು ಕುಟುಂಬದ ಸೌಕರ್ಯಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿಯನ್ನು ಕಳೆದ ಏಪ್ರಿಲ್‌ನಿಂದ ಜೂನ್ 2000ದ ವರೆಗೆ ದೇಶಾದ್ಯಂತ ಸಂಗ್ರಹಿಸಲಾಗಿದೆ. ಎರಡನೆ ಹಾಗೂ ಅಂತಿಮ ಹಂತ ಜನರ ಗಣತಿಯಾಗಿದೆ. ಜಮ್ಮು ಮತ್ತು ಕಾಶ್ಮೀರ ಹೊರತುಪಡಿಸಿ

ಮತ್ತು ತೋಟಗಾರಿಕೆಯಲ್ಲಿ ತೊಡಗಿರುವ ಕುಟುಂಬಗಳು (6) ಮಾಹಿತಿ ನೀಡಿದವರ ಸಹಿ ಅಥವಾ ಹೆಬ್ಬೆಟ್ಟಿನ ಗುರುತು ದಿನಾಂಕದೊಂದಿಗೆ.

ಜನಗಣತಿ 2001 ಭಾರತ ಜನಗಣತಿಯ ಇತಿಹಾಸಕ್ಕೆ ತಾಂತ್ರಿಕ ಕ್ರಾಂತಿಯನ್ನು ತರುವ ನಿರೀಕ್ಷೆ ಇದೆ. ನಮೂನೆಯಲ್ಲಿರುವ ಪ್ರಶ್ನೆಗಳು ಸ್ವತಃ ಸಂಕೇತಗಳನ್ನು ಹೊಂದಿದ್ದು ಸಂಯೋಜಿಸಲು ಸರಳವಾಗಿವೆ. ಇತ್ತೀಚೆಗೆ ಬಂದಿರುವ ಬಿಂಬಿತ ಅಧಾರದ ಸ್ಕಾನಿಂಗ್ ತಂತ್ರಜ್ಞಾನವನ್ನು ಜನಗಣತಿ ಇಲಾಖೆಯು ಪ್ರಪ್ರಥಮವಾಗಿ ಅಳವಡಿಸಲಾಗುತ್ತಿದ್ದು ಇದು ಮಾಹಿತಿ ಪರಿಷ್ಕರಣೆ, ಪಟ್ಟಿ ಮತ್ತು ಪ್ರಕಟಣೆ ಕಾರ್ಯವನ್ನು ಗಣನೀಯವಾಗಿ ವೇಗಗೊಳಿಸಲಿದೆ.

ಭಾರತ ಜನಗಣತಿ 2001, ಭಾರತದ ಭವಿಷ್ಯಕ್ಕೆ ಹೊಸ ಮಾರ್ಗನಕ್ಷೆಯಾಗಲಿದೆ. ಹಾಗೆಯೇ ಇತಿಹಾಸ ಸೃಷ್ಟಿಯನ್ನು ಮಾಡಲಿದೆ. ಭವ್ಯ ಪರಂಪರೆಯೇ ಇದರ ಮುಖ್ಯ ಶಕ್ತಿ.

ಇಂಗ್ಲೀಷ್ ಲೇಖನದ ಅನುವಾದ : ಎನ್.ಆರ್. ವಿಶುಕುಮಾರ್

SIGNIFICANCE AND NEW FEATURES OF CENSUS 2001

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Once again after 10 years the one hundred and thirty years old, gigantic and great Indian Census Organisation is mobilising all its men (and women), material and money to undertake the biggest administrative exercise in the World i.e., the Census of India 2001 during February 9th to 28th, 2001. The significance of Census 2001 lies in the fact that it is the first Census of the twenty-first century and third millennium. Giving complete account of the socio-economic, development and demographic health of the ever burgeoning population of India, the Census 2001 will serve as a historic bench mark for the coming decades. It will be the 14th decennial Census of India since 1871 and sixth since Independence.

The Census 2001 has many firsts to its credit. For the first time an unprecedented strength of over two million people will be appointed and trained to reach and capture information from an anticipated 1000 million or 100 crore or one billion plus people living in India as on 1st March, 2001. This whopping population living in 26 States, 6 Union Territories, 593 Districts, around 5,500 Taluks, 5,100 Cities & Towns and 6,83,000 Villages will have to be counted. Every child, woman, man eunuch and hermaphrodite regardless of age, sex and nationality will have to be enumerated without omission or duplication. Indeed, it is a stupendous task. The Indian Census Organisation has the expertise, experience and competence to undertake this task

The Indian Census has two phases. First or preliminary phase referred as the Houselisting Operation during which information on housing and household amenities is captured was held throughout the Country during April to June, 2000. Second or the main phase known as the Population Enumeration will be held (except Jammu and Kashmir) between 9th and 28th February, 2001. The houseless households will be enumerated on the night of 28th February, 2001.

One of the main features of the ensuing Census is the reduction in the number of questionnaires or schedules used. In the previous Census, three schedules, namely the houselist schedule, household schedule and individual slip were used to gather information. But in this Census, since the individual slip has been done away with, only two schedules i.e., the houselist schedule and the household schedule are going to be used. The individual particulars will be collected in the household schedule itself.

Another prominent feature of the Census 2001 is the dropping of the Economic Census which used to be held alongwith the houselisting operation in the previous Census. Similarly, the preparation of PGDHTP cards (Post Graduate and Degree Holders and Technical Personnel), for which information used to be collected during the Population Enumeration has also been dropped from this Census.

Yet another important feature of this Census is the introduction of certain new and relevant questions both for the Houselisting Operation and the Population Enumeration. The new questions in addition to the modifications of old ones, enhance the utility of Census 2001 and takes it beyond a head count of population.

The Houselisting Operation included questions for the first time on (1) condition of the house, (2) number of married couples living in the household, (3) number of married couples having independent rooms, (4) drainage facilities, (5) bathroom within the house, (6) kitchen within the house, (7) possession of Radio/Transistor/ Television/Telephone by the household, (8) possession of transport vehicle such as Bicycle/Scooter/Motor Cycle/Moped/Car/Jeep by the household and (9) Banking services availed by the household.

Similarly, the Population Enumeration between 9th and 28th Feb., 2001 will have questions for the time on (1) name of respondent and the relationship to head, (2) age of marriage for males also, (3) disabilities, (4) travel to work place, distance and mode of travel, (5) household engaged in cultivation and plantation and (6) dated signature or thump impression of the respondent.

Census 2001 is expected to bring in a sort of technological revolution for in the history of Indian Census. The questions in the schedules are self coded to make them processor friendly. Latest image-based scanning technology will be tried for the first time by the Census Organisation which should substantially speed up processing, tabulation and publication of data.

Census of India 2001, a new road map to India's future is nothing but history in the making. Glorious tradition is its' main strength.

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ಭಾರತದ ಜನಗಣತಿ 2001ರ ಸಂದರ್ಭದಲ್ಲಿ ಪ್ರಚಾರಕ್ಕಾಗಿ ಉಪಯೋಗಿಸಬಹುದಾದ ಧ್ಯೇಯಮಂತ್ರ, ಗುರಿನುಡಿ, ಸೂತ್ರ, ಸ್ಲೋಗನ್ ಇತ್ಯಾದಿ

1. ಜನಗಣತಿಯು ರಾಷ್ಟ್ರಮಟ್ಟದ ಮಹತ್ವವನ್ನು ಗಳಿಸಿದೆ. ಈ ಮಹತ್ವಪೂರ್ಣ ಕಾರ್ಯದಲ್ಲಿ ಸಹಕರಿಸುವುದು ನಮ್ಮೆಲ್ಲರ ಕರ್ತವ್ಯ.
2. ದೇಶದ ಮೂಲೆಮೂಲೆಗಳಲ್ಲಿಯೂ ಇರುವ ಜನರನ್ನು ಸಂಪರ್ಕಿಸಿ ವಿವರಗಳನ್ನು ಸಂಗ್ರಹಿಸಲು ಅಗತ್ಯವಾದ ಅಗಾಧ ಪ್ರಮಾಣದ ಮಾನವಶಕ್ತಿಗೆ ಶಾಲಾ ಉಪಾಧ್ಯಾಯರುಗಳೇ ಮೂಲಾಧಾರ.
3. ಜನಗಣತಿ ಉದ್ದೇಶಕ್ಕಾಗಿ ಗಣತಿದಾರರು ನಿಮ್ಮ ಮನೆಯ ಬಾಗಿಲ ಮೇಲೆ ಪೈಂಟ್ ಮಾಡುವ ಮನೆಸಂಖ್ಯೆಯನ್ನು ಅಳಿಸಬೇಡಿ. ಒಂದು ವರ್ಷದವರೆಗೆ ಅಚ್ಚಳಿಯದಂತೆ ಕಾಪಾಡಿರಿ.
4. ಆರ್ಥಪೂರ್ಣ ಯೋಜನೆಗಳ ತಯಾರಿಕೆಗೆ - ಜನಗಣತಿಯು ಪೂರಕ
5. ಆರ್ಥಿಕ ಮುನ್ನಡೆಗೆ - ಜನಗಣತಿ ಪ್ರಥಮ ಸೋಪಾನ
6. ಮನೆಪಟ್ಟಿ - ಕುಟುಂಬದಲ್ಲಿನ ಸೌಲಭ್ಯಗಳ ಪ್ರತಿಬಿಂಬ
7. ಮನೆಪಟ್ಟಿ ಕಾರ್ಯಾಚರಣೆ - ದೇಶದಲ್ಲಿನ ವಸತಿ ಸೌಲಭ್ಯಗಳ ನೈಜ ಸ್ಥಿತಿಯ ನಿರೂಪಣೆ.
8. ದೇಶದ ಎಲ್ಲಾ ಭಾಗಗಳಿಗೂ ಏಕಕಾಲಕ್ಕೆ ಅನ್ವಯಿಸುವಂತಹ ಏಕ ರೂಪವಾದ ಅಂಕಿ ಅಂಶಗಳ ಸಂಗ್ರಹಣೆಗೆ ಭಾರತದ ಜನಗಣತಿಯಂತಹ ಬೃಹತ್ ಪ್ರಮಾಣದ ಕಾರ್ಯಾಚರಣೆ ಅನಿವಾರ್ಯ.
9. ಪ್ರತಿಯೊಂದು ಭೌಗೋಳಿಕ ಕ್ಷೇತ್ರದಲ್ಲಿರುವ ಕಟ್ಟಡಗಳನ್ನು ಗುರುತಿಸಿ ಅವುಗಳಿಗೆ ಕ್ರಮಬದ್ಧವಾಗಿ ಸಂಖ್ಯೆಗಳನ್ನು ಕೊಡುವುದು ಹಾಗೂ ಕಟ್ಟಡಗಳು ಮತ್ತು ಮನೆಗಳ ಪಟ್ಟಿಯ ತಯಾರಿಕೆಯೇ ಜನಗಣತಿ ಕಾರ್ಯಾಚರಣೆಯ ಪ್ರಥಮ ಹಂತ.
10. ಜನಗಣತಿ ಎಣಿಕೆದಾರರು ಹಾಗೂ ಅವರ ಮೇಲ್ವಿಚಾರಕರು ಸರ್ಕಾರದ ಆದೇಶದ ಮೇರೆಗೆ ತಮಗೆ ಒಪ್ಪಿಸಲಾಗಿರುವ ಕರ್ತವ್ಯವನ್ನು ಪಾಲಿಸುತ್ತಿದ್ದಾರೆ. ಅವರಲ್ಲಿ ಸಂಪೂರ್ಣ ಭರವಸೆಯನ್ನಿಟ್ಟು ಬಿಚ್ಚು ಮನಸ್ಸಿನಿಂದ ಅವರು ಕೇಳುವ ಪ್ರಶ್ನೆಗಳಿಗೆ ಸಮರ್ಪಕವಾದ ಹಾಗೂ ಸತ್ಯವಾದ ಸಂಗತಿಗಳನ್ನು ತಿಳಿಸಿರಿ.
11. ನಿಮ್ಮಿಂದ ಪಡೆದ ವಿವರಗಳನ್ನು ಜನಗಣತಿ ಇಲಾಖೆಯ ಉಪಯೋಗಕ್ಕಲ್ಲದೇ ಇತರ ಯಾವುದೇ ಇಲಾಖೆಯ ಉಪಯೋಗಕ್ಕೆ ಒದಗಿಸಲಾಗುವುದಿಲ್ಲ. ಈ ವಿವರಗಳು ಯಾವುದೇ ಕೋರ್ಟು ಕಛೇರಿಗಳಲ್ಲಿ ಸಾಕ್ಷ್ಯಾಧಾರಗಳೆಂದು ಪರಿಗಣಿಸಲ್ಪಡುವುದಿಲ್ಲ.

12. ದೇಶದ ಅಭಿವೃದ್ಧಿಗೆ ಜನಗಣತಿ ಬೇಕು. ನೆನಪಿರಲಿ ಜರುಗಲಿದೆ ಸ್ವತಂತ್ರ ಭಾರತದ ಆರನೆಯ ಜನಗಣತಿ -2001ನೇ ಇಸವಿಯ ಫೆಬ್ರವರಿ 9ರಿಂದ ಮಾರ್ಚ್ 5ರವರೆಗೆ. ಜನಗಣತಿಯ ಯಶಸ್ವೀ ಕಾರ್ಯಾಚರಣೆಗೆ ನಿಮ್ಮೆಲ್ಲರ ಸಹಕಾರ ಅತ್ಯಗತ್ಯ.

13. ಭಾರತದ ಜನಗಣತಿ - ಪ್ರತಿ ಹತ್ತು ವರ್ಷಕ್ಕೊಮ್ಮೆ ; 2001ರ ಜನಗಣತಿ - ಭಾರತದ ಹದಿನಾಲ್ಕನೆಯ ಜನಗಣತಿ - ಸ್ವಾತಂತ್ರ್ಯಾನಂತರದ ಆರನೆಯ ಜನಗಣತಿ.

14. ಜನಗಣತಿಯೆಂದರೆ ಕೇವಲ ಜನರನ್ನು ಎಣಿಕೆ ಮಾಡುವುದಷ್ಟೇ ಅಲ್ಲ - ಜನರೆಲ್ಲರ ಬಗ್ಗೆ ಮೂಲಭೂತ ವಿವರ ಸಂಗ್ರಹಣೆಗೆ ಅದೊಂದು ಸದವಕಾಶ.

15. ಜನಗಣತಿಯ ವಿಷಯ ವ್ಯಾಪ್ತಿ ಅಪಾರ. ಅದುವೇ ಬಗೆಬಗೆಯ ಉಪಯುಕ್ತ ಅಂಕಿ ಅಂಶಗಳಿಗೆ ಮೂಲಾಧಾರ. ಜನಗಣತಿ ಎಣಿಕೆದಾರರೊಂದಿಗೆ ಸಹಕರಿಸಿರಿ.

16. ದೇಶದ ವಿಭಿನ್ನ ಆಡಳಿತ ಘಟಕಗಳಲ್ಲಿ ಉಪಲಭ್ಯವಿರುವ ಜನ ಸಂಪನ್ಮೂಲಗಳನ್ನರಿಯಲು ನಿಯತಕಾಲಿಕ ಜನಗಣತಿ ಅತ್ಯಗತ್ಯ.

17. ಆಡಳಿತಗಾರರಿಗೆ, ಆಯೋಜಕರಿಗೆ, ಸಮಾಜ ಶಾಸ್ರಜ್ಞರಿಗೆ, ಸಾಮಾಜಿಕ ಸಂಶೋಧನಾ ನಿರತರಿಗೆ ಜನಸಂಖ್ಯೆಯ ವಿವರಗಳು ಅತ್ಯಾವಶ್ಯಕ. ಈ ವಿವರಗಳನ್ನು ಕ್ರಮಬದ್ಧವಾಗಿ ಸಂಗ್ರಹಿಸಿ ಪ್ರಕಟಗೊಳಿಸಲು ಜನಗಣತಿಯೇ ಏಕೈಕ ಸಾಧನ.

18. ಮಾರ್ಚ್ 1, ಜನಗಣತಿ 2001ರ ಸೂಚಿತ ದಿನ - 2001ರ ಫೆಬ್ರವರಿ 9ರಿಂದ 28ರವರೆಗಿನ ಅವಧಿ - ಎಣಿಕೆ ಕಾರ್ಯದ ಕಾಲಾವಧಿ ತದನಂತರದ ಮಾರ್ಚ್ 1ರಿಂದ 5ರವರೆಗಿನ ಅವಧಿ - ಪುನರೆಣಿಕೆಯ ಕಾಲಾವಧಿ.

19. ಪ್ರತಿಯೊಂದು ಕುಟುಂಬಕ್ಕೂ ಜನಗಣತಿ ಎಣಿಕೆದಾರರ ಭೇಟಿ - ಪ್ರತಿ ಕುಟುಂಬಕ್ಕೊಂದು ಪ್ರಶ್ನಾವಳಿ ಅದುವೇ ಕುಟುಂಬ ಅನುಸೂಚಿ.

20. ಗಂಡು ಹೆಣ್ಣು, ನವಜಾತ ಶಿಶು, ವೃದ್ಧರಲ್ಲಿ ವೃದ್ಧ ಇತ್ಯಾದಿ ಭೇದಗಳನೆಣಿಸದೆ ಎಲ್ಲಾ ಜನರ ಎಣಿಕೆಯೇ 2001ರ ಜನಗಣತಿ ಗುರಿ.

21. ಜನಗಣತಿ ಎಣಿಕೆದಾರರಿಗೆ ನೀವು ಒದಗಿಸುವ ವಿವರಗಳ ಗೌಪ್ಯತೆಯನ್ನು ಕಾಪಾಡುವುದು ಜನಗಣತಿ ಇಲಾಖೆಯ ಸಂಪೂರ್ಣ ಜವಾಬ್ದಾರಿ.

22. ಜನಗಣತಿಗಾಗಿ ಸಂಗ್ರಹಿಸಿದ ವ್ಯಕ್ತಿಗತ ವಿವರಗಳನ್ನು ಇತರ ಯಾವುದೇ ಸರ್ಕಾರಿ ಇಲಾಖೆಗಾಗಲಿ ಬೇರೆ ಯಾರಿಗೇ ಆಗಲಿ ಯಾವುದೇ ಉದ್ದೇಶಕ್ಕೆ ಆಗಲಿ ನೀಡಲಾಗುವುದಿಲ್ಲ. ಕೇವಲ ಕ್ರೋಢೀಕರಿಸಿದ ಪ್ರಕಟಿತ ಅಂಕಿ ಸಂಖ್ಯೆಗಳೇ ಇವರೆಲ್ಲರಿಗೆ ಲಭ್ಯ.

2. 2001ರ ಜನಗಣತಿಗೆ 1948ರ ಜನಗಣತಿ ಕಾಯಿದೆಯ ರಕ್ಷೆ ಇದೆ. ಈ ಕಾಯಿದೆಯನ್ವಯ ಜನಗಣತಿ ಎಣಿಕೆದಾರರು ಸರ್ಕಾರಿ ನೌಕರರೆಂದು ಪರಿಗಣಿಸಲ್ಪಡುತ್ತಾರೆ. ಅವರು ನಿರ್ವಹಿಸುತ್ತಿರುವ ಅಧಿಕೃತ ಕಾರ್ಯಕ್ಕೆ ಅಡ್ಡಿ ಆತಂಕಗಳನ್ನೊಡ್ಡುವುದು ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ.

24. ಬಹುತೇಕ ಸ್ಥಳಗಳಲ್ಲಿ ನಿಮ್ಮ ನಿಮ್ಮ ಪರಿಸರದಲ್ಲಿರುವ ಶಾಲಾ ಉಪಾಧ್ಯಾಯರನ್ನೇ ಜನಗಣತಿ ಎಣಿಕೆದಾರರನ್ನಾಗಿ ನಿಯೋಜಿಸಲಾಗಿದೆ.

25. ಅಧಿಕೃತ ಜನಗಣತಿ ಎಣಿಕೆದಾರರು ತಮ್ಮೊಂದಿಗೆ ಗುರುತಿನ ಚೀಟಿಯನ್ನು ಹೊಂದಿರುತ್ತಾರೆ. ಅವರು ಕೇಳಲಿರುವ ಪ್ರಶ್ನೆಗಳನ್ನು ಕುಟುಂಬದ ಅನುಸೂಚಿಯಲ್ಲಿ ಮುದ್ರಿಸಲಾಗಿದೆ. ಅಸಂಬದ್ಧ, ಅಪ್ರಕೃತ ಪ್ರಶ್ನೆಗಳಿಗೆ ಅವಕಾಶವಿಲ್ಲ. ಆದರೆ, ಅವರ ಸಂದರ್ಭೋಚಿತ ಪ್ರಶ್ನೆಗಳಿಗೆಲ್ಲ ಸಮಂಜಸ ಹಾಗೂ ನಿಜ ಸಂಗತಿಯನ್ನು ತಿಳಿಸುವ ಉತ್ತರಗಳನ್ನು ನೀಡುವುದು ಸಾರ್ವಜನಿಕರ ಕರ್ತವ್ಯ.

26. ಭಾರತದ ದಂಡ ಸಂಹಿತೆಯ ಅನ್ವಯ ಜನಗಣತಿ ಕಾರ್ಯಕ್ಕೆ ಯಾವುದೇ ರೀತಿಯ ಅಡಚಣೆಗಳನ್ನೊಡ್ಡುವುದು ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ.

27. ಜನಗಣತಿಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಧರ್ಮ, ಮಾತೃಭಾಷೆ, ವೈವಾಹಿಕ ಸ್ಥಾನಮಾನ ಮುಂತಾದ ವಿಷಯಗಳ ಬಗ್ಗೆ ಚರ್ಚೆಗೆ ಅವಕಾಶವಿಲ್ಲ. ನಿಮ್ಮ ಹೇಳಿಕೆಯನ್ನೇ ಯಥಾವತ್ತಾಗಿ ದಾಖಲೆ ಮಾಡಿಕೊಳ್ಳಲು ಎಣಿಕೆದಾರರಿಗೆ ಆದೇಶ.

28. ವಯಸ್ಸು, ವಿದ್ಯಾಮಟ್ಟ, ಆರ್ಥಿಕ ಚಟುವಟಿಕೆ ಮುಂತಾದ ವಿಷಯಗಳ ಬಗ್ಗೆ ನಿಖರವಾದ ವಿವರಗಳನ್ನು ಪಡೆಯಲು ಶೋಧನಾತ್ಮಕ ಪ್ರಶ್ನೆಗಳಿಗೆ ಮುಕ್ತ ಅವಕಾಶ.

29. ಕಳೆದ ವರ್ಷದ ಅವಧಿಯಲ್ಲಿ ಪ್ರತಿಯೊಬ್ಬ ವ್ಯಕ್ತಿಯು ತನ್ನ ವೇಳೆಯನ್ನು ವಿನಿಯೋಗಿಸಿದ ಚಟುವಟಿಕೆಗಳ ಬಗ್ಗೆ ಸಂಪೂರ್ಣ ವಿವರ ಮತ್ತು ತನ್ಮೂಲಕ ಕೆಲಸಗಾರ ಅಥವಾ ಕೆಲಸಗಾರನಲ್ಲವೆಂದು ಪ್ರತಿ ವ್ಯಕ್ತಿಯ ವರ್ಗೀಕರಣ.

30. ಜನಗಣತಿಯಲ್ಲಿ ಮಾತ್ರವೇ ಮಾತೃಭಾಷೆಯ ಬಗ್ಗೆ ಮಾಹಿತಿಯ ಅಧಿಕೃತ ಸಂಗ್ರಹಣೆ. ವಿವಿಧ ಧರ್ಮಾವಲಂಬಿಗಳ ವಿವರ ಪಡೆಯಲು - ಜನಗಣತಿ ಅತ್ಯಗತ್ಯ. ಫೆಬ್ರವರಿ 9ರಿಂದ ಮಾರ್ಚ್ 5, 2001ರ ಅವಧಿ - ಜನಗಣತಿ ಕಾರ್ಯದ ಕಾಲಾವಧಿ.

31. ನಿಮ್ಮಲ್ಲಿಗೆ ಬರುವ ಜನಗಣತಿ ಎಣಿಕೆದಾರರಿಗೆ ನಿರ್ಭಯವಾಗಿ ವಿವರಗಳನ್ನು ವರದಿಮಾಡಿರಿ. ನೆನಪಿಡಿ - ಜನಗಣತಿಯಲ್ಲಿ ಸಂಗ್ರಹಿತವಾಗುವ ಮಾಹಿತಿಗಳನ್ನು ಯಾವುದೇ ನ್ಯಾಯಾಲಯದಲ್ಲಿ ಸಾಕ್ಷಿ ಪುರಾವೆಗಳೆಂದು ಮಾನ್ಯ ಮಾಡಲಾಗುವುದಿಲ್ಲ.

32. ನೀವು ಜನಗಣತಿ ಎಣಿಕೆದಾರರಿಗೆ ನೀಡುವ ಮಾಹಿತಿಗಳನ್ನು ಗೋಪ್ಯವಾಗಿಡಲಾಗುವುದು. ಜನಗಣತಿ ಎಣಿಕೆದಾರರಿಗೆ ಸರಿಯಾದ ಮಾಹಿತಿ ನೀಡಲು ನೀವು ಕರ್ತವ್ಯಬದ್ಧರಾಗಿರುತ್ತೀರಿ.

33. ಜನಗಣತಿ ಎಣಿಕೆದಾರರು ತಮ್ಮೊಡನೆ ಅಧಿಕೃತ ಗುರುತಿನ ಚೀಟಿಯನ್ನು ಹೊಂದಿರುತ್ತಾರೆ. ಅಧಿಕೃತ ಪ್ರಶ್ನಾವಳಿಯಲ್ಲಿನ ಪ್ರಶ್ನೆಗಳನ್ನಲ್ಲದೆ ಇತರ ಪ್ರಶ್ನೆಗಳನ್ನು ಎಣಿಕೆದಾರರು ಕೇಳುವಂತಿಲ್ಲ.

34. ನೀವು ನೀಡುವ ಮಾಹಿತಿಗಳ ಆಧಾರದ ಮೇಲೆ ಕ್ರೋಢಿಕರಿಸಿದ ಒಟ್ಟಾರೆ ಅಂಕಿ ಅಂಶಗಳನ್ನು ಮಾತ್ರವೇ ಪ್ರಕಟಿಸಲಾಗುವುದು.

35. ಸಂಗ್ರಹಿಸಲ್ಪಟ್ಟ ವ್ಯಕ್ತಿಗತ ವಿವರಗಳನ್ನು ಜನಗಣತಿ ಇಲಾಖೆಗಲ್ಲದೆ ಇತರರಿಗೆ ಬಹಿರಂಗ ಪಡಿಸುವುದೂ ಸಹ ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ.

ಜನಗಣತಿಯ ವ್ಯಾಖ್ಯೆಯನ್ವಯ -

- ಸ್ವಂತ ವಿವೇಚನೆಯಿಂದ ಓದಲು ಹಾಗೂ ಬರೆಯಲು ಬಲ್ಲವರೆಲ್ಲರೂ ಅಕ್ಷರಸ್ಥರೆನಿಸುತ್ತಾರೆ - ಇದಕ್ಕೆ ಗಂಡು ಹೆಣ್ಣೆಂಬ ಭೇದವಿಲ್ಲ - ಭಾಷೆಯ ನಿರ್ಬಂದವಿಲ್ಲ. ಔಪಚಾರಿಕವಾಗಿ ಶಾಲೆಯಲ್ಲಿ ವ್ಯಾಸಂಗ ಮಾಡಿರಬೇಕೆಂಬ ನಿಯಮವಿಲ್ಲ.
- ಕೇವಲ ಓದುಬಲ್ಲ ಆದರೆ ಬರೆಯಲಾರದವ ಅನಕ್ಷರಸ್ಥ - ಅಂತೆಯೇ ತನ್ನ ಹೆಸರನ್ನು ಮಾತ್ರ ಸಹಿ ಮಾಡಬಲ್ಲವ ಅನಕ್ಷರಸ್ಥ.

36. ಜನಗಣತಿಯ ಅಂಗವಾಗಿ ಕೇವಲ ಪರಿಶಿಷ್ಟ ಜಾತಿ ಮತ್ತು ಪರಿಶಿಷ್ಟ ಪಂಗಡಗಳಿಗೆ ಸೇರಿರುವವರ ಬಗ್ಗೆ ಮಾತ್ರವೇ ಅವರ ಜಾತಿಯ ಅಥವಾ ಪಂಗಡದ ಹೆಸರನ್ನು ದಾಖಲೆ ಮಾಡಿಕೊಳ್ಳಲಾಗುತ್ತದೆ. ಇತರರ ಜಾತಿಯ ವಿವರಗಳನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುವುದಿಲ್ಲ.

37. ಆದರೆ ಪ್ರತಿಯೊಬ್ಬರ ವಿಷಯದಲ್ಲಿಯೂ ಅವರು ಯಾವ ಮತ, ಅಂದರೆ ಧರ್ಮಕ್ಕೆ ಸೇರಿದವರೆಂಬ ಸಂಗತಿಯನ್ನು ಅವರವರ ಹೇಳಿಕೆಯಂತಯೇ ಯಥಾವತ್ತಾಗಿ ದಾಖಲೆ ಮಾಡಿಕೊಳ್ಳಲಾಗುತ್ತದೆ.

38. ಜನಗಣತಿಯು ವ್ಯಾಖ್ಯೆಯಂತೆ ಕಳೆದ ವರ್ಷದ ಅವಧಿಯಲ್ಲಿ ಆರ್ಥಿಕ ದೃಷ್ಟಿಯಲ್ಲಿ ಉತ್ಪನ್ನಕಾರಕವಾದುದೆಂಬ ಯಾವುದೇ ಚಟುವಟಿಕೆಯಲ್ಲಿ ಭಾಗವಹಿಸುವವರೆಲ್ಲರೂ ಕೆಲಸಗಾರರೆನಿಸುತ್ತಾರೆ. ಕೆಲಸಗಾರರಲ್ಲಿ ಎರಡು ಬಗೆ - ವರ್ಷದಲ್ಲಿ ಆರು ತಿಂಗಳುಗಳಿಗಿಂತಲೂ ಹೆಚ್ಚಿನ ಅವಧಿಯಲ್ಲಿ ಕೆಲಸ ಮಾಡಿರುವ ಪ್ರಧಾನ ಕೆಲಸಗಾರರು ಹಾಗೂ ಆರು ತಿಂಗಳುಗಳಿಗಿಂತಲೂ ಕಡಿಮೆ ಅವಧಿಯಲ್ಲಿ ಕೆಲಸ ಮಾಡಿರುವ ಅಲ್ಪಾವಧಿ ಕೆಲಸಗಾರರು.

39. ಪ್ರತ್ಯೇಕವಾದ ಪ್ರತಿಫಲವನ್ನು ಪಡೆಯದೇ, ತಮ್ಮದೇ ಕುಟುಂಬವು ನಡೆಸುತ್ತಿರುವ ಸಾಗುವಳಿ ಪಶು ಪ್ರಾಣಿಗಳ ಸಾಕಾಣಿಕೆ ಮತ್ತಿತರ ಉದ್ಯಮ ಅಥವಾ ಸೇವಾ ಕಾರ್ಯಗಳಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸುತ್ತಿರುವವರೆಲ್ಲರೂ ಕೆಲಸಗಾರರೆ. ವಿಶೇಷವಾಗಿ ಮಹಿಳೆಯರು ಮತ್ತು ಮಕ್ಕಳು ಈ ವರ್ಗದ ಕೆಲಸಗಾರರಾಗಿರುತ್ತಾರೆ.

