First Meeting

of the

National Commission on Population

Address of Dr. S. Aruna,

Minister of Health, Medical & Family Welfare

Government of Andhra Pradesh

July 22nd, 2000

First Meeting of the National Commission on Population

July 22nd, 2000

Address of Dr. S. Aruna,
Minister of Health, Medical & Family Welfare
Government of Andhra Pradesh

Hon'ble Prime Minister of India and Chairman of the National Commission on Population, Sri Atal Behari Vajpayeeji, Hon'ble Minister for Health, Dr. C P Thakurji, Hon'ble Minister of State for Health, Prof. Rita Vermaji, distinguished members of the National Commission on Population, members of the press and participants in this august gathering, it is my pleasure and a privilege to participate in the first meeting of the National Commission on Population. I congratulate Government of India for having announced a National Population Policy and for having constituted this body to address issues relating to population control, which is so crucial for the development of our nation.

I am proud to state that Andhra Pradesh has been performing well on the population control front, and that the Government of my State has given this programme a central position in the developmental efforts of the State.

Since the inception of the Family Welfare Programme, there has been a significant decline in the fertility rate. In the early 70s, 5 children were born per family. In 1998, as per the NFHS survey, this had come down to 2.25 children per family. The birth rate has declined from 35 per 1000 population in 1971 to 22.3 per 1000 population in 1998. Approximately 60% of couples in the reproductive age are now protected by contraception. The Infant Mortality Rate has also declined from 113 per 1000 live births in the early 70s to 65.8 per 1000 live births in 1998. Sustained efforts for family planning and effective delivery of Maternal and Child Health Services have helped Andhra

Pradesh overcome the handicap on account of low female literacy, relatively high incidence of child labour and low age of females at the time of marriage.

Andhra Pradesh has the distinction of being the first State in the country to announce a comprehensive Population Policy in 1997 with clearly articulated demographic goals. Our goal is to reduce the Birth Rate to 13 per 1000 population, attain a Total Fertility Rate of 1.5, a Maternal Mortality Rate of 0.5 per 1000 live births and an Infant Mortality Rate of 15 per 1000 live births by 2020. The State Population Policy has been discussed on the Floor of the House and an all-party consensus has been evolved in support of the policy. The State Government has allocated Rs. 65 crores from its own funds to implement policy initiatives and programmes. The key strategy of our initiatives is decentralisation of planning and programme implementation, making family welfare a people's programme and a shift in approach from Family Planning to Reproductive and Child Health.

In order to decentralise planning and implementation, we have established District Population Stabilisation Societies; and PHC and Hospital Advisory Committees have also been constituted to ensure the active participation of elected representatives and beneficiaries in health care delivery and family welfare. These Societies and Committees have been given both administrative and financial powers for effective functioning. We now propose to establish village level structures for enhancing the ownership of the health and family welfare programmes.

Population control in Andhra Pradesh has indeed become a people-centred programme. Family Welfare has been placed high on the agenda of the Janmabhoomi programme. Under this programme, health teams have visited each and every habitation in the State at least 12 times over the last 3 years, bringing about an improvement in service delivery and encouraging health-seeking behaviour of the community. Issues relating to Family Planning and Mother and Child Health are discussed in every gram sabha.

Active involvement of a large number of Self-Help Groups has further contributed to widespread acceptance of the small family norm.

In order to improve the infrastructural facilities that have a bearing on the quality of services, 160 First Referral Units have been newly built and fully equipped. New buildings are under construction for 626 PHCs and renovations are being carried out for 477 PHCs. Frequent recruitment of Medical Officers and para-medical staff in the last three years has reduced the vacancies to a minimum. Doubling of the budget for drugs and streamlining their supply has improved the quality and availability of drugs. Continuous clinical management and training programmes for Medical Officers and para-medical staff seek to further improve the quality of services being delivered to the people of my State.

Several specific interventions are designed to address unmet needs. 215 Round-the-clock PHCs have been established and specialist services of Gynaecologist and Paediatrician have been provided at these PHCs and at the First Referral Units. 286 surgeons across the State have been trained in innovative techniques like Double Puncture Laparoscopy and Non Scalpel Vasectomy. We have performed 107809 DPLs and 31454 NSVs during the last year. A project for social marketing of contraceptives to meet spacing needs is under implementation from this year. A massive house-to-house survey has been completed in January 2000, which identifies the unmet need for contraception in our State, and our programmes for the current year will address these needs.

A new scheme – Arogya Raksha – was introduced in 1999 to cover hospitalisation expenses of family planning acceptors and their children to infuse confidence among them. The Government recognises the role of institutional deliveries in reducing maternal and infant mortality. Such deliveries are encouraged through a novel scheme – Sukhibhava – that provides Rs. 300/- to every pregnant woman below-poverty-line, who has her

delivery at Government hospitals or PHCs. The appointment of 8500 Community Health Workers for every habitation in the tribal areas has increased the outreach services for the tribal population. Unserved population in the urban slums is sought to be covered by establishing 192 Urban Health Centres in 74 municipalities. Each of these centres is entrusted to an NGO. Our Government has also issued orders entrusting one remote PHC in each district to an NGO – this is part of our strategy to forge a strong relationship with NGOs in the State.

As a result of all these efforts, the percentage of women receiving ante-natal care has risen from 86.6% in 1992 to 92.7% in 1998; the percentage of safe deliveries has gone up from 49.3% to 65.2% and the percentage of children with full immunisation has risen from 45% to 58.7% during the same period. These are figures from the latest NFHS survey conducted by the Government of India. The number of family planning operations has registered a significant increase from 6.3 lakh during 1997-98 to 7.33 lakh in 1998-99 and a record 7.9 lakh operations in 1999-2000.

Mere availability of health services is not enough. Women's empowerment is the key determinant of success in lowering fertility rates. Demand generation for health care services is closely related to the economic well-being and status of women in the society. Acknowledging this, Andhra Pradesh has encouraged the establishment of women's thrift and credit groups. 3.25 lakh women's groups with 50 lakh members and savings of Rs. 600 crores which is having a significant impact on improving the status of women.

Focused communication campaigns can influence attitudinal and behavioural changes. State-wide communication campaigns lay stress on eight key issues – Reproductive & Child Health, Age at Marriage, Spacing, Institutional Delivery, Immunisation, Nutrition, Small Family Norm and Male Responsibility – in Family Welfare. In fact, these issues have been discussed

in every Gram Panchayat during the World Population Day functions on July 11th and will again be discussed in each and every habitation during the ensuing Janmabhoomi Programme from 1st to 7th August.

Exemplary leadership shown by the Chief Minister coupled with strong political commitment and active participation by public representatives at all levels has greatly contributed to the widespread acceptance of the family welfare programmes. The Chief Minister in his interaction in the Gram Sabhas, starts the discussions with the Population Control Programmes and related issues, and we, his cabinet colleagues, do the same. Andhra Pradesh has effected the necessary amendments to the Panchayat Raj, Municipalities and Co-operative Societies Acts, debarring those who have more than two children from contesting in the elections. My party has also passed a resolution to the effect that party posts will be given only to those with 2 children.

In order to endorse the acceptance of small family norm, we propose to give preference to those with 2 children or less for selection to Government services with effect from 2001-02. We propose to increase the age at marriage by having registers at Panchayat level to monitor adherence to the legal norms on age at marriage. We also propose to give a thrust on spacing by enhancing the acceptability, accessibility & affordability of contraceptives.

I would like to place before the commission certain issues which need to be taken up by the Government of India. The commission my recommend a step-up in the budgetary allocations for this programme by Government of India to ensure smooth execution of all planned activities. In deciding budgetary allocations, weightage must be given for good performance on the population control front. In order to bring about greater community participation, the commission may recommend to Government of India to earmark a certain percentage of funds in Rural Development programmes to be awarded as incentives to those Gram Panchayats that perform well in

family welfare programmes. The national policy document speaks of care for the aged. To encourage our tradition of caring for parents at home, benefits may be announced for families that care for the elderly in their homes. We also request that legislation may be enacted to ensure that population control and related social messages can be aired free-of-cost through the electronic media at prime time. The recent judgement of Supreme Court for payment of compensation in the case of a failure of a family planning operation, has given a set back to the family planning programme. It is internationally accepted that there will be 1-2% incidence of tubal patency when initial operative errors have been excluded. The Government of India needs to immediately take up the issue with the Supreme Court.

The Government of Andhra Pradesh is determined to provide reliable and high quality maternal and child health and contraceptive services to the people of the State. At this first and historic meeting of this distinguished body, my Government reiterates its commitment to meet the great challenges that lie ahead to achieve the goal of population stabilisation. Let us today reaffirm our resolve to participate fully in a programme, which is so crucial to the progress and development of our States and the Nation.

Jai Hind!

SPEECH OF SHRI V. HANGKHANLIAN HON'BLE MINISTER OF HEALTH GOVERNMENT OF MANIPUR DELIVERED IN THE MEETING ON NATIONAL COMMISSION ON POPULATION IN THE COMMETTEE ROOM, PARLIAMENT HOUSE, ANNEXE NEW DELHI, 22ND JULY, 2000

India to-day faces a radically different demographic situation that posed a problem - t**he Problem of Population Explosion** with one billion on 11th May,2000. As a result, developmental activities undertaken by the Government of India has been plagued. The only answer that has been found by most of the population scientists is stabilization. They recognised that stabilization of the population would make towards achievement of sustainable development . Now, a National Population Policy,2000 with immediate, medium and long term objectives to achieve a stable population by 2045 at a level consistent with the requirements of sustainable economic growth, social development and environment protection has been drawn up by the government of India which is now before us.

I, on behalf of the State of Manipur welcome the National Population Policy,2000

To-day, this August Assembly will confine to the immediate objective that address the unmet needs for contraception, health care infrastructure and health personnel and to provide integrated services delivery for basic reproductive and child health care.

In persuance of these objectives, 14 sets of National Socio-Demographic Goals to be achieved in each case by 2010 have been formulated with 12 identified strategic themes like (a) Decentralised Planning and Programme implementation (b) Convergence of services delivery at village level (c) Empowering women for improved Health and Nutrition etc. which must be simultaneously pursued in " Stand Alone" or inter sectorial programmes in order to achieve the national Socio-demographic goals for 2010.

However, the service proposed to be rendered or pursued do not reach the villagers more particularly in the hills and accordingly vast numbers of people cannot avail these services because of lack of infrastructure and service facilities. The problem is more acute for a state like Manipur that presents a unique case in terms of population characterised by hetrogeneity in respect of physical , economic, social and cultural conditions.

I would like to take up some action points for the effective implementation of the Population Policy in the State of Manipur.

1) Priority will be given to the expansion of the integrated package of essential services at village and house hold levels. Inadequacies in the exsisting health infrastructure that led to unmet needs will be improved keeping in view of the remoteness, inaccessibility, sparsely distributed population in the hills and population components of the tribes. New institutions will be opened to cover the left out areas if adequate funds are made available.

2. Unique features of Manipur demands flexibility in the yardsticks for provision of health care infrastructure in order to solve unmet needs and extend coverage.

3. Specific policy and support to provide specialists in the First Referal Units particulary for North Eastern States needs to be incoporated in the National Population Policy.

4. Cotraceptive supplies and equipement for intregated service delivery will be streamlined. Fresh innitiative will be taken up to make the comprehensive informations reached the village in locally relevant acceptable dialects.

5. Intersectoral co-ordination among the related departments need strengthening. This will be extended to the areas of child development activities, drinking water, nutrition services.

6. Registration of births, deaths will also be strengthened and registration of marriage and pregnancies will also be attempted.

7. Involvement of media personnel, private sector, Panchayati raj institutions will be encouraged to the maximum for people's participation in the national effort to stabilize population.

JAI HIND

First Meeting of the National Commission on Population

New Delhi 22nd July 2000

Speech by Chief Minister of Madhya Pradesh

- I am of the clear view that for stabilizing the population, we will have to resort to certain practical measure along with reduction in infant mortality rate, maternal mortality rate and total fertility rate. Key to the success of any policy lies in people participation. This is also a precondition for the success of population policy of Madhya Pradesh and National Population Policy as well.

  Village level democratic institution have already emerged in our state, these institutions are capable of ensuring peoples participation in various programmes.

  An important initiative which we intend to take is in terms of stream lining our grass route health infrastructure. We believe that the community control of village level functionaries like male and female health workers is far more effective and efficient. We have already gone far ahead in this direction. Madhya Pradesh has the credit of initiating the implementation of the Panchayati Raj Adhiniyam 1993. State has nearly 32000 PRIs with about 4.80 lacs elected representatives.

  State govt. has passed an act in 1995, which will enable District Planning Committees, popularly known as Zila Sarkar, to prepare consolidated development plan for the entire district. DPC have been made responsible for the implementation and monitoring of the population stabilization efforts in the district.

- We have to bring about the gender equality and equity in society by women empowerment. Madhya Pradesh in having nearly 200,000 elected women representatives out of 4,80,000 total representatives. Women member of elected bodies have a vital role to play in the process of achieving stabilized population and implementations of reproductive health services.

  State government will launch systematic campaign to make men realize their responsibility in empowering women.

State commission on women will be entrusted the responsibility of identifying barriers of gender equity and equality. Commission will also suggest measures to overcome the problems.

More attention will be paid to encourage at least 30 percent of girls in the age group 14-15 to complete elementary education.

Total literacy campaign through Padhna-Badhna Samiti covering the entire state is doing pioneering work to increase literacy among men and women. Efforts will be intensified to ensure 100 percent literacy amongst women aged 15-35 yrs.

Self-help groups will be created in each panchayat by the year 2003. These groups will be assisted to achieve economic independence.

- Certain regions in Madhya Pradesh are comparatively behind other regions in term of infant mortality rate, maternal mortality rate and total fertility rate, it will be our endeavor to specifically and closely target these region and employ greater efforts to ensure that this handicap is removed.
- The state is in the process of its latest human development report, which will include working out human development indices even at village level. We will make concerted efforts on such pocket of villages, Community, and social groups, which have high fertility rate.
- In urban areas special efforts will be made to tackle those populations particularly slum areas, which have shown higher IMR, MMR & TFR.
- The mission of the population policy of Madhya Pradesh is to improve the quality of life of the people in the state by achieving a balance between population, resources, and environment. Rapid reductions in fertility and mortality rates will be achieve for the population stabilization and improving the quality of life.
- In the state of Madhya Pradesh even the poorest of poor wants to plan his family, but our resources and services are falling short in fulfilling this desire. I was deeply agonized to know that 23 percent of the total pregnancies taking place in Madhya Pradesh are unwanted.

The health system will try to reach those families who are willing to control their fertility, and the problem of unwanted pregnancies has to be seriously heeded. A pilot project has been started in the district Rajgarh to develop a framework to identify the couple with unmet need and to convert their need into acceptance through an effective service delivery system. On the success of the framework, it would be replicated in the other districts of the state.

- Private sector and the non-governmental organizations have proven their ability in mobilizing the community support, demand generation and awareness creation. NGOs can play important role in providing health care services to the population in the inaccessible and remote areas. NGOs involvement in population stabilization efforts, providing reproductive health care services and to impart skill base training would be encouraged. For this purpose NGO networks will be created through Mother NGOs.

Similarly, private sector potential will be harnessed to provide quality reproductive health services. State govt. has plan to provide soft loans to medical practitioners with preference to lady medical practitioners for providing health services in areas not effectively served by the public institutions. Private sectors will also be utilized for promoting social marketing of contraceptives.

- State has shown its firm determination towards the implementation of the population policy. Constitution of the State Population and Development Council under the chairmanship of the Chief Minister is in process. Other members of the council would include leader of opposition party in the state, Ministers of the concern departments and representatives form organized sectors, Women's organizations, trade unions and NGOs.
- State Population Resource Centre will be established. The SPRC would provide technical support and suggest type of measures to be taken from time to time to achieve the desired goal of TFR 2.1. by the year 2011.
- Some of the initiatives taken by the state government:

Legal age at marriage has been made criteria for govt. jobs and for sanctioning govt. loans and facilities.

Inclusion of Adolescent and Family life Education will be made compulsory in all future NGO projects funded by the govt. and the donor agencies.

Provision of safe drinking water.

An integrated Information, Education & Communication strategy will also be formed to create awareness among community.

Person having more than two children after 26 January 2001 would not be eligible for contesting elections for Panchayatas, Local bodies, Mandis and Cooperatives. Govt. has also taken a decision that person having more than two children after 26 January 2001 would not be eligible for govt. jobs and other govt. benefits.

Awards will be given to Panchayati Raj Institutions and Urban local bodies in the field of community support for population stabilization.

Further the planned family has to be made a thing of pride and for this people have to be involved in the programmes, to provide new insight, new direction and modern thinking to the society.