ಭಾರತದ ಜನಗಣತಿ - 2001

(ವಿಶೇಷ ಸೂಚನೆ : ಜನಗಣತಿಯ ಬಗ್ಗೆ ವಿದ್ಯಾರ್ಥಿಗಳಲ್ಲಿ ಅರಿವು ಮೂಡಿಸಲು ಶಾಲೆ ಮತ್ತು ವಯಸ್ಕರ ಶಿಕ್ಷಣ ತರಗತಿಗಳಲ್ಲಿ ಈ ಲೇಖನವನ್ನು ಉಪಾಧ್ಯಾಯರು ಪ್ರಾರ್ಥನಾ ಸಮಯದಲ್ಲಿ ಅಥವಾ ತರಗತಿಯಲ್ಲಿ ಓದಿ ವಿವರಿಸಲು ಸಿದ್ಧಪಡಿಸಲಾಗಿದೆ)

ಭಾರತದ ಜನಗಣತಿ - 2001ರ ಕಾರ್ಯಾಚರಣೆ ಆರಂಭವಾಗಿದೆ. ಜನಗಣತಿಯು ನಮ್ಮ ರಾಷ್ಟ್ರದ ಗಮನಾರ್ಹ ಘಟನೆಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ. ಇದು ಸಧೃಡ ರಾಷ್ಟ್ರ ಮತ್ತು ಸಮಾಜವನ್ನು ಕಟ್ಟುವ ಒಂದು ಪವಿತ್ರ ಕಾರ್ಯ. ಇಂತಹ ರಾಷ್ಟ್ರವ್ಯಾಪಿಯಾದ ಒಂದು ಬೃಹತ್ ಆಡಳಿತಾತ್ಮಕ ಕಾರ್ಯಾಚರಣೆಯಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸುವುದು ಎಲ್ಲರ ಕರ್ತವ್ಯ. ಬನ್ನಿ ಇದರ ಬಗ್ಗೆ ಒಂದಿಷ್ಟು ತಿಳಿಯೋಣ.

ಜನಗಣತಿ ಎಂದರೇನು ?

ಜನಗಣತಿ ಎಂದರೆ ಬರೀ ತಲೆ ಎಣಿಸುವ ಕಾರ್ಯವಲ್ಲ. ಯಾವುದೇ ದೇಶದ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಮತ್ತು ಜನರ ಸ್ಥಿತಿಗತಿಗಳ ಉನ್ನತಿಯನ್ನು ತಿಳಿದುಕೊಳ್ಳುವ ಸಲುವಾಗಿ ಅಂಕಿಅಂಶಗಳನ್ನು ಸಂಗ್ರಹಿಸಿ ಸಂಕಲಿಸಿ ಮತ್ತು ಪ್ರಕಟಿಸುವ ಪ್ರಕ್ರಿಯೆಗೆ ಜನಗಣತಿಯೆಂದು ಕರೆಯಲಾಗುತ್ತದೆ.

ಭಾರತದಲ್ಲಿ ಜನಗಣತಿ ಯಾವಾಗ ಪ್ರಾರಂಭವಾಯಿತು ?

ಭಾರತದಲ್ಲಿ ಮೊಟ್ಟ ಮೊದಲಿಗೆ 1871ರಲ್ಲಿ ಜನಗಣತಿ ಆರಂಭವಾಯಿತು. ಅಂದಿನಿಂದ ಪ್ರತಿ ಹತ್ತು ವರ್ಷಕ್ಕೊಮ್ಮೆ ಯಾವುದೇ ಅಡೆತಡೆಗಳಿಲ್ಲದೆ ನಿರಾತಂಕವಾಗಿ ನಿಗದಿತ ಅವಧಿಗಳಲ್ಲಿ ಜನಗಣತಿಯನ್ನು ಸುಧೀರ್ಘವಾಗಿ ನಡೆಸಿಕೊಂಡು ಬಂದಿರುವ ದಾಖಲೆ ಭಾರತಕ್ಕಿದೆ.

ಮನೆಪಟ್ಟಿ ಮತ್ತು ಜನಗಣತಿ ಕಾರ್ಯಾಚರಣೆಗಳ ಸಂದರ್ಭಗಳಲ್ಲಿ ಸಂಗ್ರಹಿಸುವ ಮಾಹಿತಿಗಳು ಎಂತಹುವು ?

ಜನಗಣತಿ ಕಾರ್ಯಾಚರಣೆಯ ಸಂದರ್ಭದಲ್ಲಿ ಸಂಗ್ರಹಿಸುವ ಮಾಹಿತಿಯಿಂದ ನಮ್ಮ ದೇಶದ ಬಗ್ಗೆ ಅನೇಕ ವಿಷಯಗಳು ತಿಳಿಯುತ್ತದೆ. ನಮ್ಮ ದೇಶದಲ್ಲಿರುವ ಹಳ್ಳಿ ಹಳ್ಳಿಗಳಲ್ಲಿ, ಊರು ಪಟ್ಟಣಗಳಲ್ಲಿ ಎಷ್ಟೆಷ್ಟು ಜನ ಇದ್ದಾರೆ ? ಇವರ ಪೈಕಿ ಗಂಡಸರೆಷ್ಟು ಮತ್ತು ಹೆಂಗಸರೆಷ್ಟು ? ಯಾವ್ಯಾವ ಧರ್ಮಕ್ಕೆ ಸೇರಿದವರ ಸಂಖ್ಯೆ ಎಷ್ಟೆಷ್ಟು ? ಷೆಡ್ಯೂಲ್ಡ್ ಜಾತಿಗೆ ಸೇರಿರೋವರ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ಷೆಡ್ಯೂಲ್ಡ್ ಪಂಗಡಕ್ಕೆ ಸೇರಿರೋವರ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ಓದು ಬರಹ ತಿಳಿದಿರೋರೆಷ್ಟು, ಕೆಲಸ ಮಾಡ್ತಾ ಇರೋರೆಷ್ಟು ಮತ್ತು ಅವರ ಪೈಕಿ ಬೇಸಾಯಗಾರರ ಸಂಖ್ಯೆ ಎಷ್ಟು, ಬೇಸಾಯದ ಕೂಲಿಕಾರರ ಸಂಖ್ಯೆ ಎಷ್ಟು, ಕುಟುಂಬ ಕೈಗಾರಿಕೆಗಳಲ್ಲಿ ಕೆಲಸ

ಮಾಡ್ತಾ ಇರುವವರ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ಯಾವ ಕೆಲಸವನ್ನೂ ಮಾಡದೆ ಇರುವವರ ಸಂಖ್ಯೆ ಎಷ್ಟು - ಅವರ ಪೈಕಿ ಕೆಲಸ ಹುಡುಕ್ತಾ ಇರುವವರ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ತಮ್ಮ ತಮ್ಮ ಮನೆ ಅಡಿಗೆ ಮುಂತಾದ ಮನೆ ಕೆಲಸ ಮಾತ್ರಾ ಮಾಡ್ತಾ ಇರುವವರ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ವಿದ್ಯಾರ್ಥಿಗಳ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ಹುಟ್ಟಿದ ಊರಿನಲ್ಲೇ ಇರುವವರ ಸಂಖ್ಯೆ ಎಷ್ಟು ? ಊರಿಂದ ಊರಿಗೆ ವಲಸೆ ಬಂದಿರುವವರ ಸಂಖ್ಯೆ ಎಷ್ಟು? ಹೀಗೆ ಅವರು ವಲಸೆ ಬರೋದಕ್ಕೆ ಕಾರಣ ಏನು ? ಮದುವೆ ಆಗಿರೋ ಹೆಣ್ಣುಮಕ್ಕಳ ವಿಷಯದಲ್ಲಿ ಅವರಿಗೆ ಎಷ್ಟನೇ ವರ್ಷದಲ್ಲಿ ಮದುವೆ ಆಯ್ತು ? ಅವರಿಗೆ ಎಷ್ಟೆಷ್ಟು ಮಕ್ಕಳಿದ್ದಾರೆ ? ಇದಲ್ಲದೆ ಪ್ರತಿಯೊಂದು ಕಟ್ಟಡಕ್ಕೂ ಯಾವ ಮೂಲದಿಂದ ಕುಡಿಯುವ ನೀರು ಮತ್ತು ಬೆಳಕು ದೊರೆಯುತ್ತವೆ, ಶೌಚಾಲಯ, ಒಳಚರಂಡಿ ವ್ಯವಸ್ಥೆ, ಸ್ನಾನದ ಕೋಣೆ, ಅಡಿಗೆ ಕೋಣೆ ಮತ್ತು ಅಡಿಗೆ ಮಾಡಲು ಬಳಸುವ ಇಂಧನ ಮುಂತಾದವುಗಳ ಬಗ್ಗೆ ವಿವರ ತಿಳಿದುಕೊಳ್ಳಲಾಗುವುದು. ಇದಲ್ಲದೆ ಪ್ರತಿಯೊಂದು ಕುಟುಂಬಕ್ಕೂ ರೇಡಿಯೋ, ಟ್ರಾನ್ಸಿಸ್ಟರ್, ಟೆಲಿವಿಷನ್, ಟೆಲಿಫೋನ್, ಸ್ಕೂಟರ್, ಮೋಟಾರ್ ಸೈಕಲ್ ಮತ್ತು ಮೋಪೆಡ್, ಜೀಪು ಮತ್ತು ಕಾರು ಮುಂತಾದವುಗಳು ಲಭ್ಯವಿದೆಯೇ ಎಂಬುದನ್ನು ಸಹ ತಿಳಿದುಕೊಳ್ಳಲಾಗುವುದು. ಬ್ಯಾಂಕಿಂಗ್ ಸೇವೆ ಪಡೆಯುತ್ತಿದ್ದಾರೆಯೇ ಎಂಬ ವಿವರಗಳನ್ನೂ ಸಹಾ ಪಡೆಯಲಾಗುವುದು. ಹೀಗೆ ಎಷ್ಟೋ ವಿಷಯಗಳು ಸರ್ಕಾರಕ್ಕೆ ಆಗಿಂದಾಗ್ಗೆ ಬೇಕಾಗುತ್ತದೆ. ಈ ವಿವರಗಳನ್ನು ತಿಳಿದುಕೊಂಡರೆ ಮಾತ್ರ ಎಲ್ಲೆಲ್ಲಿ ಹೊಸ ಹೊಸದಾಗಿ ಶಾಲೆಗಳನ್ನು ತೆರೆಯಬೇಕು, ಆಸ್ಪತ್ರೆಗಳನ್ನು ಕಟ್ಟಬೇಕು, ರಸ್ತೆ, ಕುಡಿಯುವ ನೀರು, ವಿದ್ಯುತ್ ಮುಂತಾದ ಸೌಕರ್ಯಗಳನ್ನು ಒದಗಿಸಬೇಕು - ಅಂದರೆ ಹಳ್ಳಿಗಳನ್ನು ಮತ್ತು ಪಟ್ಟಣಗಳನ್ನು ಅಭಿವೃದ್ಧಿಪಡಿಸುವುದಕ್ಕೆ ಯೋಜನೆಗಳನ್ನು ಹಾಕಿಕೊಳ್ಳಬಹುದು.

ಜನಗಣತಿಯ ಉಪಯೋಗಗಳೇನು ?

ಭಾರತದ ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಗಳನ್ನು ಅರ್ಥಮಾಡಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಬಗೆಹರಿಸುವಲ್ಲಿ ಜನಗಣತಿಯ ಅಂಕಿಅಂಶಗಳು ನಮ್ಮ ನೆರವಿಗೆ ಬರುತ್ತವೆ. ದೇಶದ ಆರ್ಥಿಕ ಮತ್ತು ಸಾಮಾಜಿಕ ಸ್ಥಿತಿಗತಿಗಳ ಸ್ಪಷ್ಟ ಚಿತ್ರಣ ಸಿಗುತ್ತದೆ. ಜಾಗತಿಕ ಮಟ್ಟದಲ್ಲಿ ಭಾರತದ ಸ್ಥಾನಮಾನ ಏನೆಂಬುದು ತಿಳಿಯಲಿದೆ. ಯೋಜನೆಗಳನ್ನು ರೂಪಿಸಲು ಸರ್ಕಾರಕ್ಕೆ ಇದು ಸಹಕಾರಿಯಾಗಲಿದೆ.

ಮುಂದಿನ ಜನಗಣತಿ ಯಾವಾಗ ? ಎಷ್ಟು ಹಂತಗಳಲ್ಲಿ ನಡೆಯುತ್ತವೆ ?

ಬರಲಿರುವ ಭಾರತದ ಜನಗಣತಿ ಕಾರ್ಯವನ್ನು ಎರಡು ಹಂತಗಳಲ್ಲಿ

ನಡೆಸಲಾಗುವುದು. ಮೊದಲನೆಯ ಹಂತದ ಕಾರ್ಯಾಚರಣೆಗೆ "ಮನೆಪಟ್ಟಿ" ಕಾರ್ಯಾಚರಣೆ ಎಂದು ಕರೆಯಲಾಗುವುದು. ಕರ್ನಾಟಕದಲ್ಲಿ ಈ ಮನೆಪಟ್ಟಿ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಈ ವರ್ಷದ ಅಂದರೆ 2000ನೇ ಇಸವಿ ಮೇ 8ರಿಂದ ಜೂನ್ 6ರವರೆಗೆ ನಡೆಸಲಾಗುವುದು. ಎರಡನೆಯ ಹಾಗೂ ಅಂತಿಮ ಹಂತವನ್ನು ಜನಗಣತಿ ಅಥವಾ ವೈಯಕ್ತಿಕ ಗಣತಿ ಎಂದು ಕರೆಯಲಾಗುತ್ತದೆ. ಈ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಮುಂದಿನ ವರ್ಷ ಅಂದರೆ 2001ನೇ ಇಸವಿ ಫೆಬ್ರವರಿ 8ರಿಂದ ಮಾರ್ಚ್ 5ರವರೆಗೆ ಕೈಗೊಳ್ಳಲಾಗುತ್ತದೆ.

ವೈಯಕ್ತಿಕ ಮತ್ತು ಕುಟುಂಬದ ವಿವರಗಳನ್ನು ಗೌಪ್ಯವಾಗಿ ಇಡಲಾಗುವುದೇ ?

ಮಹತ್ವದ ವಿಷಯವೆಂದರೆ ಜನಗಣತಿ ಸಮಯದಲ್ಲಿ ಸಂಗ್ರಹವಾಗುವ ಮಾಹಿತಿಗಳನ್ನು ಕೇವಲ ಅಂಕಿಅಂಶಗಳ ರೂಪದಲ್ಲಿ ಮಾತ್ರವೇ ಪ್ರಕಟಿಸಲಾಗುವುದು ಅಂದರೆ ಸಂಗ್ರಹವಾಗುವ ವೈಯಕ್ತಿಕ ಅಥವಾ ಕುಟುಂಬದ ಮಾಹಿತಿಗಳನ್ನು ಯಾವುದೇ ಕಾರಣದಿಂದ ಬಹಿರಂಗಪಡಿಸಲಾಗುವುದಿಲ್ಲ ಮತ್ತು ಅವುಗಳನ್ನು ರಹಸ್ಯವಾಗಿಡಲಾಗುವುದು ಮತ್ತು ಆ ಮಾಹಿತಿಗಳನ್ನು ಯಾವುದೇ ನ್ಯಾಯಾಲಯವು ಸಾಕ್ಷಿ ಪುರಾವೆಗಳೆಂದು ಮಾನ್ಯತೆ ಮಾಡುವುದಿಲ್ಲ. ಜನಗಣತಿ ಕಾರ್ಯದಲ್ಲಿ ಸಹಕಾರ ನೀಡುವುದು ಕಾನೂನಿನ ಪ್ರಕಾರ ಅಗತ್ಯ ಮತ್ತು ಜನಗಣತಿ ಕಾರ್ಯದಲ್ಲಿ ಯಾವುದೇ ರೀತಿಯ ಅಡೆತಡೆಗಳನ್ನು ಉಂಟುಮಾಡುವುದು ಅಪರಾಧವೆಂದು ಪರಿಗಣಿಸಲಾಗುವುದು.

ಎಣಿಕೆಗಾರರು/ಗಣತಿದಾರರು ಅಂದರೆ ಯಾರು ?

ಜನಗಣತಿಯಲ್ಲಿ ಮಾಹಿತಿಗಳನ್ನು ಸಂಗ್ರಹಿಸಲು ಸರ್ಕಾರವು ಅಧಿಕೃತವಾಗಿ ನೇಮಿಸುವ ವ್ಯಕ್ತಿಗಳನ್ನು ಎಣಿಕೆಗಾರರು/ಗಣತಿದಾರರು ಎಂದು ಕರೆಯಲಾಗುವುದು. ಇವರುಗಳು ಮಹತ್ವವುಳ್ಳ ಹಾಗೂ ಜವಾಬ್ದಾರಿಯುತ ವ್ಯಕ್ತಿಗಳಾಗಿರುತ್ತಾರೆ. ಬಹುತೇಕ ಗಣತಿದಾರರು ಶ್ರೇಷ್ಠ ವೃತ್ತಿಗಳಲ್ಲಿ ಒಂದಾದ ಶಿಕ್ಷಕ ವೃಂದದಿಂದ ಬಂದವರಾಗಿರುತ್ತಾರೆ. ಅದೇ ರೀತಿ ಸರ್ಕಾರದ ಇನ್ನಿತರ ಇಲಾಖೆಗಳಿಂದಲೂ ಸಹಾ ಬಂದವರಾಗಿರುತ್ತಾರೆ.

ಜನಗಣತಿಯಲ್ಲಿ ವಿದ್ಯಾರ್ಥಿ ಮತ್ತು ಶಿಕ್ಷಕರ ಪಾತ್ರವೇನು ?

ಜನಗಣತಿಯಂತಹ ಬೃಹತ್ ಕಾರ್ಯಾಚರಣೆಯು ಯಶಸ್ವಿಯಾಗಲು, ಕಾರ್ಯಾಚರಣೆಯಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳುವ ಎಲ್ಲರೂ ಅಂದರೆ ಮಾಹಿತಿಗಳನ್ನು ಸಂಗ್ರಹಿಸಲು ನೇಮಕವಾಗಿರುವ ಎಣಿಕೆದಾರರು ಮತ್ತು ಅವರು ಕೇಳಲಿರುವ ಪ್ರಶ್ನೆಗಳಿಗೆ ಉತ್ತರ ಅಥವಾ

ಮಾಹಿತಿಗಳನ್ನು ನೀಡುವ ಸಾರ್ವಜನಿಕರು, ನೀಡುವ ಸಹಕಾರವನ್ನು ಅವಲಂಬಿಸಿದೆ. ಇದರಿಂದ ನೀವುಗಳು ಜನಗಣತಿಯ ಮಹತ್ವವನ್ನು ತಿಳಿಯಬಹುದು. ಈ ತಿಳಿವಳಿಕೆಯನ್ನು ನೀವು ನಿಮ್ಮ ಪರಿಚಯಸ್ಥರು, ಹಿರಿಯರು, ತಂದೆ-ತಾಯಿ ಮತ್ತು ಕುಟುಂಬದಲ್ಲಿರುವ ಎಲ್ಲಾ ಸದಸ್ಯರಿಗೆ ಹಂಚುವುದರಿಂದ ಆಗುತ್ತದೆ. ಅಂದರೆ ಅವರುಗಳಿಗೆ ತಿಳಿಸುವುದು ನಿಮ್ಮ ಕರ್ತವ್ಯ ಆಗಿದೆ. ಅಲ್ಲದೆ ಜನಗಣತಿಗಾಗಿ ನಿಮ್ಮ ಮನೆಗಳಿಗೆ ಬರಲಿರುವ ಗಣತಿದಾರರಿಗೆ ಅವರು ಕೇಳಲಿರುವ ಪ್ರಶ್ನೆಗಳಿಗೆ ಸರಿಯಾದ ಉತ್ತರಗಳನ್ನು ನೀಡುವುದು ನಮ್ಮ ನಿಮ್ಮೆಲ್ಲ ಕರ್ತವ್ಯ ಹಾಗೂ ಜವಾಬ್ದಾರಿ.

ಕೆಲವೊಮ್ಮೆ ನಮ್ಮ ಅವಿದ್ಯಾವಂತ ಹಿರಿಯರು ತಮ್ಮ ವಯಸ್ಸಿನ ಬಗ್ಗೆ ಮಾಹಿತಿ ನೀಡಲು ಅಸಾಧ್ಯವೆನ್ನುವುದನ್ನು ನಮ್ಮ ಅನುಭವದಿಂದ ತಿಳಿದುಬಂದಿದೆ. ಆದ್ದುದರಿಂದ ನೀವುಗಳು ಗಣತಿಯಾಗುತ್ತಿರುವವರ ವಯಸ್ಸನ್ನು ಅರಿಯಲು ಹಲವಾರು ಪ್ರಮುಖ ಘಟನೆಗಳ (ಉದಾಹರಣೆ : 1914-17 ಮೊದಲನೆಯ ವಿಶ್ವಯುದ್ಧ, 1920 ಅಸಹಕಾರ ಚಳುವಳಿ, 1939-45 ಎರಡನೆಯ ವಿಶ್ವಯುದ್ಧ, 1942 ಕ್ವಿಟ್ ಇಂಡಿಯಾ ಚಳುವಳಿ, 1943 ಬಂಗಾಳದಲ್ಲಿ ಭೀಕರ ಕ್ಷಾಮ, 1947 ಭಾರತ ಸ್ವಾತಂತ್ರ್ಯ ಗಳಿಸಿದ್ದು, 1948 ಮಹಾತ್ಮ ಗಾಂಧಿಯವರ ಹತ್ಯೆ (ಜನವರಿ 30), 1950 ಭಾರತ ಗಣರಾಜ್ಯವಾದದ್ದು, 1956 ರಾಜ್ಯಗಳ ಪುನರ್ವಿಂಗಡಣೆ) ಪರಿಚಯ ಮಾಡಿಕೊಳ್ಳಬೇಕು ಆ ಘಟನೆಗಳೊಡನೆ ಹೋಲಿಸಿದಾಗ ವಯಸ್ಸನ್ನು ನಿರ್ಧರಿಸಬಹುದು ಹಾಗೂ ಅವರ ಸಮಕಾಲೀನ ವ್ಯಕ್ತಿಗಳ ಅಂದರೆ ತಮ್ಮ ವಯಸ್ಸಿನ ಅರಿವು ತಿಳಿದವರೊಡನೆ ಹೋಲಿಸಿ ಅವರ ಸರಿಯಾದ ವಯಸ್ಸನ್ನು ಸೂಚಿಸುವಂತೆ ತಿಳಿಯಪಡಿಸಿರಿ.

ಆದುದರಿಂದ ನೀವು ನಿಮ್ಮ ಹಿರಿಯರಿಗೆ ಅಥವಾ ಕುಟುಂಬದ ಸದಸ್ಯರಿಗೆ ಅಥವಾ ಪರಿಚಯಸ್ಥರಿಗೆ ಅಥವಾ ಮಿತ್ರರಿಗೆ ಜನಗಣತಿಯಲ್ಲಿ ಸರಿಯಾದ ಉತ್ತರಗಳನ್ನು ನಿರ್ಭಯವಾಗಿ ನೀಡಲು ತಿಳಿಸಿರಿ ಮತ್ತು ಜನಗಣತಿ ಕಾರ್ಯದಲ್ಲಿ ನಿಮ್ಮ ಸಹಕಾರವನ್ನು ಮುಕ್ತರೀತಿಯಲ್ಲಿ ನೀಡಿರಿ.

ಜನಗಣತಿ ನಿರ್ದೇಶನಾಲಯ, ಬೆಂಗಳೂರು

लोकाभिमुख
PEOPLE ORIENTED

ಭಾರತದ ಜನಗಣತಿ - 2001

ರಾಷ್ಟ್ರದ ಪ್ರಗತಿಯ ದಿಕ್ಸೂಚಿ

ಭಾರತದ ಜನಗಣತಿ - 2001

ಭಾರತದ ಜನಗಣತಿ - 2001ರ ಕಾರ್ಯಾಚರಣೆ ಆರಂಭವಾಗಿದೆ. ಜನಗಣತಿಯು ನಮ್ಮ ರಾಷ್ಟ್ರದ ಗಮನಾರ್ಹ ಘಟನೆಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ. ಇದು ಸದೃಢ ರಾಷ್ಟ್ರ ಮತ್ತು ಸಮಾಜವನ್ನು ಕಟ್ಟುವ ಒಂದು ಪವಿತ್ರ ಕಾರ್ಯ. ಇಂತಹ ರಾಷ್ಟ್ರವ್ಯಾಪಿಯಾದ ಒಂದು ಬೃಹತ್ ಆಡಳಿತಾತ್ಮಕ ಕಾರ್ಯಾಚರಣೆಯಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸುವುದು ಎಲ್ಲರ ಕರ್ತವ್ಯ. ಬನ್ನಿ ಇದರ ಬಗ್ಗೆ ಒಂದಿಷ್ಟು ತಿಳಿಯೋಣ.

ಜನಗಣತಿ ಎಂದರೆ ಏನು ?

ವಿಶ್ವ ಸಂಸ್ಥೆಯು ಜನಸಂಖ್ಯಾ ಗಣತಿಯ ಆಧುನಿಕ ಪರಿಕಲ್ಪನೆಗಳನ್ನು ವಿವರವಾಗಿ ಹೇಳಿದೆ. ಅದರ ಪ್ರಕಾರ ಒಂದು ನಿಗದಿತ ಸಮಯದಲ್ಲಿ ನಿರ್ದಿಷ್ಟಗೊಳಿಸಿದ ವ್ಯಾಪ್ತಿಯ ಅಥವಾ ಒಂದು ದೇಶದಲ್ಲಿನ ಎಲ್ಲಾ ಜನರಿಗೆ ಸಂಬಂಧಿಸಿದ ಜನಾಂಗಶ್ಥಿತಿ ಹಾಗೂ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಅಂಕಿ ಅಂಶಗಳನ್ನು ಸಂಗ್ರಹಿಸುವ, ಸಂಕಲಿಸುವ ಮತ್ತು ಪ್ರಕಟಿಸಿಗೊಳಿಸುವ ಪ್ರಕ್ರಿಯೆಯನ್ನು ಜನಗಣತಿ ಎಂದು ಕರೆಯಲಾಗುತ್ತದೆ. ಭಾರತದ ಜನಗಣತಿಯು ಇದನ್ನು ಆಕ್ಷರಶಃ ಅಳವಡಿಸಿಕೊಂಡಿದೆ.

ಭಾರತದಲ್ಲಿ ಮೊಟ್ಟ ಮೊದಲಿಗೆ 1871ರಲ್ಲಿ ಜನಗಣತಿ ಆರಂಭವಾಯಿತು. ಅಲ್ಲಿಂದೀಚೆಗೆ ಯಾವುದೇ ಅಡೆತಡೆಯಿಲ್ಲದೆ ನಿರಾತಂಕವಾಗಿ ನಿಗದಿತ ಅವಧಿಗಳಲ್ಲಿ ಜನಗಣತಿಯನ್ನು ಸುಧೀರ್ಘವಾಗಿ ನಡೆಸಿಕೊಂಡು ಬಂದಿರುವ ಹೆಮ್ಮೆಯ ದಾಖಲೆ ಭಾರತಕ್ಕಿದೆ. ನಮ್ಮ ದೇಶ ಮತ್ತು ಜನತೆಯ ಬಗ್ಗೆ ಸಮಗ್ರವಾದ ಮತ್ತು ಅಧಿಕೃತವಾದ ಮಾಹಿತಿಯ ಮೂಲವೆಂದು ಇದನ್ನು ವಿಶ್ವಾದ್ಯಂತ ಪರಿಗಣಿಸಲಾಗಿದೆ.

ಜನಗಣತಿಯು ರಾಷ್ಟ್ರ ವ್ಯಾಪಿಯಾದ ಒಂದು ಬೃಹತ್ ಕಾರ್ಯ. ದೇಶದ ಮೂಲೆ, ಮೂಲೆಯನ್ನು ತಲುಪಿ ಯಾವುದೇ ಲೋಪ ಅಥವಾ ಪುನರಾವರ್ತನೆಗೆ ಅವಕಾಶವಿಲ್ಲದಂತೆ ರಾಷ್ಟ್ರದ ಎಲ್ಲ ಜನರನ್ನು ಇಲ್ಲಿ ಎಣಿಕೆ ಮಾಡಲಾಗುತ್ತದೆ.

ಜನಗಣತಿಯಲ್ಲಿ ಸಂಗ್ರಹಿತವಾದ ಮಾಹಿತಿಗಳಿಂದ ಪ್ರಯೋಜನವೇನು ?

ಜನಸಂಖ್ಯಾ ದೃಷ್ಟಿಯಿಂದ ಭಾರತವು ಜಗತ್ತಿನಲ್ಲಿಯೇ ಎರಡನೆಯ ಅತಿದೊಡ್ಡ ರಾಷ್ಟ್ರ. ಕ್ರಿ.ಶ.2001ನೇ ಇಸವಿಯ ವೇಳೆಗೆ ಭಾರತದ ಜನಸಂಖ್ಯೆ ಒಂದು ಬಿಲಿಯನ್ ದಾಟುವ ನಿರೀಕ್ಷೆಯಿದೆ. ಭಾರತದ ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಗಳನ್ನು ಅರ್ಥ ಮಾಡಿಕೊಳ್ಳುವಲ್ಲಿ ಮತ್ತು ಬಗೆಹರಿಸುವಲ್ಲಿ ಜನಗಣತಿಯ ಅಂಕಿ ಅಂಶಗಳು ಸಕಾಲಕ್ಕೆ ನಮ್ಮ ನೆರವಿಗೆ ಬರುತ್ತವೆ. ಆದ್ದರಿಂದ ನಮ್ಮ ರಾಷ್ಟ್ರದ ಜನಾಂಗ ಸ್ಥಿತಿ, ನಮ್ಮ ಜನರ ಆರ್ಥಿಕ ಹಾಗೂ ಸಾಮಾಜಿಕ ಸ್ಥಿತಿಗತಿಗಳನ್ನು ತಿಳಿದುಕೊಳ್ಳಬೇಕಾದ ಅವಶ್ಯಕತೆ ಇದೆ. ಜನಗಣತಿಯ ಪ್ರಾಮುಖ್ಯತೆ ಎಷ್ಟಿದೆಯೆಂದರೆ ಇಂದು ಜಗತ್ತಿನಲ್ಲಿ ಜನಸಂಖ್ಯಾ ಗಣತಿಯನ್ನು ಮಾಡದಿರುವ ಯಾವುದೇ ರಾಷ್ಟ್ರವೇ ಇಲ್ಲ.

ಭಾರತದಂತಹ ಬೃಹತ್ ಹಾಗೂ ಬಹುಮುಖಿ ರಾಷ್ಟ್ರದಲ್ಲಿ ಇದು ಒಂದು ಪ್ರಮುಖ ಆಡಳಿತಾತ್ಮಕ ಸಾಧನೆಯಷ್ಟೇಅಲ್ಲ, ನಿರಂತರವಾಗಿ ಬದಲಾಗುತ್ತಿರುವ ನಮ್ಮ ರಾಷ್ಟ್ರದ ಆರ್ಥಿಕ ಹಾಗೂ ಸಾಮಾಜಿಕ ಪ್ರಶ್ನೆಗಳಿಗೆ, ಜನಸಂಖ್ಯಾ ಸಮಸ್ಯೆಗಳಿಗೆ ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಗಳಿಗೆ ಉತ್ತರ ಕಂಡುಕೊಳ್ಳಲು ಅಗತ್ಯವಾದ ಮಾಹಿತಿಯನ್ನು ಇದು ನಮ್ಮ ಯೋಜಕರಿಗೆ, ನೀತಿರೂಪಕರಿಗೆ, ಆರ್ಥಿಕತಜ್ಞರಿಗೆ, ಸಂಖ್ಯಾ ಸಂಗ್ರಹಣಕಾರರಿಗೆ, ಸಂಶೋಧಕರಿಗೆ ಮತ್ತು ಆಡಳಿತಕಾರರಿಗೆ ಒದಗಿಸುತ್ತದೆ.

ಭಾರತಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಜನಗಣತಿಯು ಕೇವಲ ತಲೆ ಎಣಿಸುವ ಬೃಹತ್ ಕಾರ್ಯವಲ್ಲ. ಇದೊಂದು ರಾಷ್ಟ್ರವನ್ನು ಕಟ್ಟುವ ಪವಿತ್ರ ಕಾರ್ಯ. ಆದರೆ, ಸಾಮಾನ್ಯವಾಗಿ ಜನಗಣತಿಯು ರಾಷ್ಟ್ರೀಯ ಉದ್ದೇಶಗಳಿಗಾಗಿ ಪ್ರಾಮುಖ್ಯ ಎಂದು ಭಾವಿಸದಿರುವ ಜನರೇ ಹೆಚ್ಚು. ಆದರೆ, ವಸ್ತು ಸ್ಥಿತಿ ಅದಲ್ಲ ಎನ್ನುವುದನ್ನು ನಾವು ನೀವೆಲ್ಲಾ ನೆನಪಿನಲ್ಲಿಟ್ಟುಕೊಳ್ಳಬೇಕು. ರಾಷ್ಟ್ರದ ಆರ್ಥಿಕ ಮತ್ತು ಸಾಮಾಜಿಕ ಯೋಜನೆಗಳಿಗೆ ಮತ್ತು ಬಡತನ ನಿವಾರಣೆಯ ಕಾರ್ಯಕ್ರಮಗಳ ಉಸ್ತುವಾರಿಗಾಗಿ ಕೆಳ ಹಂತದಲ್ಲಿ ನೀತಿ ನಿರೂಪಿಸಲು ಹಾಗೂ ರಾಷ್ಟ್ರದ ಆಹಾರ, ಆರೋಗ್ಯ, ವಸತಿ, ಶಿಕ್ಷಣ ಮತ್ತು

ಉದ್ಯೋಗದ ಬೇಡಿಕೆಗಳ ಬಗ್ಗೆ ದೀರ್ಘಾವಧಿ ಮುನ್ನೋಟವನ್ನು ನೀಡಲು ಜನಗಣತಿ ಅತ್ಯವಶ್ಯಕವಾಗಿದೆ.

ಜನಗಣತಿಯ ಇತರ ಉದ್ದೇಶಗಳಲ್ಲಿ ಸರ್ಕಾರದ ನೀತಿ ನಿರೂಪಣೆ, ಆಡಳಿತ ಮತ್ತು ಮತವಾರರ ವಿಂಗಡಣೆ, ನಗರ ಮತ್ತು ಪಟ್ಟಣಗಳ ನ್ಯಾಯಿಕ ಅಥವಾ ಆಡಳಿತಾತ್ಮಕ ಸ್ಥಾನಮಾನ ಇವುಗಳನ್ನು ಗುರುತಿಸುವುದೂ ಸೇರಿದೆ. ಜನಗಣತಿಯು ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯ ವೈಜ್ಞಾನಿಕ ವಿಶ್ಲೇಷಣೆ, ಸಂಯೋಜನೆ, ವಿತರಣೆಯ ಬಗ್ಗೆ ಅಗತ್ಯವಾದ ಅಂಕಿ ಅಂಶಗಳನ್ನು ಒದಗಿಸುತ್ತದೆ. ಬದಲಾಗುತ್ತಿರುವ ನಗರ, ಗ್ರಾಮೀಣ ಜನಸಾಂದ್ರತೆ, ನಗರೀಕರಣಗೊಳ್ಳುತ್ತಿರುವ ಪ್ರದೇಶದ ಅಭಿವೃದ್ಧಿ, ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆ ಮಾಡಲು ವಿವಿಧ ಯೋಜನೆಗಳಿಗೆ ಅನುಗುಣವಾಗಿ ಜನಸಂಖ್ಯೆಯ ಸ್ಥಿತಿ ಆಗುತ್ತಿರುವ ಜನಾಂಗ ವಿತರಣೆ ಇವೆಲ್ಲವೂ ವೈಜ್ಞಾನಿಕ ಅಧ್ಯಯನ ಮತ್ತು ಆಸಕ್ತಿಯ ಪ್ರಶ್ನೆಗಳಾಗಿವೆ. ಜನಗಣತಿಯು, ವಾಣಿಜ್ಯ ಮತ್ತು ಕೈಗಾರಿಕಾ ಯೋಜನೆಗಳಲ್ಲಿ ತೊಡಗಿರುವ ವ್ಯಕ್ತಿಗಳಿಗೆ ಮತ್ತು ಖಾಸಗಿ ಸಂಸ್ಥೆಗಳಿಗೆ ಹಲವು ರೀತಿಯಲ್ಲಿ ಉಪಯೋಗಕ್ಕೆ ಬರುತ್ತದೆ.

ಅಂಕಿ ಅಂಶಗಳಿಗೆ ಸಂಬಂಧಿಸಿದಂತೆ ಹೇಳುವುದಾದರೆ, ಭಾರತದ ಜನಗಣತಿ ಅಂಕಿ ಅಂಶಗಳ ತಳಹದಿಯು ತನ್ನ ವಿಷಯ ವ್ಯಾಪ್ತಿಯಲ್ಲಿ ಬಹುಮುಖಿಯಾಗಿದೆ. ಜನಾಂಗದ ಸ್ಥಿತಿ, ಆರ್ಥಿಕತೆ, ಸಾಮಾಜಿಕ ಮತ್ತು ಸಾಂಸ್ಕೃತಿಕ ಗುಣಲಕ್ಷಣಗಳಾಗಿವೆ.

ಫಲವಂತಿಕೆ, ಶಿಶುಮರಣ, ಪರಿಶಿಷ್ಟ ಜಾತಿ, ಪಂಗಡ, ಭಾಷೆ, ಧರ್ಮ, ವಲಸೆ, ಶಿಕ್ಷಣ, ಆರೋಗ್ಯ, ಸಂಪರ್ಕ, ಬಾಲಕಾರ್ಮಿಕರು, ಉದ್ಯೋಗ, ವಯೋಮಾನ, ವಸತಿ, ಕೌಟುಂಬಿಕ ವ್ಯವಸ್ಥೆ, ನಗರೀಕರಣ, ಮೂಲಸೌಲಭ್ಯ ಹೀಗೆ ಹತ್ತು ಹಲವು ವಿಷಯಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿ ನೀಡುತ್ತದೆ. ನೀವು ಯಾವುದನ್ನೇ ಹೇಳಿ ಅದು ಜನಗಣತಿಯಲ್ಲಿರುತ್ತದೆ. ಇಷ್ಟರ ಮಟ್ಟಿಗೆ ಇದರ ವಿಷಯ ವ್ಯಾಪ್ತಿ ವಿಶಾಲವಾಗಿದೆ. ಒಟ್ಟಾರೆ ಹೇಳುವುದಾದರೆ, ಜನಗಣತಿಯು ಬೃಹತ್ ಅಂಕಿ ಅಂಶಗಳ ಮಾಹಿತಿಯ ಅಭೂತಪೂರ್ವ ಗಣಿಯಾಗಿದೆ. ಇದರ ವೈಶಾಲ್ಯವನ್ನು ಉಪಯೋಗಿಸಿಕೊಳ್ಳುವುದಿರಲಿ, ಇದರ ಮಹತ್ವವನ್ನು ನಾವು ಸಂಪೂರ್ಣವಾಗಿ ಅರಿತಿಲ್ಲವೆಂದೇ ಹೇಳಬೇಕು. ಇದನ್ನು ಸಂಪತ್ತಿನ ನಡುವೆ ಇರುವ ದಾರಿದ್ರ್ಯ ಎನ್ನದೇ ವಿಧಿ ಇಲ್ಲ.

ಜನಗಣತಿ ಸಮಯದಲ್ಲಿ ಸಂಗ್ರಹವಾಗುವ ಮಾಹಿತಿಗಳು ರಹಸ್ಯವೇ ?

ಜನಗಣತಿ ಕರ್ತವ್ಯದ ಜವಾಬ್ದಾರಿ ಹೊತ್ತುಕೊಂಡಿರುವ ಸಿಬ್ಬಂದಿಯು ಈ ಕಾರ್ಯವನ್ನು ವಿಶ್ವಾಸದಿಂದ ಮತ್ತು ಹೊಣೆಗಾರಿಕೆಯಿಂದ ಮಾಡಬೇಕಾಗಿರುವುದು ಜನಗಣತಿ ಕಾಯಿದೆ 1948ರ ರೀತ್ಯಾ ಕಡ್ಡಾಯವಾಗಿದೆ. ಇದೇ ರೀತಿ ಜನಗಣತಿಯ ಸಂದರ್ಭದಲ್ಲಿ ಕೇಳುವ ಪ್ರಶ್ನೆಗಳಿಗೆ ಸಂಬಂಧಿಸಿದ ವ್ಯಕ್ತಿಗಳು ಸರಿಯಾದ ಮತ್ತು ಪೂರ್ಣವಾದ ಮಾಹಿತಿ ಮತ್ತು ಉತ್ತರವನ್ನು ನೀಡುವುದು ಸಹಾ ಕಾಯಿದೆಯ ರೀತ್ಯ ಕಡ್ಡಾಯವಾಗಿದೆ. ಜನಗಣತಿಕಾರರಿಗೆ ಮಾಹಿತಿ ನೀಡುವಾಗ ಸಾರ್ವಜನಿಕರು ಯಾವುದೇ ರೀತಿಯ ಅನುಮಾನ ಮತ್ತು ಹಿಂಜರಿಕೆಗಳನ್ನು ಇಟ್ಟುಕೊಳ್ಳಕೂಡದು. ಸಾರ್ವಜನಿಕರು ನೀಡುವ ಮಾಹಿತಿಯ ರಹಸ್ಯವನ್ನು ಮತ್ತು ಮಾಹಿತಿ ನೀಡಿದ ವ್ಯಕ್ತಿಯ ಅನಾಮಧೇಯತೆಯನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ಕಾಪಾಡುವ ಸುರಕ್ಷತೆಯನ್ನು ಜನಗಣತಿ ಕಾಯಿದೆಯು ಒದಗಿಸಿದೆ.

ಒಟ್ಟಿನಲ್ಲಿ ಹೇಳುವುದಾದರೆ ಸಮಾಜದ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಮತ್ತು ಇತರೆ ಉನ್ನತಿಗಳಿಗಾಗಿ ರೂಪಿಸುವ ಎಲ್ಲಾ ಯೋಜನೆಗಳಿಗೆ ಜನಗಣತಿಯೇ ಆಧಾರ ಮತ್ತು ದೇಶದಲ್ಲಿ ಲಭ್ಯವಿರುವ ಮಾನವ ಸಂಪನ್ಮೂಲಗಳನ್ನು ಅರಿಯಲು ಏಕೈಕ ಮೂಲವಾಗಿದೆ.

ಕರ್ನಾಟಕ ಮತ್ತು ಭಾರತದಲ್ಲಿ ಮುಂದಿನ ಜನಗಣತಿ ಯಾವಾಗ ? ಎಷ್ಟು ಹಂತಗಳಲ್ಲಿ ನಡೆಯುತ್ತವೆ ?

ಬರಲಿರುವ ಭಾರತದ ಜನಗಣತಿ ಕಾರ್ಯವನ್ನು ಎರಡು ಹಂತಗಳಲ್ಲಿ ನಡೆಸಲಾಗುವುದು. ಮೊದಲನೆಯ ಹಂತದ ಕಾರ್ಯಾಚರಣೆಗೆ "ಮನೆಪಟ್ಟಿ" ಕಾರ್ಯಾಚರಣೆ ಎಂದು ಕರೆಯಲಾಗುವುದು. ಕರ್ನಾಟಕದಲ್ಲಿ ಈ ಮನೆಪಟ್ಟಿ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಈ ವರ್ಷದ ಅಂದರೆ 2000ದ ಇಸವಿ ಮೇ - ಜೂನ್ ತಿಂಗಳುಗಳಲ್ಲಿ ನಡೆಸಲಾಗುವುದು. ಎರಡನೆಯ

ಹಾಗೂ ಅಂತಿಮ ಹಂತವನ್ನು ಜನಗಣತಿ ಅಥವಾ ವೈಯಕ್ತಿಕ ಗಣತಿ ಎಂದು ಕರೆಯಲಾಗುತ್ತದೆ. ಈ ಕಾರ್ಯಾಚರಣೆಯನ್ನು ಮುಂದಿನ ವರ್ಷ ಅಂದರೆ 2001ನೇ ಇಸವಿ ಫೆಬ್ರುವರಿ 8ರಿಂದ ಮಾರ್ಚ್ 5ರವರೆಗೆ ಕೈಗೊಳ್ಳಲಾಗುತ್ತದೆ.

ಜನಗಣತಿಯ ಸಮಯದಲ್ಲಿ ಸಾರ್ವಜನಿಕರ ಪಾತ್ರವೇನು ?

ಜನತೆಯು ನೀಡುವ ಸರಿಯಾದ ಮಾಹಿತಿಯು ಜನಗಣತಿ ಯಶಸ್ಸಿನ ಬುನಾದಿಯಾಗಿದೆ.

2000ನೇ ಇಸವಿಯ ಮೇ - ಜೂನ್ ತಿಂಗಳುಗಳ ಅವಧಿಯಲ್ಲಿ ಮಾನೆಪಟ್ಟ ಕಾರ್ಯಾಚರಣೆ ನಡೆಸಲಾಯಿತು. ಈ ಸಂದರ್ಭದಲ್ಲಿ ಜನಗಣತಿ ಸಿಬ್ಬಂದಿಯವರು ಜನಗಣತಿ ಮನೆಗಳಿಗೆ ಸಂಖ್ಯೆ ನೀಡಿ ವಸತಿ ಸೌಕರ್ಯಗಳ ಬಗ್ಗೆ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸಲು ನಿಮ್ಮನ್ನು ಭೇಟಿ ಮಾಡಲಿದ್ದಾರೆ.

2001ನೇ ಇಸವಿಯ ಫೆಬ್ರುವರಿ 9ರಿಂದ ಮಾರ್ಚ್ 5ರ ಅವಧಿಯಲ್ಲಿ ಜನಗಣತಿಗಾಗಿ ಎಣಿಕೆದಾರರು ವೈಯಕ್ತಿಕ ಹಾಗೂ ಕುಟುಂಬದ ವಿವರಗಳನ್ನು ಪಡೆಯಲು ನಿಮ್ಮ ಮನೆಗೆ ಭೇಟಿ ನೀಡಿ ಮಾಹಿತಿ ಪಡೆಯಲಿದ್ದಾರೆ.

ನಿಮ್ಮ ಸಹಕಾರ ಮತ್ತು ಕರಾರುವಾಕ್ಕಾದ ಉತ್ತರಗಳ ಮೇಲೆ ಜನಗಣತಿಯ ಯಶಸ್ಸು ಅವಲಂಬಿಸಿದೆ.

ಜನಗಣತಿ - ಇದೊಂದು ರಾಷ್ಟ್ರ ಕಟ್ಟುವ ಕೆಲಸ

ಬನ್ನಿ, ಕೈಗೂಡಿಸಿ

ಜನಗಣತಿ ನಿರ್ದೇಶನಾಲಯ

ಕೇಂದ್ರೀಯ ಸದನ, ಕೋರಮಂಗಲ,

ಬೆಂಗಳೂರು - 34

CENSUS OF INDIA 2001 - ENUMERATION OF THE DISABLED

A STATE LEVEL SEMINAR ORGANISED JOINTLY BY THE DIRECTORATE OF CENSUS OPERATIONS, KARNATAKA, GOVERNMENT OF INDIA AND DIRECTORATE OF WELFARE FOR DISABLED, GOVERNMENT OF KARNATAKA ON 1.12.2000

INTRODUCTION

Disabled persons who were born with disability or victims of circumstances for reasons beyond their control are entitled to the same fundamental rights just like their fellow citizens. It is the responsibility and duty of any civilized society to protect the self respect and dignity of the disabled at any cost. The practical redressal of the problems of the disabled have always been a challenge to Governments and organisations. If reasonable opportunities are opened up the disabled can be as productive as normal people and they can be drawn into main stream of the society. By this the disabled will be rehabilitated and thereby the society would be fulfilling a great obligation.

To establish the prevalence, nature and distribution of the various types of disabilities, region wise, a comprehensive survey like Census is absolutely necessary. With this objective, the Census of India 2001 has designed and included a question on disability.

This helps to strengthen the planning, implementation, monitoring and evaluation of disability programmes pertaining to prevention of disability, early detection, early intervention and opportunities for tracing and rehabilitation.

This is for the second time since Independence, 1st in 1981 and now in 2001 a question on disability will be asked. In the absence of any data on people with disability it is difficult to formulate policies and programmes for the welfare of the disabled.

PURPOSE OF THE SEMINAR

This seminar aims to bring awareness amongst the Organisations working for the welfare of the disabled on one hand and the people on the other. The office bearers of about 250 Organisations spread over the State of Karnataka have been invited to participate in the Seminar. It is envisaged that these office bearers would get back to their districts and spread the message of Census in general and the enumeration of the disabled in particular in Census of India 2001 so that all the disabled are covered.

Disability is one of the challenging and prominent social problems. Questions on disability are always sensitive. If questions are not asked carefully and delicately, the respondent or any member of the household will get offended. **Therefore the Enumerator who seeks information on the type of disability has to be doubly cautions, sensitive and full of empathy with a lot of patience.** The Enumerator should try to explain the actual purpose of the question of disability by emphasizing that the information collected would help the governments and voluntary organisations in planning for the welfare of the disabled.

Voluntary organisations working for the welfare of the disabled can help the Enumerator in identifying and providing the addresses **particularly the children and woman among the disabled,** in their area of operation. They can also motivate the members in the household of the disabled to provide correct information without any hesitation and reservation. These organisations with their network of grassroot level workers should be in a position to reach out to the people and help in making the Census a success.

Help of other voluntary organisations working for the rehabilitation in areas such as child abuse and child labour, prostitutes, violence against women, juvenile delinquency, beggary, family welfare, crime and criminals, AIDS, drug abuse, bonded labour and other social problems will also be sought by this Directorate.

Media's role can hardly be over-emphasized. They have the ability to bring the theme and spirit of **Census to the centre stage.** This helps the people to actively and willingly participate in the Census Operations and thereby help the Census Organisation in their endeavour.

The Seminar thus envisages to achieve all these and to launch publicity measures to bring awareness among the public about the Census of the disabled in particular and the Census in general.

QUESTION ON PHYSICALLY HANDICAPPED IN CENSUS 1981

Since Independence, question on disability was canvassed only in 1981 Census. As part of the 1981 Census for the first time in addition to the listing of houses, some essential data on the Physically Handicapped which were badly wanted for planning for this disadvantage group was collected through Houselist. The information so collected was about the number of those who are totally blind / crippled/ dumb.

The term Totally Crippled was referred to such persons who had lost their arms or limbs. The loss of either of the arms or legs was sufficient for classification was totally crippled. However, the loss of only one arm and / or one leg was not classified as totally crippled. The paralytic who will have lost the use of both the legs and both the arms was also treated as totally crippled. Though the legs or arms were physically present in case of persons who have more than one of the disabilities mentioned above, the greater disability was considered for the purpose. A person who was blind or crippled due to old age was also treated as disable person.

QUESTION ON DISABILITY IN CENSUS 2001

The question on disability is very sensitive. The Enumerators will be repeatedly instructed to be very polite and careful in eliciting the information to answer this question.

Question No.15 of the Household Schedule through which the data will be collected during the Population Enumeration is designed as under and an extract of the Question and the instructions thereunder for recording the answers is given below :

"Q.15 : If the person is physically / mentally disabled, give appropriate Code Number from the list below

75. **This question will be asked of all persons in the household.** You may have to obtain the response to this question for every member of the household from the main respondent who is answering other questions. **Please note that this is a sensitive question and you have to probe delicately so as not to offend the respondent or any other member of the household. You may first explain the actual purpose of the question by emphasizing that the information on the number and type of disability would help the governments in planning for the welfare of the disabled. You may then find out if any member of the household is suffering from any physical or mental disability.** For persons who do not suffer from any disability, put a dash (-) under this question. **This disability of a person will be decided with reference to the date of enumeration.**

75.1 The five types of disabilities identified for Census purpose are given below:

75.2 **In Seeing :** A person who cannot see at all (has no perception of light) or has blurred vision even with the help of spectacles will be treated as visually disabled and code '1' will be entered under this question. A person with proper vision only in one eye will also be treated as visually disabled. You may come across a situation where a person may have blurred vision and had no occasion to test whether her/his eye-sight would improve by using spectacles. Such persons would be treated as visually disabled.

75.3 **In Speech :** A person will be recorded as having speech disability, if she / he is dumb. Similarly a person whose speech is not understood by a listener of normal comprehension and hearing, she / he will be considered to having speech disability and code '2' will be entered. **This question will not be canvassed for children upto three**

years of age. Persons who stammer but whose speech is comprehensible will not be classified as disabled by speech.

75.4 **In Hearing** : A person who cannot hear at all (deaf) or can hear only loud sounds will be considered as having hearing disability and in such cases code '3' be entered. A person who is able to hear, using hearing-aid will not be considered as disabled under this category. If a person cannot hear through one ear but her / his other ear is functioning normally, should be considered having hearing disability.

75.5 **In Movement** : A person who lacks limbs or is unable to use the limbs normally, will be considered having movement disability and code '4' will be entered here. Absence of a part of a limb like a finger or a toe will not be considered as disability. However, absence of all the fingers or toes or a thumb will make a person disabled by movement. If any part of the body is deformed, the person will also be treated as disabled and covered under this category. A person who cannot move herself / himself or without the aid of another person or without the aid of stick, etc., will be treated as disabled under this category. Similarly, a person would be treated as disabled in movement if she / he is unable to move or lift or pick up any small article placed near her / him. A person may not be able to move normally because of problems of joints like arthritis and has to invariably limp while moving, will also be considered to have movement disability.

75.6 **Mental** : A person who lacks comprehension appropriate to her / his age will be considered as mentally disabled. This would not meant that if a person is not able to comprehend her / his studies appropriate to her / his examination is mentally disabled. Mentally retarded and insane persons would be treated as mentally disabled. A mentally disabled person may generally depend on her / his family members for performing daily routine. **It should be left to the respondent to report whether the member of the household is mentally disabled and no tests are required to be applied by you to judge the member's disability.**

75.7 If a person is disabled, enter only one of the five disability for that person, in codes, as given below :

In Seeing	1
In Speech	2
In Hearing	3
In Movement	4
Mental	5

75.8 **Please note that a person may have two or more types of disability but only one of these is to be recorded. In such cases you will have to leave it to the respondent to decide as to the type of disability she / he wants the member of her / his household to be classified into. The disability of a person will be decided with reference to the date of enumeration.** Persons with temporary disability on the date of enumeration will not be considered as disabled. For example, a person's movement may have been restricted because of the some temporary injury and she / he is likely to return to his normal state after sometime, such a person will not be treated as disabled ".

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A BRIEF NOTE ON
CENSUS AND CENSUS OF INDIA 2001

- Director of Census Operations,
Karnataka

ABOUT CENSUS . . . . .

CENSUS IS NEITHER A MERE GIGANTIC HEADCOUNT NOR A STATISTICAL EXERCISE. IT IS NOT EVEN A NUMBER GAME. IT IS MUCH MORE THAN THAT. IT IS A MULTI-DIMENSIONAL MOVE FROM NUMBERS TO POPULATION TO PEOPLE.

" A CENSUS OF POPULATION MAY BE DEFINED AS THE TOTAL PROCESS OF COLLECTING, COMPILING AND PUBLISHING DEMOGRAPHIC, ECONOMIC AND SOCIAL DATA ON A SPECIFIED TIME OR TIMES TO ALL PERSONS IN A COUNTRY OR DELIMITED TERRITORY "

- UNITED NATIONS

" IN FACT IN THESE DAYS YOU CANNOT TAKE UP ANY SERIOUS ADMINISTRATIVE, ECONOMIC OR SOCIAL WORK WITHOUT REFERRING TO THE CENSUS REPORT WHICH IS AN ESSENTIAL PART OF EVERY ENQUIRY, OF EVERY STUDY. EVEN FOR SOLUTION OF MINOR PROBLEMS YOU HAVE OFTEN TO CONSULT THE CENSUS REPORTS "

- SRI G.B. PANT

" THE INDIAN CENSUS IS ONE OF THE COUNTRY'S MOST REMARKABLE EVENTS AND UNIVERSALLY ACKNOWLEDGED AS THE MOST AUTHENTIC AND COMPREHENSIVE SOURCE OF INFORMATION ABOUT OUR LAND AND PEOPLE "

- PROF. S. CHANDRASHEKHAR

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SIGNIFICANCE OF CENSUS OF INDIA 2001

" THE 2001 CENSUS WILL BE THE 14TH DECENNIAL CENSUS, SINCE 1871 AND THE 6TH CENSUS SINCE INDEPENDENCE. ITS SIGNIFICANCE LIES IN THE FACT THAT IT COMES AT THE COMMENCEMENT OF NOT ONLY THE NEXT CENTURY BUT ALSO THE NEXT MILLENNIUM. AS IT PROVIDES A TURNING POINT IN HISTORY, THE 2001 CENSUS MAY BE DESCRIBED AS THE MILLENNIUM CENSUS. IT WILL SERVE AS A HISTORIC BENCHMARK ON THE STATE OF THE NATION'S SOCIETY, DEMOGRAPHY AND ECONOMY. "

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CHANGE IN SCHEDULES

Earlier there used to be three Census Schedules namely the Houselist, the Household Schedule and the Individual Slip. **Individual Slip - one of the important schedules being used hitherto to collect particulars of individuals is done away with.**

For the 2001 Census, the only two schedules being canvassed are the 'HOUSELIST SCHEDULE' during the first phase that is the Houselisting Operation and the 'HOUSEHOLD SCHEDULE' through which both the details of the households and the individuals are going to be collected during the second phase.

HOUSELIST SCHEDULE (will be used during the Houselisting Operations between 8th May and 6th June, 2000 in Karnataka)

In the Houselist Schedule information on the following additional NEW ITEMS in addition to 1991 is proposed to be collected such as,

1. Condition of house
2. Number of married couples
3. Number of married couples having independent bedroom
4. Drainage facilities
5. Bath room within the house
6. Kitchen within the house
7. Possession of radio/transistor/television/telephone by the household
8. Possession of transport equipment such as bicycle/ scooter/motor cycle/moped/car/jeep/van by the household
9. Banking service availed by the household

HOUSEHOLD SCHEDULE (will be used at the time of Population Enumeration during 9th to 28th February 2001)

In the Household Schedule information on the following new items is proposed to be collected.

1. Name of the respondent & relationship to Head
2. Composition of the household
3. Number of persons in the age-group 0-6
4. Number of persons in the household covered under any Life Insurance Scheme
5. Food Habits of the household – number of members taking non-vegetarian food
6. Members in the household aged 60+ requiring physical support, giving financial support, financially depending and those help in the household work
7. Number of persons attending school in the age group (5 – 14)
8. Travel to work place – distance, mode of travel and time taken
9. Age at marriage for males
10. Land Tenure

SLUM ENUMERATION BLOCKS

It is proposed to identify in each State slum areas in all Municipal Towns having a population of 50,000 or more as per the 1991 Census. Slum Enumeration Blocks with a population size of 650-750 each would be formed separately to generate data on slums.

SIZE OF ENUMERATION BLOCKS

During 1991 Census, for the Houselisting Operations the population size of Rural Blocks was kept between 750 to 1000 in rural areas and 600 to 800 in urban areas depending on the operational convenience. For enumeration, it was approximately around 800 and 700 respectively. For Census of India 2001, the population size per block would be between 650 and 750 per Enumerator.

VILLAGE PERMANENT LOCATON CODE NUMBERS

For the first time, village Permanent Location Code Numbers are being allotted. Location Code is a simple device by which every area comprised in any administrative unit can be identified by assigning specific code numbers for different levels of administrative units –Permanent location code numbers have been given to all the 29,454 villages in Karnataka.

Encl : Draft Houselist Schedule, Household Schedule &
Instruction Manual for House numbering and Houselisting

CENSUS AND ITS HISTORY

Prepared by : **H.SHASHIDHAR**
Director
Directorate of Census Operations,
Karnataka

CENSUS IS NEITHER A MERE GIGANTIC HEADCOUNT NOR A STATISTICAL EXERCISE.

IT IS NOT EVEN A NUMBER GAME. IT IS MUCH MORE THAN THAT.

IT IS A MULTI-DIMENSIONAL MOVE FROM NUMBERS TO POPULATION TO PEOPLE.

1

HISTORY OF CENSUS

- THE WORD 'CENSUS' IS DERIVED FROM LATIN WORD 'CENSERE' MEANING 'TO ASSESS' OR 'TO RATE'.
- IN THE 3RD CENTURY B.C. - KAUTILYA - COLLECTION OF POPULATION STATISTICS.
- IN THE FIRST/ SECOND CENTURY B.C. - MAGISTRATES IN ROME - TAXES AND ADULT MALES FOR MILITARY SERVICE.
- IN THE 12/13TH CENTURY, CHENGIS KHAN - PEOPLE OF HIS CONCURRED TERRITORY.
- AKBAR THE GREAT, IN THE ADMINISTRATION REPORT ANI-I-AKBARI INCLUDED COMPREHENSIVE DATA ON POPULATION WEALTH AND OTHER CHARACTERISTICS.
- IN 1676, UNIVERSITY OF TEXAS TOOK THE FIRST CENSUS OF NORTH AMERICA
- IN 1872, THE BRITISH GOVERNMENT - FIRST SYNCHRONOUS CENSUS IN INDIA. SINCE 1881, THERE HAS BEEN A CONTINUOUS AND UNBROKEN CHAIN OF DECENNIAL CENSUSES.

2

	CENSUS COMMISSIONERS OF INDIA	SUPERINTENDENTS/ DIRECTORS OF CENSUS OPERATIONS OF KARNATAKA	
1871	NO SPECIFIC APPOINTMENT	MAJOR. A.W.C. LINDSAY	SUPERIN-TENDENTS
1881	W.W. PLOWDEN	LEWIS RICE	
1891	J.A. BAINS	V.N. NARASIMIENGAR	
1901	H.H. RISLEY E.A. GAIT	T. ANANDA RAO	
1911	E.A. GAIT	V.R. THYAGARAJA AIYAR	
1921	J.T. MARTEN	V.R. THYAGARAJA AIYAR	
1931	J.H. HUTTON	M. VENKATESHA IYENGAR	
1941	M.W.M. YEATTS	P.H. KRISHNA RAO	
1951	M.W.M. YEATTS R.A. GOPALASWAMY	J.B. MALLARADHYA	
1961	A. MITRA	K. BALASUBRAMANYAM	
1971	A. CHANDRASEKHAR	P. PADMANABHA	DIRECTORS
1981	P. PADMANABHA	B.K. DAS	
1991	A.R. NANDA	SOBHA NAMBISAN	
2001	JAYANT KUMAR BANTHIA	H. SHASHIDHAR	

3

ABOUT CENSUS

" A CENSUS OF POPULATION MAY BE DEFINED AS THE TOTAL PROCESS OF COLLECTING, COMPILING AND PUBLISHING DEMOGRAPHIC, ECONOMIC AND SOCIAL DATA ON A SPECIFIED TIME OR TIMES TO ALL PERSONS IN A COUNTRY OR DELIMITED TERRITORY "

- UNITED NATIONS

4

ABOUT CENSUS

" IN FACT IN THESE DAYS YOU CANNOT TAKE UP ANY SERIOUS ADMINISTRATIVE, ECONOMIC OR SOCIAL WORK WITHOUT REFERRING TO THE CENSUS REPORT WHICH IS AN ESSENTIAL PART OF EVERY ENQUIRY, OF EVERY STUDY. EVEN FOR SOLUTION OF MINOR PROBLEMS YOU HAVE OFTEN TO CONSULT THE CENSUS REPORTS "

- SRI G.B. PANT

5

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.....

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7

UTILITY OF CENSUS

- IN ADMINISTRATION AND POLICY
- FOR RESEARCH PURPOSES
- IN BUSINESS AND INDUSTRY
- AS FRAME FOR SAMPLE SURVEYS
- IN PLANNING
- BASIS FOR REPRESENTATION IN PARLIAMENT/ ASSEMBLIES/ URBAN LOCAL BODIES/ PANCHAYAT RAJ SYSTEM
- TO OTHER TYPES OF CENSUSES
- TO CIVIL REGISTRATION AND VITAL STATISTICS

8

POPULATION OF WORLD, INDIA AND KARNATAKA

GROWTH OF WORLD POPULATION, STONE AGE - 2001

SL. NO.	PERIOD	WORLD POPULATION IN MILLION (APROX.)	GROWTH RATE IN YEARS
1.	STONE AGE	15	
			IN ABOUT 8000 YEARS - INCREASE BY 16 TIMES
2.	BEGINNING OF CHRISTIAN ERA	250	
			IN 1800 YEARS - INCREASE BY 4 TIMES
3.	1830 AD	1000	
			IN 95 YEARS - INCREASE BY 100 PERCENT
4.	1925	2000	
			IN 35 YEARS - INCREASE BY 50.2 PERCENT
5.	1960	3014	
			IN 10 YEARS - INCREASE BY 22.2 PERCENT
6.	1970	3683	
			IN 20 YEARS - INCREASE BY 21 PERCENT
7.	1990	4453	
			IN 10 YEARS - INCREASE BY 34.74 PERCENT
8.	2000	6000	
			IN 1 YEARS - INCREASE BY NEARLY 2.5 PERCENT
9.	2001 (PROJECTED)	6140	

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POPULATION & SURFACE AREA OF SELECTED COUNTRIES OF THE WORLD (1991)

SL. NO.	COUNTRY	SURFACE AREA IN MILLION SQ. KMS. AND PERCENTAGE TO TOTAL AREA (APROX.)	POPULATION IN MILLIONS & PERCENTAGE TO POPULATION (APROX.)	
1.	CHINA	9.60 (7.00)	1160 (26.00)	MORE THAN 50%
2.	INDIA	3.28 (2.40)	843 (16.00)	
3.	U.S.A.	9.37 (6.90)	251 (5.63)	
4.	INDONESIA	1.90 (1.39)	179 (4.00)	
5.	BRAZIL	8.51 (6.26)	146 (3.27)	
6.	JAPAN	0.38 (0.28)	123 (2.76)	
7.	BANGLADESH	0.14 (0.10)	109 (2.44)	
8.	PAKISTAN	0.79 (0.58)	108 (2.42)	
9.	GERMANY	0.35 (0.25)	80 (1.79)	
10.	FRANCE	0.54 (0.39)	57 (1.28)	
11.	IRAN	1.64 (1.20)	58 (1.30)	
12.	UNITED KINGDOM	0.24 (0.17)	57 (1.28)	
13.	IRAQ	0.43 (0.31)	17 (0.38)	
14.	REMAINING ABOUT 143 COUNTRIES	98.62 (72)	1270 (30.00)	
	TOTAL	**135.79 (100)**	**4455 (100)**	

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PERCENTAGE OF SURFACE AREA AND POPULATION AMONG MAJOR STATES AND UNION TERRITORIES, 1991

STATE/UNION TERRITORY	AREA IN SQ. KMS.	POPULATION (RANK)
INDIA	**32,87,263 (100.00)**	**8.46 (100)**
MADHYA PRADESH	4,43,446 (13.48)	7.82 (6)
RAJASTHAN	3,42,239 (10.41)	5.20 (9)
MAHARASHTRA	3,07,713 (9.36)	9.93 (3)
UTTAR PRADESH	2,94,411 (8.95)	16.44 (1)
ANDHRA PRADESH	2,75,045 (8.36)	7.96 (5)
JAMMU & KASHMIR	2,22,236 (6.76)	0.91 (17)
GUJARAT	1,96,024 (5.96)	4.88 (10)
KARNATAKA	**1,91,791 (5.83)**	**5.31 (8)**
BIHAR	1,73,877 (5.28)	10.21 (2)
ORISSA	1,55,707 (4.73)	3.74 (11)
TAMILNADU	1,30,058 (3.95)	6.60 (7)
WEST BENGAL	88,752 (2.69)	8.04 (4)
REMAINING 14 STATES AND 6 UNION TERRITORIES	4,65,964 (14.23)	13.06

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POPULATION GROWTH IN INDIA AND KARNATAKA, 1901 - 2001

	INDIA		KARNATAKA	
CENSUS YEAR	TOTAL POPULATION (IN MILLION)	PERCENTAGE TO DECENNIAL GROWTH RATE	TOTAL POPULATION (IN MILLION)	PERCENTAGE TO DECENNIAL GROWTH RATE
1901	238	-	13.00	-
1911	252	+ 5.75	13.52	+ 3.60
1921	251	- 0.31	13.37	- 1.09
1931	278	+ 11.00	14.63	+ 9.38
1941	318	+ 14.21	16.25	+ 11.09
1951	361	+ 13.31	19.40	+ 19.36
1961	439	+ 21.51	23.50	+ 21.57
1971	548	+ 24.80	29.29	+ 24.22
1981	683	+ 24.66	37.13	+ 26.75
1991	846	+ 23.85	44.97	+ 21.12
2001 (PROJ.)	1012	+ 19.62	52.72	+ 17.23

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DENSITY OF POPULATION PER SQ. K.M., IN INDIA AND KARNATAKA, 1901 - 2001

CENSUS YEAR	INDIA	KARNATAKA
1901	77	67
1911	82	70
1921	81	69
1931	90	76
1941	103	85
1951	117	101
1961	142	126
1971	177	153
1981	216	193
1991	267	235
2001 (PROJ.)	305	275

DELHI	6352	HIGHEST
CHANDIGARH (UT)	5632	

IN OTHER COUNTRIES, 1991

SL. NO.	COUNTRY	DENSITY
1.	AUSTRALIA	2
2.	CANADA	3
3.	BRAZIL	7
4.	U.S.A.	27
5.	AUSTRIA	93
6.	INDONESIA	94
7.	FRANCE	104
8.	CHINA	121
9.	PAKISTAN	137
10.	GERMANY	223
11.	U.K.	236
12.	SRILANKA	261
13.	JAPAN	327
14.	BANGALDESH	745

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BROAD AGE COMPOSITION IN INDIA AND KARNATAKA, 1991

(PERCENTAGE TO TOTAL POPULATION)

AGE GROUP	INDIA	KARNATAKA
0 - 14	37.25	36.02
15 - 19	9.43	9.80
20 - 24	8.88	9.08
25 - 29	8.26	8.45
30 - 39	13.21	13.37
40 - 49	9.38	9.54
50 - 59	6.27	6.21
60+	6.76	6.99
AGE NOT STATED	0.56	0.54
TOTAL	**100.00**	**100.00**

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POPULATION BY SEX IN INDIA AND KARNATAKA, 1991-2001

	INDIA		KARNATAKA	
YEAR	MALE	FEMALE	MALE	FEMALE
1991	51.8	48.2	51	49
2001 (PROJ)	51.6	48.4	51	49

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ARE THE NUMBER OF MEN AND WOMEN BALANCED?
SEX RATIO IN INDIA AND KARNATAKA, 1901 - 1991

CENSUS YEAR	INDIA	KARNATAKA
1901	972	983
1911	964	981
1921	955	969
1931	950	965
1941	945	960
1951	946	966
1961	941	959
1971	930	957
1981	935	963
1991	927	960

REASONS FOR LOW SEX RATIO IN INDIA

- PREFERENCE TO MALE BABIES
- LOWER EXPECTATION OF LIFE AT BIRTH FOR GIRLS
- HIGH MORTALITY RATES
- BIOLOGICALLY SEX SELECTIVE
- FEMALE INFANTICIDE
- MIGRATION OF MALE MEMBERS
- STATUS OF WOMEN

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SEX RATIO IN A FEW DEVELOPED COUNTRIES

SL.NO.	COUNTRY	DENSITY
1.	U.S.A.	1031
2.	RUSSIA	1135
3.	JAPAN	1037
4.	AUSTRIA	1077
5.	GERMANY	1073
6.	ITALY	1059
7.	U.K.	1047
8.	MEXICO	1037
9.	CANADA	1017
10.	GREECE	1029
11.	AUSTRALIA	1003
12.	FRANCE	1054
13.	INDIA	927

PROPORTION OF RURAL/ URBAN POPULATION IN INDIA AND KARNATAKA (IN PERCENT), 1981 - 91

	INDIA		KARNATAKA	
YEAR	RURAL	URBAN	RURAL	URBAN
1981	76.66	23.34	71.11	28.89
1991	74.29	25.71	69.08	30.92

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NUMBER OF VILLAGES AND TOWNS IN INDIA AND KARNATAKA, 1901-1991

	KARNATAKA				INDIA			
YEAR	NO. OF VILLAGES	% GROWTH RATE	NO. OF TOWNS	% GROWTH RATE	NO. OF VILLAGES	% GROWTH RATE	NO. OF TOWNS	% GROWTH RATE
1901	-	-	219	-	-	-	1916	-
1911	-	-	183	-	-	-	1908	-
1921	-	-	197	-	-	-	2048	-
1931	-	-	215	-	-	-	2220	-
1941	-	-	212	-	-	-	2427	-
1951	-	-	289	-	-	-	3060	-
1961	29,349	-	231	-	-	-	2700	-
1971	29,533	-	245	-	-	-	3126	-
1981	29,390	(- 0.48)	281	(+ 14.69)	6,05,224	-	4029	(+ 28.88)
1991	29,193	(- 0.67)	306	(+ 8.89)	6,27,616	(+ 3.69)	4689	(+ 16.38)

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CENSUS OF INDIA 2001

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- RGI AND CCI

19

IMPORTANT PHASES - 2001 CENSUS

I.	PRELIMINARY PHASE OR HOUSE LISTING OPERATION	8TH MAY TO 6TH JUNE, 2000 IN KARNATAKA
	a. HOUSE NUMBERING	
	b. HOUSE LISTING	
II.	MAIN PHASE OR ENUMERATION IN THE COUNTRY	
	a. ACTUAL ENUMERATION	9TH TO 28TH FEBRUARY, 2001
	b. ENUMERATION FOR HOUSELESS HOLDS	NIGHT OF 28TH FEBRUARY, 2001
	c. REVISIONAL ROUND	1ST TO 5TH MARCH, 2001
	d. REFERENCE DATE	1ST MARCH, 2001

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PREPARATIONS FOR THE PRELIMINARY PHASE OR HOUSELISTING OPERATION, CENSUS 2001

I. CENSUS CALENDAR FOR KARNATAKA

II. FINALISATION OF RURAL AND URBAN FRAME

a. VILLAGES	29, 193	(1991)	TO	29,454	(2001)
b. TOWNS					
1. STATUTORY	179	(1991)	TO	226	(2001)
2. NON STATUTORY OR CENSUS TOWNS	127	(1991)	TO	44	(2001)
	306			270	

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PREPARATIONS FOR THE PRELIMINARY PHASE OR HOUSELISTING OPERATION, CENSUS 2001

III. PRETEST WAS CONDUCTED IN JULY/ AUGUST, 1999

IV. APPOINTMENT OF CENSUS OFFICERS/ OFFICIALS

A. OFFICERS
B. OFFICIALS - BELOW CHARGE OFFICERS
C. CENSUS HIERARCHY

V. TRANSLATION INTO KANNADA AND OTHER LANGUAGES

A. INSTRUCTIONS MANUAL
B. HOUSELIST SCHEDULE
C. HOUSELIST ABSTRACT

22

CHANGE IN THE SIZE OF ENUMERATION BLOCKS, 2001 CENSUS

1991

RURAL AREAS - 750 TO 1000 POPULATION/ BLOCK/ ENUMERATOR

URBAN AREAS - 600 TO 800 POPULATION/ BLOCK/ ENUMERATOR

2001

RURAL OR URBAN - 600 TO 650 POPULATION/ BLOCK/ ENUMERATOR

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CREATION OF SLUM ENUMERATION BLOCK, 2001 CENSUS

A. IDENTIFICATION OF SLUMS IN ALL MUNICIPAL TOWNS HAVING A POPULATION OF 50,000 OR MORE AS PER 1991 CENSUS

B. CREATION OF ENUMERATION BLOCKS EXCLUSIVELY FOR SLUMS

C. 600 TO 650 POPULATION/ BLOCK/ ENUMERATOR

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ADOPTION OF PERMANENT LOCATION CODE NUMBERS TO STATES/ DISTRICTS/ VILLAGES, 2001 CENSUS

1. PLCN FOR 26 STATES AND 6 UTs - 01 TO 32
   PLCN FOR KARNATAKA - 26

2. PLCN FOR 27 DISTRICTS IN KARNATAKA - 01 TO 27

   BELGAUM - 01,
   BANGALORE - 20,
   CHAMARAJANAGAR - 27

3. PLCN FOR TALUKS IN EACH DISTRICT IN KARNATAKA

25

ADOPTION OF PERMANENT LOCATION CODE NUMBERS TO STATES/ DISTRICTS/ VILLAGES, 2001 CENSUS

4. PLCN FOR 29,454 VILLAGES IN KARNATAKA -
   EIGHT DIGITS - 0000-0000

   PLCN FOR FIRST VILLAGE - 00000100 - 26/ 01/ 01/ 100 (EB)
   PLCN FOR LAST VILLAGE - 02945400 - 26/ 27/ 04/ 02945400 (EB)

5. HOW TO GIVE PLCN FOR TOWNS & CITIES?

STATE	/ DISTRICT	/ CITY OR TOWN	/ DN. OR WARD
26	/ 20	/ IX	/ 1 TO 100 (EB)
KARNATAKA	/ BANGALORE	/ BANGALORE MC	/ DN. OR WARD

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CHANGES IN CENSUS SCHEDULES, 2001 CENSUS

1. HOUSELIST SCHEDULE

2. HOUSEHOLD SCHEDULE

AND

3. INDIVIDUAL SLIP - X - DELETED

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NEW ITEMS IN THE HOUSELIST SCHEDULE, 2001 CENSUS

1. CONDITION OF HOUSE
2. NUMBER OF MARRIED COUPLES
3. NUMBER OF BED ROOMS
4. DRAINAGE FACILITIES
5. BATH ROOMS WITHIN THE HOUSE
6. KITCHEN WITHIN THE HOUSE
7. SOURCE OF LIGHTING
8. POSSESSION OF RADIO/ TRANSISTOR/ T.V./ TELEPHONE BY THE HOUSEHOLD
9. POSSESSION OF TRANSPORT EQUIPMENT SUCH AS BICYCLE/ SCOOTER/ MOTOR CYCLE/ MOPED/ CAR/ JEEP/ VAN BY THE HOUSEHOLD
10. BANKING SERVICE AVAILED BY THE HOUSEHOLD

DATA ON THE ABOVE ITEMS ARE BEING COLLECTED FOR THE FIRST TIME IN THE HISTORY OF CENSUS, INDIA

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NEW ITEMS IN THE HOUSEHOLD SCHEDULE, 2001 CENSUS

1. COMPOSITION OF HOUSEHOLD
2. NUMBER OF PERSONS IN THE HOUSEHOLD COVERED UNDER ANY LIFE INSURANCE SCHEME
3. FOOD HABITS OF THE HOUSEHOLD - NUMBER OF MEMBERS TAKING NON-VEGETARIAN FOOD BY SEX
4. MEMBERS IN THE HOUSEHOLD AGED 60+ REQUIRING PHYSICAL SUPPORT, GIVING FINANCIAL SUPPORT, FINANCIALLY DEPENDING AND THOSE HELP IN HOUSEHOLD WORK
5. NUMBER OF PERSONS ATTENDING SCHOOL IN THE AGE GROUP (5-14)
6. TRAVEL TO WORK PLACE - DISTANCE, MODE OF TRAVEL AND TIME TAKEN
7. AGE AT MARRIAGE FOR MALES

DATA ON THE ABOVE ITEMS ARE BEING COLLECTED FOR THE FIRST TIME IN THE HISTORY OF CENSUS, INDIA

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- ASHISH BOSE

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HOUSEHOLD AMENITIES IN KARNATAKA

CENSUS HOUSES AND THE USES TO WHICH THEY ARE PUT IN KARNATAKA, 1981-1991

SL. NO.	NO. OF CENSUS HOUSES USED AS	PERCENTAGE OF VARIATION (1981 - 91)
1.	CENSUS HOUSES VACANT	28.55
2.	RESIDENCE	30.22
3.	SHOP CUM RESIDENCE	16.61
4.	WORKSHOP, FACTORY CUM RESIDENCE + HOUSEHOLD INDUSTRIES ETC	- 13.00
5.	HOTELS, DHARMASALAS TOURIST HOUSES, IB ETC.	0.01
6.	SHOPS (EXCLUDING EATING PLACES	49.19
7.	BUSINESS HOUSES, OFFICES	48.42
8.	FACTORIES, WORKSHOPS WORKSHEDS ETC.	63.93
9.	RESTAURANTS, SWEET MEAT SHOPS, EATING PLACES	49.20
10.	PLACES OF ENTERTAINMENT & COMMUNITY GATHERINGS	0.01
11.	OTHER PLACES	14.63
	TOTAL NO. OF CENSUS HOUSES	28.55

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PUCCA AND KUTCHA HOUSES IN KARNATAKA, 1991

(IN PERCENT)

STATE/ DISTRICT	TOTAL CENSUS HOUSES	KUTCHA HOUSES	PUCCA HOUSES	
KARNATAKA	**1,06,14,850**	**56,88,935**	**49,25,915**	
BANGALORE		14.91	85.09	**HIGHEST % - PUCCA HOUSES**
BIDAR		28.77	71.23	
KOLAR		40.29	59.71	
		REMAINING 14 DISTRICTS FALL HERE		
RAICHUR		78.21	21.79	**LEAST % - PUCCA HOUSES**
BIJAPUR		76.70	23.30	
HASSAN		76.17	23.83	

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HOUSEHOLDS BY TENURE STATUS IN KARNATAKA, 1991

(PER THOUSAND)

	OWNED		RENTED	
RANK	DISTRICT	NO.	DISTRICT	NO.
1	BIDAR	912	BANGALORE	525
2	MANDYA	880	KODAGU	372
3	TUMKUR	874	CHIKMAGALORE	222
			KARNATAKA	**202**
	REMAINING 14 DISTRICTS FALL HERE			
18	SHIMOGA	806	HASSAN	138
KARNATAKA		**798**		
19	KODAGU	628	BANGALORE (R)	126
20	BANGALORE	475	BIDAR	88

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HOUSEHOLD BY NUMBER OF ROOMS IN KARNATAKA, 1971 - 1991

(PER THOUSAND)

NO. OF ROOMS	1971	1981	1991
1	490	398	357
2	315	324	348
3	112	115	145
4	83	117	121
UNSPECIFIED	-	32	41

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HOUSEHOLDS BY NUMBER OF ROOMS IN KARNATAKA, 1991

(PER THOUSAND)

RANK	ONE ROOM		TWO ROOMS		THREE ROOMS		FOUR ROOMS & ABOVE	
1	RAICHUR	495	U.K.	395	SHIMOGA	243	KODAGU	408
2	BIDAR	464	DHARWAD	391	U.K.	217	D.K.	286
3	BELLARY	429	BIJAPUR	389	KODAGU	211	RAICHUR	245
KARNATAKA		**357**		**348**		**137**		**117**
18	U.K.	158	D.K.	297	BIDAR & BELLARY	100	MANDYA	71
19	SHIMOGA	127	KODAGU	285	MYSORE	102	BELLARY	64
20	KODAGU	94	KOLAR	275	RAICHUR	92	MYSORE	56

35 REMAINING 14 DISTRICTS FALL BETWEEN SL. NO. 3 AND 18

SIZE OF HOUSEHOLDS BY THE NUMBER OF MEMBERS - KARNATAKA, 1981-91

(PER THOUSAND)

NUMBER OF MEMBERS IN A HOUSEHOLD	1981	1991
1 - 2	124	111
3 - 5	399	459
6 +	477	310
9 +	-	120

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SIZE OF HOUSEHOLDS BY THE NUMBER OF MEMBERS - KARNATAKA, 1991

(PER THOUSAND)

RANK	1 TO 2 MEMBERS		3 TO 5 MEMBERS		6 TO 8 MEMBERS		9 AND ABOVE	
1	KODAGU	159	KODAGU	573	BIDAR	378	BIJAPUR	168
2	U.K.	133	BANGALORE	541	GULBARGA	350	BIDAR	167
3	RAICHUR	123	CHIKMAGALUR	511	BIJAPUR	335	D.K.	163
KARNATAKA		**111**		**459**		**310**		**120**
18	SHIMOGA	98	GULBARGA	393	CHIKMAGALUR	290	CHIKMAGALUR	87
19	HASSAN	97	BIJAPUR	381	BANGALORE	261	BANGALORE	79
20	BIDAR	83	BIDAR	372	KODAGU	220	KODAGU	48

37 REMAINING 14 DISTRICTS FALL BETWEEN SL. NO. 3 AND 18

STATE/DISTRICTWISE PERCENTAGE OF HOUSEHOLDS HAVING ELECTRICITY, SAFE DRINKING WATER, TOILET AND NONE OF THESE THREE FACILITIES, 1991

RANK	ELECTRICITY		SAFE DRINKING WATER		TOILET		NONE OF THESE THREE FOR INDIA & KARNATAKA
1	BANGALORE	79.40	KOLAR	89.78	BANGALORE	72.86	- INDIA
2	BELGAUM	59.37	CHITRADURGA	88.10	D.K.	34.06	RURAL URBAN
3	KOLAR	57.96	BLR (R)	86.51	KODAGU	32.12	31.32 5.41
	KARNATAKA	**52.47**		**71.68**		**24.13**	
					INDIA	**23.55**	**KARNATAKA**
18	KODAGU	36.28	BELGAUM	64.23	BIDAR	10.28	RURAL URBAN
19	GULBARGA	35.91	GULBARGA	62.98	RAICHUR	7.32	19.93 4.13
20	RAICHUR	32.51	BIDAR	60.46	BIJAPUR	6.95	
	INDIA	**30.54**		**55.54**			

38 REMAINING 14 DISTRICTS FALL BETWEEN SL. NO. 3 AND 18

PERCENTAGE DISTRIBUTION OF HOUSEHOLDS BY TYPE OF FUEL USED FOR COOKING IN KARNATAKA AND INDIA, 1991

TYPE OF FUELS	KARNATAKA TOTAL	KARNATAKA RURAL	KARNATAKA URBAN	INDIA TOTAL	INDIA RURAL	INDIA URBAN
WOOD	**78.58**	94.43	43.36	**61.50**	71.69	32.74
KEROSENE	**9.78**	1.23	28.78	7.16	1.34	23.62
COOKING GAS	**6.35**	0.73	18.84	**7.94**	1.22	26.93
ELECTRICITY	1.86	0.35	5.22	0.31	0.16	0.72
BIOGAS	1.17	0.76	2.07	0.49	0.43	0.68
COWDUNG CAKE	1.16	1.44	0.54	**15.39**	19.60	3.51
CHARCOAL	0.08	0.04	0.17	0.77	0.41	1.77
COAL/COKE/LIGNITE	0.04	0.02	0.09	3.47	1.54	8.95
OTHERS	0.99	1.01	0.93	2.91	3.59	1.00

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PERCENTAGE OF HOUSELESS POPULATION AND HOUSELESS HOUSEHOLDS IN KARNATAKA, 1991

RANK	STATE/ DISTRICT	TOTAL RURAL URBAN	NO. OF HOUSELESS HOUSEHOLDS		HOUSELESS POPULATION	
	KARNATAKA	**TOTAL**	**30,433**	**(100.00)**	**1,06,935**	**(100.00)**
		RURAL	**15,870**	**(52.00)**	**64,207**	**(60.00)**
		URBAN	**14,563**	**(48.00)**	**42,728**	**(40.00)**
1	BANGALORE	TOTAL	5,175	(17.00)	12,158	(11.36)
2	BELGAUM	TOTAL	2,511	(8.25)	10,148	(9.48)
3	DAKSHIN KANNADA	TOTAL	2,830	(9.29)	9,592	(8.96)
	REMAINING 14 DISTRICTS FALL HERE					
18	HASSAN	TOTAL	703	(1.30)	3,190	(2.98)
19	BANGALORE (R)	TOTAL	729	(2.39)	2,493	(2.33)
20	KODAGU	TOTAL	402	(1.32)	1,576	(1.49)

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- WORK, PARTICIPATION
- MIGRATION
- FERTILITY, MORTALITY, INFANT MORTALITY, EXPECTANCY AT BIRTH, MEAN AGE AT MARRIAGE BY EDUCATION AND BY RELIGION
- SCHEDULED CASTES AND TRIBES
- LITERACY
- LANGUAGE
- RELIGION

PERCENTAGE OF MAIN WORKERS, MARGINAL WORKERS AND NON-WORKERS IN INDIA AND KARNATAKA, 1991

CATEGORY		INDIA	KARNATAKA
MAIN WORKERS			
I	CULTIVATORS	13.13	13.15
II	AGRICULTURAL LABOURERS	9.04	11.12
III	LIVESTOCK, FORESTRY etc.	0.65	1.37
IV	MINING QUARRYING	0.21	0.26
V (a)	HOUSEHOLD INDUSTRY	0.83	0.72
V (b)	OTHER THAN HOUSEHOLD INDUSTRY	2.65	3.40
Vi	CONSTRUCTION	0.66	0.95
VII	TRADE & COMMERCE	2.55	3.07
VIII	TRANSPORT, STORAGE & COMMUNICATIONS	0.96	1.01
IX	OTHER SERVICES	3.50	3.40
MARGINAL WORKERS		3.32	3.54
NON-WORKERS		62.50	58.01

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REASONS FOR MIGRATION TO URBAN AREAS IN KARNATAKA, 1991

(IN PERCENT)

SL.NO.	REASONS	MALES	FEMALES
1,	EMPLOYMENT	37.91	5.04
2.	BUSINESS	5.37	0.63
3.	EDUCATION	9.42	2.82
4.	FAMILY MOVED	24.71	28.11
5.	MARRIAGE	1.46	47.82
6.	NATURAL CALAMITIES	0.63	0.28
7.	OTHERS	20.50	15.30
TOTAL		**100.00**	**100.00**

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PERCENTAGE OF MIGRANTS TO TOTAL POPULATION IN THE STATE OF KARNATAKA ACCORDING TO PLACE OF BIRTH, 1991

RANK	TOTAL MIGRANTS AT THE PLACE OF ENUMERATION		MIGRANTS FROM WITHIN THE STATE		MIGRANTS FROM OTHER STATES		MIGRANTS FROM OUTSIDE INDIA	
1.	KODAGU	44.66	KODAGU	36.14	BLR	11.50	U.K.	0.30
2.	DHARWAD	36.13	DHARWAD	34.89	KODAGU	8.05	KODAGU	0.25
3.	CHIKMGLR	35.65	CHIKMGLR	33.26	BELLARY	5.77	BLR	0.21
	KARNATAKA	**29.57**		**25.71**		**3.68**		**0.09**
18.	GULBRG	24.42	RAICHUR	18.97	DHARWAD	1.15	HASSAN	0.03
19.	RAICHUR	22.29	BLR	17.96	BLR (R)	1.00	SHIMOGA	0.02
20.	BLR (R)	17.54	BLR (R)	16.34	HASSAN	0.93	BIDAR	0.01

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REMAINING 14 DISTRICTS FALL BETWEEN SL. NO. 3 AND 18

FERTILITY INDICATORS - INDIA

(LIVE BIRTHS PER THOUSAND WOMEN)

CENSUS DATA ON BIRTHS 1901-2001

CENSUS YEAR	RATE
1901	49.2
1951	42.7
1991	29.5
2001 (PROJ.)	24.0

SRS DATA ON BIRTHS (1989)

STATE/UNION TERRITORY	RATE
UTTAR PRADESH	37.0
MADHYA PRADESH	35.1
BIHAR	34.4
RAJASTHAN	33.9
D & HAVELI (UT), ARUNACHAL PRADESH, HARYANA, SIKKIM, MEGHALAYA, J & K, ORISSA	
INDIA	**29.5**
ASSAM, L. DWEEP (UT), GUJARAT, PUNJAB & MAHARASHTRA	
KARNATAKA	**27.9**
DAMAN AND DIU (UT), HIMACHAL PRADESH, DELHI, W.B., TRIPURA, A.P., TAMILNADU, CHANDIGARH (UT), MANIPUR, PONDICHERRY (UT), A & N ISLANDS (UT), NAGALAND	
KERALA	**19.8**
GOA	**15.5**

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MORTALITY INDICATORS - INDIA

(PER THOUSAND POPULATION)

CENSUS DATA ON DEATHS 1901-2001

CENSUS YEAR	RATE
1901	49.20
1951	22.80
1991	9.80
2001 (PROJ.)	8.99

SRS DATA ON DEATHS (1989)

STATE/UNION TERRITORY	RATE
MADHYA PRADESH	12.8
ORISSA	12.6
UTTAR PRADESH	12.6
BIHAR	12.1
MEGHALAYA, RAJASTHAN, ARUNACHAL PRADESH, ASSAM	
INDIA	**10.2**
GUJARAT, A.P., SIKKIM, H.P.	
KARNATAKA	**8.7**
W.B., TAMILNADU, D & N, HAVELI (UT), HARYANA, PUNJAB, DAMAN & DIU (UT), J & K, MAHARASHTRA, GOA, TRIPURA, PONDICHERRY (UT), TRIPURA, MANIPUR, DELHI, L. DWEEP	
KERALA	**5.9**
ANDAMAN ISLANDS, NAGALAND CHANDIGARH (UT)	**3.8**

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INFANT MORTALITY IN INDIA

(PER THOUSAND LIVE BIRTHS)

CENSUS DATA ON INFANT MORTALITY 1901-2001

CENSUS YEAR	MALES	FEMALES
1901	290	284
1951	235	218
1991	85	82
2001 (PROJ.)	63	64

SRS DATA ON INFANT MORTALITY (1989)

MAJOR STATES	RATE
ORISSA	122
UTTAR PRADESH	118
MADHYA PRADESH	117
RAJASTHAN	96
INDIA, ASSAM, BIHAR	91
GUJARAT, HARYANA, A.P.	
KARNATAKA	**80**
W.B., HIMACHAL PRADESH, J & K TAMILNADU, PUNJAB, MAHARASHTRA	
KERALA	**22**