Madhya Pradesh Government has implemented its new Population Policy with the hope that its success will contribute in paving the way for the building of a modern Madhya Pradesh.

Digvijay Singh
Chief Minister Madhya Pradesh

Population Programme in Ninth Plan

P H Reddy

The Approach Paper *to the Ninth Five-Year Plan (1997-2002) has identified the three factors that contribute to population growth as: the large population in the reproductive age, higher fertility due to unmet need for family planning and high wanted fertility due to high infant mortality rate. How much do these factors contribute to population growth? Although the paper recognises the need for promotion of male participation in family planning, no strategy is spelled out. Other issues like the need to promote spacing methods, incentives and disincentives, family planning targets, demographic goals, etc, are not even mentioned in the* Approach Paper. *The preferred strategy to bring down the birth rate to be adopted is far from clear.*

INDIA is often cited as the first country in the world to have started an official family planning programme as far back as 1952. But the family planning programme began to be implemented vigorously from the Third Five-Year Plan (1961-66). In the Third Plan document, the planning patriarchs started thinking in terms of "the objective of stabilising the growth of population over a reasonable period". In pursuit of this objective, policy-makers began to set family planning method-specific targets for various states and union territories and demographic goals for the entire country. Much has been said about the 'tyranny of targets'. But not many people know the sad saga of demographic goals.

Table 1 presents data on demographic goals set and actual achievement. It is clear that demographic goals were set as many as 11 times between 1962 and 1992. The Third Plan set for the first time the demographic goal of reducing the crude birth rate (CBR) to 25 per 1,000 population by 1973. No one knows the criteria on the basis of which the demographic goal was set. In 1965, India had a war with Pakistan and its economy suffered a temporary set-back. Instead of Fourth Five Year Plan immediately after the Third Plan, there were three annual plans during 1966-69. The first annual plan (1966-67) set the demographic goal of reducing the CBR in the country to 25 per 1,000 population as expeditiously as possible. In 1968, a new demographic goal was set to reduce the birth rate to 23 by 1978-79. Like this, demographic goals were set on several occasions.

Mention must, however, be made of the fact that based on the recommendations of a Working Group on Population Policy [Planning Commission 1980], the National Health Policy [Ministry of Health and Family Welfare 1983] set the goal of reducing the net reproduction rate (NRR) to one by 2000 AD by reducing the CBR to 21, crude death rate to 9, infant mortality rate to less than 60 per 1,000 live births and by increasing the proportion of couples practising family planning to 60 per cent. But the Seventh Plan (1985-90) document said, "In the light of the progress made in the initial period of the Sixth Plan, the health policy targeted a net reproduction rate of one by the year 2000 AD; a review, however, indicates that this goal would be reached only by the period 2006-2011" [Planning Commission 1985: 281]. Thus, every time a demographic goal was set, it was either revised upwards or deferred to be achieved in a later year. However, it may be mentioned that the achievement in CBR is likely to be close to the target set for the Eighth Plan.

As can be seen from Table 1, CBR was stagnant at about 33 per 1,000 population from 1962 to 1985. This was so notwithstanding considerable increase in the proportion of couples effectively protected by diffrent family planning methods from less than 5 per cent in 1962 to 32 per cent in 1985. This anomalous relationship between couple protection rate (CPR) and the CBR prompted some social scientists to analyse the situation and conclude that India was in a demographic trap [Reddy 1989: 93-102].

Objectives

Since the reduction in the CBR achieved so far has not been satisfactory, people are waiting eagerly to find out whether the Ninth Plan will chart out a new strategy in the implementation of the family welfare programme. The direction of government thinking on the issue can be gleaned from two documents – the document, *A Common Approach to Major Policy Matters and a Minimum Programme*, popularly known as the Common Minimum Programme (CMP), released on June 5, 1996 by the 13-party United Front, and the *Approach Paper to Ninth Five-Year Plan, 1997-2002* [Planning Commission 1997]. The CMP document contains a couple of small paragraphs under the sub-heading, 'Drinking Water, Primary Health Care and Housing' in which it is mentioned that the United Front government would draw up special plans during the Ninth Plan period to ensure that, among other things, one primary health centre (PHC) is established for a population of 5,000 (it is one PHC for 30,000 population at present). This is likely to make family planning services more easily accessible to people. This is the closest the CMP document comes to population programme. But the basic question is whether there are enough resources to establish one PHC for every 5,000 population during the Ninth Plan period. The *Approach Paper* makes no mention of establishment of one PHC for 5,000 population.

"Containing the growth rate of population" is one of the nine priority objectives of the Ninth Plan and its serial number is five [Planning Commission 1997: 12]. How does this compare with the population objective of the Eighth Plan? "Containment of population growth through active peoples' participation and an effective scheme of incentives and disincentives" was not only one of the six major objectives of the Eighth Plan, but also two in serial number, next only to the objective of "Generation of adequate employment to achieve near full employment level by the turn of the century" [Planning Commission 1992, I: 9]. We should not read too much into the serial numbers of the population objectives in the Eighth and Ninth Plans. However, the objective in the Eighth Plan was a little more detailed, while that in the Ninth Plan is brief. The Ninth Plan *Approach Paper* does not say anything about incentives and disincentives.

The *Approach Paper* has not only identified the factors that contribute to high population growth, but also estimated the percentage of their contribution [Planning Commission 1997: 59]. These are (1) the large size of the population in the reproductive age group and its estimated contribution to population growth is 60 per cent; (2) higher fertility due to unmet need for contraception and its estimated contribution to population growth is 20 per cent; and, (3) high unwanted fertility due to high infant mortality rate and its estimated contribution to population growth is 20 per cent [Planning Commission 1997: 59]. Let us examine briefly the three factors in turn.

Large Size

Table 2 presents data on the number and proportion of currently married women (CMW) in the reproductive age of 15-44 years in 1961, 1971, 1981 and 1991. It is immediately clear that there is a substantial

increase in the number of CMW in the reproductive age of 15-44 years between 1961 and 1991. Even after making allowance for the proportion of couples effectively protected by different family planning methods, the number of CMW in the reproductive age would be more in 1991 than in 1961. The reason for the increase in the number of CMW in the reproductive age is not far to seek. It is a direct result of high fertility in the past. The result is sometimes called 'echo effect'.

Further analysis of data in Table 2 reveals that the proportion of CMW in the age group 15-19 years in the total number of CMW in the reproductive age has gradually declined from a little over 15 per cent in 1961 to 9 per cent in 1991. The reason is obvious: increase in age at marriage of girls. There is also some decline in the proportion of CMW in the age group 20-24 years from a little over 22 per cent in 1961 to a little less than 21 per cent. As might be expected, there is an increase in the proportion of CMW in the older age groups.

The proportion of couples with wives in the child-bearing age in India effectively practising some method of family planning was about 22 per cent in April 1980, the beginning of the Sixth Plan, 32 per cent in April 1985 and about 40 per cent in August 1988. But CBR was about 33 per 1,000 population in April 1980, in April 1985 and in August 1988. Several scholars had identified family planning programme factors and community factors responsible for the anomalous relationship between the CBR and CPR [Srikantan and Balasubramanian 1988; Natrajan 1988; Pathak 1988; Gandotra 1988; Jolly 1988; Reddy 1988a; Reddy 1988b, Reddy 1988c; Gulati 1988]. One of the community factors identified was an increase in the proportion of females in the age group 15-29 years between 1971 and 1988 and the consequent increase in the CBR [Reddy 1988c: 1811]. As can be seen from Table 2, this is no longer the case. On the contrary, there is a decline in the proportion of CMW in the age groups 15-19 years and 20-24 years.

Another factor identified for lack of decline in the CBR between 1980 and 1988 was improvement in the health and nutritional status and the resultant improvement in the reproductive functions of women below 30 years of age and the consequent increase in their marital fertility rates. There were also increases in the total marital fertility rate and general marital fertility rate during the period [Reddy 1988c: 1811]. It would be important to examine whether this factor continues to contribute to an increase in the CBR. Table 3 presents data on age-specific marital fertility rates, total marital fertility rates and general marital fertility rates in India in 1988 and 1993. It may be noted that in none of the six five-year age groups of CMW in the reproductive age is there an increase in fertility between 1988 and 1993. On the contrary, there is a decline in the fertility of all the six five-year age groups. There are also declines in the total marital fertility rate (TMFR) and general marital fertility rate (GMFR) between 1988 and 1993. This does not mean that there is no improvement in the health and nutritional status of women. The reason for decline in the age-specific marital fertility rates, TMFR and GMFR is undoubtedly increase in the proportion of couples with wives in the child-bearing age practising some method of family planning. Thus, the *Approach Paper*, is in good company when it said that the large size of the population in the reproductive age group was one of the factors for high population growth rate in the country. But it is not clear how its estimated contribution to population growth is 60 per cent.

Unmet Need

Unmet need for contraception is identified as one of the three factors that contribute to high population growth in India and its contribution is estimated to be 20 per cent. Incidentally, what is meant by unmet need?

Table 3: Age-Specific Marital Fertility Rates, Total Marital Fertility Rates and General Marital Fertility Rates in India

Age Group (Years)	1988	1993
15-19	259.0	236.1
20-24	319.8	307.9
25-29	227.9	207.6
30-34	138.5	121.3
35-39	81.2	65.7
40-44	38.9	31.8
TMFR	5.4	4.9
GMFR	170.7	153.7

Notes: TMFR = Total marital fertility rate
GMFR = General marital fertility rate

Table 1: Demographic Goals Set and Actual Achievement

Year	Specified Demographic Objective (CBR)*	Year by Which the Goal Was to Be Achieved	Actual Achievement
1962	25	1973	34.6
1966	25	as expeditiously	
1968	23	1978-79	33.3
1969	32	1974-75	34.5
	25	1979-81	33.8
1974	30	1979	33.7
	25	1984	33.8
April 1976	30	1978-79	33.3
	25	1983-84	33.7
April 1977	30	1978-79	33.3
	25	1983-84	33.7
January 1978			
Central Council of Health	30	1982-83	33.8
National Health Policy (1983)	31	1985	32.9
	27	1990	29.9
	21	2000	
Seventh Plan	29.1	1990	29.9
Eighth Plan	26.0	1997	

Note: * CBR = Crude birth rate.
Source: Planning Commission, *Eighth Five-Year Plan, 1992-97*, Vol II, Government of India, New Delhi, 1992.

Table 2: Number and Proportion of Currently Married Women in the Reproductive Age in India

Age Group (Years)	1961	1971	1981	1991
15-19	12,024,245	12,325,666	13,079,599	12,983,391
	(15.25)	(13.23)	(11.66)	(9.00)
20-24	17,557,341	19,122,792	23,933,293	30,236,237
	(22.27)	(20.53)	(21.34)	(20.96)
25-29	16,997,625	19,447,045	23,559,607	32,599,649
	(21.56)	(20.88)	(21.00)	(22.60)
30-34	13,581,216	16,801,352	19,730,736	27,103,296
	(17.22)	(18.04)	(17.59)	(18.79)
35-39	10,320,406	14,309,752	17,675,654	23,454,214
	(13.09)	(15.36)	(15.76)	(16.26)
40-44	8,366,885	11,137,240	14,192,716	17,871,167
	(10.61)	(11.96)	(12.65)	(12.39)
Total	78,847,718	93,143,847	112,171,605	144,248,054
	(100.00)	(100.00)	(100.00)	(100.00)

Note: Numbers in parentheses are percentages to total.

The unmet need for terminal family planning methods is estimated on the basis of survey information on the number of CMW in the reproductive age who say that they do not want any more children but are not practising any terminal method; the unmet need for spacing methods is estimated on the basis of survey information on the number of CMW in the reproductive age who say that they want to wait for at least two years before having another child but are not practising any temporary family planning method; and the combined estimate gives the total unmet need [Robey, Piotrow and Saltern 1995: 6].

To my mind, the concept of unmet need is an artifact of large-scale family planning surveys. In India, family planning programme has been propagating for the last 45 years that a couple should have only two or three children and that there should be a gap of at least three years between two children. To be fair to the family planning programme, this message has reached every nook and corner of India. So when survey interviewers fire two questions at the CMW in the reproductive age asking them whether they want any more children and whether they are practising any terminal family planning method, some of them reply in the negative to both the questions. The survey researchers then estimate the unmet need for terminal family planning methods on the basis of such information. Three comments need to be made here. The first is that the respondents do not really mean what they say: they do not want any more children. The second is that they may not be practising a terminal family planning method for a variety of reasons such as unwillingness of mother-in-law or husband, religious proscription, etc, but not necessarily due to the failure of the family planning programme to provide services. The third comment is that many surveys have revealed that some couples use a spacing method like IUD in the place of a terminal method to limit the number of children.

To estimate the unmet need for spacing methods, survey researchers ask the CMW in the reproductive age whether they want a child in the next two years. The other question put to those respondents who say that they do not want a child in the next two years is whether they are practising any spacing method. Some of them answer the question in the negative. Then survey researchers rush to estimate the unmet need for spacing methods. Here again all of them may not be telling the truth.

Why do some of the respondents not tell the truth? They do not tell the truth because they want to please the interviewers and because they want to create the impression that they are also well informed, modern people. The respondents know very well that the interviewers will not be around the next day to check the veracity of their responses.

A study of the causes of demographic change in south India, employing micro approaches, including participant observation, found many discrepancies in the responses of CMW in the reproductive age in the initial surveys and in the later informal discussions [Caldwell, Reddy and Caldwell 1988]. The comment of a noted anthropologist about the way large-scale family planning surveys are conducted in India and about the validity and reliability of data generated by such surveys is worth quoting: "The manner in which survey workers elicited information was not always conducive to providing useful data. Commonly, for example, a village woman finds herself suddenly confronted by a young lady, carrying official-looking papers, who fires a series of questions at her. The village woman takes in the young lady's austerely elegant sari, her thin, expensive bangles, her carefully tended hair, smooth complexion, and her soft hand cleverly manipulating a ball-point pen. She is likely to give the kind of answers that she believes an educated person would like to hear" [Mandelbaum 1974: 14]. Though this comment was made more than 20 years ago, it is valid even today. The point that I am trying to make is that allowance has to be given for such defects of surveys and that not all the unmet need estimated by survey researchers is really unmet need.

If the motivation of CMW in the reproductive age or of couples with wives in the reproductive age is really strong to limit the number of children or postpone the birth of the next child, they will go to a primary health centre or any government hospital, irrespective of its distance, and adopt a suitable family planning method. Alternatively, they can adopt traditional methods like *coitus interruptus* or safe period method. These traditional methods may be unreliable at the individual level, but they can reduce the aggregate birth rate considerably. The major portion of the

TABLE 4: NUMBER OF VASECTOMIES AND TUBECTOMIES AND VASECTOMIES AS PERCENTAGE OF TOTAL STERILISATIONS IN INDIA, 1956-57 TO 1992-93

Year	Number of Sterilisations			Percentage of Vasectomies to Total
	Vasectomy	Tubectomy	Total	
1	2	3	4	5
1956-57	2,834	5,965	8,799	32.21
1957-58	5,411	11,178	16,589	32.62
1958-59	11,300	18,137	29,437	38.39
1959-60	22,624	25,187	47,811	47.32
1960-61	44,167	30,232	74,399	59.37
1961-62	75,999	41,972	1,17,926	64.45
1962-63	1,12,923	48,099	1,61,022	70.12
1963-64	1,36,259	58,816	1,95,075	69.85
1964-65	2,95,030	74,850	3,69,880	79.76
1965-66	4,32,457	70,660	5,03,117	85.96
1966-67	7,85,378	1,01,990	8,87,368	88.50
1967-68	16,48,152	1,91,659	18,39,811	89.60
1968-69	13,83,053	2,81,764	16,64,817	83.10
1969-70	10,55,860	3,66,258	14,22,118	74.20
1970-71	8,78,800	4,51,114	13,29,914	66.10
1971-72	16,20,076	5,67,260	21,87,336	74.10
1972-73	26,13,263	5,08,593	31,21,856	83.70
1973-74	4,03,107	5,39,295	9,42,402	42.80
1974-75	6,11,960	7,41,899	13,53,859	45.20
1975-76	14,38,337	12,30,417	26,68,754	53.90
1976-77	61,99,158	20,62,015	82,61,173	75.00
1977-78	1,87,609	7,61,160	9,48,769	19.80
1978-79	3,90,922	10,92,985	14,83,907	26.30
1979-80	4,72,687	13,05,237	17,77,924	26.60
1980-81	4,38,909	16,13,861	20,52,770	21.40
1981-82	5,73,469	22,18,905	27,92,374	20.50
1982-83	5,85,489	33,97,700	39,83,189	14.70
1983-84	6,61,041	38,71,181	45,32,222	14.60
1984-85	5,49,703	35,34,880	40,84,583	13.50
1985-86	6,39,477	42,62,132	49,01,609	13.00
1986-87	8,09,605	42,33,580	50,43,185	16.10
1987-88	7,54,086	41,85,670	49,39,756	15.30
1988-89	6,17,331	40,60,846	46,78,177	13.20
1989-90	3,41,581	38,46,582	41,88,163	8.20
1990-91	2,54,905	38,70,650	41,25,555	6.20
1991-92	1,74,201	39,15,838	40,90,039	4.30
1992-93	1,50,496	41,35,922	42,86,418	3.50
Total	2,73,77,659	5,77,34,444	8,51,12,103	32.17

European fertility decline in the 19th and early 20th centuries occurred long before the widespread use of modern contraceptives [Notestein and Stix 1940: 148]. The French birth rate dropped almost continuously from the Napoleonic period onwards to 1930s with the use of traditional methods [Beaver 1975: 6].