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EXPECTANCY OF LIFE AT BIRTH, INDIA

CENSUS DATA ON EXPECTANCY OF LIFE AT BIRTH 1901-2001

CENSUS YEAR	MALES	FEMALES
1901	22.59	23.31
1951	41.89	40.55
1991	59.00	59.40
2001 (PROJ.)	62.36	63.99

FOR MAJOR STATES - 1993

	TOTAL	MALES	FEMALES
KERALA	72.0	68.8	74.7
PUNJAB	66.4	65.2	67.6
MAHARASHTRA	64.2	63.0	65.4
HIMACHAL PRADESH, HARYANA, TAMILNADU			
KARNATAKA	**61.9**	**60.2**	**63.5**
WEST BENGAL, ANDHRA PRADESH, GUJARAT			
INDIA	**59.4**	**59.0**	**59.7**
BIHAR, RAJASTHAN, U.P., ORISSA, ASSAM			
MADHYA PRADESH	**54.0**	**54.1**	**53.8**

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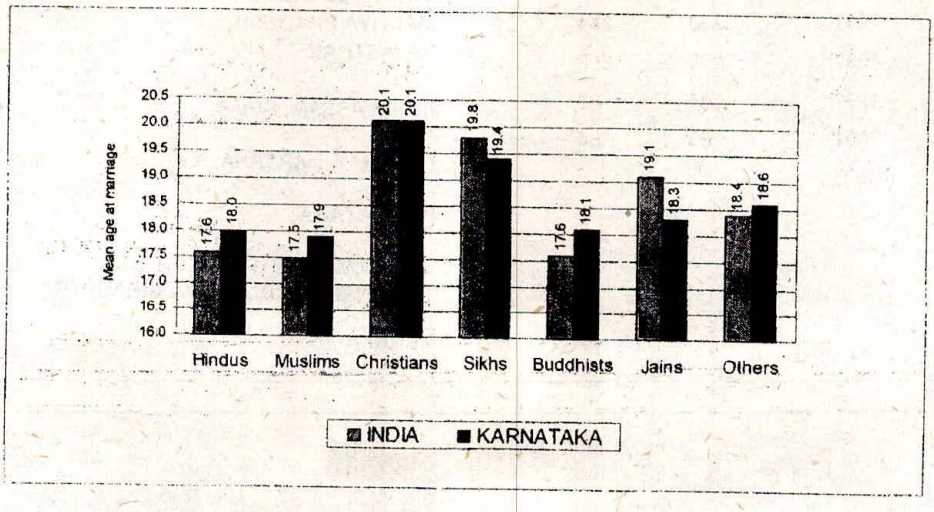
MEAN AGE AT MARRIAGE OF WOMEN BY RELIGION IN INDIA AND KARNATAKA, 1991



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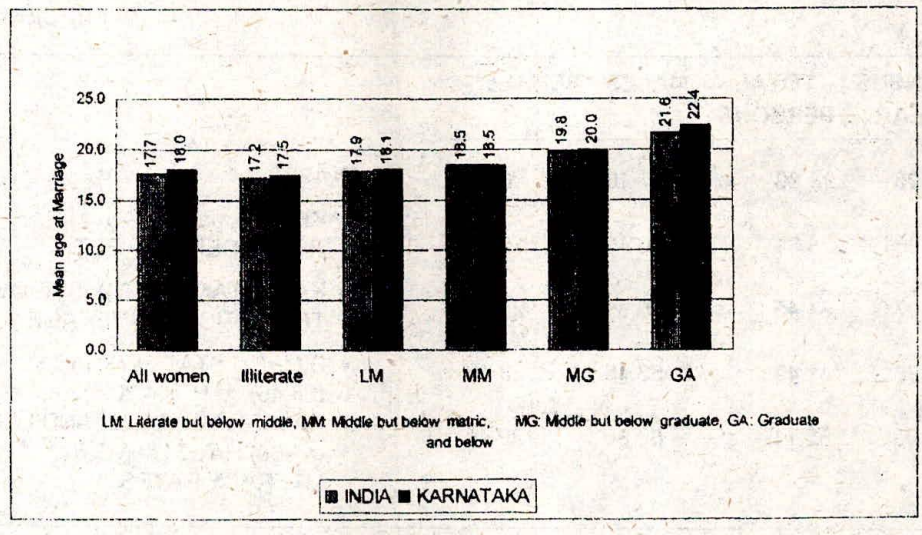
MEAN AGE AT MARRIAGE OF WOMEN BY EDUCATIONAL LEVEL IN INDIA AND KARNATAKA, 1991



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SCHEDULED CASTES AND SCHEDULED TRIBES IN INDIA AND KARNATAKA (PERCENT), 1991

SL. NO.	PARAMETERS	GENERAL CATEGORY		SCHEDULED CASTE		SCHEDULED TRIBE	
		INDIA	KARNATAKA	INDIA	KARNATAKA	INDIA	KARNATAKA
1.	PERCENTAGE TO TOTAL POPULATION	75.44	79.36	16.48	16.38	8.08	4.26
2.	POPULATION DISTRIBUTION BY URBAN/ RURAL AREAS						
	A : URBAN	28.12	30.92	11.99	23.40	2.32	14.94
	B : RURAL	71.88	69.08	18.04	76.60	10.08	85.06
3.	LITERACY RATES						
	1981	43.67	46.21	21.38	20.59	16.35	20.14
	1991	52.21	56.04	37.41	38.06	29.60	36.01
4.	SEX RATIO	927	960	922	962	972	961

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HOW MANY OF US CAN READ AND WRITE?

LITERACY RATE IN INDIA, 1951 - 1991

(IN PERCENT)

CENSUS YEAR	TOTAL PERSONS	MALES	FEMALES
1951	18.33	27.16	8.86
1961	28.31	40.40	15.34
1971	34.45	45.95	21.97
1981	41.42	53.45	28.46
1991	52.11	63.86	39.42

IN 1991

* KERALA (89.8) HAS RECORDED HIGHEST
* KARNATAKA (56.04) IS ABOVE THE NATIONAL AVERAGE
* BIMARU STATE - BIHAR (38.46), M.P. (44.20), RAJASTHAN (38.55) AND U.P. (41.60) HAVE LOWEST LITERACY RATES

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LITERACY RATES IN KARNATAKA (IN PERCENT)

SL. NO.	STATE/ DISTRICT	LITERACY RATES 1991	RATE OF GROWTH OF LITERACY, (1981-91)
1.	BANGALORE	76.27 (1)	26.13
2.	DAKSHIN KANNADA	75.86 (2)	20.20
3.	KODAGU	68.35 (3)	15.83
	UTTARA KANNADA, SHIMOGA, CHIKMAGALUR, DHARWAD,HASSAN		
	KARNATAKA	**56.04**	**21.27**
	CHITRADURGA, BIJAPUR, TUMKUR, BELGAUM,		
	INDIA	**52.11**	**52.21**
	KOLAR, BANGALORE RURAL, MANDYA, MYSORE, BELLARY		
18.	BIDAR	45.11 (18)	40.22
19.	GULBARGA	38.54 (19)	26.86
20.	RAICHUR	35.96 (20)	19.35

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DISTRIBUTION OF LANGUAGES IN KARNATAKA, 1991

(inclusive of other Mother tongues grouped under each) specified in Schedule VIII to the Constitution of India

SL. NO.	NAME OF THE LANGUAGE	NUMBER OF SPEAKERS	PERCENTAGE
1.	KANNADA	29,785,004	66.22
2.	URDU	4,480,038	9.96
3.	TELUGU	3,325,062	7.39
4.	TAMIL	1,728,361	3.84
5.	MARATHI	1,640,020	3.65
6.	HINDI	885,251	1.97
7	MALAYALAM	757,030	1.68
8.	KONKANI	706,397	1.57
9	GUJARATHI	53,785	0.12
10.	BENGALI	20,926	0.05
11.	SINDHI	13,930	0.03
12.	PUNJABI	13,824	0.03
13.	ORIYA	5,474	0.01
14.	NEPALI	4,702	0.01
15.	KASHMIRI	1,140	N
16.	ASSAMESE	829	N
17.	SANSKRIT	695	N
18.	MANIPURI	272	N

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DISTRIBUTION OF LANGUAGES IN KARNATAKA, 1991

(inclusive of other Mother tongues grouped under each) other than those specified in Schedule VIII to the Constitution of India

ADI, ANGAMI, AO, ARABIC/ ARBI, BHILI/ BHILODI, BHOTIA, BODO/BORO, COORGI/KODAGU,DOGRI, ENGLISH, GANGTE, GARO, GONDI, HALABI, HO, JATAPU, KARBI/ MIKRI, KHANDESHI, KHARIA, KHASI, KISAN, KODA/ KORA, KONAYAK, KOM, KORWA, KOYA, KUI, KUKI, KURUKH/ ORAON, LAHNDA, LIMBU, LOTHA, LUSHAI/ MIZO, MISHMI, MONPA, MUNDA, MUNDARI, NICOBARES, POITE, SANTALI, SHERPA, SEMA, TANGKHUL, THADO, TIBETAN, TRIPURI, TULU, OTHERS.

15,54,461
= 3.47%

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PROPORTION OF POPULATION BY MAJOR RELIGIONS OF KARNATAKA AT SELECTED CENSUS YEARS

RELIGIONS	1991	1981	1971	1961	1951	1931	1911
HINDUS	85.45	85.77	86.46	87.26	87.03	87.70	88.60
MUSLIMS	11.64	11.21	10.63	9.87	10.05	9.36	8.64
CHRISTIANS	1.91	2.08	2.09	2.07	2.16	1.63	1.31
JAINS	0.73	0.77	0.75	0.74	0.72	0.76	0.69
BUDDHISTS	0.16	0.11	0.05	0.04	0.01	0.02	0.01
SIKHS	0.02	0.02	0.02	0.02	0.02	N	N

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PERCENTAGE DISTRIBUTION OF POPULATION BY RELIGIONS IN INDIA & KARNATAKA - 1991

SL. NO.	RELIGIOUS COMMUNITIES	INDIA PERCENTAGE TO TOTAL POPULATION	KARNATAKA PERCENTAGE TO TOTAL POPULATION
1.	HINDUS	82.00	85.45
2.	MUSLIMS	12.12	11.64
3.	CHRISTIANS	2.34	1.91
4.	SIKHS	1.94	0.02
5.	BUDDHISTS	0.76	0.16
6.	JAINS	0.40	0.73
7.	OTHER RELIGIONS & PERSUATIONS	0.39	0.01
8.	RELIGIONS NOT STATED	0.05	0.08

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PROCEEDINGS OF GOVERNMENT OF KARNATAKA

SUB : Census of India, 2001 – Constitution of District Level Census Co-ordination Committee

READ : D.O.letter No.TCH 9 CPO 99 (Vol.II) dated 06-03-2000 of the Director of Census Operations in Karnataka, Bangalore, Government of India, Ministry of Home Affairs addressed to the Chief Secretary to Government of Karnataka, Bangalore.

PREAMBLE

The Houselisting Operations which is the first phase of the two phases of the Census of India 2001 is scheduled to be conducted between 8th May and 6th June, 2000 throughout the State. The organisational work connected with Houselisting Operations involves many stages and each stage is to be completed according to the schedule as per the Calendar drawn up and circulated by the Director of Census Operations.

In the first meeting of the State Level Census Co-ordination Committee held on 5.1.2000 at Bangalore it was felt that there is need for constituting co-ordination committees at the district levels also under the Chairmanship of Deputy Commissioners (Principal Census Officers).

The Government of Karnataka, therefore, after careful consideration of this proposal hereby orders as follows :

GOVERNMENT ORDER NO.RD .8.ETC.2000. DATED .27.03.2000.

Government of Karnataka is pleased to authorise/empower the Deputy Commissioners of the Districts to constitute Census Co-ordination Committees at the District level with a view that the guidelines and instructions issued by the Director of Census Operations, Karnataka from time to time are implemented with utmost promptitude and care by all the departments concerned.

The Committee may comprise of the following officers :

1. Deputy Commissioner & Principal Census Officer — Chairman
2. Chief Executive Officer & Additional Principal Census Officer — Vice-Chairman
3. District Superintendent of Police — Member
4. District Forest Officer — Member

Contd.

5. District Health Officer	Member
6. Joint Director/Deputy Director of Public Instructions	Member
7. Joint Director/Deputy Director of Collegiate Education	Member
8. Joint Director/Deputy Director of Agriculture	Member
9. District Information & Publicity Officer	Member
10. Deputy Director of Women and Child Welfare	Member
11. All Assistant Commissioners of District	Member
12. Secretary, Mass Education	Member
13. District Statistical Officer	Members
14. Officials of five different NGOs	Convenor
15. Headquarters Assistant to Deputy Commissioner	

The Committee :

(1) Shall meet once in a fortnight to review and co-ordinate the work relating to Census of India 2001;

(2) Each Officer member shall be allotted a rural Charge (taluk) or an urban Charge (Urban Local body) for supervising, monitoring and guiding the Census authorities in that Charge for smooth conduct of Census Operations. He/she shall also see that proper training is imparted to Supervisors and Enumerators by the Charge Officers and Training Supervisors at Hobli/Circle level;

(3) During the period of Houselisting Operations i.e. between 8th May, 2000 and 6th June, 2000, the officer entrusted with the particular Charge shall frequently visit the Charge area for supervising the work of the Supervisor/Enumerator;

(4) All the members of the Committee shall attend the training classes of the district to acquaint themselves with the instructions issued from time to time regarding the different aspects of Census taking so that the supervision work regarding Houselisting Operations and the Actual Population Enumeration becomes easy;

(5) In the absence of Principal Census Officers, the Additional Principal Census Officers shall discharge the functions of the Chairman;

(6) Shall organise publicity through various media regarding Census Operations to bring awareness among public;

contd.

(7) Census Operations being of national importance, TA/DA, Honorarium/ Remuneration, etc., shall be paid only to the census authorities designated under the Census Act and not to others;

(8) The Committee may if it so desires, nominate any officer/s as an additional member/s.

The action taken by the Committee shall be intimated to the Director of Census Operations, Karnataka from time to time.

BY ORDER AND IN THE NAME OF THE
GOVERNOR OF KARNATAKA

(K.RAGHU RAM SHANDARY)
Under Secretary to Govt. (Secondary Ed

To

The Compiler, Karnataka Gazette, Bangalore, for publication in the next issue of the Gazette. He is also requested to supply ..100..... copies of the same to this office.

Copy to :

1. The Principal Secretary to Chief Minister
2. The Chief Secretary to Government of Karnataka
3. The Additional Chief Secretary and Development Commissioner, Government of Karnataka, Bangalore
4. The Additional Chief Secretary and Resident Commissioner, Karnataka Bhavan, New Delhi.
5. The Additional Chief Secretary and Principal Secretary to Government, Forest, Ecology and Environment Dept.
6. The Principal Secretary to Govt., Home & Transport Department
7. The Principal Secretary to Govt., Finance Department
8. The Principal Secretary to Govt., Revenue Department
9. The Principal Secretary to Govt., Urban Development Department
10. The Secretary to Govt., Planning Department
11. The Secretary to Govt., Rural Development & Panchayat Raj Dept.
12. The Secretary to Govt., Education Department
13. The Secretary to Govt., DPAR
14. Sri B.K.Das, IAS, Chairman, Karnataka Urban Water Supply and Drainage Board, 7th Floor, KHB Complex, Kempegowda Road, Bangalore (Ex-Director of Census Operations, Karnataka, Bangalore)
15. Smt. Sobha Nambisan, IAS, Managing Director, Karnataka State Handicrafts Development Corporation Ltd., M.G.Road, Bangalore (Ex-Director of Census Operations, Karnataka, Bangalore)

contd.

CENSUS OF INDIA 2001 : A STUPENDOUS NATIONAL TASK

- AN OVERVIEW

H.Shashidhar, IAS
Director of Census
Operations, Karnataka

INTRODUCTION

☛ The countdown has begun for the next Census in 2001. The 2001 Census, coming at the commencement of the twenty-first century and the third millennium, will quietly register the Indian Population crossing the one billion mark. This Indian population drama will soon unfold in the guise of Census figures and statistics once again after ten years and remind us to review the successes and failures of India's people, policies and programmes. It is likely to evoke world-wide interest in reassessing India's position among the developing countries. **Therefore, reaching or counting one billion = 1000 million = 100 crore is not about numbers. It is beyond that. It is about a multidimensional move from numbers to population to people.**

HISTORY OF INDIAN CENSUS

☛ Census has a long history behind it, being primarily used for purpose of taxation. Kautilya's *Arthasastra* written around 321-296 B.C. laid stress on Census taking as a measure of State Policy for purpose of taxation. Originally, thus, Census and taxation were virtually inseparable. In India the year 1872 marked the beginning of Census

taking. From 1881 onwards, however, a complete and synchronous Census has been held once in ten years without break. India is proud of long and uninterrupted record of decennial Censuses since 1871. The Census of India 2001 will be the 14th decennial Census since 1871 and the 6th Census since Independence.

MODERN CONCEPTS OF A POPULATION CENSUS

☛ The modern concepts of a Population census has been very well defined by the United Nations. It states, *"a census of population may be defined as the total process of collecting, compiling and publishing demographic, economic and social data pertaining at a specified time or times, to all persons in a country or delimited territory"*. **The Indian Census has been adopting this in letter and spirit. There is hardly any country in the world today which does not take Census.**

AUTHORITY TO CONDUCT CENSUS AND THE CENSUS ACT, 1948

☛ **The authority to conduct Census in India comes from Article 246 of the Constitution of India.** This article empowers the Parliament to make laws with respect to any of the matters enumerated in the List-I in the Seventh Schedule referred to as 'Union List' and the subject 'Census', figures at Serial No.69 in the List. Accordingly, the Indian Parliament made 'The Census Act, 1948' (Act No.37 of 1948) which provides *"for the taking of Census in India or any part thereof whenever necessary or desirable and to promote for certain matters for taking such Census"*.

☛ The Census Act of 1948 makes it obligatory for a person assigned with Census duty to perform the same faithfully and diligently. It also makes it obligatory for the person to answer all the questions correctly and fully. While giving any information to the Census Enumerators, **the public need not have any hesitation or reservation as the Census Act guarantees the confidentiality of the information and total non-identification of the individual.**

ROLE OF STATE AND CENTRAL GOVERNMENTS

☛ Coming under the Ministry of Home Affairs, Government of India, at the National level, the Census Organisation is headed by the Registrar General and Census Commissioner of India. There is a separate Directorate in each State and Union Territory to carry out the Census Operation. The Directorate of Census Operations in Karnataka with the active help and support of the State Government is making all necessary arrangements for the 2001 Census.

APART FROM BEING A MAJOR ADMINISTRATIVE FEAT

☛ Perhaps no other account about the Indian Census is as complete and comprehensive as the one given by renowned economist Ashish Bose. To quote him *"... apart from being a major administrative feat in a country of India's size and diversity, the Census possess an intellectual validity to planners, policy makers, administrators, economists, statisticians,. researchers and others to address themselves to the ever changing demographic, development, social and economic questions of our country."* Further, *"the Indian Census is a monumental affair" he said.*

WEALTH OF INFORMATION

☛ Apart from being the biggest administrative exercise in the world, the Indian Census is "*one of country's most remarkable events and universally acknowledged as the most authentic and comprehensive source of information about our land and people*",

☛ Information on the Indian Census, considered to be a treasure house of multidimensional data is known for *"its range and scope encompassing demographic, economic, social and cultural characteristics, fertility and mortality, nuptiality, scheduled caste, tribe, language, religion, migration, education, health, communication, child labour, employment, ageing, housing, household amenities, organisation infrastructure and many more issues. You name it, Census has it"*. **This huge database is a veritable mine of information, the value of which has not been fully realised, let alone utilised. It is a case of poverty amidst plenty.**

☛ The source on Indian Census is in plenty and is available in the form of published reports, CD-Roms, internet, floppy, e-mail, etc., at :

1. O/o the Registrar General & Census Commissioner, India, Data Processing Division, II Floor, E Wing, Pushpa Bhavan, Madangir Road, New Delhi-110 062., Phone : (91-11) 698 1558, Fax: : (91-11) 698 0295, E-mail : rgdpd@rgi.satyam.net.in, Internet : http://www.censusindia.net.

2. O/o the Director of Census Operations, Karnataka, 7th Floor, F Wing, Kendriya Sadan, Koramangala, Bangalore-560 034, Phone & Fax : 5538973, E-mail : dcokar@rgi.satyam.net.in.

UTILITY OF CENSUS DATA

☛ The utility of the Indian Census data can hardly be over emphasized. They are used in administration and policy; for research purposes; in business and industries; as frame for sample surveys; in planning; basis for representation in parliament / assemblies / urban local bodies / Panchayat Raj Systems and **for other democratic**

purposes; to other types of census; to Civil Registration and Vital Statistics and in many others.

HOW CENSUS IS TAKEN

☛ Before the commencement of the enumeration, a tremendous amount of spade work has to be done. This includes listing of all villages along with hamlets, if any, towns in every taluk and district and identifying them in suitble maps indicating the boundaries of all the administrative units. This frames the basic task and facilitates the operation, to conduct the census in a systematic manner without any overlapping or omission. This frame with reference to 1991 Census, has to be continuously updated by taking into account the changes that occurred and occurring in the jurisdiction of State / District / Taluk / Town / Village from time to time upto a certain date. It is a massive administrative operation involving a network of intricate steps which have been carefully planned and worked out to a definite time schedule on a war footing. Therefore, demands on time are numerous and exact.

SIGNIFICANCE OF CENSUS OF INDIA 2001

☛ Once again after 10 years the 130 years old, gigantic and great Indian Census Organisation is mobilising all its women and men, material and money to undertake the biggest administrative exercise in the World i.e., **the Census of India 2001 during February 9th to 28th, 2001. The significance of Census 2001 lies in the fact that it is the first Census of the twenty-first century and the third millennium. Giving complete account of the socio-economic, development and demographic health of the ever burgeoning population of India, the Census 2001 will serve as a**

historic bench mark for the coming decades. It will be the 14th decennial Census of India since 1871 and sixth since Independence.

PHASES OF CENSUS 2001

☛ The Indian Census has two phases. **First or preliminary phase referred as the Houselisting Operation** during which information on housing and household amenities is captured was held throughout the Country during April to June, 2000. **Second or the main phase known as the Population Enumeration** will be held (except Jammu and Kashmir) between 9th and 28th February, 2001. The houseless households will be enumerated on the night of 28th February, 2001. The Population Enumeration in Jammu & Kashmir and snow bound areas of Himachal Pradesh and Uttar Pradesh has already been completed.

MAIN FEATURES - THE SCHEDULES USED IN CENSUS 2001

☛ One of the main features of the ensuing Census is the reduction in the number of questionnaires or schedules used. In the previous Census, three schedules, namely the houselist schedule, household schedule and individual slip were used to gather information. But in this Census, since the individual slip has been done away with, only two schedules i.e., the houselist schedule and the household schedule are going to be used. The individual particulars will be collected in the household schedule itself.

☛ Another prominent feature of the Census 2001 is the dropping of the Economic Census which used to be held alongwith the houselisting operation in the previous Censuses. Similarly, the preparation of PGDHTP cards (Post Graduate and Degree

Holders and Technical Personnel), for which information used to be collected during the Population Enumeration has also been dropped from this Census.

☛ Yet another important feature of this Census is the introduction of certain new and relevant questions both for the Houselisting Operation and the Population Enumeration. The new questions in addition to the modifications of old ones, enhance the utility of Census 2001 and takes it beyond a head count of population.

NEW ITEMS IN HOUSELISTING OPERATION OF CENSUS 2001

☛ The Houselisting Operation included questions for the first time on (1) condition of the house, (2) number of married couples living in the household, (3) number of married couples having independent rooms, (4) drainage facilities, (5) bathroom within the house, (6) kitchen within the house, (7) possession of Radio/Transistor/ Television/Telephone by the household, (8) possession of transport vehicle such as Bicycle/Scooter/Motor Cycle/Moped/Car/Jeep by the household and (9) Banking services availed by the household.

NEW ITEMS IN POPULATION ENUMERATION OF CENSUS 2001

☛ Similarly, the Population Enumeration scheduled to be held between 9th and 28th Feb., 2001 will have questions for the first time on (1) name of respondent and the relationship to head, (2) age of marriage for males also, (3) **disabilities,** (4) travel to work place, distance and mode of travel, (5) household engaged in cultivation and plantation and (6) dated signature or thumb impression of the respondent.

THE TASK AHEAD

☛ The Census 2001 has many firsts to its credit. **For the first time an unprecedented strength of over two million people are being appointed and trained to capture information from an anticipated 1000 million or 100 crore or one billion plus people living in India as on 1st March, 2001.** Every child, woman and man regardless of age, sex and nationality will have to be enumerated without omission or duplication. Indeed, it is a stupendous task. The Indian Census Organisation has the expertise, experience and competence to undertake this task.

☛ In the Census of India 2001, the Indian Census Organisation has been given the following stupendous task.

1. Cover every nook and corner of all the 27 States, 6 Union Territories, 593 Districts, around 5500 Taluks, 5100 Cities and Towns and 6,38,000 Villages in the country.

2. In the projected One billion plus population of India, count every individual i.e., every child, woman and man (even those who don't want to be counted) regardless of age or sex or nationality without omission or duplication.

3. Identify and appoint more than two million Census staff and train them to undertake this huge administrative operation during 9th to 28th February, 2001. Enumerate all the Houseless households on the night of 28th February, 2001. The reference time and date being 00.00 hrs (midnight) of 1st March 2001.

4. Maintain confidentiality of the information and total non-identification of the individual or the household who provides information to the enumerator.

5. Data so collected to be compiled and tabulated for preparing and publishing written reports including statements, tables and maps.

6. Provide the general public and data users with published reports, CD ROMs, floppies, internet and through other media with summary data at the Country / State / Union Territory / District / City /Taluk / Town / Village level.

TECHNOLOGICAL REVOLUTION

☛ Census 2001 is expected to bring in a sort of technological revolution in the history of Indian Census. The questions in the schedules are self coded to make them processor friendly. Latest image-based scanning technology will be tried for the first time by the Census Organisation which should substantially speed up processing, tabulation and publication of data.

CENSUS 2001 IN KARNATAKA

☛ The Houselisting Operation in Karnataka was undertaken in May-June 2000 and the preparations for the Population Enumeration to be held from 9th February to 28th February 2001 are under way.

☛ The preparations for taking the Population Enumeration in Karnataka are under way. In our State, this gigantic task would have an army of more than a lakh Enumerators and Supervisors, who would move from house to house covering six City Municipal Corporations, nearly 300 urban local bodies over 29,480 villages and 28,300 hamlets spread over the entire length and breadth of Karnataka. Every child, woman and man regardless of sex, age and citizenship status in an anticipated population of 535 million in Karnataka will be counted without omission and duplication.

☛ Karnataka has an excellent record of Census taking. It is needless to emphasise the fact that the success of the 2001 Census largely depends on the willing and enthusiastic co-operation of the people, media, government and non-governmental agencies associated in this stupendous national task.

☛ Therefore, every citizen should extend fullest co-operation and support for performing in what has been considered as a largest administrative operation in the world.

HISTORY IN THE MAKING

☛ Census will help to grasp the gravity of socio-economic and demographic problems of our society. The unchecked and rapid growth of population in India carries along with it multi-dimensional problems such as disability, unemployment, lack of education, sub-standard health services and sanitation, inadequate welfare measures, child labour, the poor status of women in general, inadequate housing and transportation, urban ward migration and its effects and so on. The Census 2001 throws light on all these problems directly or indirectly. No section of the society remains untouched by the Census statistics, which is the ultimate aim and utility of Census.

☛ Thus, Census of India 2001, a new road map to India's future is nothing but history in the making. Glorious tradition is its' main strength.

एच. शशिधर भा प्र से
निदेशक
H. Shashidhar I A S
Director
भारत सरकार
GOVERNMENT OF INDIA
गृह मंत्रालय
MINISTRY OF HOME AFFAIRS
जनगणना निदेशक का कार्यालय, कर्नाटक
OFFICE OF THE DIRECTOR OF
CENSUS OPERATIONS, KARNATAKA
केंद्रीय सदन, '७' वाँ तल, 'एफ' विंग,
Kendriya Sadan, 7th Floor, 'F' Wing,
कोरमंगल, बेंगलूर - 560 034
Koramangala, BANGALORE - 560 034

CENSUS - URGENT

मुख्य कार्यालय/Main Office
दूरभाष/फैक्स/Tel/Fax : 080-5538973
दूरभाष (सा)Tel [Gen] : 080-5520352
इ-मैल/e-mail : dcokar@rgi.satyam.net.in
अन्य कार्यालय/Other Offices
सीधा आँकडे प्रविष्टि प्रणाली
Direct Data Entry System
दूरभाष/Tel : 080-2223306
केन्द्रीय रिकार्ड अनुभाग
Central Record Section
दूरभाष/Tel : 080-2261716

भारत की जनगणना 2001 CENSUS OF INDIA
लोकाभिमुख
PEOPLE ORIENTED

सं. / No. TCH 59 CPO 2000

IMPORTANT

दिनांक/Date : 30.11.2000

POPULATION ENUMERATION CIRCULAR NO.13

SUB : CENSUS OF INDIA 2001 - PUBLICITY PLAN FOR POPULATION ENUMERATION

INTRODUCTION

This is yet another important Population Enumeration Circular which requires your personal attention for compliance.

2 The countdown has begun for the Population Enumeration for Census of India 2001. By now it is hoped, you must have intensified the preparations for the actual operation. Nevertheless, a very important factor i.e. publicity needs to be intensified now so as to draw interest of the people at large who are the respondents in this massive task. The publicity campaign should be such that it reaches people of even the farthest villages.

Since there are a few new features to be adopted in this Millennium Census, it is rather more important that publicity of these features of the Population Enumeration schedule is taken up in its right spirit for capturing accurate data.

The following publicity materials are sent herewith. Please make use of these materials.

1. Census message for printing hand bills.
2. Census message for banners.
3. Census slogans for telecasting through cable operators.

Please acknowledge receipt of this circular.

(H.SHASHIDHAR)
Director of Census
Operations, Karnataka

To

All Commissioners of City Corporations & Principal Census Officers
The Commissioner, Bangalore Development Authority & Principal Census Officer
All the Deputy Commissioners of Districts & Principal Census Officers
All the Zonal Deputy Commissioners, Bangalore City Corporation & Zonal Census Officer
The Secretary, BDA & Additional Principal Census Officer
The Addl.Joint Commissioner, Bangalore City Corporation & Additional Principal Census Officer
The Chief Executive Officers of Zilla Panchayats & Additional Principal Census Officers
All the Headquarters Assistant to Deputy Commissioners & District Census Officers
All the District Statistical Officers & Additional District Census Officers
All the Assistant Commissioners of Sub-Divisions & Sub-Divisional Census Officers
All the Commissioners of City Municipalities & City Census Officers
All the City Census Officers of Bangalore City Corporation
All Chief Officers of Town Municipalities/Town Panchayats/Notified Area Committees/ Cantonment Boards, etc., & Census Charge Officers (Urban)
All Tahsildars of the Taluks & Census Charge Officers (Rural)
All the Deputy Tahsildars of Taluks & Additional Census Charge Officers (Rural)
All the Additional Census Charge Officers (Urban), Bangalore City Corporation.

Copy to

The Registrar General & Census Commissioner, India, New Delhi
The Secretary to Governor, Government of Karnataka
The Secretary to Speaker, Legislative Assembly
The Secretary to Chairman, Legislative Council
All Ministers, Government of Karnataka
The Nodal Officer of State Government & Additional Secretary to Revenue Department
All Divisional Commissioners of Divisions
The Chief Secretary to Government of Karnataka, Bangalore/Additional Chief/Principal Secretaries and Secretaries to Government of Karnataka
The Director of Economics & Statistics, Government of Karnataka
All Members of the State Level Census Co-ordination Committee
All Officers/Investigators & District Team Leaders of this Directorate
PA to Director

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लोकाभिमुख
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NEED OF THE HOUR

3 The Census Co-ordination Committee formed in the District/ Taluk are to be activated and various other departments in the district should be made to actively associate in the publicity programme by exhibiting Census messages in their offices and other public places to bring awareness among public about Population Enumeration.

4. Frequent meetings regarding organisational set up should be conducted to review the progress achieved on various items of work regarding Population Enumeration and reported to this Directorate.

5. For vigorous publicity campaign in the rural and urban charges announcing messages of Census through Public Address System by authorised persons near important public places like Railway Station, Bus Stand, Market place, places of worship etc., using easy mode of available transport should be resorted to.

6. Apart from those referred above, there may also be other effective conventional media through which you feel can carry the Census message down to the villager. You may do so. The main purpose is to bring awareness among public about the importance of Census and make them realise their responsibility and co-operate in this gigantic task by furnishing correct information.

7. To achieve this all out effort at all levels is the need of the hour.

PUBLICITY PLAN THROUGH DIFFERENT MEDIA

8. **Cloth Banners / Hoardings / Posters / Pamphlets and handouts :** Cloth Banners with Census messages and slogans are required to be displayed in prominent junctions in the city viz., Railway Stations, Bus Stands, important road junctions etc. Visual publicity through posters conveying Census theme is an important tool of communication. It is less expensive but very effective. Hence the Principal Census Officers may find out sources for getting maximum number of posters printed and get displayed at important places in the Districts, Taluks and Villages. Financial commitments have to be met indigenously. Efforts need to be made to get pamphlets and handouts printed locally and distributed to the people. This approach of publicity is very economical and most effective in the rural side.

For all these, local organisations may be requested to sponsor.

9. **Participation in Fairs and Exhibitions :** Participation in fairs and exhibitions and displaying Census posters/ materials give magical returns both at rural and urban areas. The period from November to February basically being festival season in our country, many fairs and exhibitions take place in the towns and villages across the countryside. The Principal Census Officers are requested to avail these opportunities and exert efforts for spreading the message regarding importance of Census and peoples' participation in the national task.

10. **Beating of Drum :** The Village Panchayat may be requested to spread the message of Census through the cross section of the village. This needs to be done for a continuous period from January 2001 till the end of February 2001.

11. Local Cable TV : Census slogans and messages are to be telecast through local cable TV. This is one of the most effective media. The Principal Census Officers are required to impress upon the Cable TV owners regarding their participation in this national task and utilize their services for spreading the message of Census taking.

12. Cinema Slides : Cinema Slides with Census theme will be provided by DCO, Karnataka. These slides need to be properly distributed to different Cinema Halls in the Districts/Taluks with instructions to project the slides before the start of film shows and during 'intermission' of the film shows from 1st December, 2000 to 5th March, 2001.

13. State Level Essay Competition : The Director of Census Operations has already issued a Circular regarding Taluk and District Level Essay Competition in both Kannada and English. The modalities for the event have been detailed in the Circular. Wide publicity for Essay Competition needs to be given so that maximum number of entries are received. Procedural details have been circulated separately.

14. District and State Level Elocution Competitions : The Director of Census Operations has already issued a Circular regarding Taluk and District level elocution competitions. The Principal Census Officers are required to make this competition a great success. The procedure for conducting this competition has already been circulated separately.

15. Seminars : With the help of District Information and Publicity Officers, District level and Taluk Level seminars are required to be organised on Census 2001 to bring awareness among people so that they are motivated to actively and willingly participate in this national task. Necessary literature is being supplied.

16. Press Meetings : Press meetings at regular intervals at District and Charge level may be arranged and information be given regarding organisational and other arrangements made for conducting Census 2001. It needs to be emphasized that Census is people oriented and hence to reap the fruit of Census, people need to participate and co-operate with the Census authorities whenever they are called upon.

17. Press Notes : Series of Press Notes will be prepared by the Directorate of Census Operations, Karnataka on different aspects and features of Census of India 2001. Copies will be sent to all the Principal Census Officers, District Information and Publicity Officers etc. These Press notes may be got released in prominent District Newspapers.

QUIZ ON "KNOW YOUR FAMILY"

18. Students in all schools in different classes should be first asked to get the details about their family by questioning each of the family members as under :

(1) Who are the members in your household ?

(2) What is your relationship to the head of household ?

(3) What is your age & religion ?

(4) Do you belong to Scheduled Castes /Scheduled Tribes ?

(5) Can you read and write ?

(6) Do you have any type of disability ?

(7) During last year what work you have done ?

(8) How many days you have worked during last year ?

(9) Whether you are cultivator / Agricultural Labourer / Household Industry worker or any other worker ?

(10) Since when do you live in the village ?

(11) Where were you born ?

(12) If married female, how many children were born to you ?

(13) Whether your family is engaged in Cultivation / Plantation ?

(14) How much land do you have ?

19. This should also be taken up by the officers of the Education department at the taluk and district level. These should be then discussed with them by the teachers in a specific period to make the students acquainted with the questions. This procedure helps the students to know about themselves and their families and would help increase their confidence and develop their personality.

20. To assess the knowledge of the students towards their family members it is felt necessary that a **Quiz Competition** is to be conducted in the schools. For this purpose groups by age category may be formed. To the qualifying students token awards may also be given.

21. Newspaper Articles : This Directorate will be releasing Press Notes and Articles in leading Newspapers from December 2000 and continue till the end of Population Enumeration.

22. Newspaper Advertisement : Messages both in English and vernacular language regarding conduct of Population Enumeration will be published just before commencement of Population Enumeration. This advertisement will include the questions that are going to be canvassed during Population Enumeration.

23. Publishing Messages by VIPs in Newspapers : On the first day of Population Enumeration, Messages from Hon'ble Governor and Hon'ble Chief Minister of Karnataka requesting people at large to extend full co-operation will be published in leading newspapers.

24. Publicity Through AIR : Apart from regular radio talk by experts on Census subject messages from celebrities from different walks of life will be broadcast in prime chunks of AIR programmes. Small skits of 15 minute duration and Census jingles are proposed to be broadcast. It is also proposed to compose a thematic music (signature tune) and broadcast each time a Census message is in the air. During the operation of Population Enumeration, the AIR news will carry out Census news at frequent intervals. Details are being worked out.

25. Publicity Through TV : Messages from Hon'ble Governor and Hon'ble Chief Minister will be beamed through TV. Also, Census messages from popular celebrities informing the importance of Census in Nation's Development and people's participation will be telecast before and during the operation of Population Enumeration. Audio Video Spots on Census theme are also proposed to be beamed through TV. A signature tune is proposed to be composed and played during the telecast of Census messages over TV. Details are being worked out.

YOUR ROLE

26. Various methods through which publicity could be undertaken are detailed in this circular. Some of these measures will be taken care of by the Registrar General, India and some by this Directorate. However, publicity through Press Notes, Press Meetings, Elocution Competition, Newspaper Articles, Banners / Hoardings, utilising the services of Charge Officers, Beating of Drums, participation in Fairs and Exhibitions and printing and distribution of Pamphlets and Handouts are the areas where the Commissioners and Principal Census Officers of Municipal Corporations, the Deputy Commissioners and Principal Census Officers of the District / Chief Executive Officers and Additional. Principal Census Officers of Zilla Panchayats, can play an effective role in sensitising the people about the concept, utility and purpose of the Census.

Since there are a few new features to be adopted in this Millennium Census, it is rather more important that publicity of these features of the Population Enumeration schedule is taken up in its right spirit for capturing accurate data.

The following publicity materials are sent herewith. Please make use of these materials.

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(H.SHASHIDHAR)
Director of Census
Operations, Karnataka

To

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The Commissioner, Bangalore Development Authority & Principal Census Officer
All the Deputy Commissioners of Districts & Principal Census Officers
All the Zonal Deputy Commissioners, Bangalore City Corporation & Zonal Census Officer
The Secretary, BDA & Additional Principal Census Officer
The Addl.Joint Commissioner, Bangalore City Corporation & Additional Principal Census Officer
The Chief Executive Officers of Zilla Panchayats & Additional Principal Census Officers
All the Headquarters Assistant to Deputy Commissioners & District Census Officers
All the District Statistical Officers & Additional District Census Officers
All the Assistant Commissioners of Sub-Divisions & Sub-Divisional Census Officers
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All the City Census Officers of Bangalore City Corporation
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All Tahsildars of the Taluks & Census Charge Officers (Rural)
All the Deputy Tahsildars of Taluks & Additional Census Charge Officers (Rural)
All the Additional Census Charge Officers (Urban), Bangalore City Corporation.

Copy to

The Registrar General & Census Commissioner, India, New Delhi
The Secretary to Governor, Government of Karnataka
The Secretary to Speaker, Legislative Assembly
The Secretary to Chairman, Legislative Council
All Ministers, Government of Karnataka
The Nodal Officer of State Government & Additional Secretary to Revenue Department
All Divisional Commissioners of Divisions
The Chief Secretary to Government of Karnataka, Bangalore/Additional Chief/Principal Secretaries and Secretaries to Government of Karnataka
The Director of Economics & Statistics, Government of Karnataka
All Members of the State Level Census Co-ordination Committee
All Officers/Investigators & District Team Leaders of this Directorate
PA to Director

(H.SHASHIDHAR)
Director of Census
Operations, Karnataka

भारत की जनगणना
CENSUS OF INDIA
2001

लोकाभिमुख
PEOPLE ORIENTED
ಜನಪರ

WHY CENSUS ?

To know the socio-economic and demographic health of the Nation

Census is a great national task. We owe it to the Nation to make the Census a success

Please co-operate during the Population Enumeration being conducted from 9th to 28th February, 2001

Provide accurate and complete information to the census enumerator

Information collected from you will be kept confidential

Director of Census Operations, Karnataka, Bangalore and Principal Census Officer (Deputy Commissioner, or Commissioner of City Municipal Corporation and Bangalore Development Authority and Officers of Local Bodies)

भारत की जनगणना
2001
CENSUS OF INDIA

लोकाभिमुख
PEOPLE ORIENTED
ಜನಪರ

ಜನಗಣತಿ ಏಕೆ ?

ದೇಶದ ಸಾಮಾಜಿಕ, ಆರ್ಥಿಕ ಮತ್ತು ಜನಾಂಗಗಳ ಸ್ಥಿತಿಗತಿಗಳನ್ನು ತಿಳಿಯಲು ಜನಗಣತಿ ಅವಶ್ಯಕ

ಜನಗಣತಿ ಒಂದು ರಾಷ್ಟ್ರೀಯ ಮಹತ್ಕಾರ್ಯ.
ಅದನ್ನು ಯಶಸ್ವಿಯಾಗಿಸುವುದು ನಮ್ಮ ಕರ್ತವ್ಯ
ಮತ್ತು ಜವಾಬ್ದಾರಿ

2001ರ ಫೆಬ್ರವರಿ 9ರಿಂದ 28ರ ಅವಧಿಯಲ್ಲಿ
ನಡೆಯುವ ಜನಗಣತಿಯಲ್ಲಿ ದಯವಿಟ್ಟು ಸಹಕರಿಸಿ

ಗಣತಿದಾರರಿಗೆ ಸರಿಯಾದ ಮತ್ತು ಸಂಪೂರ್ಣವಾದ
ಮಾಹಿತಿಯನ್ನು ನೀಡಿ

ನಿಮ್ಮಿಂದ ಸಂಗ್ರಹಿಸಲಾದ
ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿಡಲಾಗುವುದು

ನಿರ್ದೇಶಕರು, ಜನಗಣತಿ ನಿರ್ದೇಶನಾಲಯ, ಕರ್ನಾಟಕ, ಬೆಂಗಳೂರು ಮತ್ತು
ಪ್ರಧಾನ ಜನಗಣತಿ ಅಧಿಕಾರಿಗಳು
(ಜಿಲ್ಲಾಧಿಕಾರಿಗಳು ಅಥವಾ
ನಗರಪಾಲಿಕೆಗಳ ಆಯುಕ್ತರು ಅಥವಾ
ಬೆಂಗಳೂರು ಅಭಿವೃದ್ಧಿ ಪ್ರಾಧಿಕಾರದ ಆಯುಕ್ತರು ಮತ್ತು
ಸ್ಥಳೀಯ ಅಧಿಕಾರಿಗಳು)

TEXT FOR BANNER

ಜನಗಣತಿ - ರಾಷ್ಟ್ರದ ಪ್ರಗತಿಯ ದಿಕ್ಸೂಚಿ

CENSUS - A POINTER TO NATION'S DEVELOPMENT

भारत की जनगणना

CENSUS OF INDIA

लोकाभिमुख

PEOPLE ORIENTED

ಜನಪರ

ಫೆಬ್ರವರಿ
February **9 - 28, 2001**

ನೀವು ನಿಮ್ಮ ಬಗ್ಗೆ ತಿಳಿಸಿ. ನಾವು ದೇಶದ ಬಗ್ಗೆ ತಿಳಿಸುತ್ತೇವೆ

Tell about you. We will tell about the Nation

ಜನರಿಂದ ಸಂಗ್ರಹಿಸಲಾದ ಮಾಹಿತಿಗಳನ್ನು ಗೌಪ್ಯವಾಗಿಡಲಾಗುತ್ತದೆ

Information collected will be kept confidential

ಬೆಂಗಳೂರು ಮಹಾನಗರ ಪಾಲಿಕೆ, ಬೆಂಗಳೂರು
BANGALORE MAHANAGARA PALIKE, BANGALORE

ಜನಗಣತಿ ನಿರ್ದೇಶನಾಲಯ, ಕರ್ನಾಟಕ
CENSUS DIRECTORATE, KARNATAKA

ಭಾರತದ ಜನಗಣತಿ 2001ರ ಬಗ್ಗೆ ಘೋಷಣೆಗಳು

ಜನಗಣತಿ ಏಕೆ ?

1 ಭಾರತದಲ್ಲಿ 1872ರಿಂದ ಪ್ರತಿ 10 ವರ್ಷಕ್ಕೊಮ್ಮೆ ಜನಗಣತಿ ನಡೆಯುತ್ತಾ ಬಂದಿದೆ. 2001ರ ಜನಗಣತಿ ಭಾರತದ 14ನೇ ಮತ್ತು ಸ್ವಾತಂತ್ರ್ಯ ನಂತರದ 6ನೇ ಜನಗಣತಿ

2 2001ರಲ್ಲಿ ಫೆಬ್ರವರಿ 9ರಿಂದ 28ರವರೆಗೆ ರಾಷ್ಟ್ರಾದ್ಯಂತ ಜನಗಣತಿ ನಡೆಸಲಾಗುತ್ತದೆ. ಇದನ್ನು ಯಶಸ್ವಿಯಾಗಿಸುವುದು ಪ್ರತಿಯೊಬ್ಬರ ಕರ್ತವ್ಯ ಹಾಗೂ ಜವಾಬ್ದಾರಿ

3 ಜನಗಣತಿಯು ರಾಷ್ಟ್ರೀಯ ಮಹತ್ಕಾರ್ಯ. ಈ ಮಹತ್ವಪೂರ್ಣ ಕಾರ್ಯದಲ್ಲಿ ಸಹಕರಿಸುವುದು ನಮ್ಮನಿಮ್ಮೆಲ್ಲರ ಕರ್ತವ್ಯ ಹಾಗೂ ಜವಾಬ್ದಾರಿ

4 ಜನಗಣತಿ ಕೇವಲ ತಲೆ ಎಣಿಕೆಯ ಬೃಹತ್ ಕಾರ್ಯವಲ್ಲ. ಇದೊಂದು ಸಧೃಡ ಸಮಾಜವನ್ನು ಕಟ್ಟಲು ಅಗತ್ಯವಾದ ಮಾಹಿತಿ ಒದಗಿಸುವ ಸಾಧನ

5 ದೇಶದ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಮತ್ತು ಜನಾಂಗಗಳ ಸ್ಥಿತಿಗತಿಗಳನ್ನು ತಿಳಿಯಲು ಜನಗಣತಿ ಅವಶ್ಯಕ

6 ಜನಗಣತಿಯು ಒಂದು ಬೃಹತ್ ಆಡಳಿತಾತ್ಮಕ ಕಾರ್ಯಾಚರಣೆ ಆಗಿದ್ದು ಜನಜೀವನ, ಕಾರ್ಯನೀತಿ ಮತ್ತು ಕಾರ್ಯಕ್ರಮಗಳ ಪುನರ್ ವಿಮರ್ಶೆಗೆ ಸಹಾಯವಾಗುವುದಲ್ಲದೆ ಸಾಕ್ಷರತೆ, ವಿದ್ಯಾಭ್ಯಾಸ, ಉದ್ಯೋಗ, ಸಂತಾನಫಲ, ವಸತಿ, ಕೃಷಿ ಮತ್ತಿತರ ರಂಗಗಳಲ್ಲಿನ ಬೇಡಿಕೆಗಳಿಗೆ ದೀರ್ಘಾವಧಿ ಯೋಜನೆ ತಯಾರಿಸುವಲ್ಲಿ ಉಪಯುಕ್ತ ಸಾಧನ

7 ಜನಗಣತಿ ನಮ್ಮ ದೇಶ ಮತ್ತು ಸಮಾಜದ ಬಗ್ಗೆ ಸರ್ವ ಮಾಹಿತಿಯ ಭಂಡಾರವೇ ಆಗಿದೆ

8 ಜನಗಣತಿ ದೇಶದ ಪ್ರಗತಿಯ ದಿಕ್ಸೂಚಿ

9 ಜನಗಣತಿ ಸಮಾಜದ ನೈಜ ಪ್ರತಿಬಿಂಬ

10 ಜನಗಣತಿಯೇ ಮಾನವಸಂನ್ಮೂಲಗಳ ಬಗ್ಗೆ ಒದಗಿಸುವ ಏಕೈಕ ಸಾಧನ

11 ಜನಸಂಖ್ಯಾ ಬೆಳವಣಿಗೆಯ ವೈಜ್ಞಾನಿಕ ವಿಶ್ಲೇಷಣೆಗೆ ಜನಗಣತಿ ಅತ್ಯಗತ್ಯ

12 ಬದಲಾಗುತ್ತಿರುವ ನಗರ ಹಾಗೂ ಗ್ರಾಮೀಣ ಜನಸಾಂದ್ರಕ್ಕೆ ಮತ್ತು ನಗರೀಕರಣಗೊಳ್ಳುತ್ತಿರುವ ಪ್ರದೇಶದ ಅಭಿವೃದ್ಧಿ ಮುಂತಾದವುಗಳ ವೈಜ್ಞಾನಿಕ ಅಧ್ಯಯನ ನಡೆಸಲು ಜನಗಣತಿ ಬೇಕು

13 ಜನಗಣತಿ ಸರ್ಕಾರದ ನೀತಿ ನಿರೂಪಣೆ, ಆಡಳಿತ ಮತ್ತು ಮತದಾರ ವಿಂಗಡಣೆಗೆ ಮೂಲಭೂತ ಮಾಹಿತಿ ಒದಗಿಸುತ್ತದೆ

14 ವಸತಿ, ಕುಟುಂಬದ ವ್ಯವಸ್ಥೆ ಮತ್ತು ಮೂಲಸೌಲಭ್ಯಗಳ ಬಗ್ಗೆ ಜನಗಣತಿಯು ಅಪೂರ್ವ ಅಂಕಿಅಂಶಗಳನ್ನು ನೀಡುತ್ತದೆ

15 ಜನಗಣತಿ - ಸದೃಢ ರಾಷ್ಟ್ರ ಮತ್ತು ಸಮಾಜವನ್ನು ಕಟ್ಟುವ ಒಂದು ಪವಿತ್ರ ಕಾರ್ಯ

16 ಜನಗಣತಿ - ಇದೊಂದು ರಾಷ್ಟ್ರ ಕಟ್ಟುವ ಕೆಲಸ ಬನ್ನಿ, ಕೈಗೂಡಿಸಿ

ವಿಕಲತೆ

1 ಮುಂಬರುವ ಜನಗಣತಿಯಲ್ಲಿ ವಿಕಲತೆ ಬಗ್ಗೆ ಮಾಹಿತಿಯನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುವುದು. ಇದರಿಂದ ರಾಷ್ಟ್ರದಲ್ಲಿ ವಿಕಲಾಂಗರ ಕಲ್ಯಾಣ ಯೋಜನೆಗಳಿಗೆ ಸಹಾಯವಾಗುವುದು

2 ನಿಮ್ಮ ಕುಟುಂಬದಲ್ಲಿ ವಿಕಲಾಂಗರಿದ್ದರೆ, ಅವರ ಬಗ್ಗೆ ನೈಜ ಮಾಹಿತಿ ನೀಡಿ, ಅವರ ಕಲ್ಯಾಣ ಯೋಜನೆಗಳನ್ನು ರೂಪಿಸಲು ಸಹಕರಿಸಿ

3 ದೃಷ್ಟಿ, ಶ್ರವಣ, ಮಾತು, ಚಲನೆ ಮತ್ತು ಮಾನಸಿಕ ವಿಕಲತೆಗಳ ಬಗ್ಗೆ ಈ ಬಾರಿ ಜನಗಣತಿಯಲ್ಲಿ ಮಾಹಿತಿ ಸಂಗ್ರಹಿಸಲಾಗುವುದು

ಜನಗಣತಿಯಲ್ಲಿ ಮಹಿಳೆಯರು ಮತ್ತು ಮಕ್ಕಳು

1 ಜನಗಣತಿ - ದೇಶದ ಆರ್ಥಿಕ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ಮಹಿಳೆಯರ ಮತ್ತು ಮಕ್ಕಳ ಪಾಲುದಾರಿಕೆಯ ನೈಜ ಚಿತ್ರಣ ಹೊರತರಲಿದೆ

2 ಭಾರತದ ಆರ್ಥಿಕ, ಸಾಮಾಜಿಕ ಮತ್ತು ಜನಾಂಗಗಳ ಸಂದರ್ಭದಲ್ಲಿ ಮಹಿಳಾ ಮತ್ತು ಮಕ್ಕಳ ಸ್ಥಾನಮಾನವೇನು ಎಂದು ತಿಳಿಯಲು ಜನಗಣತಿ ಅವಶ್ಯಕ

ಜನಗಣತಿಯಲ್ಲಿ ಕೃಷಿ

1 ಸಾಗುವಳಿ ಹಾಗೂ ತೋಟಗಾರಿಕೆಯಲ್ಲಿ ತೊಡಗಿರುವ ಕುಟುಂಬಗಳ ಜಮೀನಿನ ವಿಸ್ತೀರ್ಣದ ಬಗೆಗಿನ ಮಾಹಿತಿಗಳನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುವುದು. ಈ ಮಾಹಿತಿ ರಾಷ್ಟ್ರೀಯ ಕೃಷಿ ಯೋಜನೆಗಳನ್ನು ರೂಪಿಸಲು ಪೂರಕವಾಗಲಿದೆ

ಜನಗಣತಿಯಲ್ಲಿ ಸಾರ್ವಜನಿಕರ ಪಾತ್ರ

1 ಜನಗಣತಿ ಸಂದರ್ಭದಲ್ಲಿ ಸರಿಯಾದ ಮತ್ತು ಸಂಪೂರ್ಣವಾದ ಮಾಹಿತಿ ನೀಡುವುದು ಸಾರ್ವಜನಿಕರ ಜವಾಬ್ದಾರಿ ಹಾಗೂ ಕರ್ತವ್ಯ

2 ನಿಮ್ಮ ಸಹಕಾರ ಮತ್ತು ಕರಾರುವಾಕ್ಕಾದ ಉತ್ತರಗಳ ಮೇಲೆ ಜನಗಣತಿಯ ಯಶಸ್ಸು ಅವಲಂಬಿಸಿದೆ

ಜನಗಣತಿಯಲ್ಲಿ ಮಾಹಿತಿಯ ಗೌಪ್ಯತೆ

1 ಸಾರ್ವಜನಿಕರು ನೀಡುವ ಮಾಹಿತಿಯ ರಹಸ್ಯವನ್ನು ಮತ್ತು ಮಾಹಿತಿ ನೀಡಿದ ವ್ಯಕ್ತಿಯ ಮತ್ತು ಕುಟುಂಬದ ಅನಾಮಧೇಯತೆಯನ್ನು ಕಾಪಾಡುವುದು ಕಾನೂನಿನ್ವಯ ಅವಶ್ಯಕ

2 ಸಾರ್ವಜನಿಕರು ಯಾವುದೇ ಬಗೆಯ ಅನುಮಾನ ಮತ್ತು ಹಿಂಜರಿಕೆಯನ್ನು ಇಟ್ಟುಕೊಳ್ಳದೇ ಕುಟುಂಬ ಅಥವಾ ವ್ಯಕ್ತಿಯ ಬಗ್ಗೆ ನೀಡಲು ವಿವಂತಿಸಲಾಗಿದೆ. ಜನಗಣತಿಯಲ್ಲಿ ಪಡೆದ ಮಾಹಿತಿಯನ್ನು ಗೌಪ್ಯವಾಗಿಡಲಾಗುವುದು

ಎಣಿಕೆದಾರರು 2001ನೇ ಇಸವಿ ಫೆಬ್ರುವರಿ 9ರಿಂದ 28ರ ಅವಧಿಯಲ್ಲಿ ನಿಮ್ಮನ್ನು ಭೇಟಿಯಾದಾಗ ಸರಿಯಾದ ಮತ್ತು ಸಂಪೂರ್ಣವಾದ ಮಾಹಿತಿಯನ್ನು ನೀಡಿ ಸಹಕರಿಸಿ

ನೀವು ಕೊಟ್ಟ ಮಾಹಿತಿಯ ಗೌಪ್ಯತೆಯನ್ನು ಕಾಪಾಡಲಾಗುವುದು

WORKSHOP ON

CENSUS 2001 - ENUMERATION OF PERSONS WITH DISABILITY - CAMPAIGN

Venue : Shruthi Auditorium, Kendriya Sadan, Koramangala, Bangalore

WORKSHOP SCHEDULE

9.30	10-15	Registration of participants	Core group volunteers
10-15	10-30	Tea	
10-30	10-40	Welcoming the participants	Mr.Basavaraj, BGVS
10-40	11-15	About Census 2001	Mr.H.Shashidhar, IAS Director of Census
11-15	11-45	Enumeration of Persons with Disability (PWD) in Census 2001 - its importance	Dr.Pruthvish, ACTION AID INDIA
11-45	12-00	Efforts of Dept. of Welfare for Disabled, GOK in Census 2001	Mr.Veda Murthy, Director, Dept. of Welfare for Disabled, GOK
12-00	1-00	Gender perspective in Census 2001	Ms. Vinutha, BGVS
		Census 2001 - view from an education perspective	Mr. Chega Jagadeva Reddy BGVS
		Woman & Children - from work perspective, reflection in Census 2001	Ms. Tasqeen, ACTION AID INDIA
1-00	1-45	LUNCH BREAK	
1-45	2-10	A Brief presentation on mass education strategies by some NGOs on the issue	D.K.Venu & B.C.Patil NGOs, ARD & SPEED
2-10	3-00	Group exercise by NGOs on strategies to spread the message of enumeration of PWD in Census 2001	Exercise in groups
3-00	3-20	Brief presentation of group exercise by two groups	
3-20	3-40	Summing up of the workshop	Mr. Rajendra, LEONARD CHESHIRE INTERNATIONAL
3-40	4-00	Vote of thanks	Ms. Jayashri Ramesh NGO - ASHA
4-00	4-30	Distribution of materials to NGOs	
4-30		Tea & Workshop Concludes	

HP-1.

Mari Kalkally

DEALING WITH THE TRANSFERABILITY PROBLEM IN COMPARATIVE APPLIED POLICY RESEARCH AND ADVICE

Guest Lecture Faculty of Health Sciences
Monday 18 March 1996

February 1996

Dr J.G.A. van Mierlo
Associate Professor of Public Economics
Faculty of Economics and Business Administration
University of Limburg, Maastricht

1. Introduction

1. The Problem in International Policy Analysis:

CAN SOLUTIONS FOR POLICY PROBLEMS,
PROVEN TO BE SUCCESSFUL IN SOME COUNTRIES,
BE APPLIED TO SOLVE THE SAME POLICY PROBLEMS
IN OTHER COUNTRIES?

2. What can we learn from the methodology of comparative (social or policy research to answer this central question?

3. Types of (comparative) policy research

a. descriptive analysis (establishing statistical relations between different variables).

b. explanatory analysis (explaining dependent variables by independent variables by the logic of theory: causal modelling, and by empirical testing of these causal models).

c. prescriptive analysis (translating causal models in final models, translating cause-effect relations in instrument-goal relations).

2. Causal modelling

a. Descriptive analysis:

variable A <------> variable B

b. Explanatory analysis:

independent------> dependent
variable A variable B
CAUSE EFFECT

c. Prescriptive analysis:

instrument-----> target
variable A variable B
POLICY POLICY
INSTRUMENTS OBJECTIVES

3. Conclusion 1

1. Empirical research (testing hypotheses derived from theory: the concept of the empirical cycle of Karl Popper!) is the only scientific basis for the formulation of policy proposals to solve policy problems! (the process is a spiral, which goes into newer realms of theories)

2. Problem is: can causal models be translated into final models, how, under what conditions, to which extent, etc.

4. Problems in comparative research

(: from the point of view of researcher)

1. The choice of the unit of analysis
   > countries versus problems

2. Comparability and functional equivalence
   > 'idiographic' versus 'nomothetic research'

3. Substitution of country names by variables
   > explanation of similarities/differences between countries

4. Subjectivity and ethnocentrism
   > absolutism versus relativism

5. Confusion of levels of analysis
   > individual versus country characteristics
   > ecological fallacy, reverse ecological fallacy

6. Translation
   > the meaning of language

5. Transferability problems

1. The translation-problem of causal models into final models
2. The problem of elaboration and intervening variables
3. The problem of field-experiments versus laboratory-experiments
4. The stability condition and the ceteris-paribus clause
5. The seduction of thinking in blue-print models
6. The contingency problem
7. The determination of success and failure,
8. The determination of factors of success of failure
9. The manipulation of factors of success and failure
10. The problem of society's culture and culture shocks
11. The problem of society's structure and structural change
12. The problem of conflicting policy priorities
13. Other problems?