How did the *Approach Paper* arrive at the estimate of 20 per cent contribution of unmet need to high population growth? It is perhaps taken from the 'findings' of the National Family Health Survey (NFHS) conducted in 1992-93 [International Institute for Population Sciences 1995: 188]. But the finding of the NFHS is that the CMW with unmet need for family planning accounted for about 20 per cent. I do not think that the finding of the NFHS that the need for family planning of about 20 per cent of the CMW has not been met and the *Approach Paper's* estimate of 20 per cent contribution of unmet need for family planning to high population growth are the same. Incidentally, in the developing world as a whole also, about 20 per cent of CMW in the reproductive age have an unmet need for family planning [Robey, Piotrow and Salter 1995: 6].

Infant Mortality

The *Approach Paper* has rightly identified high infant mortality rate as one of the factors contributing to high population growth. It is true that unless couples are reasonably certain that the two or three children born to them will survive to adulthood, they will not accept the idea and some method or the other of family planning.

A quick examination of the decline in crude death rate and infant mortality rate reveals that the former has declined by about 42 per cent from about 16 per 1,000 population in 1975 to a little over nine in 1994, while the latter has declined by about 48 per cent from 140 per 1,000 live births in 1975 to 73 in 1994. Although infants have benefited slightly more than adults from the improvement in living conditions, infant mortality rate is so high that it cannot create confidence in the minds of couples to accept a family planning method, especially a terminal method.

The *Approach Paper* has estimated that the contribution to high population growth because of high desired level of fertility due to high infant mortality rate is 20 per cent. How this contribution is estimated is not clear.

Apart from the three factors identified by the *Approach Paper*, there could be other factors that contribute to high population growth. A large-scale survey conducted in Karnataka has revealed that the reasons for non-acceptance of family planning, as given by CMW in the reproductive age, included desire for son, desire for daughter, desire for as many children as possible, objection from elders/spouse, personally against family planning, family planning against religion and no one to help at the time of bed-rest after tubectomy or in the event of complications arising from the adoption of a family planning method (Reddy and Gopal 1993: 91-92). Thus, the assumption of the *Approach Paper* that only three factors contribute to high population growth is not correct.

Objectives and Strategies

On the basis of the three factors identified and their estimated contributions to high population growth, the *Approach Paper* has set out to state the objectives of the population programme in the Ninth Plan and identified the strategies to achieve the objectives. But before that, the *Approach Paper* has said, "While the population growth contributed by the demographic factor of large population in the reproductive age group will continue, the other two factors need effective and prompt remedial action" [Planning Commission 1997: 59]. This is a defeatist attitude. While it is not possible to reduce the large size of the population in the reproductive age group, it should be certainly possible to reduce its contribution of '60 per cent' to the high population growth.

The twin objectives are, therefore, limited to (1) meeting the unmet need for contraception, and (2) reducing the infant and maternal morbidity and mortality so that there is a reduction in the desired number of children [Planning Commission 1997: 59].

The twin strategies proposed to be adopted are (1) assessment of the needs for reproductive and child health (RCH) at the primary health centre level and undertaking of area-specific micro-planning, and (2) provision of need-based, client-centred and demand-driven high quality RCH services [Planning Commission 1997: 59]. All these years, the emphasis was on macro-planning and population-based approach. The shift to area-specific micro-planning and need-based approach is a welcome one.

The *Approach Paper* has declared that the programmes will be directed towards filling the gaps in infrastructure and manpower, providing additional resoures to poorly performing districts, ensuring uninterrupted supply of drugs, vaccines and contraceptives, and promoting male participation in family planning. These are all important measures which will go a long way in improving RCH services. We will have occasion to say more about male participation.

The *Approach Paper* has also contemplated enhancement of coverage of family welfare services by involving private medical practitioners, practitioners of Indian Systems of Medicine and Homoeopathy, panchayat raj institutions, industries, agriculture workers and labour representatives [Planning Commission 1997: 60]. These could also be called strategies to improve family welfare services. But the contemplation should go beyond rhetoric and identify mechanisms through which the measures would become effective.

Male Participation

The *Approach Paper* has rightly said that programmes will be directed, *inter alia*, towards "promoting male participation in the planned parenthood movement and increasing level of acceptance of vasectomy" [Planning Commission 1997: 60]. In other words, the *Approach Paper* has admitted that the onus of family planning has been on women and that men have been avoiding responsibility in controlling population growth. Has this been so since the inception of the family planning programme? Or is it a later phenomenon? In any case, it is worth speculating about the reasons for it.

Table 4 presents data on the number of vasectomies (male sterilisations), tubectomies (female sterilisations), total sterilisations and vasectomies as percentage of total sterilisations in India from 1956-57, the year in which sterilisations were introduced into the family planning programme, to 1992-93, the latest year for which information is available. It is immediately clear that in the first four years, the proportion of vasectomies in the total sterilisations ranged from about 32 per cent in 1956-57 to a little over 47 per cent in 1959-60. Between 1960-61 and 1972-73, the proportion of vasectomies increased enormously ranging from a little over 59 per cent in 1960-61 to nearly 90 per cent in 1967-68. A number of factors seemed to account for this increase in the proportion of vasectomies, one of which is organisation of mass vasectomy camps.

The proportion suddenly dropped to much less than 50 per cent in 1973-74 and 1974-75 before increasing to about 54 per cent in 1975-76 and 75 per cent in 1976-77, the two emergency years. The increase in the proportion of vasectomies during the two emergency years was not normal; it was induced by compulsion and coercion [Panandikar, Bishnoi and Sharma 1978]. Once the emergency was lifted and the Janata Party came to power at the centre in 1977, the proportion of vasectomies came down to less than 20 per cent in 1977-78. From then on, the proportion of vasectomies never increased. In 1992-93, the proportion of vasectomies in the total sterilisations accounted for as low as 3.5 per cent. Between 1956-57 and 1992-93, the proportion of vasectomies accounted for less than one-third of the total sterilisations.

Reasons

It is worth speculating on reasons, even if some of them are questionable, for the sharp decline in the proportion of vasectomies in the total number of sterilisations. Every vasectomy acceptor should use condoms in seven or eight intercourses after vasectomy. This is necessary because there will be sperms in the semen left in the seminal vesicle after vasectomy. In the beginning, condoms were not given to all the vasectomy acceptors and not all the vasectomy acceptors who were given condoms used them. Further, in the mass vasectomy camps, especially during the emergency period, vasectomies were not done properly. As a result, wives of many vasectomy acceptors became pregnant. This created a serious social problem. It is not fortuitous that demand for vasectomies declined sharply after the emergency. Also, wives of vasectomy acceptors were subjected to psychological trauma whenever their menstruation was delayed by two or three days. Therefore, women thought and still think that it would be safer if they accept tubectomy.

There is the belief, perhaps to a lesser extent now than before, that vasectomy is 'castration' and that vasectomy acceptors lose their virility. There is also the belief that vasectomy is an 'operation' and that it is likely to result in physical disability and that it will not be possible for the vasectomy acceptors to carry the same heavy loads which they were carrying earlier and do the same hard work which they were doing earlier. There is the more serious apprehension that the 'operation' may result in death and should this occur to the vasectomy acceptor, who is the main breadwinner, it will spell disaster to the family. All these raise the question of effectiveness of information, education and communication (IEC) programme in family planning. Admittedly, IEC programme does not seem to be effective in removing misconceptions about different family planning methods, including vasectomy.

One more factor that seems to be contributing to a decline in the proportion of vasectomies or to an increase in the proportion of tubectomies is the differential role played by the female and male health workers. Female health workers are more successful in motivating women for tubectomy than male health workers in motivating men for vasectomy. There are two reasons for this. One is that female health workers are more sincere and more hard working than male health workers. It is not an exaggeration to say that whatever success the family planning programme has achieved is mainly due to the efforts of female health workers. The other reason is that the nature of services (such as the provision of ante-natal, intranatal and post-natal services) provided by female health workers enables them to more easily establish rapport with married women in the reproductive age and to motivate them for tubectomy. The nature of services (such as the provision of services for malaria, tuberculosis, leprosy, etc), provided by male health workers does not facilitate the establishment of rapport with men whose wives are in the child-bearing age and motivate them for vasectomy, as all suffer from the diseases.

Yet another reason is that when women go to hospitals for delivery, they accept tubectomy there. The post-partum tubectomy is preferred by women for two reasons. For one thing, post-partum tubectomy seems to be easier than interval tubectomy. And secondly, women need not stay in bed for additional days because of tubectomy since they will, any how, be in bed for post-partum rest. This fact also contributes to a higher proportion of tubectomies in the total number of sterilisations.

Thus, a combination of factors has contributed to a virtual disappearance of demand for vasectomy. Even in the adoption of spacing methods, men lag behind women. In India, in 1993, 8.3 per cent of the CMW in the reproductive age were effectively protected by spacing methods (6.3 per cent by IUD and 2 per cent by oral pills), as compared with 4.9 per cent of men with wives in the child-bearing age who were using condoms. Thus, family planning has become the sole responsibility of women.

The situation should not be allowed to continue any longer. The IEC programme should be improved, condoms provided without interruption and other measures taken to generate adequate demand for vasectomy and male spacing methods and make men share in family planning responsibility.

Other Issues

There are other issues which are relevant to the population programme but are not raised by the *Approach Paper*. These are promotion of spacing methods, application of incentives for family planning acceptors and disincentives for non-acceptors, family planning method-specific targets for all the states and union territories, the number and proportion of couples to be protected by different family planning methods, and demographic goal to be achieved by the end of the Ninth Plan period.

Right from the inception of the family planning programme, emphasis has been on limiting the number of children and not so much on spacing the children. As a result, sterilisation has been promoted and spacing methods neglected. Of all the family planning acceptors, sterilisation acceptors account for more than 80 per cent and acceptors of spacing methods for less than 20 per cent. Generally, couples accept sterilisation when they are somewhat old and when they already have more children than the number propagated by the family planning programme. The mean age of tubectomy acceptors at the time of accepting tubectomy was a little over 36 years in 1974-75 and a little over 29 years in 1991-92. The mean number of children of women at the time

of accepting tubectomy was 3.7 in 1980-81 and 3.2 in 1991-92. Though there is considerable decrease in the mean age of tubectomy acceptors, the reduction in the mean number of children is not much. The mean age of vasectomy acceptors at the time of accepting vasectomy was close to 33 years in 1974-75 and a little over 32 years in 1991-92. The mean number of children of men at the time of accepting vasectomy was 3.5 in both 1980-81 and 1991-92. Thus, there is little reduction in the mean age of vasectomy acceptors and no reduction at all in the mean number of their children. In order to have significant reduction in population growth, especially in a relatively short period, it is absolutely necessary to promote the adoption of spacing methods by young couples. But the *Approach Paper* is silent about the importance of promoting spacing methods.

The Eighth Plan made incentives and disincentives as a strategy to promote family planning. But no mention is made of incentives and disincentives in the *Approach Paper* to the Ninth Plan. Of course, the issue of incentives and disincentives bristles with controversies. Some argue that since Indian family planning programme is a voluntary one, no incentives should be given to lure couples to accept family planning. Others argue that the term 'incentives' is a misnomer and that 'compensations' should be given, especially to the poor, for the wages foregone during the post-sterilisation and post-IUD insertion rest period. The latter seems to be a valid argument. But administration of incentives only to the poor is difficult. Therefore, incentives may be given to all the sterilisation and IUD acceptors. Disincentives to non-acceptors of family planning raise many ethical issues. Therefore, it is advisable not to apply disincentives to non-acceptors or their children.

In the past, family planning method-specific targets were set for all the states and union territories. But because of the 'tyranny' created by the targets for both family planning workers and couples, these have been discontinued from 1996-97. It is like throwing away the baby with bath water. The performance of family planning programme in 1996-97 seems to have suffered a set-back in many states because of the target-free approach. It is necessary to have targets which will serve as guide-posts towards which action should be oriented. Of course, care should be taken not to use coercion or compulsion in achieving the targets.

In the previous five-year plans, the number and proportion of couples to be protected by different family planning methods and the demographic goal of reducing the crude birth rate to a particular level used to be fixed. But the *Approach Paper* makes no mention about them. Perhaps the final document of the Ninth Five-Year Plan will contain all the details about the family welfare programme.

References

Beaver, Steven E (1975): *Demographic Transition Theory Reinterpreted*, Heath and Company, Lexington, DC.

Caldwell, John C, P H Reddy and Pat Caldwell (1988): *The Causes of Demographic Change: Experimental Research in South India*, The University of Wisconsin Press, Madison.

Gandotra, M M (1988): 'Reconciliation of Family Planning Performance and Birth Rate in India', a paper presented at the National Workshop on New Issues in Population Research for Planning and Policy Making, New Delhi, February 10-11.

Gulati, S C (1988): 'Some Aspects of Evaluation of Family Planning Programme', a paper presented at the National Workshop on New Issues in Population Research for Planning and Policy Making, New Delhi, February 10-11.

International Institute for Population Sciences (IIPS) (1995): *National Family Health Survey (MCH and Family Planning) India 1992-93*, IIPS, Bombay.

Jolly, K G (1988): 'Strengthening Demographic Data Base to Study the Impact of Family Planning Programme on Population Growth', a paper presented at the National Workshop on New Issues in Population Research for Planning and Policy Making, New Delhi, February 10-11.

Mandelbaum, David G (1974): *Human Fertility in India: Social Components and Policy Perspectives*, University of California Press, Berkeley.

Ministry of Health and Family Welfare (1983): *National Health Policy*, Government of India, New Delhi.

Natarajan, K S (1988): 'Couple Protection Rate and Crude Birth Rate in India', a paper presented at the National Workshop on New Issues in Population Research for Planning and Policy Making, New Delhi, February 10-11.

Notestein, Frank, W and Regine K Stix (1940): *Controlled Fertility*, Williams and Wilkins, Baltimore.

Panandikar, V A Pai, R N Bishnoi and O P Sharma (1978): *Family Planning under the Emergency: Policy Implications of Incentives and Disincentives*, Radiant Publishers, New Delhi.

Pathak, K B (1988): 'Some Issues Concerning Contraception and Fertility in India', a paper presented at the National Workshop on New Issues in Population Research for Planning and Policy Making, New Delhi, February 10-11.

Planning Commission (1980): *Working Group on Population Policy: Report*, Government of India, New Delhi.

– (1985): *Seventh Five-Year Plan, 1985-90*, Vol II, Government of India, New Delhi.

– (1992): *Eighth Five-Year Plan, 1992-97*, Vol I, Government of India, New Delhi.

– (1997): *The Approach Paper to the Ninth Five-Year Plan, 1997-2002*, Government of India, New Delhi.

Reddy, P H (1988a): 'Enigmatic Birth Rate in India', a paper presented at the National Workshop on New Issues in Population Research for Planning and Policy Making, New Delhi, February 10-11.

– (1988b): 'Bringing Down Fertility', *Deccan Herald*, April 7.

– (1988c): 'Population Front of India's Economic Development', *Economic and Political Weekly*, XXIII, 35, 1809-12.

– (1989): 'India in the Demographic Trap', *Janasamkhya*, VII, 2, 93-102.

Reddy, P H and Y S Gopal (1993): 'Trends and Differentials in Fertility, Mortality and Family Planning: An Evaluation of IPP-III (Karnataka)', Population Centre (mimeo), Bangalore.

Robey, B, P T Piotrow and C Salter (1995): 'Family Planning Lessons and Challenges: Making Programmes Work', *Population Reports*, Series J, No 40, Johns Hopkins School of Public Health, Baltimore.

Srikantan, K Sivaswamy and K Balasubramanian (1988): *Factors underlying Stalling of the Birth Rate Decline in India*, Gokhale Institute of Politics and Economics (mimeo), Pune.

Global Population Growth, Economic Development and Environmental Impact

Case-Study of India, 1991-2100

Mahinder Chaudhry

The nature of environmental problems depends upon the level of economic development, the nature of industrialisation, the degree of urbanisation and the effectiveness of public policies. This article examines the impact of population growth and economic development separately, but with reference to the conjectured global warming between 1991 and 2100, with special reference to India.

I Introduction

BOTH developed and developing economies face the challenge of sustained economic development without environmental damage. Although sustained economic growth is a necessary condition for eradication of poverty and wide-spread increase in human welfare, it is by no means a sufficient condition. Economic progress has, in general, potential adverse environmental effects. The evidence of it is not lacking in the industrialised as well as in the less developed countries. The environmental damage that is global in nature and irreversible over a very long time underscores the truly international nature of the problem. Since the 'external diseconomies' associated with environmental damage are not a part of the private (firms and households) costs, the role for the national public policy becomes imperative. Also the environmental impacts which are global in nature necessitate policies at the international level. The formulation of economic development strategies with full consideration for environmental concerns must be based on accurate and clearer understanding of the problems involved.

The nature of environmental problems depends upon the level of economic development (gross national product per capita), the nature of industrialisation, the degree of urbanisation, and the effectiveness of public policies. In general, the developing countries experience immediate environmental problems related to scarcity and safety of drinking water; inadequate sanitation facilities; air pollution in urban areas; soil depletion and degradation; indoor smoke from burning biomass (wood, coal, and dung); and outdoor smoke from burning coal for industrial production. In addition to the direct negative effects on human and animal health, the economic productivity is significantly reduced. In contrast, the industrialised societies encounter a different set of problems such as carbon dioxide emissions (CO_2), petrochemical smog, depletion of spheric ozone, acid rain, and hazardous wastes. Ever expanding industrial production, agriculture, and transportation systems are endangering the sustainability of the healthy globe.

This paper examines the impact of population growth and economic development separately, but with reference to the conjectured global warming between 1991 and 2100. The exercise is primarily based on the CO_2 emissions which account for nearly two-thirds of global warming. The contribution of deforestation to total carbon emission is projected to decline from 12 per cent in 1985 to less than 3 per cent in 2100. Following the World Bank classification scheme of low, middle, and high income countries, the total world increases in CO_2 emissions over the next century are assessed within these groups of countries. India is

TABLE 1: POPULATION SIZE ESTIMATES AND PROJECTIONS, AND GROSS NATIONAL PRODUCT PER CAPITA BY THE WORLD BANK CLASSIFICATION OF GROUP OF COUNTRIES, 1991-2100

	Total World	Low Income Countries (a)	Middle Income Countries (b)	High Income Countries (c)	India (d)
Population Size (millions)					
1991	5,350	3,127	1,401	822	866
2000	6,111	3,686	1,561	864	1,017
2025	8,247	5,184	2,140	922	1,365
2100	12,036	7,784	3,285	966	1,635
Economic development					
GNP per capita (1991) US $	4,010	350	2,480	21,050	330

Notes: (a) Low income countries are those with a GNP per capita of US $ 635 or less in 1991.
(b) Middle income countries are those with a GNP per capita of more than $ 635 but less than $ 7,911 in 1991.
(c) High income economies are those with a GNP per capita of $ 7,911 or more in 1991.
(d) India is included in the low-income countries.

Sources: *World Development Report 1993* (June 1993). World Bank Working Paper Series Number 601 (February 1991).

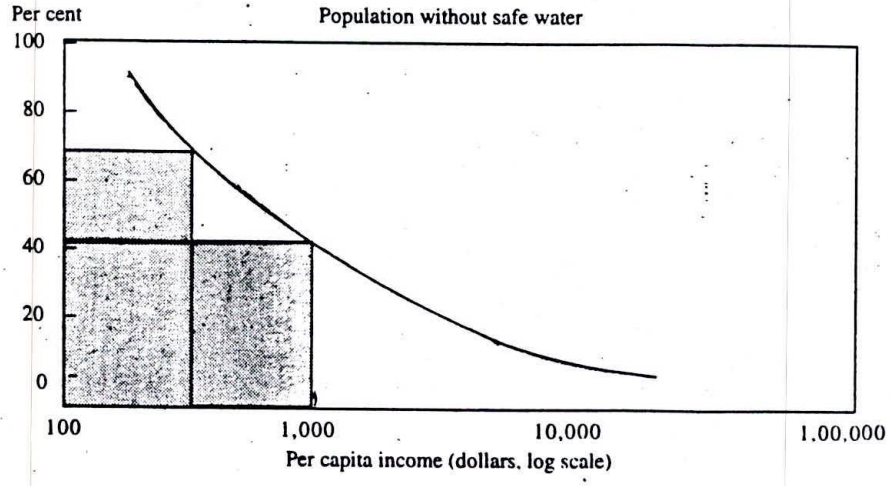
TABLE 2: TOTAL AND PER CAPITA CARBON DIOXIDE (CO_2) EMISSION[a] BY GROUP OF COUNTRIES AND TOTAL WORLD, 1991 TO 2100

	Total World	Low Income Countries	Middle Income Countries[b]	High Income Countries	India[c]
Total CO_2 [Pgr (Petagrams, i.e. 10_{15} grams) of CO_2 per year]					
1991[d]	6.79	2.03	2.10	2.66	0.53
2000[d]	8.13	2.73	2.45	2.95	0.75
2025	12.45	5.24	3.63	3.58	1.38
2100	30.09	12.30	9.94	7.85	2.58
CO_2 Increase (Petagrams)					
1991	1.27	0.65	1.50	3.24	0.65
2000	1.33	0.74	1.57	3.42	0.74
2025	1.51	1.01	1.70	3.88	1.01
2100	2.50	1.58	3.03	8.13	1.58

Notes: (a) Including emissions from deforestation and cement production;
(b) For middle-income countries values obtained by residual method.
(c) India included in low income countries; data for low income countries assumed for India.
(d) For years 1991 and 2000 linear interpolation between 1985 and 2025 values

Sources: US Environmental Protection Agency, *Policy Options for Stabilising Global Climate: Report to Congress*, Washington, DC 1990; data adapted by Bongaarts (1992).

CHART 1: POPULATION WITHOUT SAFE WATER AND COUNTRY INCOME LEVELS: GLOBAL AND INDIA

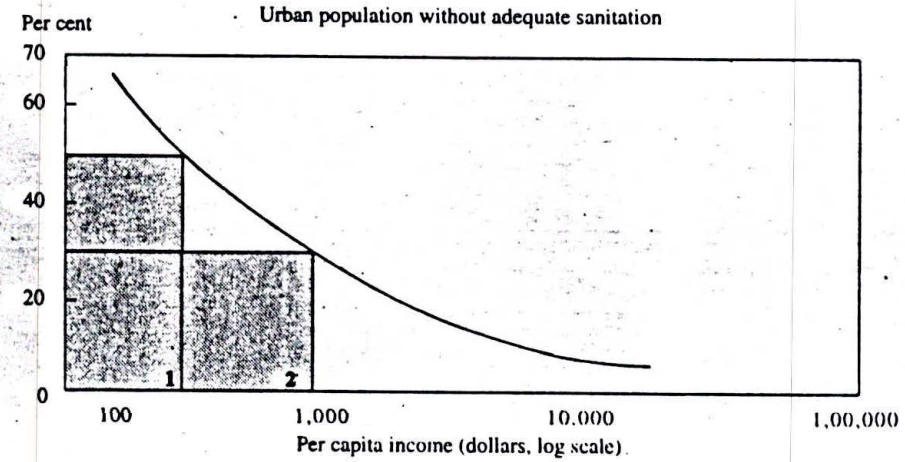


1 India GNP US $ 350 (Log_{10} = 2.544 in 1990)
2 India GNP US $ 985 (Log_{10} = 2.993 in 2025)

Notes: (a) Global: based on cross-country regression analysis (1980s data).
(b) India: gross national product US $ 350 in 1990.

Source: Adapted from World Bank data (1992).

CHART 2: URBAN POPULATION WITHOUT ADEQUATE SANITATION AND COUNTRY INCOME LEVELS, GLOBAL AND INDIA



1 India GNP US $ 350 (Log_{10} = 2.544 in 1990)
2 India GNP US $ 985 (Log_{10} = 2.993 in 2025)

Notes: (a) Global: based on cross-country regression analysis (1980s data).
(b) India: gross national product US $ 350 in 1990.

Source: Adapted from World Bank data (1992).

treated as a separate group by itself. The basic data estimated by the US Environmental Protection Agency (EPA) (1990) and by the Intergovernmental Panel on Climate Change (IPCC) (1991) are employed for analytical purposes.

Section II outlines the scientific framework of the climate change and projected global warming. As an illustration of the economic costs involved from the projected global warming, the findings about the US economy as estimated by Cline (1992) are highlighted. Section III discusses the decomposition process and presents the findings. The period under study is divided into two sub-periods: between 1991 and 2025; and between 2025 and 2100. Section IV examines environmental scenarios for India for a medium-term period of 35 years (1991-2025) with respect to safe water supply, sanitation facilities, urban concentration of particulate matter, and urban concentration of urban sulphur dioxide. The concluding remarks follow in the next section.

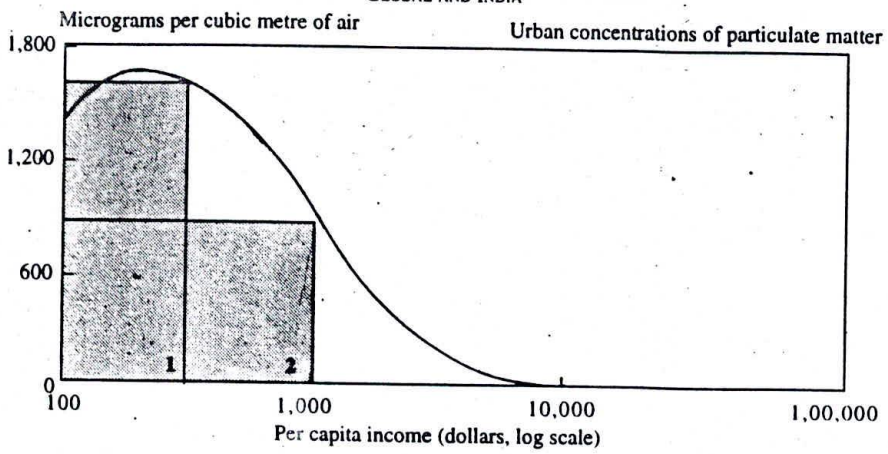
II
Economics of Global Warming

The global warming or the greenhouse effect is the process of heat trapping due to rising atmospheric concentrations of CO_2 and other gases emitted from deforestation, the burning of fossil fuels, and other human activity. These CO_2 gases are transparent to incoming shortwave solar radiation but opaque to outgoing long-wave (infra-red) radiation from earth. The scientists estimate that the natural levels of these gases raise the earth's average temperature by some 33°C, from −18°C to +15°C. The General Circulation Models (GMCS) prepared by the international expert climatologists estimate that "a doubling of carbondioxide-equivalent above preindustrial concentrations would increase global mean temperatures by a best-guess estimate of 2.5°C, with typical bounds of 1.5°C and 4.5°C [Cline 1992]. It is further projected that this doubling of carbon dioxide-equivalent is expected to arrive as soon as year 2025 under the assumption 'business as usual'. Further, if allowance is made for ocean thermal lag, the doubling year perhaps would be around 2050.

The IPCC estimates that the greenhouse effect will cause significant global warming by the middle of next century in the absence of any policy intervention. It may be noted that while most European countries, Japan, and Canada have set targets for reducing emissions of carbon dioxide, the policy-makers in the US have yet to do so. According to the IPCC calculations, under the business as usual scenario, the average global warming would reach 5.7°C by the year 2100. Since this process of global warming does not stop at the conventional bench-mark of a doubling of CO_2 concentration, Cline (1992) estimates that global emissions could increase from 6 billion tons of carbon or 6 GtC (GtC = gigatons of carbon) today to 20 GtC by the year 2100 and over 50 GtC by late in the 23rd century. Then the atmospheric concentrations of carbon could multiply eight-fold and global temperatures would ultimately rise by a central estimate of 10°C and by 18°C for the upper bound. In brief, this is the scientific framework for the projected climate change.

As an illustration of possible economic damage from the carbondioxide-equivalent doubling in the atmosphere (bench-mark 2.5°C) some of the costs to the US economy as estimated by Cline (1992) are as follows. These estimates are calibrated in absolute dollars and are expressed as percentages of the 1990 gross domestic product (GDP) of six trillion dollars (O^{12}): (a) The overall economic damage suffered by the US would be of the order of $ 60 billion, or 1 per cent of GDP. (b) The agricultural losses from heat stress and drought are placed at $ 18 billion. (c) The sea-level rise due to thermal expansion of sea water and melting of glacial ice will cost $ 7 billion. (d) The increased costs of air-conditioning (increased use of electricity) would amount to $ 11 billion; in contrast, the off-set for reduced heating costs would be only about $ 1 billion. (e) The costs of reduced water supply amount to $ 7 billion due to lesser run-off in the water basins. (f) The increased urban

CHART 3: URBAN CONCENTRATION OF PARTICULATE MATTER AND COUNTRY INCOME LEVELS, GLOBAL AND INDIA



1 India GNP US $ 350 (Log_{10} = 2.544 in 1990)
2 India GNP US $ 985 (Log_{10} = 2.993 in 2025)

Notes: (a) Global: based on cross-country regression analysis (1980s data).
(b) India: gross national product US $ 350 in 1990.

Source: Adapted from World Bank data (1992).

pollution (tropospheric ozone) associated with warmer weather would impose an annual cost of $ 4 billion. (g) An increased incidence of mortality with heat stress would amount to $ 6 billion when annual life losses are conservatively valued at life-time earnings. (h) The lumber value of forest loss would be over $ 3 billion annually. (i) The ski-industry losses due to shortened ski-seasons and relatively smaller quantities of snow would amount to $ 1.5 billion annually. (j) In addition, there would be other tangible costs on account of increased hurricane and forest fire damage. (k) If other intangible losses, particularly species loss and human 'disamenity', are included in the total damage, the costs as proportion of national GDP could be as high as 2 per cent. (l) With upper-bound warming of 4.5°C from doubling of carbon-dioxide-equivalent, the corresponding range of damage could be 2 to 4 per cent of GDP.

The above quantitative case study demonstrates substantial damage costs in the medium, long-term, and very long-term future. The costs of delays in policy formulation and implementation are indeed high in economic terms. The intellectual demands for a proper policy formulation are equally challenging.

III

Decomposition of Carbon Dioxide Emissions

If the carbon dioxide emissions (CO_2) concentrations (or an equivalent combination of several greenhouse gases) are doubled from the pre-industrial level, the equilibrium temperature of the globe is predicted to increase from 1.9°C to 5.2°C. The 'climate sensitivity' is conservatively assumed to be 2.5°C and the globe will be warmer by 4°C by 2100. The US Environmental Protection Agency estimated a mean rise of 0.6°C above the pre-industrial level and predicted a temparature rise of 1.5°C by 2025 and of 4.4°C by 2100. The IPCC estimated a mean rise of 0.9°C in 1985 and predicted a temperature increase of 1.9°C by 2025 and of 4.2°C by 2100. However, the actual warming by 2100 could be as high as 9°C, in case the 'climate sensitivity' turns out to be 5.2°C instead of the generally assumed 2.5°C, or as low as 3.2°C at the lower end of the range.

The determinants of annual CO_2 emissions could be divided into two groups: population growth and economic growth. The latter group may be further subdivided into energy intensity of gross national product, carbon intensity of energy consumption, and tropical deforestation. The data estimated by the US EPA and IPCC form the basis of the decomposition into two broad determinants. It is assumed that the population growth is not an endogenous variable in the model, and further it as assumed that there is no interaction term between these two determinants, that is, the two determinants are independent [Bongaarts 1992]. For analytical purposes the period under study between 1991 and 2100 is divided into two sub-periods of 1991-2025 and 2025-2100. Following the World Bank classification scheme, countries are grouped as: low-income (GNP/capita in 1991 of US $ 635 or less); middle-income countries (GNP/capita in 1991 of more than US $ 635 but less than US $ 7,911); and high-income

TABLE 3: AVERAGE ANNUAL EXPONENTIAL GROWTH RATE OF POPULATION AND TOTAL (CO_2) EMISSION INCREASE, 1991-2100

	Total World	Low Income Countries	Middle Income Countries	High Income Countries	India
Population (growth rate/year)					
1991-2025	1.236	1.45	1.21	0.328	1.300
2025-2100	0.504	0.54	0.57	0.062	0.241
1991-2100	0.737	0.83	0.78	0.146	0.577
CO_2 increase (growth rate/year)					
1991-2025	1.73	2.71	1.56	0.85	2.58
2025-2100	1.18	1.14	1.34	1.05	0.83
1991-2100	1.35	1.64	1.41	0.98	1.39

Sources and Notes: Tables 1 and 2.