6. Case: Public Management Reform in Western Europe and Central and Eastern Europe

1. Research question
2. Research methods
3. The financier
4. Research problems
5. Research solutions
6. Further research

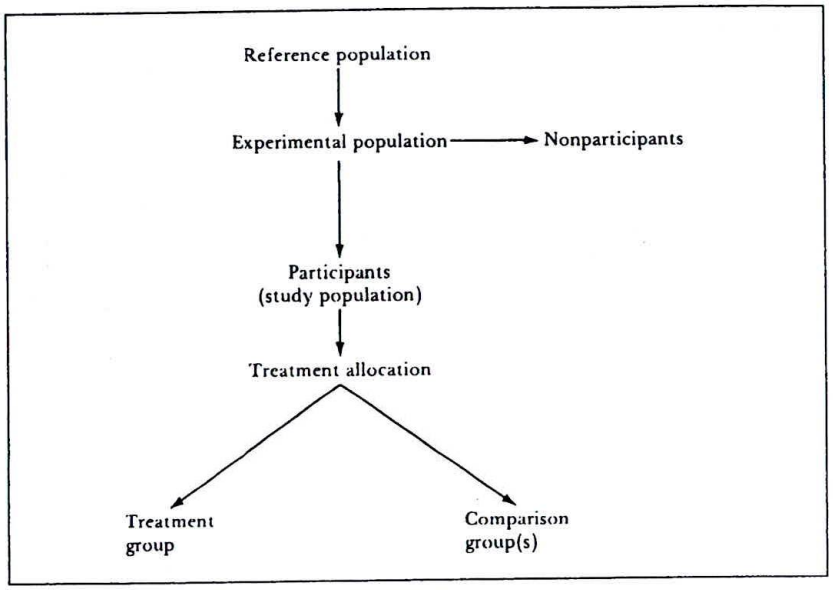

Fig. 8-1. Population hierarchy for an intervention study.

results are obtained. These include the selection of the study population, allocation of the treatment regimens, maintenance and assessment of compliance, and achieving high and uniform rates of ascertainment of outcomes.

Selection of a Study Population

The groups of individuals among whom an intervention study is conducted are derived from a number of interrelated populations, which can be considered as a population hierarchy (Fig. 8-1). The reference population is the general group to whom the investigators expect the results of the particular trial to be applicable. The reference population may include all human beings, if it seems likely that the study findings are universally applicable. Conversely, the reference population may be restricted by geography, age, sex, or any other characteristic that is thought to modify the existence or magnitude of the effects seen in the trial. Thus, the reference population represents the scope of the public health impact of the intervention. For example, the Physicians' Health Study [19] is a randomized trial of aspirin in the reduction of total cardiovascular mortality and beta-carotene in decreasing cancer incidence that is being conducted among over 22,000 male physicians aged 40 to 84 years in the U.S. There seems to be no reason to believe that the

effects of either aspirin or beta-carotene would be inherently different among male physicians in the U.S. than in a comparable group of males who are not physicians or even among those who do not live in the U.S. Therefore, the reference population of this trial may reasonably include all men 40 years of age and older. While some may consider the reference population to be as broad as all people over 40 years of age, others might be unwilling to generalize the findings of this trial to women. Thus, the reference population is related to the issue of generalizability, which involves a judgment about an intervention based on considerations beyond the data from an individual trial.

The experimental population is the actual group in which the trial is conducted. While, in general, it is preferable that this group not differ from the reference population in such a way that generalizability to the latter is not possible, the primary consideration in the design of the trial should always be to obtain a valid result. The selection of the experimental population is crucial to achieving that aim and involves consideration of each of several important issues. First, it is essential to determine whether the proposed experimental population is sufficiently large to achieve the necessary sample size for the trial. For example, in considering design features for a trial of intravenous streptokinase therapy in acute myocardial infarction to decrease subsequent cardiovascular mortality, a single hospital would certainly not admit enough patients to permit enrollment of the requisite number of participants to test the hypothesis of a small to moderate benefit, even within a study period of several years. It would therefore be necessary to design a multicenter trial, including a number of hospitals in the community, across the country, or throughout the world. Such a study is currently underway in 15 countries and expects to enroll perhaps 20,000 patients over 2 years [24].

Analogously, it is essential to choose an experimental population that will experience a sufficient number of the end points or outcomes of interest to permit meaningful comparisons between various treatments or procedures within a reasonable period of time. For example, if a primary prevention trial of regular aspirin consumption in reducing the risk of total cardiovascular mortality were conducted among a group of 20,000 women under age 40, it would take several decades to accumulate sufficient end points to test the hypothesis because of the relatively low frequency of this disease in this population. In contrast, a similar trial conducted among men aged 40 and over could provide sound evidence on this question after several years, since total cardiovascular disease death rates are several-fold higher in men than women and increase markedly in middle age. A third major concern is the likelihood of obtaining complete and accurate follow-up information for the duration of the trial. A long-term trial conducted among a highly mobile group such as college students or a study requiring frequent clinic visits among

a group of infirm elderly subjects might result in low follow-up rates, which would render the findings uninterpretable.

In designing the Physicians' Health Study [19], for example, the considerations described above contributed to the choice of doctors as the experimental population. The number of willing and eligible physicians in the age groups at risk of death from cardiovascular disease as well as the development of cancer seemed sufficient for an adequate test of each hypothesis. Moreover, because of their training, doctors would be able to recognize any side effects of the agents promptly. They are also well aware of their medical history and health status and would report this information with a high degree of accuracy and detail. Finally, since physicians are less mobile and easier to trace than members of the general population, a high rate of follow-up could be attained, even for an extended duration of the trial. Pilot studies conducted among random samples of this group also indicated a high degree of compliance with the study regimen as well as adherence to the trial protocol, which included the completion of follow-up questionnaires. Thus, the trial could be conducted entirely by mail at a small fraction of the usual cost for previous intervention studies of primary prevention [18]. These general considerations must all be addressed in the design phase of any trial, to avoid the possibility of wasting valuable time and resources on studies that cannot provide either a definitive positive finding or a null result that is truly informative.

Once the experimental population has been defined, subjects must then be invited to participate after being fully informed as to the purposes of the trial, the study procedures, and the possible risks and benefits. If appropriate, this information will include knowledge that they may be allocated to a group receiving no active treatment and that they may not know the treatment they received until the end of the trial. Those willing to participate must then be screened for eligibility according to predetermined criteria. Reasons for exclusion from the trial may include factors such as a previous history of any end points under study, a definite need for the study treatments, as well as contraindications to their use. Those who are eventually determined to be both willing and eligible to enroll in the trial compose the actual study population and are often a relatively small subgroup of the experimental population. For example, as shown in Figure 8-2, in the Hypertension Detection and Follow-Up Program (HDFP) [23], a randomized trial testing a stepped-care approach compared with usual medical care to treat hypertension, an initial enumeration of the populations of the 14 participating communities identified a total of 178,009 men and women in the eligible age range, 30 to 69 years. Of these potentially eligible subjects, 158,906 completed a first screen, and 22,978 were found to have diastolic blood pressures of at least 95 mm Hg. Subsequently, 17,476 of these individuals completed a second screen to establish the final study population of

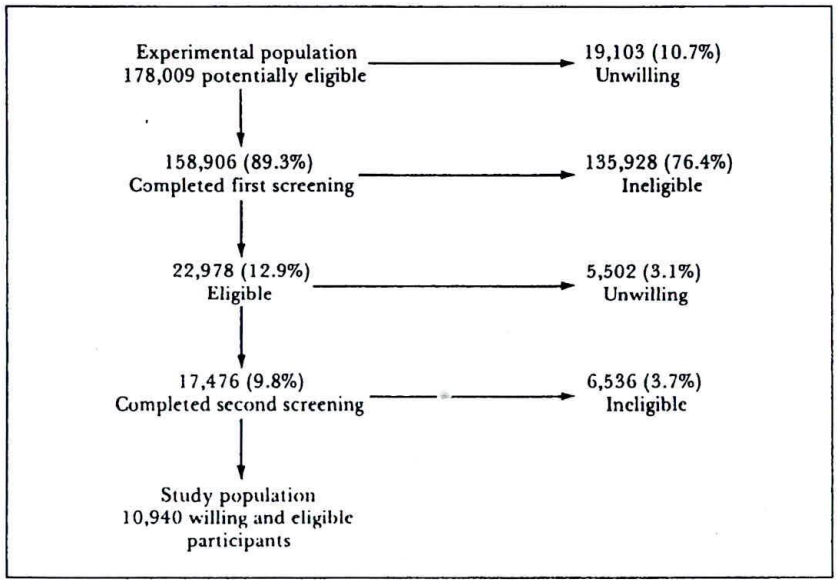

Fig. 8-2. Population hierarchy for hypertension detection and follow-up program. (From Hypertension Detection and Follow-up Program Cooperative Group, Five-year findings of the Hypertension Detection and Follow-up Program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. *J.A.M.A.* 242:2562, 1979.)

10,940 persons with diastolic blood pressures greater than or equal to 90 mm Hg who were both willing and eligible to participate in the trial. Thus, only 6.1 percent of the total experimental population formed the study population for the HDFP.

The actual study population of a trial is often not only a relatively small but also a select subgroup of the experimental population. It is well recognized that those who participate in an intervention study are very likely to differ from nonparticipants in many ways that may affect the rate of development of the end points under investigation [16]. Among all who are eligible, those willing to participate in clinical trials tend to experience lower morbidity and mortality rates than those who do not, regardless not only of the hypothesis under study, but of the actual treatment to which they are assigned [44]. Volunteerism is likely to be associated with age, sex, socioeconomic status, education and other, less well-defined correlates of health consciousness that might significantly influence subsequent morbidity and mortality. Whether the subgroup of participants is representative of the entire experimental population will not affect the validity of the results of a trial conducted among that group. It may, however, affect the ability to generalize those results to either the experimental or the reference population.

If it is possible to obtain baseline data and/or to ascertain outcomes for subjects who are eligible but unwilling to participate, such information is extremely valuable to assess the presence and extent of differences between participants and nonparticipants in a particular trial. This will aid in the judgment of whether the results among trial participants are generalizable to the reference population. For example, in the previously discussed CASS trial [6], 780 patients at 11 participating institutions entered the trial and were randomized to either coronary artery bypass surgery or medical management. An additional 1315 patients at the same institutions met the randomization criteria but were unwilling to participate. Of these 1315 eligible but unwilling patients, 435 started with surgical therapy, and 880 received medical treatment. These 1315 eligible/unwilling patients were compared with the 780 eligible/willing patients regarding a number of baseline characteristics such as demographic factors, medical history, extent of disease, and life-style variables, and all were followed for an average of 5 years. The investigators found that the entry characteristics of randomized patients were generally similar to those of eligible but unwilling patients. Moreover, mortality rates in both the randomized and nonrandomized groups of medically treated patients were similar, as were those for the two groups of surgically treated subjects [7]. These data indicate that those who were willing to enter the CASS trial do not appear to have been a special subset of those eligible for randomization but seemed representative of all eligible patients. The availability of these data strengthen the belief that the study results are generalizable beyond the trial population.

Allocation of Study Regimens

Since participants and nonparticipants may differ in important ways related to the outcome under study, allocation into the various treatment groups should take place only after subjects have been determined to be eligible and have expressed a willingness to participate (see Fig. 8-1). The effects of a treatment, procedure, or program can be compared with those of one or more of a variety of groups, such as another dosage of the same drug, another therapy or program, continuation of standard medical practice, or a placebo. To maximize the probability that the groups receiving these differing interventions will be comparable, assignment to a study group should be at random. Random assignment implies that each individual has the same chance of receiving each of the possible treatments and that the probability that a given subject will receive a particular allocation is independent of the probability that any other subject will receive the same treatment assignment. The two methods most commonly used to achieve this objective are the use of a table of random numbers or the use of a computer-generated randomization

list. In addition, when the outcome under study is anticipated to vary appreciably in frequency among subgroups of the study population, for instance, between men and women, or when response is likely to differ markedly between subjects, such as those with different stages of disease, the efficiency of the study might be increased by ensuring that treatment groups are approximately equal or balanced with respect to such characteristics. This can be accomplished by a somewhat more complex form of randomization, called blocking, in which every participant is classified with respect to each such variable before allocation and then randomized within the subgroup. Since randomization of large samples virtually guarantees comparability of treatment groups, blocking has particular relevance when the study size is limited [31, 32].

Randomization has many unique advantages when compared with other methods of allocation. First, if randomization is properly done, nobody either involved in deciding whether a patient is eligible to enter into a trial or responsible for the allocation procedure will know the assigned treatment group. Thus, the potential for bias in allocation to study groups is removed, and investigators can be confident that observed differences are not due to the selection of particular patients to receive a given therapy. Whenever a system can be predicted, as with the use of any other procedure to allocate treatment, there is the potential for manipulation. For example, alternate assignment to study and comparison groups is often used but is always liable to potential bias. Specifically, if two willing and eligible subjects presented at the same time with different prognoses, a physician might, consciously or not, enter them into the study in the order that would allow the more seriously ill patient to receive the treatment the physician already believed to be more (or perhaps even less) promising. If a large proportion of subjects were entered in this way, a serious imbalance in the treatment groups with respect to factors affecting the outcome under study would result. A truly more promising treatment could in fact appear less effective than the alternative simply because it was administered to a group less likely to benefit from any form of therapy than the individuals who were systematically assigned to the alternative being studied. Allocation on the basis of day of the week is also subject to a systematic bias, especially for patients presenting at or near midnight.

Another unique advantage of randomization is that on average, the study groups will tend to be comparable with respect to all variables except for the interventions being studied. "On average" implies that the larger the sample size, the more successful the randomization process will be in distributing these factors equally among the groups. For example, the total population of 10,940 participants in the HDFP [23] consisted of 34.3 percent white males, 25.9 percent regular smokers, 26.0 percent current takers of antihypertensive medications, and 5.2 percent

Table 8-1. Selected baseline characteristics of the total study population and the two treatment groups of the Hypertension Detection and Follow-up Program (HDFP)

Baseline characteristics	Total HDFP ($n = 10,940$)	Stepped care ($n = 5485$)	Referred care ($n = 5455$)
White male	34.3%	34.5%	34.1%
Regular smoker	25.9%	25.6%	26.2%
Currently taking antihypertensive medication	26.0%	26.3%	25.7%
History of myocardial infarction	5.2%	5.1%	5.2%

Source: Hypertension Detection and Follow-up Program Cooperative Group. Five-year findings of the Hypertension Detection and Follow-up Program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. *J.A.M.A.* 242:2562, 1979.

with a history of myocardial infarction. Randomization resulted in two study groups of 5485 (stepped care) and 5455 (referred care) with virtually identical proportions of each of these factors (Table 8-1).

This feature of randomization is important because all baseline characteristics that affect risk and differ between the treatment groups could potentially confound the relationship between exposure and disease. An even more crucial implication, however, is that on average not only will all known confounding variables be equally distributed, but so will all potential confounders that are unsuspected by the investigator because of limitations of biologic knowledge at the time the trial is initiated. Variables that are not identifiable cannot be dealt with by any direct procedures. Consequently, the only possible way to achieve control for any influence of unknown variables is through randomization. When the sample size is sufficiently large, both known and unknown confounding factors are distributed equally among treatment groups. Thus, randomization can provide a degree of assurance about the comparability of the study groups that is simply not possible in any observational study design.

Finally, a significant advantage of randomization is the deservedly favorable impression that this design strategy may have on those reading the published results of a trial. When exposure is assigned by a method other than randomization, the burden of proof is on the investigator to show that all possible biases in the allocation of patients to a study group or confounding effects of known or unknown factors that may differ between the study groups did not account for the observed result. Thus,

there is an inherent confidence in the results of a well-designed and conducted randomized trial that cannot be achieved with any alternative allocation scheme [16].

A type of nonrandomized intervention study that is sometimes seen in the literature is one in which the comparison group is historical. In this instance, the experience of a group of hospitalized patients allocated to a new agent or procedure is compared with that of other patients in the same hospital who had been exposed to the preexisting standard form of treatment. In general, such observational comparisons can provide reliable evidence when there is a relatively large effect of the new treatment compared with previous standard therapy. For example, the efficacy of treatment of malignant hypertension was demonstrated by observing a far lower mortality experience of newly treated patients with those previously untreated [12]. However, in the more common circumstance, where the effects are small to moderate, it is difficult to distinguish reliably such differences between the study groups. Since data on the new treatment and the standard therapy are collected during two different time periods, there may have been changes in the patient population admitted to the hospital, other advances in diagnostic or treatment methods, or even general modifications of health behavior. Any or all such factors may result in changes in the frequency of the disease that are totally unrelated to the intervention being tested.

Maintenance and Assessment of Compliance

By definition, an intervention study requires the active participation and cooperation of the study subjects. After agreeing to participate, subjects in a trial of medical therapy may deviate from the protocol for a variety of reasons, including developing side effects, forgetting to take their medication, or simply withdrawing their consent after randomization. Analogously, in a trial of surgical therapy, those who were randomized to one group may choose to obtain the alternative treatment on their own initiative. In addition, there will be instances where participants cannot comply, such as when the condition of a randomized patient rapidly worsens to the point where therapy becomes contraindicated. Consequently, the problem of achieving and maintaining high compliance is an issue in the design and conduct of all clinical trials.

The extent of noncompliance in any trial is related to the length of time that participants are expected to adhere to the intervention, as well as to the complexity of the study protocol. There are a number of possible strategies that can be adopted to try to enhance compliance among the participants in a trial. As discussed earlier, selection of a population of individuals who are both interested and reliable can enhance compliance rates. For example, the CPPT [26] was conducted among men with elevated blood cholesterol levels, who were consequently at increased

risk of developing CHD. Such individuals in general have a much stronger motivation to comply with a study regimen than those at usual risk. Other ways of attempting to increase compliance include frequent contact with participants by home or clinic visit, telephone, or mail; the use of calendar packs of study medication, in which each pill is labelled with the day it is to be taken; and the use of incentives such as detailed medical information not ordinarily available from their usual source of health care.

Monitoring compliance is important because noncompliance will decrease the statistical power of a trial to detect any true effect of the study treatment. Thus, the interpretation of any trial result must take into account the extent to which there was adherence to the intervention regimen. To the extent that participants in the alternative treatment group receive the intervention under study or those in the intervention group do not actually adhere to their assigned regimen, the two groups will become very similar in terms of exposure. Consequently, any true magnitude of effect of the intervention may be obscured. For example, in the Multiple Risk Factor Intervention Trial (MRFIT) [27], 12,866 healthy men, aged 35 to 57 years, who were at high risk of developing CHD on the basis of current cigarette smoking, elevated blood pressure, and high blood cholesterol were randomized either to a special intervention program designed to promote the reduction of these three risk factors or to their usual sources of health care in the community. After 7 years of follow-up, there was a nonsignificant 7-percent decrease in deaths from CHD in the special intervention group compared with those allocated to usual medical care. One factor that contributed to the inability of the study to detect a significant difference despite sizeable reductions in the levels of all three risk factors in the special intervention group was that a large proportion of individuals in the usual care group also stopped smoking, received antihypertensive medication, and lowered their serum cholesterol through weight loss or dietary changes. Although it is not possible to know for certain why these men assigned to receiving usual care became "noncompliant" with their treatment regimen, it seems likely that it was due to the increasing awareness of the general public of the adverse effects of smoking, hypertension, and high cholesterol and attempts to alter these risk factors.

The higher the degree of compliance with the offered program, the greater the extent to which observed differences between those allocated to alternative therapies reflect real differences in the effects of the treatments themselves. Thus, compliance levels must be measured, which is generally not easy. All of the measures available to estimate compliance have inherent limitations. The simplest measure is a self-report. In fact, for some interventions, such as exercise programs or behavior modifications, this may be the only practical way to assess compliance. In trials of pharmacologic agents, pill counts have been used, where participants

bring unused medication to each clinic visit or return it to the investigators at specified intervals. For example, participants in the CPPT brought unused packets of cholestyramine or placebo to each follow-up visit [26]. Although this method may eliminate inaccuracies due to poor memory, it assumes that the subject has ingested all medication that has not been returned to the clinic. A more objective means of assessing compliance, which is also expensive and logistically difficult, is the use of biochemical parameters to validate self-reports. Laboratory determinations on either blood or urine can frequently detect the presence of active drugs or metabolites. In cases where drugs or metabolites are difficult to measure, or for subjects taking an inert placebo, a safe biochemical marker such as trace amounts of riboflavin can be added to the treatment. Laboratory determinations are limited, however, in that they usually only reflect whether medication was taken in the preceding day or two and thus cannot be used as a reliable measure for long-term compliance.

Inevitably, some proportion of participants in a trial will become noncompliant despite all reasonable efforts. In such instances, maintaining any level of compliance is preferable to complete noncompliance. Moreover, as will be discussed, every randomized subject should be included in the primary analysis of any intervention study, so that it is essential to obtain as complete follow-up information as possible on those who have discontinued the treatment program. Investigators should pursue follow-up data on outcome for such individuals for the duration of the trial in a manner identical to that for subjects who continue to comply.

Uniform and High Rates of Ascertainment of Outcome

Another crucial issue to be considered in the design and conduct of an intervention study is the ascertainment of the outcome(s) of interest. The primary objective is to ensure that results are not biased by the collection of more complete or accurate information from one or another of the study groups. In addition to the need for uniform ascertainment of outcome is the requirement for complete follow-up of study participants over the duration of the trial. For some research questions, ascertainment of the outcome may require only a short follow-up period, as in a study of in-hospital mortality after treatment for acute myocardial infarction or in a trial assessing the acute toxicity following administration of a new chemotherapeutic agent. In these circumstances, it is often relatively easy to maintain contact with all participants during the entire study period. Often, however, many years of follow-up will be needed, especially for trials of treatments or other interventions that affect the risk of developing or dying from chronic diseases. As the period of time over which subjects must be followed increases, maintaining complete ascertainment of outcomes becomes more difficult. When outcomes for

a proportion of study subjects are not identified but that proportion is similar for all treatment groups, the smaller the losses, the greater the likelihood that the magnitude of a bias will be small. On the other hand, if the proportion of outcomes that are not ascertained is large or differs among the study groups, the result could be an under- or overestimate or even, by chance, reflect the true effect. To avoid this situation, where it is not possible to know the magnitude or direction of the bias, it is crucial to keep the number of individuals lost to follow-up to an absolute minimum. For studies with mortality as an end point, the availability of the U.S. National Death Index has enabled researchers, at the very least, to assess the vital status on every individual entered into a trial [37]. Methods to maintain high follow-up rates in intervention studies are identical to those used in prospective cohort studies, which have been described in Chapter 7.

The potential for observation bias in ascertainment of outcome can exist in an intervention study in that knowledge of a participant's treatment status might, consciously or not, influence the identification or reporting of relevant events. The likelihood of such bias is directly related to the subjectivity of the outcomes under study. If the end point being considered is total mortality, observation bias is unlikely, since the fact of death is objective and indisputable and cannot be affected by knowledge of a patient's treatment regimen. In contrast, ascertainment of a specific cause of death may be less clear-cut and thus may be influenced by a clinician's knowledge of treatment assignment. Moreover, there are trials in which the end points of interest may include subjective outcomes such as severity of illness, frequency of side effects, increased mobility, or decreased pain. In all these circumstances, it is especially important to utilize methods to minimize the likelihood of any systematic difference in the ascertainment of outcomes between study groups.

One such approach is to keep the study participants and/or the investigators blinded so far as possible to the identity of the interventions until data collection has been completed. In a double-blind design, neither the participants nor the investigators responsible for assessment of outcomes know to which treatment group an individual has been assigned. The ability to conduct a double-blind trial is dependent on having treatment and comparison programs that are as nearly identical as possible. Consequently, in many trials, especially of drug therapies, the comparison group is assigned to receiving a placebo, which is an inert agent indistinguishable from the active treatment. By making it extremely difficult, if not impossible, to differentiate between the treatment and comparison groups, the use of a placebo will minimize bias in the ascertainment of both subjective disease outcomes and side effects.

One problem in the evaluation of such end points is the well-documented tendency for individuals to report a favorable response to any therapy regardless of the physiologic efficacy of wh hey receive. This

phenomenon is referred to as the placebo effect. If a study does not use placebo control, it is impossible to tell whether subjective outcomes are due to the actual trial treatments, to the extra attention participants receive, or merely to their belief that the treatment will help. For example, in 1962, Wangensteen and colleagues [43] introduced a new technique for the treatment of duodenal ulcer, gastric "freezing," in which a coolant was administered by nasogastric tube to suppress secretions. In their case series of 31 patients, all reported marked or complete relief of pain following this procedure. Despite the fact that the data were descriptive and therefore could not test the hypothesis, gastric freezing began to be used in many clinical centers. Subsequently, concern about its efficacy and safety led to the initiation of a randomized trial [36]. Specifically, of 137 patients with duodenal ulcer, 69 were assigned at random to gastric freezing and 68 received a placebo, in that the nasogastric tube was inserted but coolant applied only as far as the upper esophagus. Using these procedures, all patients were aware of the presence of the coolant, but in the placebo group, no direct effect on gastric secretions was possible. The trial showed similar proportions of marked or complete relief of pain, suppression of secretions, as well as frequency and severity of recurrence between those who received the actual freezing procedure and those who did not. These statistically nonsignificant results suggested that the relief of symptoms reported by all subjects in the case series may have been due to the psychological effect of the procedure rather than any true physiologic benefits.

On the other hand, persons taking a drug or undergoing a medical procedure may be sensitized to their physical condition and tend to ascribe every symptom or unusual occurrence to their treatment. For example, in the Veterans Administration Cooperative Study of Antihypertensive Agents [42], 186 men were randomized to a combination of hydrochlorothiazide, reserpine, and hydralazine, and 194 were assigned to placebo. One of the anticipated side effects of these agents is impotence. Nevertheless, the proportions of subjects reporting this outcome at any time during the study period were virtually identical in the treatment and placebo groups (29% and 28%, respectively). Similarly, in the Aspirin Myocardial Infarction Study [3], 23.7 percent of subjects randomized to receiving 1 gm of aspirin per day reported symptoms suggestive of peptic ulcer, gastritis, or erosion of gastric mucosa, whereas 14.9 percent of those receiving placebo reported similar symptoms. If the trial had not used placebo control, an erroneously high rate of gastrointestinal side effects would have been attributed to aspirin, whereas in actuality the rate was 23.7 percent minus 14.9 percent, or 8.8 percent. The use of a placebo will ensure that all aspects of the program offered to participants are identical except for the actual experimental treatment. Consequently by comparing the proportions of individuals in the active treatment an lacebo groups who report a particular symptom

or outcome, the true incidence of subjective treatment-related effects can be determined.

Thus, the primary strength of a double-blind design is to eliminate the potential for observation bias. Of course, a concomitant limitation is that such trials are usually more complex and difficult to conduct. Procedures must be established for immediate "unblinding" of a participant's physician in the event of serious side effects or other clinical emergencies in which this information seems essential. Moreover, in some circumstances, it is not possible to "blind" both the participants and the investigators to the allocated treatment regimen. It is very difficult to design a double-blind trial for the evaluation of programs involving substantial changes in life-style, such as exercise, cigarette smoking or diet, surgical procedures, or drugs with characteristic side effects. In these circumstances, a single-blind or unblinded trial may be necessary. In a single-blind design, the investigator alone is aware of which intervention a subject is receiving, while in an unblinded or open trial, both the subject and the investigator know to which study group the individual has been assigned.

Single-blind or unblinded trials are simpler to execute than double-blind studies and may be more acceptable both to physicians randomizing their patients and to participants. Of course, these designs also have special problems. For example, subjects aware that they are not on the new or experimental program may become dissatisfied and drop out of the trial, thus resulting in differential compliance or loss to follow-up. Moreover, as discussed earlier, knowledge of the intervention to which the participant has been assigned again raises the potential for observation bias in the reporting of side effects or assessment of outcomes. Thus, when a double-blind design is not possible, it is imperative that special precautions be taken to reduce the potential for observation bias. For measurement of both side effects and end points, objective criteria should be used, and the study groups should be followed with equal intensity by independent examiners who are unaware of the subjects' treatment status.

Use of a Factorial Design

In this chapter, we have thus far considered issues in the design of intervention trials of a single factor, where one treatment or regimen is compared with one or more alternatives or placebo. Given the cost and feasibility issues in designing clinical trials, one technique to improve efficiency is to test two or more hypotheses simultaneously in a factorial design. A clinical trial of two hypotheses can utilize a two-by-two factorial design, in which subjects are first randomized to treatments α or β to address one hypothesis, and then within each treatment group there is further randomization to treatments A or B to evaluate a second question. Similarly, in a two-by-two-by-two factorial design, each of these subgroups would be further randomized into two additional intervention groups to address a third hypothesis, and so on.

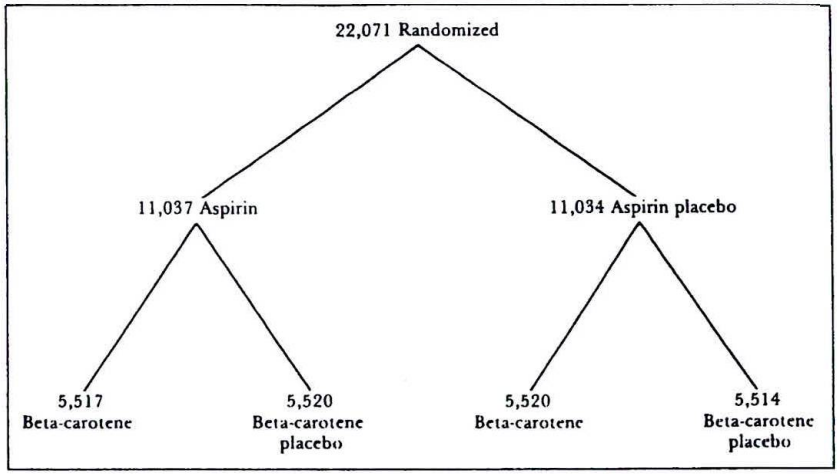

Fig. 8-3. Randomization scheme for a two-by-two factorial design: Physicians' Health Study.

The Physicians' Health Study [19, 38] utilizes a two-by-two factorial design to evaluate the two hypotheses that consumption of low-dose aspirin reduces cardiovascular mortality and that beta-carotene consumption decreases cancer incidence. As shown in Figure 8-3, the more than 22,000 willing and eligible physicians were first randomized into two groups, one receiving aspirin and the other aspirin placebo. Each of these treatment groups was further randomized to receiving either beta-carotene or its placebo. Thus, physicians in the trial were allocated to one of four possible regimens: aspirin alone, beta-carotene alone, both active agents, or both placebos.

The principal advantage of the factorial design is its ability to answer two or more questions in a single trial for only a marginal increase in cost. Moreover, as in the Physicians' Health Study, the use of a factorial design can allow testing a less mature hypothesis together with a more mature question having reliable evidence available to justify its evaluation. The Physicians' Health Study sought primarily to test the hypothesis that a single 325-mg aspirin tablet taken every other day could reduce total cardiovascular mortality among men with no history of a prior myocardial infarction. Since there was a large body of laboratory and observational epidemiologic data, as well as information from trials of aspirin among those with a history of myocardial infarction or unstable

angina [2, 25], a primary prevention trial of aspirin seemed warranted. Whether beta-carotene could decrease cancer incidence, however, was a promising but as yet immature hypothesis [20, 21, 33]. Nevertheless, as discussed earlier, because of the continuing widespread use of multivitamin supplements in the U.S., for reasons of feasibility it seemed important that a trial of beta-carotene be conducted as soon as possible. By using a two-by-two factorial design, the carotene hypothesis could also be tested in the Physicians' Health Study without materially affecting the sensitivity or the cost of the aspirin component.

Ideally, of course, the additional treatments in a factorial design should not complicate trial operations, materially affect eligibility requirements, or cause side effects that could lead to poor compliance or losses to follow-up. In addition, the possibility of an interaction between treatment regimens must be considered. Fortunately, such interactions tend to affect the magnitude of observed treatment effects rather than changing their direction from benefit to harm or vice versa. Moreover, while the effects of interactions could be viewed as a potential limitation of a factorial trial, this design in fact facilitates the identification of their existence [38]. For example, in the Second International Study of Infarct Survival [24], the two major questions of interest are the efficacy of intravenous streptokinase and of low-dose oral aspirin in the reduction of cardiovascular mortality after an acute myocardial infarction. It may well be that any benefit of the thrombolytic agent intravenous streptokinase would be greater in the presence of the antiplatelet drug aspirin than in its absence. The use of a two-by-two factorial design allows for the assessment of such an interaction, which could not be done in a single-factor study.