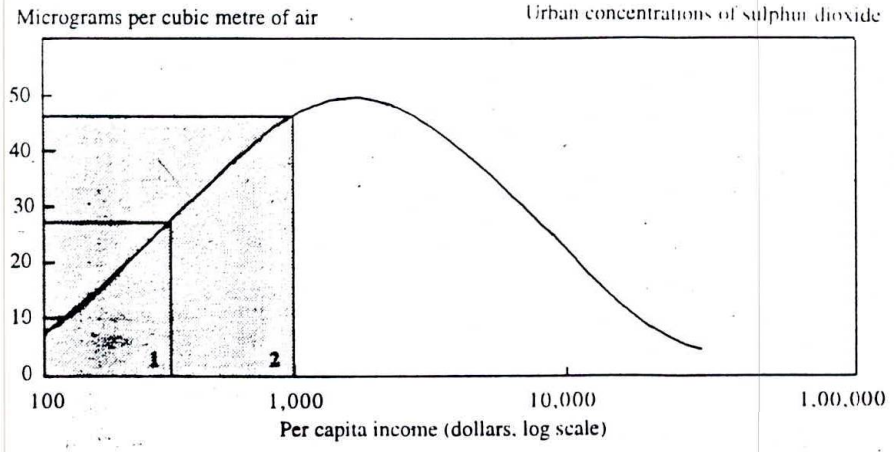
TABLE 4: ESTIMATES OF CONTRIBUTION OF POPULATION AND ECONOMIC DEVELOPMENT TO THE INCREASE IN CO_2 EMISSION, 1991-2100

	Total World	Low Income Countries	Middle Income Countries	High Income Countries	India
Total CO_2 (Petagrams per year)					
1991-2025	5.66	3.21	1.53	0.92	0.82
2025-2100	17.64	7.06	6.31	4.27	1.20
1991-2100	23.30	10.27	7.84	5.19	2.02
Contribution of population to emission growth (per cent)					
1991-2025	57.8	53.51	77.56	32.90	50.39
2025-2100	42.7	47.37	42.54	5.90	29.03
1991-2100	54.6	50.61	55.32	14.90	41.51
Conribution of ECO development to emission growth (per cent)					
1991-2025	42.2	46.49	22.44	67.10	49.61
2025-2100	57.3	52.63	57.46	94.10	70.97
1991-2100	45.4	49.49	44.68	85.10	58.49

Notes: Decomposition is calculated as the proportional reduction in the average annual CO_2 emission growth rate that would be if population size is kept constant. Further independence between population growth and GNP growth is assumed for simplification.

Sources: Tables 1, 2 and 3.

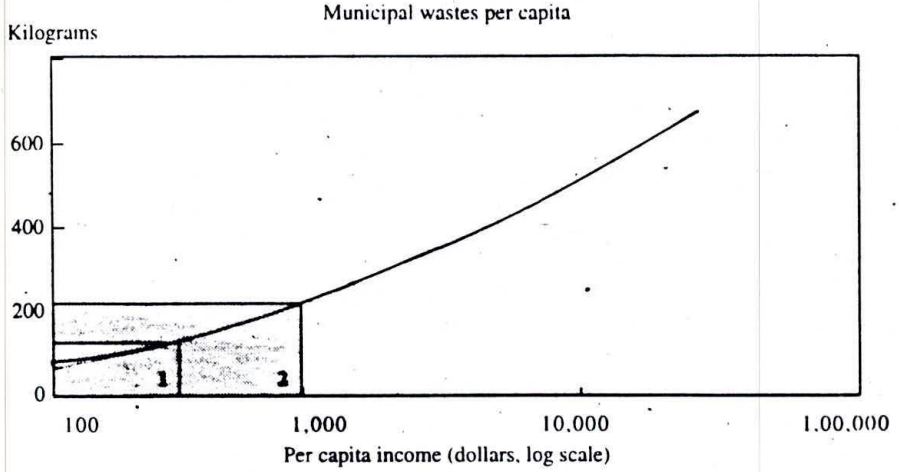
CHART 4: URBAN CONCENTRATION OF SULPHUR DIOXIDE AND COUNTRY INCOME LEVELS, GLOBAL AND INDIA



1 India GNP US $ 350 (Log_{10} = 2.544 in 1990).
2 India GNP US $ 985 (Log_{10} = 2.993 in 2025).

Notes: (a) Global: based on cross-country regression analysis (1980s data).
(b) India: gross national product US $ 350 in 1990.
Source: Adapted from World Bank data (1992).

CHART 5: MUNICIPAL WASTE PER CAPITA AND COUNTRY INCOME LEVELS, GLOBAL AND INDIA



1 India GNP US $ 350 (Log_{10} = 2.544 in 1990).
2 India GNP US $ 985 (Log_{10} = 2.993 in 2025).

Notes: (a) Global: based on cross-country regression analysis (1980s data).
(b) India: gross national product US $ 350 in 1990.
Source: Adapted from World Bank data (1992).

countries (GNP/capita in 1991 of US $ 7,911 or more). Although India is included in the low-income group, it is treated as a separate group by itself (GNP/capita in 1991 of US $ 330).

The low-income economies (40 countries with a weighted average per capita income of US $ 350 in 1991) account for 58 per cent of global population. By the year 2100 the global population share is projected to be 65 per cent (Table 1). Over the 35 years period, 1991-2025, the population growth alone will contribute 54 per cent of the CO_2 emissions, and during the following 75 years, 2025-2100, their contribution will decline by 13 per cent (Table 4). The total emissions are shared almost equally by the two determinants.

In contrast, the high-income group includes 22 countries with a weighted average per capita GNP of US $ 21,050, accounting for only 15 per cent of the total population in 1991. During the first sub-period, the population growth will contribute one-third and economic development the remaining two-thirds. However, during the second sub-period (2025-2100) the economic growth will contribute almost the entire increase in the emission; only a 6 per cent share is attributed to population growth (Table 4).

India's projected population growth is very sizeable indeed, almost doubling from the present level of 866 million in 1991 to 1,635 million by 2100 (Table 1). According to the very long-term projections, India's population will stabilise at 1,862 million sometime in the middle of the 22nd century (Chart 7). During the first sub-period, India's population growth will contribute 50.39 per cent share of the total emissions, but during the second sub-period the share attributed to population growth declines by about 40 per cent. In other words, the proportion attributed to economic growth increases by 43 per cent during the second sub-period (Table 4).

The estimates of CO_2 emissions by the US EPA are based on the assumption of annual growth in per capita income at the rate of 3 per cent for the developing countries and 2 per cent for the developed countries between 1985 and 2100. The global average GDP per capita is projected to rise from US $ 3,000 to $ 36,000 between 1985 and 2100 in terms of 1985 dollars. These assumed rates are derived from the actual growth over the past two decades. No doubt this assumption remains very crucial in this exercise. India's average annual rate of growth rate of GDP during 1970-80 was 3.4 per cent and during 1980-91 was 5.4 per cent (World Bank 1993). If the economic growth trends of the 1980s continue and further improve in the future, our assumed rate of 3 per cent growth in real income over a long period may turn out to be on the low side.

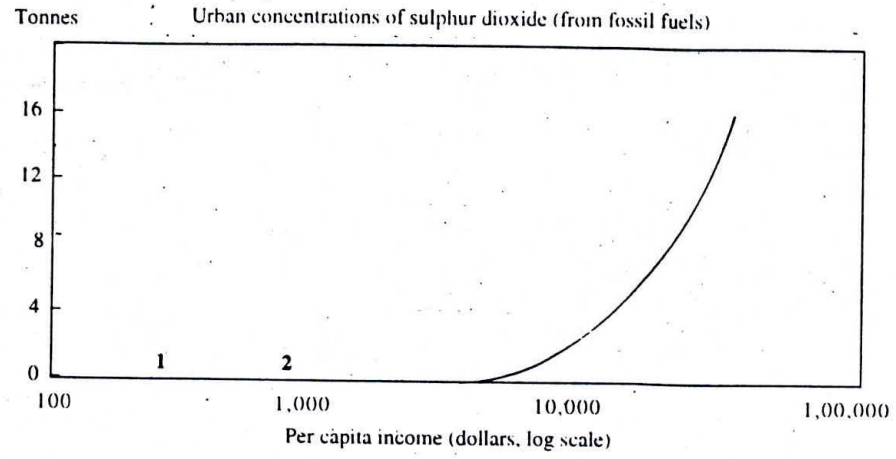
The energy intensity is projected to decline rapidly. For the developed economies (in megajoules per dollar GDP) it declines from 20 in 1990 to 4, and for the developing countries from 25 in 1990 to 4. However, the pace of decline for the developing countries is very slow. The carbon intensity is measured as grams of carbon per megajoule. At present, the average carbon intensity in developing countries is higher than that of the developed economies. This is so because the developing countries derive a sizeable part of their energy from coal and use less energy from non-fossil fuels.

Deforestation produces about 0.7 petagrams of carbon per year. This annual rate of emissions is to rise slowly to 1.1 petagrams in 2075 and subsequently decline to 0.8 petagrams in 2100. As noted earlier, the proportion of total global emissions attributed to deforestation in 2100 is only 3 per cent by the US EPA estimates. The estimated values of different factors used in these calculations are the product of a very detailed assessment and complex computer models.

IV
Environmental Scenarios in India

A recent World Bank study (1992) has traced an 'average' relationship between the level of economic development (GNP per capita) and the corresponding environmental damage/stress. India's current position is identified on each of these 'average' patterns of economic development-environmental relationships for the current year (1991), and

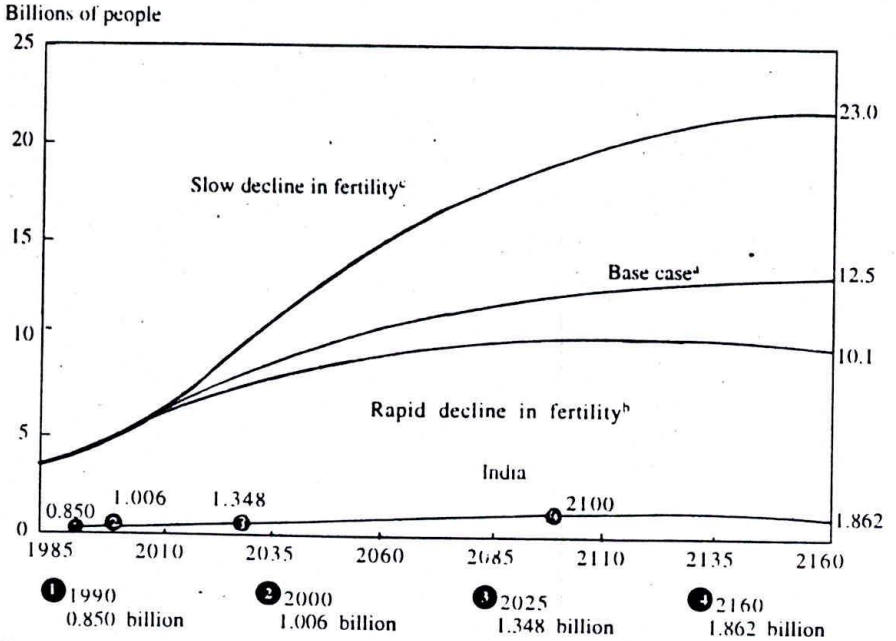
CHART 6: CARBON DIOXIDE EMISSIONS FROM FOSSIL FUELS PER CAPITA AND COUNTRY INCOME LEVELS, GLOBAL AND INDIA



1 India GNP US $ 350 (Log_{10} = 2.544 in 1990).
2 India GNP US $ 985 (Log_{10} = 2.993 in 2025).

Notes: (a) Global: based on cross-country regression analysis (1980s data).
(b) India: gross national product US $ 350 in 1990.
Source: Adapted from World Bank data (1992).

CHART 7: LONG TERM GLOBAL AND POPULATION PROJECTIONS UNDER DIFFERENT FERTILITY TRENDS, 1985-2160



Notes: (a) Base Case: Countries with high and non-declining fertility levels begin the transition toward lower fertility by the year 2005 and undergo a substantial decline by more than half in many cases over the next 40 years. All countries reach replacement fertility levels by 2060.
(b) Rapid Decline: Countries not yet in transition towards lower fertility begin the transition immediately; for countries already in transition, total fertility declines at twice the rate for the base case.
(c) Slow Decline: Transition towards lower fertility (triggered when life expectancy reaches 53 years) begins after 2020 in most low income countries. For countries in transition, declines are half the rate for the base case.
(d) India: Assumed year of reaching net reproductive rate of one (total fertility rate of approximately 2.2) by year 2015. The projected 'stationary' population is 1.862 million around 2150-2160.
Source: Adapted from World Bank data (1992).

the likely change over the next 35 years (1991-2025) is measured. India's per capita GNP is projected to increase to US $ 985 in terms of 1990 US dollars at the average annual rate of 3 per cent. For calculating the change over time the log values of GNP per capita are used. The following general observations can be made: (a) The proportion of population without safe water supply will decline from 75 per cent to 42 per cent between 1990 and 2025; four out of every 10 households will be without safe water supply (Chart 1). (b) Similarly, one out of every four households will be without adequate sanitation by 2025 (Chart 2). (c) The level of urban concentrations of particulate matter will drop by about 50 per cent, from 1,600 to 800 micrograms per cubic metre of air (Chart 3). (d) The urban concentrations of sulphur dioxide will increase by about 70 per cent over the same 35-year period in terms of micrograms per cubic metre of air (Chart 4). (e) Municipal waste per capita is projected to double, amounting to 200 kg in the year 2025 from the present level of about 100 kg (Chart 5).

V
Concluding Remarks

The future is uncertain, especially in economic and social developments. These long-term projections over the next century must be interpreted as no more than broad trends. As a member of the profession of economic-demographers I must inject much needed modesty in claiming the degree of accuracy reflected in mathematical manipulations and assumed relationships. Nevertheless, it is clear that any rapid decline in the population projection for India over the next two decades will result in a considerable environmental improvement in the long run. The best environmental policy will remain a rapid decline in population growth in the country in general and Uttar Pradesh in particular.

[The paper was presented at the XVII Conference of the Indian Association for the Study of Population, to be held at the University of Annamalai, Annamalai Nagar, Tamil Nadu, December 16-19, 1993, in Session G: 'Population Growth and Sustainable Development', organised by M K Premi for the *Volume of Contributions* (for the United Nations World Population Conference, September, 1994).]

References

Bongaarts, John (1992): 'Population Growth and Global Warming', *Population and Development Review 18*, Number 2, June, 1992, pp 299-319.

Cline, William R (1992): *The Economics of Global Warming*, Institute of International Economics, Washington, D C.

Intergovernmental Panel on Climate Change (1991): *Climate Change: The IPCC Scientific Assessment*, edited by J Houghton, G Jenkins, and J Ephraums, Cambridge University Press, Cambridge.

US Environmental Protection Agency (1990): *Policy Options for Stabilising Global Climate: Report to Congress*, Washington, D C.

World Bank (1992): *World Development Report 1992*, Oxford University Press.

– (1993): *World Development Report 1993*, Oxford University Press.

GOVERNMENT OF INDIA
(DEPARTMENT OF WOMEN & CHILD DEVELOPMENT)

NATIONAL POPULATION POLICY : WOMEN AND CHILD PERSPECTIVE

The population projection up to the year 2016 made by Technical Group on Population Projections set up by Planning Commission under the chairmanship of Registrar-General of India provides a new vision to plan invest, and implement the interventions in the Social Sector, especially programmes aimed at development and empowerment of women and children. In addition, this is the right opportunity to look at the issues related to women and children in the futuristic perspective and enrich/amend the existing programmes aimed at women and children.

NPP : THE TASK AHEAD

2. Our experience of about 50 years of economic progress, political developments and social transformation have indicated that non-participation of women and children in the developmental agenda is an impediment to success and achievement of desirable results. Despite major gains for children and women in terms of a sharp decline in vaccine-preventable diseases, eradication of dracunculiasis, virtual elimination of Polio, progress in the physical provisioning of primary school, progress in expanding food supply, virtual elimination of famines and famine deaths, women's empowerment through legislation for sharing of property, reservations in local self-governance and formation of more than 1 lakh self-help groups, a daunting task for development of women and children still lies ahead of us. About 20 lakh children still die every year before completing one year and about 53 per cent of children under the age of 5 years remain moderately or severely mal-nourished with a high proportion remaining stunted with life-long consequences. About 1,25,000 women die during pregnancy and from pregnancy-related causes every year, and HIV/AIDS is beginning to spread to the general population, greatly increasing the risk of vertical transmission of AIDS to new-born children.

3. The regional disparities pose another challenge in implementation of the proposed population policy. There exist significant disparities across States, geographic locations, caste and gender. Infant mortality rates, for instance, vary from 13 per 1000 live births in Kerala to 94 in Madhya Pradesh. The infant mortality rate among Scheduled Castes is 24 per cent higher than the national average; and the literacy rate among Scheduled Tribe population is almost 30 per cent lower than the national average. Child malnutrition rates vary from 28 – 30 per cent in Keala, Manipur, Mizoram, and Nagaland to 63 per cent in Bihar. Whereas Kerala and Himachal Pradesh have both achieved almost universal schooling for primary school children, only 50 per cent of children between 6-10 years attend school in Bihar.

4. Apart from this, the population pyramid as projected for the year 2016 provides a new challenge for population, health, nutrition and gender planning in a different perspective. The last decade has been marked by wide social disturbances and natural disasters across the country. Women and children are the first and worst sufferers of such disturbances. Inadequate provision of health, nutrition and educational interventions further aggravate the situation of women and children in these areas.

5. The situation of women in terms of their condition and position needs to be understood in the larger socio-economic, cultural and political framework of the country. Three main factors have contributed to the dis-empowerment of women, and particularly of poor women: a) a culture built on patriarchy, discriminatory notions of social hierarchy and division of labour that adversely affects women; b) an unequal distribution and control over resources with women having very limited access when compared with men; c) systemic barriers at various levels that restrict women's access, participation, and decision-making powers in economic, political and legal structures. Efforts to promote women's empowerment must, therefore, address all these three issues.

6. Poverty in general, and extreme poverty in particular, has a significant gender dimension. Women are more sensitive than men to the extremes of poverty and its consequences. Studies reveal that (i) the percentage of adult women below the poverty line exceeds the percentage of adult men below the poverty line, both in rural and urban areas; (ii) the percentage of children in the 0-4 age-group in poor households exceeds that

in non-poor households, with corresponding implications for the mobility of women and for child-care services; and (iii) in both urban and rural areas, disadvantaged groups of women from Scheduled Castes and Scheduled Tribes constitute a high proportion of the poor.

7. Maternal deaths in 1993 accounted for 1.3 per cent of total deaths in India, and for 15.1 per cent of all deaths of women of reproductive age. These proportions have increased from 0.8 per cent and 11.7 per cent of deaths respectively in 1989. These figures imply that at present between 1,00,000 and 1,25,000 Indian women die from pregnancy-related causes each year, accounting or nearly 25 per cent of all maternal deaths every year in the world – many of which are preventable. Many maternal deaths could be avoided through a range of relatively simple and low-cost interventions – early treatment of anemia or, better, its prevention. The Medical Termination of Pregnancy (MTP) Act has not achieved the desired results. These aspects of maternal health need to be addressed very seriously.

PLAN OF ACTION IN NPP : KEY TO SUCCES

8. The operational strategies under Action Plan for National Population Policy : 2000 begin with convergence of service delivery at village levels. The Department of Women & Child Development has supported such a mechanism of convergence of services at different fora, especially since the Anganwadi Centres under the ICDS Scheme have a reach to the villages unparalleled by any other such intervention.

9. However, the success of the Action Plan will depend on how the Anganwadi Centres are equipped with adequate facilities and empowered personnel (Anganwadi Workers and Helpers). At present, only 75 per cent of the blocks in the country are covered under the ICDS programme. Unless the ICDS Scheme is universalized and Anganwadi Centres are available for every village/hamlet, the Action Plan under the National Population Policy will not be successfully executed.

10. In those blocks which have ICDS projects, the number of Anganwadi Centres are sanctioned on the basis of old population figures. It has been estimated that not the

whole of the eligible population is being served by the ICDS Scheme. Unless these Anganwadi Centres are opened, the question of providing services in convergent manner in villages through Anganwadi Centres becomes difficult.

11. The Integrated Child Development Services (ICDS) Scheme is a unique intervention which has emerged as the biggest beneficiary programme for women also. The programme at the grass-root level is being managed by over a million voluntary women workers providing necessary services to over 50 lakh pregnant and nursing women. However, the strong women force remains very inadequately remunerated. The demand for a higher honorarium for these crucial grass-root workers has to be considered before assigning them the gigantic task to implement the new Population Policy. Time and again, the Department has raised the issue with the Ministry of Health and Family Welfare to provide additional honorarium to Anganwadi Workers and Helpers to compensate them for their invaluable contribution made for the implementation of various health and family welfare schemes and programmes. Without provision of additional honorarium to these committed women workers, it will not be justified to load them with additional work of implementation of the National Population Policy.

12. The population projection in 2016 shows a massive increase of population in the 15-59 age-group from 519 million to 800 million which will constitute the core working population of the country. In view of the fact that at least 50 per cent of our children are mal-nourished today, it is quite logical that 50 per cent of our working population will be under-nourished, diseased and will have dismal to low productivity by the time they reach adulthood during 2011-16. This will lead to huge loss to the nation. The Supplementary Nutrition provided under the ICDS Scheme is one of the most vital components under **Basic Minimum Services Programme** aimed at eradication of the menace of malnutrition of children and women. The success of the programme, however, depends largely on adequate provisioning of funds to the States and UTs. We have already requested the Planning Commission for adequate funds to be earmarked for this. The Department is also finalizing an Action Plan for taking up nutrition as a project in Mission Mode to cover infants, adolescent girls, pregnant women and lactating mothers, the three critical links in the inter-generational cycle of malnutrition. The details of this project would be shared as soon as finalized.

13. Unless the women are empowered to be a part in decision-making in the family, the community and the society, the overall goal of the Population Policy to improve the quality of lives will remain unfulfilled. Over the years, the Department has made considerable efforts to empower the women in the country. The effort of the Department on group formation amongst women has proved successful. Recently, Government's schemes for formation of women's self-help groups like Indira Mahila Yojana (under revision) attempt to provide a platform for their self-development. Apart from that, with the feeling of ownership and management of their own resources and savings, poor women have been able to choose their priorities and may be able to cover the cost of additional nutrition and health gaps. However, the Department is constrained in implementing the women's empowerment programmes due to paucity of funds.

******

File: NPC-WCD-Perspective/MyDoc

Message of Smt. Sumitra Mahajan, Minister of State for Human Resource Development, Government of India.

When we discuss Population Policy, we must be very clear about the inter-linkages among different components of our developmental Policy. It is high time that Population Policy should be linked to the developmental aspirations of the Indian people. To my mind, following points come:

i) The whole idea of popoulation control should be linked to a mechanism whereby we give incentives to those individuals, groups, villages, districts and ultimately to the States which perform well in meeting the popoulation control measures. Here, I would like to make my point very clear that population control would have to be free from the psyche which unfolds the whole regime of targets and controls. The incentives may be in the form of higher developmental assistance, when it comes to an area, and more increments when it comes to individual officers. Similar incentives would have to be thought of for organizations doing pioneering work in this field. At the same time we would have to work out some disincentives also for those who do not perform.

ii) Population control or checking the population growth, if I may say so, has to be linked to various other measures such as education of girl child, pre-marital consultations for adolescent girls and a good health for feeding mothers. Until and unless, we aim at addressing these issues we can not have a meaningful population policy. However, one would have to consistently review the synergies between the population and developmental policies.

iii) A concerted effort is also required at the level of media. A committee should be set up with the Chairperson of the Prime Minister, to strike the right campaign, not only at the official electronic media, but also with private channels. If in this process, we have to approach any major sponsors of various popular programmes, we should not hesitate in the same. I am sure if PM himself appeals to the private channels they would certainly respond and they would also realize that they are part of the system. Private industry can also be approached to plug the various gaps which adversely affect the growth of developmental indicators. Similar efforts would have to be made by NGOs on "Svamsavi Sangathans" as I call them.

National Institute of Urban Affairs

National Population Policy: Agenda in the Urban Context

Urban Poverty and Population Perspectives

Urbanisation process has been speeding up in the country and imposing tremendous strain on capacities of cities to respond to people's developmental needs. About 30 percent of the country's population are already urban. By the year 2031 it is expected that nearly half of the country's population would be living in cities. Rural to urban migration has been the main factor contributing to the growth of our cities. Large proportion of migrants who are attracted to the city end up in the under-serviced/illegal settlements in the city, commonly known as slums, in environmentally degraded conditions. Urbanisation of the nation is therefore accompanied by an urbanisation of poverty, with nearly 30-50 percent people in cities living in poor settlements. Cities seem to be growing more in the slums, both as an outcome of migration of the rural poor into cities and the high natural growth rate in these settlements. Urban poor have also spilled out of organised squatter settlements onto streets/pavements, in the homes of the rich, on construction sites etc. Large proportions of city population may not be poor by conventional definitions but vulnerable to economic shocks that push them into poverty.

Large cities have nearly half their population living in these settlements. Enrolment rates in these settlements are lower than the rest of the city and with a high drop out rate nearly half the children belonging to the urban poor perhaps do not go to schools, particular among them being girls. Most women from these communities work in the informal sector and leave behind unattended or younger children in the care of older siblings, who have to miss school in order to meet their child care /household responsibilities. Due to the high incidence of sexual abuse in these communities, in the absence of any family safety nets girls are often married off early and become young mothers with a long child bearing span. Gender biases persist and most women do not have any choice over their reproduction.

Poverty Alleviation Programmes of the Ministry of Urban Development and Poverty Alleviation

Ministry of Urban Development supports two major national programmes for urban poverty alleviation and provision of basic services to the urban poor, the Swarna Jayanti Shahari Rozgar Yojna (SJSRY) and the National Slum Development Programme (NSDP). While the former aims at building capacities of individuals for improving incomes through self or wage employment and opportunities to access loans, the latter assists the city governments to provide minimum basic services in the poor settlements. Both programmes are founded on the UBSP (Urban Basic Services for the Poor) strategy for community organisation.

Apart from these two programmes, several schemes have been started to address specific issue in the urban context; i.e. Accelerated Urban Water Supply Programme (AUWSP), Low Cost Sanitation (LCS) scheme, Scheme for the Integrated Development of Small and

Medium Towns (IDSMT) etc. State schemes have also been initiated to brace the national intervention programmes based on specific needs of the state.

Community building is an important strategy under the two urban poverty initiatives of the Government of India, SJSRY and NSDP. Community organisation processes begin at the neighbourhood level with a group of women from adjacent households coming together as a neighbourhood group (NHG) with a chosen representative leader called the Resident Community Volunteer (RCV), a community voice. Ten RCV leaders are associated into a neighbourhood committee (NHC) and several NHC leaders are federated at the community/ward/city level into a Community Development Society (CDS). CDS forms the entry point for all programme interventions under the SJSRY and NSDP. Community development plans developed by the CDS are integrated into larger city plans for poverty alleviation and provision of basic services. CDS is also responsible for monitoring and supervision of service delivery at the community level.

As part of programme interventions, CDS groups identify the poorest for capacity building and subsidised loans for income generation activities (up to Rs50000) under the Urban Self-employment Programme (USEP) of SJSRY. They are also recognised for contracts in smaller towns, for development works under the wage employment programme (UWEP) of SJSRY. CD Societies are encouraged to initiate thrift and credit groups under SJSRY that are entitled to a matching grant under the programme, that is a revolving fund enabling the group to meet costs of travel, meetings, child care activities etc. DWACUA (Development of Women and Children in Urban Areas) groups are also supported with loan subsidies up to Rs1.25lakh for setting up co-operative economic ventures. Women who are members of the T&C/DWACUA groups are entitled to personal health insurance and for one additional family member depending upon the level of her savings.

Under NSDP, ULBs are granted soft loans to provide basic infrastructure in poor settlements based on needs and priorities determined by the CDS. CD Societies are awarded contracts for executing physical development works. Services provided under the programme include water, toilets, paved roads, drains, etc. at the community/household level. Since both programmes, SJSRY and NSDP, use a common strategy and are implemented by a single authority, there is synergy in its execution. Philosophy underlying the urban poverty alleviation approach postulates convergent community action with the objective of ensuring the rights of women and children in the communities. As such SJSRY is implemented with flexibility, and in co-operation with other social sector departments in several cities.

Decentralisation under the 74th Constitutional Amendment Act

Decentralisation under the 74th Constitutional Amendment Act has also resulted in elected municipal bodies in 23 states with over 60,000 women representatives, creating a bridge between the authorities and the planning systems. As part of their responsibilities, the elected representatives are expected to represent the needs of the urban poor into city level action plans, ensuring that city provides for the basic needs of the poor. Most of these

urban local bodies are therefore, both vibrant and actively involved in ensuring services in their wards.

Agenda for Implementing the National Population Policy in the Context of the Urban Poor

Urban poverty is not just the outcome of economic insufficiency or infrastructure disparity but also a social and ecological poverty. NPP in the urban context therefore must address a range of interwoven issues that cut across different sectors for achieving the goals set out. To address the challenges posed under the NPP in the urban sector, interventions would need to be integrated with existing programmes of SJSRY and NSDP as well all state and local initiatives, and their strategy of working with communities and community structures. An interface with all other sectors to converge the programme components under different programmes for achieving TFR replacement levels by 2010 would be essential.

The following strategic interventions will be pursued in the urban sector:

Establishment of City Task Forces

At present, no comprehensive plans exist at the city level that address holistically the problems of urban poor and health care, including the population goals. It is therefore planned that:

- TUDA or the Town Urban Development Agency will form a City Level Task Force that cuts across the social sectors of health and education to prepare a city wide, action plan under the NPP. The Task Force would have a wide representation of all stakeholders including the poor, the NGOs and civil society and the women elected representatives.
- City Level Task Force will also be responsible for monitoring inputs, training and capacity building where jointly proposed, mobilising resources, gathering data etc.
- Training of city administrators to develop city wide action plans including the health plan will also be managed under the regular capacity building activities of SJSRY.

Involvement of Neighbourhood Groups and Community Development Societies

Neighbourhood groups form the fulcrum for community organisation processes under the UPA programmes. Due to their proximity to each other and the sense of society that exists in these groups, it is proposed that:

- NHGs will be made the focal point for advocacy of messages on population. The integrated package of services will be delivered through the CDS, which will become the axis in the urban poor settlements. CDS will be responsible for registration of birth/deaths, provision of contraceptives, meeting needs of poor women with regard to reproductive and child health information, facilitate routine immunisation programmes, etc. They would be trained for maintenance of records through the urban/health training networks, at the local level and in partnership with the MOHFW. They would need to be in close contact with the health functionaries from the urban health centres.
- NHG/CDS will become the platform for advocacy for all health messages, particularly the small family norm, during their meetings.

- CDS groups will form a health sub committee with community level health functionaries co-opted as members, that would debate all issues of family and child welfare and prepare suitable action plans for their settlements.
- Selected RCVs will be trained as Dais at the community level through the health network and given delivery kits to provide trained assistance at the time of delivery. They would be responsible for creating awareness among women on their right to control births.
- NHG/CDS members with small families will be given priority under capacity building and for loans for IG activities as also wage employment under the UWEP to set examples for the rest of the community. NHG/CDS members with larger families up to 4/5 and are in the reproductive span, who have adopted terminal methods, voluntarily limiting family size may also be encouraged through capacity building.
- CDS members will organise settlement wide campaigns focussing on the small family norm/immunisation/health care practices/reproductive rights etc. with the support of Department of Health.

Identification of 'At Risk' Families

As part of the poverty alleviation strategy, families at risk are identified using non-economic parameters and prioritised for loans. Such identification is done on a whole town basis. As part of the process of identifying families at risk, it is proposed that:

- Integrating specific indices within the socio-economic parameters under the SJSRY programme will also help to identify families that are potentially at risk of becoming large. Health Functionaries can then specifically target such families under the Family Welfare programme.

Focus on Thrift and Credit Societies

Saving and credit groups have been deemed as important elements in the strategy for poverty alleviation, that enables poor women to access small loans for personal emergencies and economic activities. Amount of saving per member entitles her to a personal health insurance.

- T&C groups whose members have adopted the small family norm will be given additional grants under the revolving fund for a range of activities that they may wish to pursue. Quantum of additional funds will depend upon the number of members with small families/women who have adopted preventive measures in each group. Such groups will also be acknowledged at CDS meetings at the ward and city level in partnership with the elected representatives in that area.
- Health insurance to women with small families will be extended to three/all members of the household instead of only two.

Support to DWACUA groups

DWAUA groups are being organised and supported under the SJSRY programme for co-operative economic ventures through venture capital, capacity building and marketing linkages.