STOPPING RULES: DECISION FOR EARLY TERMINATION OF A TRIAL

In the design phase of a trial, there is a need to develop guidelines for deciding whether a trial should be modified or terminated before originally scheduled. In addition, in some trials of preventive and therapeutic regimens, individuals enter the study over an extended period of time, and the experience of the early participants becomes available while later individuals are still being enrolled. To assure that the welfare of the participants is protected, interim results should be monitored by a group that is independent of the investigators conducting the trial. If the data indicate a clear and extreme benefit on the primary end point due to the intervention, or if one treatment is clearly harmful, then early termination of the trial must be considered. For example, the Beta-Blocker Heart Attack Trial [10] was a randomized double-blind study comparing propranolol with placebo in 3837 patients with a recent myocardial infarction. The trial was terminated 9 months before the scheduled closing date on the recommendation of an external data monitoring board. At that time, the propranolol group had a highly statistically significant ($P = 0.005$) 26-percent reduction in the primary end point, total mortality, when compared with the placebo group. The emergence of such an extreme result raised the question of whether it would be ethical to continue withholding propranolol from the placebo group.

Of at least equal importance, it would also seem unethical to stop a trial prematurely based solely on emerging trends from a small number of patients. Such findings might well be only transient and disappear or even reverse after data have accumulated from a larger sample. For example, on three occasions during the first 30 months of the Coronary Drug Project (CDP) trial [9], the mortality of the group receiving clofibrate was significantly lower, at the conventional $P = 0.05$ level, than that of the placebo group. However, the finding did not achieve the extreme level of significance recommended for consideration of early termination [31, 32]. The study group therefore decided not to stop the trial but to continue to monitor the results closely. On this basis, the scheduled follow-up period was completed, and when the final results were analyzed, the mortality of the clofibrate group was, in fact, identical to that of the placebo group (25.5% versus 25.4%).

Thus, a decision to terminate a study early is based on a number of complex issues and must be made with a great deal of caution. There are a variety of sophisticated statistical methods that are currently available for monitoring the accumulating data from a clinical trial. As a general rule, the first requirement for even considering modification or early termination of an ongoing trial is the observation of a sustained statistical association that is so extreme, and, therefore, so highly significant, that it is virtually impossible to arise by chance alone [1, 16, 31, 34]. While a statistical test should not normally be used as the sole basis for the decision to stop or continue a trial, it serves an important function to alert those responsible for monitoring interim data to the possibility that there may be cause for concern. The observed association must then be considered in the context of the totality of evidence, including known or postulated biologic mechanisms that might explain such an effect, if it was unanticipated; results from other randomized trials and, to a lesser extent, those from observational studies; and an assessment of how the observed association would affect the overall risk-to-benefit ratio of the intervention. Similarly, the specific statistical criterion used to alert investigators to the need to consider these issues cannot be specified exactly for all trials. In fact, there are many different views of what constitutes sufficient proof that an observed association in interim data does not represent a temporary, random fluctuation. Moreover, some investigators feel that this criterion should not be equally stringent for beneficial and harmful effects, or with respect to antici-

pated and unanticipated findings. Whatever the specific guideline, however, the aim is to achieve an equitable balance between, on the one hand, protection of randomized participants against real harm and, on the other, minimizing the risk of mistakenly modifying or stopping the trial prematurely. Detailed discussions of the issues involved in such decisions can be found elsewhere [1, 9, 10, 16, 31, 34].

SAMPLE SIZE CONSIDERATIONS: STATISTICAL POWER

Although sample size must be addressed early in the planning stage of any analytic epidemiologic investigation, it has particular importance in an intervention study. Observational analytic study designs can most reliably study large effects, so that the sample may be moderate in size. In contrast, a trial must have a sufficient sample size to have adequate statistical power or ability to detect reliably the small to moderate but clinically important differences between treatment groups that are most likely to occur [47]. Peto [29] has stated that most of the roughly 2000 randomized clinical trials currently underway worldwide are of "little or no scientific value," based primarily on the fact that these studies are of inadequate sample size to detect such effects reliably. We believe that such trials actually have the potential for great scientific harm, especially if their results are misinterpreted as demonstrating that an intervention has no effect when in fact the sample size was not sufficient to provide an informative null result. Even if an investigator feels confident that a new intervention will have a large benefit (i.e., a 50% or greater reduction in the primary end point), it is far preferable to design a trial to test the more likely small to moderate benefit (i.e., 10–20%) and stop the trial early than to anticipate a larger effect and have no ability to detect smaller but nonetheless clinically important differences.

In designing a clinical trial, investigators often devote much time and effort to increasing the total number of participants enrolled. However, the statistical power of a trial to detect a postulated difference between treatment groups, if one truly exists, is dependent not simply on the sample size, but more specifically on two factors: (1) the total number of end points experienced by the study population and (2) the difference in compliance between the treatment groups [29].

Accumulation Of Adequate End Points

To accumulate sufficient numbers of end points, two major strategies may be considered: first, selecting a high-risk population for study and, second, ensuring an adequate duration of follow-up.

Selection of a High-Risk Population

A primary strategy to ensure the accumulation of an adequate number of end points is to select individuals at increased risk of developing the outcomes of interest. With respect to the general population, a simple but important criterion for this selection is age. Since the frequency of most outcomes rises with increasing age, the impact of this factor can be dramatic. For example, in a study of mortality from CHD, 10,000 men aged 45 and 54 would be expected to experience only about 27 coronary deaths during a 1-year follow-up period, while a comparable group of men aged 65 to 74 followed for 1 year would yield about 167 such fatalities [40]. Other risk factors on which selection of a study population might be based include sex, occupation, geographic area, or one or more medical or life-style variables. As mentioned earlier, the CPPT [26] was conducted among middle-aged men at increased risk of CHD due to elevated blood cholesterol levels (above 265 mg/dl). Similarly, MRFIT [27] selected men aged 35 to 57 years who were in the upper 15 percent of a risk score distribution based on combined levels of cigarette smoking, blood cholesterol, and/or blood pressure.

The collection of baseline data can be planned to allow the identification of particular subgroups who might experience different effects of an intervention. For example, in the Physicians' Health Study, if the true reduction in cancer incidence due to beta-carotene is 30 percent or greater, there is excellent power to detect that difference among the total of more than 22,000 randomized physicians. On the other hand, if the overall reduction in risk is only 10 percent, it would not be possible to detect such an effect with great assurance. However, a 10-percent overall reduction could result from a much larger effect confined exclusively to a particular subgroup, in this case, those with the lowest levels of beta-carotene or vitamin A at baseline [30]. This finding could easily be detected if participants were stratified by baseline levels of these parameters. For this reason, prerandomization blood specimens were collected by mail from 14,916 of the participating physicians, to be analyzed for baseline levels of retinol, carotene, retinol-binding protein, as well as other relevant parameters. The availability of these prerandomization blood specimens will increase the sensitivity of the trial to identify which particular subgroup of doctors, if any, stands to benefit most from beta-carotene. If there is a benefit confined to those having low baseline levels, then future public health interventions could be aimed at that target population. Conversely, if there is no true effect of beta-carotene supplementation on cancer incidence, this strategy would in fact produce a more convincing and truly informative null result, for then it could be stated that not only was there no significant overall effect observed, but in addition, no effect of supplementation with this agent was apparent regardless of initial blood levels. Despite the fact that such hypotheses

are formulated before data collection, it remains important to keep in mind that such comparisons are not strictly randomized.

Length of the Follow-Up Period

The length of any planned follow-up period should always consider that the actual rate of accrual of end points will be less than projected. This situation is not unusual in clinical trials and may occur for reasons beyond the control of the investigators. First, as discussed previously, those who volunteer to participate in intervention studies are a self-selected group who also tend to experience generally lower morbidity and mortality rates than those who do not take part, regardless of the hypothesis under study or the treatment allocated at random. For example, in planning the Physicians' Health Study, we considered the likelihood that the relatively small proportion of all potential participants who were actually both willing and eligible to enroll would have substantially lower rates of cardiovascular mortality and cancer than the general population, due to the generally better health and habits of U.S. doctors as a whole, to the impact of our exclusion criteria, and to the "healthy volunteer effect." We therefore postulated that the rates of these end points in the trial would be about half those that might be expected. In fact, mortality rates during the first year were less than 20 percent of what would have been expected among a general population with the same age distribution, or about 40 percent of our projection for the initially planned duration of the study (3.5 years). The only way to compensate for this deficit in expected end points would be to extend the length of the follow-up period. In fact, with the continued cooperation and permission of participating doctors, we have doubled the length of follow-up and expect to accrue about four times the number of end points.

Moreover, there may be secular changes in disease rates during the course of the trial, sometimes as great as that due to the intervention studied. For example, as discussed previously, MRFIT [27] was designed to evaluate whether the combined effects of cessation of smoking, control of hypertension, and reduction of cholesterol would decrease the mortality rate from CHD. During the decade in which this trial was conducted, the entire U.S. population, including all MRFIT participants, experienced a marked 25- to 30-percent decline in CHD mortality [17]. In part due to this secular trend, the observed numbers of deaths in the trial were less than two-thirds the numbers expected for the 6-year follow-up period. Extending the length of follow-up would have increased the number of end points, thereby increasing the power of the trial.

The choice of duration of the follow-up period must also take into consideration the postulated mechanism by which the study agent exerts its effects. In the Physicians' Health Study, for example, any benefit from aspirin in reducing cardiovascular mortal[illegible]s likely to be acute, since the postulated mechanism relates to imme[illegible]e effects on platelet aggregability. On the other hand, if the beneficial effect of beta-carotene supplementation is analogous to the effect of cessation of cigarette smoking on reduction of lung cancer risk, where it may take 2 years before any decrease begins to become apparent and 6 to 9 before the effect becomes maximal [11], then a much longer period of follow-up is required.

While every effort should be made to incorporate an adequate length of follow-up during the planning phase of a trial, the emergence of new evidence on mechanisms, changes in rates of disease within the general population, and even, on occasion, the failure to achieve a sufficient sample size or enough end points within the trial itself may all, for the reasons discussed above, raise the question of increasing the duration beyond the planned period of follow-up. Any such decision should be made as early in the trial as possible to maintain the scientific credibility of the study and avoid the implication that the change in study design was based on last-minute efforts to achieve statistical significance [16]. For this reason, with the consent of the participating doctors, the Physicians' Health Study research group was able, at an early stage of the study, to secure funding to extend the duration of the trial, based primarily on far lower than expected mortality rates among trial participants. Additional issues that should be considered in making a decision regarding extensions of a trial can be found elsewhere [16].

The Effect of Compliance

In addition to the number of end points accrued, the second major factor influencing the power of the study to detect a true difference between treatment groups is compliance. It is important to remember that the assessment of whether compliance is adequate must include all the study participants, regardless of their particular treatment assignment. The effect of noncompliance in any participant is to make the intervention and comparison groups more alike, which has the result of decreasing the ability of the trial to detect any true differences between the groups. For example, in MRFIT, while the compliance among participants in the special intervention program was generally higher than expected, individuals in the usual care group also stopped smoking, reduced their blood pressure, and lowered their cholesterol to an extent unanticipated by the investigators. As a result, the small differences in risk factors between the groups could only result in a 22-percent reduction in CHD mortality. When coupled with secular decreases in mortality from CHD in the general population, this study did not have adequate power to detect this small effect [27].

The impact of noncompliance is illustrated in Figure 8-4, which shows power curves calcu[illegible]d for various postulated reductions in risk of mortality from CHD due to aspirin in the Physicians' Health Study. The top

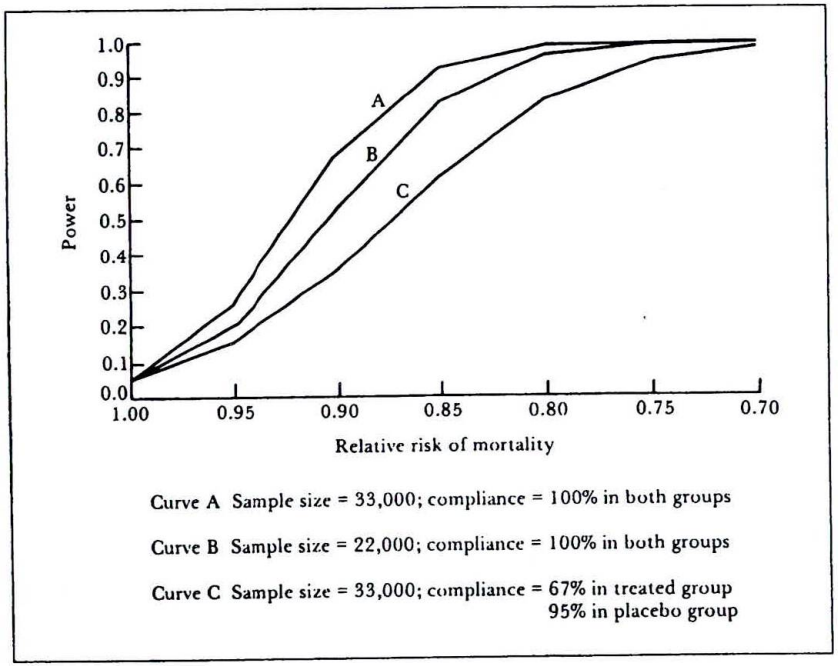

Fig. 8-4. Power curves for various postulated reductions in risk of mortality, total sample sizes, and levels of compliance in those receiving active treatment and placebo.

curve *(A)* represents the power for a total sample size of 33,000 and 100-percent compliance in the active aspirin and placebo groups. The bottom curve *(C)* shows the decrease in power that results when the same number of subjects are randomized, but the compliance rates are only 67 percent among those in the active aspirin group and 95 percent for those taking placebo. The shapes of both curves are approximately the same, but with noncompliance there is less power for the detection of an effect of any size. Moreover, the greatest reduction in power is for the most plausible relative risks, which are on the order of 0.8 to 0.9.

One strategy to maximize compliance that has been used infrequently to date in intervention studies but could have wide applicability in clinical trials is the implementation of a run-in or "wash-out" period prior to actual randomization. All participants receive either the active treatment or placebo for a number of weeks or months before formal randomization to a treatment group. This permits potentially eligible participants who have difficulty adhering to the intervention program or those perceiving adverse effects to withdraw before randomization without affecting the validity of the study [5, 18]. Such a strategy seems particularly

attractive in trials where it is not necessary for an intervention to begin during or immediately following an acute event. The effects on power of reducing the sample size in this way is illustrated in Figure 8-4. The middle curve *(B)* represents the power associated with a sample size that is one-third smaller than the 33,000 enrollees in the Physicians' Health Study, or 22,000 subjects, but again with compliance rates of 100 percent in both groups. This results in an intermediate power curve, with less power than if a larger number of good compliers had been randomized, but considerably more than if a larger, mixed group of compliers and noncompliers were randomized. Consequently, the use of techniques to maintain high compliance, such as the use of a run-in period, will maximize the power of a clinical trial to detect small to moderate effects between treatment groups [5].

The actual format of the run-in period will depend on the particular hypotheses being tested. For example, in the Veterans Administration Cooperative Group Study on Antihypertensive Agents [41], male patients whose diastolic blood pressures averaged 90 to 129 mm Hg were considered for admission to a randomized trial of active drug (hydrochlorothiazide plus reserpine plus hydralazine hydrochloride) versus placebo treatment. Following discharge from the hospital, the patients entered a prerandomization phase, where for 2 to 4 months they took daily tablets of a placebo containing a fluorescent biochemical marker (riboflavin) and were seen in the clinic at monthly intervals. Failure to appear for a clinic appointment, failure of the urine to exhibit fluorescence, or a count of returned tablets outside a specific range excluded a potential participant from randomization into the actual trial. Using this procedure, nearly 50 percent of the patients initially eligible for this trial were excluded before randomization for one of these reasons. While decreasing the actual sample size, this technique resulted in a study of greater power due to the exclusion of noncompliers before randomization.

Both the postulated mechanisms of action and frequency of side effects should be considered in determining the specific agents for a run-in period. In the Physicians' Health Study, the postulated beneficial effects of aspirin are acute and side effects common [35], so that it was desirable to expose all willing and eligible subjects to active aspirin during a run-in prior to randomization. On the other hand, as the possible beneficial effects of beta-carotene are cumulative and side effects minimal [21, 33], a placebo rather than active agent was given. Thus, during the 18-week run-in period, all 33,211 physicians who were initially willing and eligible to enroll in the trial took a daily pill from calendar packs containing active aspirin alternating with beta-carotene placebo. At the end of that time, each physician was sent a questionnaire to identify doctors reporting side effects or a desire to discontinue participation, those

who wished to continue but whose self-reported compliance was considered inadequate by the investigators, and those who developed a cardiovascular or cancer end point during this period. Using these criteria, about 35 percent of enrolled physicians were deemed ineligible to be randomized and were excluded from the trial. The remaining 22,071 willing and eligible physicians who were proven good compliers were then randomized into one of the four treatment groups.

One possible limitation of a run-in is that by restricting a trial to a group of proven good compliers, the study subjects may differ from the general population with respect to factors that might affect the development of the outcomes of interest. Of course, to the extent that the noncompliers who were eliminated can be followed, this question can be evaluated directly. From a more theoretic perspective, however, this issue relates solely to the generalizability of study findings to the total experimental or reference populations. In that regard, as has been discussed previously, the primary goal in the design of a trial is to ensure that the results obtained are valid. Consequently, any procedure that maximizes compliance, thus increasing the chances of obtaining a valid result, will positively affect the ability to generalize that finding to other populations. The proven good compliers resulting from a run-in period who contribute to a valid result are a far greater asset to the generalizability of the trial results than would be a more representative study population who were unable to maintain adequate compliance for the duration of the study. Such an investigation would lead to an invalid result and, therefore, one that has no potential for generalizability despite having been conducted among a representative population.

ISSUES IN ANALYSIS AND INTERPRETATION

The basic approach to the analysis of intervention studies is similar to that discussed for cohort studies (see Chap. 7), where the fundamental comparison is between the rates of the outcome of interest in the treated group(s) and the corresponding rates in the comparison group(s). As for any analytic epidemiologic study, the roles of chance, bias, and confounding must be evaluated as possible alternative explanations for the findings. Clinical trials, however, have unique design features with special implications for their analysis and interpretation.

As regards chance, a sufficient sample size addresses this issue in a manner analogous to other analytic designs. Moreover, randomization minimizes the potential for bias in the allocation of participants to treatment group, and bias in the observation of outcomes of interest can be minimized by using blind or double-blind procedures. With respect to

confounding, randomization tends to distribute both known and unknown confounders evenly among the treatment groups. If the sample size is large, this comparability is virtually guaranteed. However, as discussed previously, with a small sample size or even, in the rare instance, as a result of the play of chance in a large sample, randomization may not always result in groups that are alike with respect to every factor except the treatment under study. Consequently, one important early step in the analysis of any clinical trial is to compare the relevant characteristics of the randomized treatment and comparison groups to assure that balance was achieved. This comparison should always be presented as one of the first tables in the report of the study findings.

For example, Table 8-2 shows the baseline distribution of subjects in the CASS trial [6] for a number of potentially important risk factors for subsequent mortality and the development of CHD. Additional comparisons were made of electrocardiographic, arteriographic, and ventriculographic characteristics. There were no imbalances between patients assigned to receive surgical and those allocated to medical therapy with respect to any of these baseline characteristics. Thus, randomization was effective in establishing two study groups that were similar with respect to other factors that could independently affect the outcome under study. If such a comparison had indicated that randomization was not effective and that there were imbalances between the study groups with respect to known confounding factors, such discrepancies could be controlled in the analysis using statistical techniques analogous to those employed in observational cohort studies (see Chap. 12).

A second important issue that often arises in clinical trials is the question of which subjects to include in the analysis. Some investigators remove from the analysis subjects who were determined to be ineligible after randomization or who did not comply with the study protocol. We believe, however, that the exclusion of any randomized patients from the analysis can lead to biased results. It may be particularly appealing, intuitively, to eliminate those who become noncompliant. However, it is unwarranted and incorrect to perform a fundamental analysis that compares the outcome rates of only those individuals who actually received that treatment with only those who did not.

First, in most trials, perfect compliers represent only a fraction of the total study population. As with losses to follow-up, noncompliance may be related to factors that also affect the risk of the outcome under study, and failure to analyze data on all randomized participants could introduce bias. For example, as mentioned earlier, when all randomized subjects in the Coronary Drug Project trial of clofibrate in the reduction of mortality following myocardial infarction were included in the major analysis, the 5-year total mortality rates in the two groups were very similar (18.0% versus 19.5%) [9]. To explore the effect of compliance on

Table 8-2. Baseline characteristics of participants in the Coronary Artery Surgery Study, by treatment group

Variable	Medical group (n = 390)	Surgical group (n = 390)
Sex		
Male	90.0%	90.5%
Female	7.5	7.3
Race: White	98.7	98.0
Work status		
Full-time	64.1	71.0
Part-time	4.6	4.6
Retired or quit	22.8	19.5
Other	8.5	4.9
Angina		
None	21.5	22.1
Class I	12.1	16.9
Class III–IV	0.0	0.0
Nonexertional	4.1	5.4
Cigarette use		
Present smoker	40.8	38.7
Former smoker	43.6	44.4
Never smoked	15.6	16.9
Medical history		
Prior MI	62.6	57.2
Hypertension	29.4	32.7
Congestive failure	2.3	3.9
Diabetes mellitus	8.1	9.3
Stroke	2.1	2.1
Peripheral artery disease	9.3	7.3
Use of medications		
Nitroglycerin	54.9	56.2
Long-acting nitrates	44.6	47.3
Beta-blockers	42.6	44.1
Antiarrhythmics	9.0	9.7

Source: Coronary Artery Surgery Study (CASS), A randomized trial of coronary artery bypass surgery: Comparability of entry characteristics and survival in randomized patients and nonrandomized patients meeting randomization criteria. *J.A.C.C.* 3:114, 1984.

this outcome, the investigators then analyzed the mortality experience within the clofibrate group and found that those whose compliance was at least 80 percent had a mortality rate of 15.0 percent, compared with 24.6 percent among those who were poor compliers. Such a finding might be erroneously interpreted to indicate that clofibrate reduces mortality. Indeed, a similar analysis within the placebo group found a comparable disparity in mortality among compliers and noncompliers, with rates of 15.1 and 28.2 percent, respectively [8]. These data do indicate that in both the active and placebo groups, compliers are different from noncompliers in ways that affect their prognosis. Even after controlling for 40 known possible confounders, there was still a difference in the mortality rates in the placebo group between good (16.4%) and poor (25.8%) compliers. Thus, there must be additional but unknown variables associated with both compliance and mortality in this trial. These data clearly show that subgroup comparisons of compliers did not provide valid results.

A second limitation in evaluating data on only those subjects who comply with the study regimen is that such an analysis does not address the actual research question being posed in an intervention study—whether the *offering* of a treatment program is of benefit. While we wish to study the actual effect of the treatment, we are in fact randomizing only on the basis of the offering of treatment, so that we must analyze the data on this basis to preserve the power of randomization. It is only the entire groups allocated by randomization that are truly comparable. Once participants are randomized to a treatment group, their subsequent health experience must be assessed and analyzed along with all others in that group, regardless of whether they comply with their assigned regimen. This methodologic issue emphasizes the need to maintain high compliance with their assigned regimen among all study participants. It is also important to keep in mind that if a particular regimen is so difficult and uncomfortable that it is likely to be accepted and used by only a small proportion of the reference population, it may not be practical to recommend its use, no matter how effective the actual treatment may be.

Thus, in all circumstances, the comparison that is optimal to estimate the true benefit to be obtained from the intervention program is to analyze by intention to treat—in other words, "once randomized, always analyzed." For this reason, it is imperative to maintain high levels of compliance, keep losses to follow-up at a minimum, and to collect complete information on all randomized subjects. Those who are no longer complying with the study regimen should continue to provide all follow-up information whenever possible, or at the very least, their vital status should be ascertained. Subsequent analyses can certainly be performed based on that subgroup of participants who actually received their assigned treatment. However, if this is done, while it is possible to perform

analyses that achieve balance in the distribution of known confounders, it is impossible to regain the control of unknown confounders that had been achieved originally through randomization.

The need to perform randomized comparisons in the analyses of data from a trial is equally important when subgroups are identified on the basis of other characteristics besides compliance. Investigators are often tempted to examine differences in treatment effects among those with various baseline characteristics, such as age, prognostic factors, or previous medical history. For example, in MRFIT [28], a subgroup analysis by presence or absence of resting electrocardiogram abnormalities suggested that among men with such abnormalities at baseline, those receiving the special intervention program actually had an increased risk of death from CHD relative to those in the group allocated to usual medical care. This finding led to a further exploration of the effects of the intervention among those with various levels of hypertension. The investigators wisely concluded that "subgroup analyses must be interpreted with caution, particularly those that go beyond the randomized clinical trial design by the MRFIT" and added that "these findings pose hypotheses for investigation by other researchers in systemic hypertension" [28].

In general, the caveats needed to compare subgroups defined a priori by baseline characteristics are far less than those required when comparisons are made on the basis of variables chosen after randomization such as compliance. As regards the former, a minor concern involves a loss of statistical power because only subgroups of the total number of randomized subjects are being compared. A greater concern, however, is to ensure adequate control of variables that may no longer be distributed at random among the subgroups. With respect to analyses of subgroups defined a posteriori on the basis of information accumulated after randomization, they can only raise data-derived hypotheses, not test particular research questions.

CONCLUSION

The ultimate goal of any intervention study is to provide either a definitive positive result on which public policy can be based or a reliable and informative null finding that can then safely permit the redistribution of resources to other important areas of research. Intervention studies certainly can be more difficult to design and conduct than observational epidemiologic studies, due to their unique problems of ethics, feasibility, and costs. However, trials that are sufficiently large, randomized, and carefully designed, conducted, and analyzed can provide the strongest and most direct epidemiologic evidence on which to make a judgment about the existence of a cause-effect relationship

STUDY QUESTIONS

1. In the Physicians' Health Study [19], 22,071 male physicians were randomized and mortality was postulated to be 70 percent that of white males in the general population. During the first 2 years, mortality was less than 25 percent rather than the anticipated 70 percent.
   a. How do you explain these findings?
   b. What could be done at that stage of the trial to increase the power of the study to maximize the chances of observing the small to moderate effects anticipated, which include a 20-percent reduction in total cardiovascular mortality, a 10-percent reduction in mortality from all causes, and a 30-percent reduction in cancer rates?
2. During the planning phase of the Physicians' Health Study, which restricted admission to male physicians between the ages of 40 and 84, it was suggested that female physicians be included to study the effect of aspirin in women and to see if there was a different effect in women as compared with men. Discuss the advantages and disadvantages of including female physicians in the trial.
3. As discussed earlier, in the MRFIT trial [27], 480 end points were anticipated, and only 260 were observed. Consequently, at the end of the trial, the reduction in cardiovascular deaths was statistically nonsignificant.
   a. What factors contributed to these findings?
   b. What changes in the study design might have enabled MRFIT to report a more definitive result?

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The Efficacy of Influenza Vaccination in Elderly Individuals

A Randomized Double-blind Placebo-Controlled Trial

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Objective.—To determine the efficacy of influenza vaccination in elderly people.

Design.—Randomized double-blind placebo-controlled trial.

Setting.—Fifteen family practices in the Netherlands during influenza season 1991-1992.

Participants.—A total of 1838 subjects aged 60 years or older, not known as belonging to those high-risk groups in which vaccination was previously given.

Intervention.—Purified split-virion vaccine containing A/Singapore/6/86(H1N1), A/Beijing/353/89(H3N2), B/Beijing/1/87, and B/Panama/45/90 (n=927) or intramuscular placebo containing physiological saline solution (n=911).

Main Outcome Measures.—Patients presenting with influenzalike illness up to 5 months after vaccination; self-reported influenza in postal questionnaires 10 weeks and 5 months after vaccination; serological influenza (fourfold increase of antibody titer between 3 weeks and 5 months after vaccination).

Results.—The incidence of serological influenza was 4% in the vaccine group and 9% in the placebo group (relative risk [RR], 0.50; 95% confidence interval [CI], 0.35 to 0.61). The incidences of clinical influenza were 2% and 3%, respectively (RR, 0.53; 95% CI, 0.39 to 0.73). The effect was strongest for the combination of serological and clinical influenza (RR, 0.42; 95% CI, 0.23 to 0.74). The effect was less pronounced for self-reported influenza.

Conclusion.—In the elderly, influenza vaccination may halve the incidence of serological and clinical influenza (in periods of antigenic drift).

(*JAMA*. 1994;272:1661-1665)

BASED on studies among young healthy volunteers, influenza vaccination appears to have a protective effect of 40% to 70%.[1-3] Since 95% of the deaths due to influenza occur among people aged 60 years and older, it is important to know the efficacy of vaccination among the elderly.[4] Several studies have suggested that vaccination of elderly people results in a decrease in complication rate (up to 72%) and mortality (up to 87%).[5-8] However, these studies were primarily retrospective. Only a few prospective studies have been performed among the elderly[9-12]; none were randomized and blinded.

For editorial comment see p 1700.

We conducted a randomized double-blind placebo-controlled trial of the efficacy of influenza vaccination in elderly individuals, using both clinical and serological outcome parameters.

METHODS

Patients

The study was conducted in the winter of 1991-1992 and involved 34 family physicians in 15 practices in the southern region of the Netherlands. All persons aged 60 years or older (n=9907), not known as belonging to those high-risk groups in which vaccination had previously been given, were invited to enter the trial.

According to the Dutch Health Council,[13] high-risk groups are patients with heart or lung conditions, diabetes mellitus, chronic renal insufficiency, and chronic staphylococcal infections. Of the people invited to enroll in the trial, 1838 (19%) agreed. The following reasons were given for nonparticipation: not understanding the letter of invitation; hesitation about participating in an investigation; fear of receiving an injection and having blood samples taken; and being pressed for time. Of those who enrolled, 238 indicated that they had been vaccinated against influenza in 1989 and/or in 1990. A history of cardiological, pulmonary, or metabolic problems were reported in 490 participants. (The family physicians appear to have had different interpretations of what it means to be at high risk for influenza.) To assess the influence of risk status on the effect of vaccination, the participants were divided into the following categories: cardiac disease, pulmonary disease, diabetes mellitus, and other conditions or healthy.

Intervention

The vaccine used was the purified split-virus vaccine produced by Evans Medical Ltd (Langhurst, Horsham, England). This vaccine was composed in

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Census of India 2001

Why Census?
Kutumbada Anusuchi (Household Schedule)
Census of India 2001: Household Schedule.
Brocure
Deshada habagabateyalli angavikala vyaktigala samiksheya serpade.
Disability status of people of India.
vandu bilion anikeyindachege by S Shashidhar.
janaganati 2001ra mahathwa mathu hosa lakshanagalu.
Significance and new features of Cenus 2001.
sadarbhadalli pracharakkagi upayoogisabahudaada dhyeyamanthra.
Bharatada janaganati 2001.
Rasthrada Pragatiya dikshuti.
Enumeration of the disabled.
A Brief note on census and census of India 2001
Census and its history by H Shashidhar.
Proceedings of Governement of karnataka.
Census of India 2001: A Stupendous National Task - An Overview.
Population Enumeration Circular No. 13: Census of India 2001 - Publicity plan for population enumeration.
Workshop schedule "Cenus 2001 - Enumeration of Persons with disability - campaign.