- Under the DWACUA programme, in Nellore district, the Government of Andhra Pradesh has developed a set of guidelines that defines group membership. These include: women who are saving regularly, who have all school going children at school, etc. These

guidelines will be enlarged to include women with less number of children and the idea up-scaled across the country. Kudumbashree model proposed by Kerala, under which the State government proposes to eradicate poverty by year 2008 includes reduction in family size as a primary objective. The ideas will be shared with other states at various Seminars/Workshops. States will be encouraged to evolve similar models for their states/districts/cities.

- DWACUA groups with a larger proportion of members having small families/acceptors will be prioritised for subsidies under IGA initiatives and assisted with marketing linkages. An IGA activity for which they may be funded could be the ambulance service from within the community to the nearest hospital.
- DWACUA groups will be supported to set up partnerships with ICDS for setting up child-care centres.

Formation of Youth Groups

Advocating messages of delayed marriage and parenthood and reproductive rights must begin with the youth. It is therefore proposed to establish youth groups in partnership with the Nehru Yuvak Kendra/Youth Welfare Departments:

- Adolescent groups of girls /boys will be formed using the CDS strategy with an objective to create awareness. Child-to-adult approach will be used for communicating messages to parents.
- Focus of these meetings will be to delay the age of marriage, protection of young girls from sexual harassment/abuse and right of choice with regard to age of marriage and parenthood.
- In order to delay marriages these girls/boys would be provided training under the SJSRY and assisted in obtaining loans and subsidies for IGA.
- Youth groups, especially adolescent girls will be encouraged to set up thrift and credit societies.
- Young girls and boys who will delay marriages and have been part of the Savings group will be provided health insurance.

Participation of Men in Planned Parenthood

Husbands of women leaders can become important advocates of messages in the community, having been encouraged by the success of their wives. It is therefore proposed that:

- Husbands of CDS members will be encouraged to come together and be actively involved in planning families, creating awareness among community men about birth control and ensuring reproductive rights of women.
- Acceptor male groups will be formed in the settlements to set examples and to advocate messages.

Health Insurance for Old Persons

Increasing older people due to better health care and increased longevity implies more old people in communities. In urban poor areas the aged are often without care and support, as they are lack income and family networks. It is therefore proposed that:

- Aged will form also be provided health insurance under the SJSRY programme. Those who are still active will constitute a DWACUA/T&C group and be supported for IGA.

Involvement of Local Health Practitioners

Local private doctors are normally the first choice of urban poor because of their proximity to the home and savings in terms of invisible health costs. Many of these doctors are RMP. It is proposed to include them as part of the health delivery system in the urban poor settlements.

- Private practitioners will be trained in collaboration with the MOHFW for RCH services and equipped with contraceptives, supplies etc.
- Private doctors/hospitals/nursing homes from adjoining better income neighbourhoods will be encouraged to adopt poor communities for promoting better health and family planning practices. Modalities of this can be planned with the private practitioners at meetings called by the City Level Task Force.

Inclusion of the Private Sector

Private sector participation can be explored for urban poor settlements, as urban sector has an advantage of a rich private sector network including for health.

- Participation of the private sector will be encouraged to mobilise resources and services at the settlement level, particularly where legal issues constrain ULBs from reaching the poor.
- Private sector will also be encouraged to associate in the delivery of basic services under the NSDP.

City Networks of NGOs /Civil Society

NGOs and the civil society are important agencies that can support successful practices at the ground level.

- NGOs working in the areas of health, community development and education will be brought together under a single umbrella network that would then be involved in meeting the sectoral goals and over arching goals of the NPP.
- In order to do so lists of NGOs will be prepared at the city level by combining the NGOs that have been associated with programmes of different sectoral departments. City lists will be combined at the national level into a master list to create a data bank of successful NGOs/Civil society groups. Lists will also be drawn from other departments who have successfully associated with NGOs such as CAPART, RMK etc.
- Lists developed would be dynamic in nature to enable new NGOs to be included. Under the UPA programmes, NGO formation will be facilitated with the help of retired professionals /resource persons from the social development field.

Linkages with NSDP

It is important to create a synergy between the basic services programme, the wage employment activities and the IGA initiative under the two programmes, as together they can help to alleviate poverty as well address the problems of population growth.

- Physical services of water, sanitation etc. for the settlements will be planned and implemented in consultation with the CDS groups. Settlements that show reductions in family sizes may be prioritised for relocation/resettlement, household facilities, additional facilities etc.
- Such CDS groups will also be prioritised for contracts under the UWEP programme for physical works.

- NSDP has provision for construction of community centre to develop a sense of community in the settlements. These Community centres will be made nodal points for family welfare activity. Centres will be used by CDS for family welfare activities apart from other community programmes.

Linkages with Shelter Programmes

Urban poverty is closely associated with lack of affordable shelter. A large number of people living in squatter settlements are not income poor but continue to live in these areas as inexpensive land/housing is not available to them. It is therefore important to converge with shelter development programmes. Improvement in the habitats would mean better health for the poor and reduction in health related expenses. SJSRY will make

Information Systems on Urban Poor and their Locations

It is important that at the city level an effective information system is developed that includes data with regard to the urban poor cutting across all sectors and that enables the ULBs to monitor the service delivery in the settlements.

- All cities will develop a Geographic Information System (GIS) relating to urban poor and flag communities with high growth rates. Such communities will be prioritised for family welfare interventions.
- Household level information on the poor will be included in the GIS. Community level GIS including demographic and health status of each poor community will be linked to the city GIS. The data on poor households and family sizes will be shared with the City Task Force and the Department of Health for monitoring purposes.
- The GIS will be useful in developing local area monitoring systems.
- Training in the development of GIS will be provided by NIUA to the local bodies as part of its training activities under the SJSRY.

Development and dissemination of IEC Material

Training and advocacy material is developed as part of the capacity building activities under the SJSRY. Population messages will need to be integrated into the IEC material. It is proposed to:

- Adapt IEC material available with the MOHFW to the urban context and disseminate these to the settlements through the CDS /NHG network.
- Additional material will be developed with the help of national agencies such as NIUA, HSMI and disseminated.
- Urban Poverty Newsletter a publication of the MOUE&PA brought out by the NIUA provides a platform for sharing experiences and ideas with city functionaries. One page of the newsletter will be devoted to NPP news/update/community experiences.

Establishment of Urban RCH centres

Urban areas do not have a wide reaching network of health services as in the case of rural communities. As part of the Urban RCH programme being supported by the MOHFW in selected cities, it is proposed that:

- CDS will be involved in the identification of sites for urban RCH centres within /near the community that would be able to provide specialised health services/services for

abortion and delivery, growth monitoring facilities etc. and improve access of the urban poor to health services.

- Timings of the urban RCH centres will need to be made more flexible in consultation with the CDS groups to enable the working women in the urban slums to avail of its services. Each settlement may have different timings and services depending upon settlement needs.
- Urban RCH centres would be established irrespective of the legal status of the settlements in areas that are easily accessible to the community.
- Urban RCH programme will need to be expanded to the rest of the cities in synergy with the SJSRY community structures and the NSDP resources for community centres.

Convergence with the Education Sector

Education is an important thrust area that will ensure sustainable change in population growth. It is important that all development programmes converge with education intervention programmes in cities.

- Primary Education Enhancement programme being implemented through the active partnership of NIUA, UNICEF and AUSAID with the Urban Local Bodies in Delhi is a model whose technology will be transferred to other cities for developing similar convergent efforts. The base of the present model will be widened to include health inputs. Some efforts in this direction have already begun in cities such as Gwalior, Jaipur, Surat.
- NIUA will focus on the preparation of Master Trainers under the SJSRY to implement such a model in other cities and to help develop partnerships between the local governments, resource agencies for education and CDS groups.

Interface between Administrators and Community Members

Need for city managers to understand the problems of the community and enable them to plan effective intervention strategies is essential to improve the governance of the NPP in the urban sector.

- Borrowing from the Andhra Janambhoomi model, a vertical interface would be planned in each city focussing on the issue of population where state administrators will be responsible for visiting the settlements, meeting CDS groups and preparing action plans under NPP.
- Meetings will be held once every quarter to ensure there is proper follow up of the actions planned. This will enable the city managers to receive feedback and also report back to the settlements.

Training of Elected Representatives

Elected representatives are an important part of decentralised governance. They need to be involved in the promotion of the population policy objectives.

- Women elected representatives will be trained at the city level on NPP concerns, goals and objectives. Constituencies /Wards that achieve targeted goals may be prioritised for development works and honoured for exemplary performance.
- National training agencies such as NIUA and HSMI and regional training institutes will organise training of master trainers to work with elected representatives on issues of concern.

- Joint training programmes will be planned for Community Organisers under the SJSRY programme and health functionaries at the city level to ensure synergy of inputs.

General Comments

Some general comments on the National Population Policy are:

- The Policy has a significant rural bias. In view of the fact that urban areas are growing rapidly and constitute nearly thirty percent of the present population of the country, it needs to be adjusted to focus more sharply on the urban sector as well. Issues, strategies and interventions related to rural-urban migration and spatial distribution of population need to be integrated with the National Population Policy.
- A large number of urban poor migrate from rural areas in search of economic opportunities. NPP must be in synergy with the National Urban Policy and the National Slum Policy being developed by the MOUD&PA that seeks to articulate an urban vision and strategies for addressing the issue of migration.
- State Urban Commission on Population may be desirable or the existing Population Commission proposed may ensure adequate representation from the urban sector.
- Cities may be rewarded for exemplary performance with additional grants under development programmes.
- Partnership with ICDS in the urban areas is not possible, as ICDS cover in cities is limited. ICDS will have to have a more specific urban agenda and target slums for child-care activities to promote immunisation and health care in settlements.
- All schemes such as the Balika Samridhi Yojna, Maternity Benefit Scheme should be extended to the urban sector.

Ministry of Health & Family Welfare
(Department of ISM & H)

Indian Systems of Medicine and Homoeopathy & Population Stabilization

The Indian Systems of Medicine (Ayurveda, Siddha, Unani, Yoga & Naturopathy) & Homoeopathy offer a range of safe, cost effective, preventive and curative therapies which could be very useful in reaching the goal of 'Health for all', in a cost effective manner. In the developed world, the interest in alternative medicine has surged 60% since 1989 and the market is growing as at the rate of 30% annually. Employers and insurers including several major Managed Care Organizations have begun to respond to the demand for adding alternative therapies to the insurance coverage. Alternative Medicine practitioners are already working in the U.K., Germany and USA and the herbal medicines and food supplements are gaining popularity. WHO has estimated that the global market for medicinal herbs and herbal products is today $62 billion and will grow to US $5 trillion by 2050. In India, the Central Government Health Scheme already extends reimbursement to Government servants who opt to avail of treatment under the Ayurveda, Siddha, Unani and Homoeopathy systems in recognized centers. However, for quality drugs to be available there has to be an assured supply of medicinal plants. Except for Yoga and Naturopathy which are drugless therapies all the systems need plants for the preparation of medicines.

Infrastructure

There is a huge infrastructure available in India and according to information updated till 1998 there are 2,862 hospitals, 22,104 dispensaries and 5.87 practitioners of Indian medicine and Homoeopathy in the country. There are more than 300 colleges, conducting 5 ½ year degree courses and 45 Ayurvedic colleges imparting Postgraduate training apart form Gujarat Ayurveda University, Jamnagar, Institute of Medical Sciences, Banaras Hindu University and National Institute of Ayurveda, Jaipur which offer both Postgraduate and Doctoral courses. PG colleges have been established under the Unani, Siddha and Homoeopathy systems as well. These can be utilized for improving health status of women and children counseling and achieving community participation in RCH programme. There are 3 autonomous Research Councils and their responsibility includes conducting clinical

research into health care, drug research covering survey and cultivation of medicinal plants, pharmacognosy, phyto chemistry, pharmacology, toxicology, drugs standardization, literacy research for revival of the ancient classical literature and research into antenatal and postnatal care and the development of contraceptive drugs. The Pharmacopoeia Committees are working rapidly to see that formularies are prepared for all the drugs of common usage under all the systems of Medicine. This will help standardize the drugs. Ayurvedic and Unani drugs have been included in the drug kits for distribution by ANH in selected states and cities.

Utilization of Indian Systems of Medicine and Homeopathy (ISM & H) practitioners in RCH programme current status:

The approach seeks to concentrate on the known, documented, widely used strategies and applications set out in the Ayurveda, Siddha, Unani & Homoeopathy Systems of Medicine relating to the care of mother and child, the whole cycle of conception, the growth of the foetus, antenatal care, delivery, postnatal care, the growth of the infant and allied areas. It is widely known that village people still depend very largely upon Traditional Systems of medicine in looking after the needs of women and children. These practices were documented in the ancient texts of Ayurveda, Siddha and Unani which have been refined and are widely used in Ayurveda and Siddha hospitals run both by the State Governments and the private sector in different parts of the country. The public, both in rural and urban areas are accessing these forms of preventive and promotive health care and can be seen in large numbers frequenting the OPDs & IPDs of the Prasuti Tantra Departments of Banaras Hindu University, the Poddar Ayurvedic Hospital, Worli, Mimbai, the Government Ayurvedic College & Hospital in Bangalore, the Government Ayurvedic college & Hospital in Thiruvananthapuram, the Arinagar Ann Government Hospital of Indian Medicine in Chennai and the Government Siddha Medical College & Hospital at Palaymkottai to name only a few examples. People go of their own volition and the entire approach is based on Ayurveda or Sidhha.

The fact that the Ayurvedic/Siddha/Unani system is recognized officially by the Government, the practices are taught as part of the curriculum of the B.A.M.S. and P.G. courses according to standards set by the Central Council of Indian Medicine (the counterpart of Medical Council of India) set up by an Act of Parliament supported by University degrees awarded for practice within the country. This brings about a piquant situation where two systems which have been conferred equal status by the law of the land, supported by their own Professional Councils set up under

Acts of Parliament having hospitals, registered practitioners, therapies and drug regimen for different applications, continue to remain polarized.

In China, consultation meetings have been held under the aegis of the WHO to bring about harmony between the approach to traditional and modern medicine in general. In the National Population Policy, 2000 of India, the following strategies and actions points find place and have the approval of the Government.

Mainstreaming Indian Systems of Medicine & Homoeopathy visualised in NPP – 2000

"India's community supported ancient but living traditions of indigenous systems of medicine has sustained the population for centuries, with effective cures and remedies for numerous conditions, including those relating to women and children, with minimal side effects. Utilization of ISM & H in basic Reproductive and Child Health Care will expand the pool of effective health care providers, optimize utilization of locally based remedies and cures, and promote low cost health care. Guidelines need to be evolved to regulate and ensure the standardization, efficacy and safety of ISM & H drugs, for wider entry into national markets.

Particular challenges include providing appropriate training, and raising awareness and skill development in reproductive and child health care to the institutionally qualified ISM & H medical practitioners. The feasibility of utilizing their services to fill in gaps in manpower at village levels, and at subcentres and primary health centres may be explored. ISM & H institutions, hospitals and dispensaries may be utilized for Reproductive Child Health care programmes. At village levels, the services of the ISM & H 'barefoot doctors', after appropriate training, may be utilized for advocacy and counseling, for distributing supplies and equipment, and as depot holders. ISM & H practices may be applied at village maternity huts, and at household levels, for antenatal and postnatal care and for nurture of the born."

Action Plans for Mainstreaming Indian Systems of Medicine & Homoeopathy

1. Provide appropriate training and orientation in respect of the RCH programme for the institutionally qualified ISM & H medical practitioners (already educated in midwifery, obstetrics and gynecology over 5 ½ years), and utilize their services to fill in gaps in manpower at appropriate levels in the health infrastructure, and at subcentres and primary health centres, as necessary.

2. Utilize the ISM & H institutions, dispensaries and hospitals for health and population related programmes.

3. Disseminate the tried and tested concepts and practices of the indigenous systems of medicine, together with ISM & H medication at village maternity huts and at household levels for antenatal and postnatal care, besides nurture of the newborn.

4. Utilize the services ISM & H 'barefoot doctors' after appropriate training and orientation towards providing advocacy and counseling for disseminating supplies and equipment, and as depot holders at village levels."

Implementation of the identified issues for mainstreaming of Indian Systems of Medicine

To implement the above said four identified issues, there is need to draw a clear cut implementation policy.

1. Although there is huge infrastructure of Government ISM & H dispensaries and hospitals in 20 States yet their utilization in the RCH programme as well as in the National Population Policy Programme cannot be harnessed till there is suitable organizational set up i.e., Directorate of ISM & H in the States and it is properly strengthened by appointing Directors as well as supporting staff. 5 ½ years degree trained doctors are competent to carry out various national programmes. However, they need short re-orientation training also for various RCH programmes. This requires a clear cut allocation of resources and targets.

2. The ISM institutions e.g., dispensaries and hospitals also need strengthening in their infrastructure which require additional allocation of financial resources. These institutions can be meaningfully utilized if they are also designated as official institutions for various health programmes. So far this has been done only in a couple of States like Himachal Pradesh, Karnataka and Gujarat only.

3. There is need to propagate various health and RCH related concepts of ISM & H among the masses in rural and urban areas. The villages midwives and dais also need to reinforce their traditional knowledge relating to RCH. There is need of making linkage of dais with Government ISM & H institutions. Specific targets and resources need to be identified.

4. Over 6 lakh registered practitioners of ISM & H are covering all the villages of the country. There is a need to specifically designate them to carry out specific activities relating to RCH and other population control programmes. Material resources could be distributed through them and modest financial remuneration, also need to be made for this purpose.

5. There is a professional rivalry in the allopathic doctors for the practitioners of Indian systems of medicine. It is a known fact that allopathic doctors are not available in majority of the rural areas. ANMs are also not available in all the subcentres. Therefore, there is need to have explicit policy decision to utilize 6 lakh practitioners of ISM & H, institutions and medicines of these systems for RCH and National Population Policy Programmes.

DEMOGRAPHIC DEFINITIONS

Crude Birth Rate: The number of births per 1,000 population in a given year.

Crude Death Rate: The number of deaths per 1,000 population in a given year.

Sex Ratio: The number of females per 1000 males, in the population.

Contraceptive Prevalence Rate: The percentage of married women of child-bearing age (15-49 years) who are using or whose husbands are using any form of contraception, whether modern or traditional.

Natural Population Growth Rate: The difference between birth rates and death rates.

Infant Mortality Rate: The number of deaths to infants under one year of age, per 1,000 live births in a given year.

Maternal Mortality Ratio: The number of deaths to women due to pregnancy and childbirth complications per 100,000 live births in a given year.

Total Fertility Rate: The average number of children a woman would have in her life time, given current birth rates.

Replacement Level Fertility: This implies a Total Fertility Rate of 2.1 children per couple, which is enough to replace themselves.

Population Stabilisation is when population growth ceases and population number remains unchanged.

SPEECH OF SARDAR PARKASH SINGH BADAL, CHIEF MINISTER, PUNJAB, AT THE FIRST MEETING OF THE NATIONAL COMMISSION ON POPULATION IN NEW DELHI ON JULY 22, 2000.

Hon'ble Prime Minister . . . . . Hon'ble Members of the National Commission on Population.

It gives me great pleasure to ~~be participating~~ participate in this first meeting of the National Commission on Population and I take this opportunity to heartily congratulate the Hon'ble Prime Minister for having taken the initiative for the formulation of the new National Population Policy and for convening this meeting today.

Punjab State has always had a place of pride in providing accessible health care to its people. This is evident from the fact that most

of the targets set for achievement by the year 2000 AD in family welfare programmes have been achieved in Punjab. The death rate and maternal mortality rate are already better than the goals set to be achieved by 2010 AD. The birth rate in Punjab is 22.4 per1000 against the target rate of 21 per1000 while the birth rate in India is 26.5 per1000. The total fertility rate in Punjab is 2.7 against the target of 2.1 while in India it is 3.3. However, Punjab has always had the inborn capacity to face every challenge and I have no doubt that it shall achieve the goals set for the year 2010AD much before that date.

I. AS REGARDS THE INITIATIVE TO MEET THE UNMET NEEDS –

Punjab has identified the areas where a certain amount of unmet need still persists. The awareness regarding family planning programme is 100% but the practice of various family planning methods by the eligible couples is 66%, ~~and there is an unmet need of nearly 10%~~. To meet this requirement, the Punjab Govt. is determined to provide Family Planning

services to all the needy eligible couples by improving the out reach of services with quality care. It will also be ensured that supply of various contraceptives is adequate. As regards cent percent registration of ante-natal mothers is concerned, there is an unmet need of nearly 25%. As far as achievement of atleast 80% institutional deliveries is concerned, only 37% antenatal mothers are availing institutional services currently. Similarly, there is a gap of 28% in the achievement of full immunization of Infants. The shortfall in these areas is largely because of the dearth of ANMs and Nurses in our Primary Health centres and I will, therefore, urge the Government of India to provide more funds for Punjab State for hiring them on contractual basis.

II REGARDING ISSUES OF QUALITY OF CARE

To ensure quality services to ante-natal mothers, staff has been hired on contractual

basis. For the transportation of high risk mothers and emergency cases, ambulances have been made available by Punjab Health System Corporation(PHSC) .

In order to improve the working skill of medical and para-medical staff, short term training courses have been organised.

III SYNERGY BETWEEN DIFFERENT DEPARTMENTS

The new approach to family welfare programme envisages intersectoral coordination and cooperation. The creation of Istri Sehat Sabha has been done with an aim to get coordination and cooperation from the community.

Punjab is the only State in the country where 26000 Istri Sehat Sabhas have been formed, ensuring their presence in each and

every village and urban slums of the State. These grassroot level Sabhas have ex-officio members representing different departments.

IV. ROLE OF MEDIA, NON-GOVERNMENT ORGANISATIONS, PRIVATE SECTORS & PANCHAYATI RAJ INSTITUTIONS.

In Punjab the role of Information, Education and Communication activities has always occupied a prominent place in the dissemination of information about activities of the Health Department.

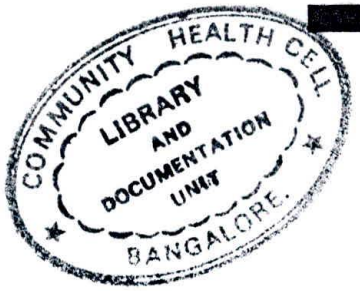
I would like to assure the Hon'ble Prime Minister and all other members of the National Commission that Punjab State will not lag behind in implementing the National Population Policy and would be amongst the first in the country in achieving the targets set by it as it has been doing in the past also. Here I would like to inform the august audience that Punjab had won National Awards in family planning

for four consecutive years(1982-1986) in the past too.

I would once again express my gratitude to the Hon'ble Prime Minister for having given me the opportunity to participate in today's meeting.

Jai Hind.

HP 5.18



Dr. J. K. JAIN
PRESIDENT

July 21, 2000

Hon'ble Shri K.C. Pant
Deputy Chairman
Planning Commission
Yojana Bhawan
Parliament Street
New Delhi – 110 001

Sub.: Some suggestions for "Population Stabilization"

Dear Shri Pantji,

1. a) The "National Population Policy" is exceedingly ambitious. Only one developing country with high fertility reached replacement fertility in 10 years. This was the Peoples Republic of China. The socio political structure of our society is quite different than of China.

   b) The Action Plan of the policy appears to be patterned after the successful Indonesian experience. There are important differences between the Indian and Indonesian political/bureaucratic structures. Indonesia, since independence until very recently, was ruled by a single political party and ministers, including Ministers of Health, were primarily retired Generals. Corruption existed only at the highest levels. The press would not question Government policy. India is far more democratic with a free press. Corruption at lower levels of the political and bureaucratic structure is well known. The experience has shown that the free press can be destructive to introduction of new contraceptives as happened to the introduction of Norplant in England and the introduction of Quinacrine based non-surgical female sterilization in India. Norplant and Quinacrine Sterilization are not used in India due to a hostile press and misinformation distributed by some "feminist" actually urban elitist groups. Norplant is widely used in Indonesia, and Indonesia has completed phase two trial of Quinacrine Sterilization.

2. i) A rapid reduction in fertility though voluntary acceptance cannot be achieved through incentives or disincentives schemes. The women belonging to the developed world and rich societies have been refusing to bear children inspite of large incentives being offered to them, while our poor women living in rural India keep falling in the trap of unwanted pregnancies on account of lack of knowledge and availability of contraceptive services, inspite of all the disincentives.

JAIN TV INTERNET E-COMMERCE

Studios : Jain Studios Campus, Scindia Villa, Ring Road, Sarojini Nagar, New Delhi - 110023. Tel : 011-4103722, 4103725
Corporate Office : Mohan Co-operative Industrial Estate, G-8, Block B-1, Mathura Road, New Delhi 110044. Tel : 011-6950911, 6950912, Fax : 011-6950917, E-mail : dr.jain@jaintv.com

ii) I am in favour of concentrating on women of the reproductive age as the target of our primary attention. The focused campaigns should be planned for womens' all round development.

iii) The critical need for achieving rapid reduction in fertility, especially in societies with low educational levels, is to build a form of social pressure. Can we create a climate of a strong social pressure in favour of family planning? I believe this can be done but it requires a very intensive information, education and communication campaign especially in rural India.

iv) The campaign should aim at creating a demand for contraceptive services. Once the people understand that fertility regulation services will be good for improving their quality of life, they will even come forward to buy these services instead of expecting it to be free. Once the demand gets created, than only the supply be arranged to ensure success. Even the social marketing of contraceptive services may be the part of the campaign.

3. Based on our field experience, May I suggest an innovative rural outreach communication strategy for the purpose:-

i) We have identified a traditional institution which can become the focal point of our rural resurgence movement. For centuries, on certain days of the week, buyers and sellers in Rural India congregate together to trade and barter, buy and sell at **Rural Haats**, which serve as transient bazars to meet rural consumer's need. **Melas** are another prominent feature of Indian rural and tribal life. These Melas are held periodically at different places to commemorate an event or to honour a deity. Besides their marketing and religious significance, these Rural Haats and Melas have lot of social significance. We have been working in this sector for a number of years and our conclusion is that these Rural Haats and Melas can be the corner stone of our rural outreach strategy through which our target audiences in remotest Huts and Hamlets can be effectively reached while they visit these Rural Haats and Melas.

ii) More than one rural media outfits are already working on this idea and the entire detailed information is available and valuable data about these rural Haats and Melas, is stored in the computers of these agencies. Thus, it is possible today to make an immediate beginning in select hundred or more districts in States like Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh and Orissa where the challenge of population stabilization is immediate and more grave than the rest of the country.

iii) A suitable dispensation of a multi-media mix consisting of Doordarshan, Satellite TV channels, Video on Wheels, local newspapers in vernacular languages and the outdoor media like wall paintings, hoardings, banners etc. not excluding inter personal communication based on folk media shall have to be deployed to create a WAVE in favour of development in general and family welfare in particular by organizing events at the rural Haats and Melas.

iv) The messages of family welfare services should be packaged with health, education, women's empowerment, child development, drinking water, nutrition, environment protection and rural development, maternal morbidity and mortality and infant mortality.

v) Infotainment and entertainment formats in local languages and dialects shall be far more effective than centrally produced programmes.

vi) The Government is not the best agency to undertake the implementation of such campaigns. One or several private sector professional media companies or N.G.O.'s should be encouraged to be the implementing agency, which should further seek and channelize the participation of -

(a) private commercial sector interested in reaching rural markets;
(b) Agencies of the State Government;
(c) the Ministries of the Central Government like Ministry of Family Welfare, Ministry of Rural Development, Ministry of Human Resource Development, Ministry of Environment, Ministry of Rural Employment, Ministry of Social Justice and Empowerment, Ministry of Women and Child Development;
(d) N.G.O.'s;
(e) International development agencies;

vii) I propose that we should plan a set of three mobile vans in each of these chosen hundred districts.

1) A publicity van to disseminate the message.
2) A mobile clinic to deliver the family welfare services.
3) A mobile teleinfo centre which can be connected to the Internet through a V-Sat network.

I believe that it is a doable idea and once we start implementing the scheme, the objectives of the Population Policy shall definitely appear achievable.

With kind regards,

Yours sincerely,

Virendra Jain

(DR. J.K. JAIN)

ADDRESS

BY

SHRI KC PANT,
DEPUTY CHAIRMAN, PLANNING COMMISSION

&

VICE CHAIRMAN, NATIONAL COMMISSION ON POPULATION

AT

THE FIRST MEETING OF NATIONAL COMMISSION OF POPULATION

ON

JULY 22ND, 2000

I welcome you all to the first meeting of the National Commission on Population. As you may know, India became the first country in the world to initiate a National Family Planning Programme as far back as 1952. The programme is Centrally Sponsored and 100% centrally funded.

As was brought out in the presentation – over the years, there has been a rapid decline in death rate and a slower decline in birth rate and India's population has grown from 36 crores in 1951 to 100 crore in May 2000. If the current trend continues the replacement level of fertility can be achieved only by 2026 and population will stabilize in late 21st century. This would have serious implications.

We see the consequences of population growth all around us. India has only 2.4% of global land but 16% of global population. We have so far been successful in meeting the food requirements of the growing population. How will this be affected by a declining land-man ratio and further fragmentation of land holdings? Urban basic services are struggling vainly to cope with the rapid pace of urbanization. Per capita water availability has been declining all over the country, with some areas facing the spectre of water scarcity. Many other ill-effects of population growth can be cited. Suffice it to say that population stabilization is necessary for sustainable development.

It is a sobering thought that experts do not expect India's population to stabilize before 2045 at a level of 150 to 160 crores. To reach that goal, the National Population Policy 2000 seeks to achieve replacement level of fertility by 2010 with a population of 111 crores. That this goal is attainable in our democratic polity while respecting human freedom and dignity is supported by a number of success stories in different parts of the country.

Kerala the first State to achieve replacement level of fertility, did so in spite of relatively low per capita income, perhaps because of high female literacy and low Infant Mortality Rate. The decline in Tamil Nadu, in spite of higher IMR and lower female literacy rate than Kerala, was attributed to political commitment, bureaucratic support and effective health infrastructure. Andhra Pradesh is likely to achieve replacement level of fertility in the next two years. The State has shown a steep decline in fertility in spite of relatively lower age at marriage, low literacy and poorer outreach of health care infrastructure. The reason, perhaps, is empowerment of women and commitment at all levels. In the North-eastern States of Tripura, Manipur and Mizoram, despite difficulty in accessing primary health care facilities, it has been possible to achieve not only low fertility rates but low infant mortality, suggesting thereby that a literate population with awareness can overcome substantial difficulties and attain success.

During the presentation you saw that currently five states viz. Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa, constitute 45% of the total

population of India. The population in these states has poor access to health services and poor health indices. It is estimated that unmet needs for contraception are between 25-30% in these states. It is estimated that these states will contribute 55% of the total increase in population of the country during the period 1996-2016. Their performance would, therefore, determine the size of the population and the year in which the country achieves population stabilisation. I should point out that even in these States, there are districts with health indices comparable to the national levels; these experiences have to be studied and replicated so that there is rapid improvement .

All these states have excellent human, mineral and agricultural potential which have not been fully utilized or realised. For this, they have to over come poverty, illiteracy and poor development which co-exist and reinforce each other. This calls for political commitment, good governance and planned coordinated efforts from all sectors and all sections of the population.

In a vast and diverse country like India, we have to assess area-specific needs and respond to them. It is important to ensure that all births and deaths are registered and the data utilized for decentralized planning and monitoring.

In all states, a vast health care infrastructure has been created by Departments of Health and Family Welfare, Municipalities and Zilla parishads. However, much of it is functioning suboptimally; part of the problem lies in lack of facilities like labour rooms and operation theatres or lack of drugs and diagnostic facilities. Sufficient resources have to be provided by each State and the Centre to meet these requirements. At the same time, the existing infrastructure has to be restructured so that it functions effectively and provides needed quality services to the population near the vicinity of their homes. PRIs should be taking up increasing responsibility for monitoring delivery of primary health care services. It is of paramount importance that accountability and governance improve so that the existing infrastructure and resources are utilised appropriately.

Resources are important, but it is even more important to use them efficiently. During the Ninth Plan every effort has been made to provide additional funds to social sector programmes. The outlay for the Dept of Family Welfare was increased form Rs 6,500 crores in the Eighth Plan to Rs15,120 crores in the Ninth Plan. In 2000-2001, under the Prime Minister's Gramodya Yojana, funds have been provided for improving rural connectivity, health, education and nutrition, all of which have a direct bearing on population stabilisation. Planning Commission provided earmarked funds to meet the arrears payable to the States every year. However the basic problem that leads to the recurrent arrears payable to the States has to be tackled. The recommendations of the Consultative Committee on restructuring of the Family

Welfare infrastructure and revision of norms have to be discussed with the states and implemented.

To achieve the goals set in the Population Policy it is crucial that there is widest participation of the civil society; NGOs, Voluntary organizations, corporate sector and labour. The media will have to utilise their talent and reach to create awareness of the benefits of small families, like better health of mothers, and better education of children. Men will have to assume their rightful role in promoting planned parenthood.

The education and empowerment of women is one of the critical factors that determines and enables them to achieve their reproductive goals. There is a need to give a special thrust to girls' education. Schemes for empowerment of women such as DWCRA can play critical roles both in population stabilization and human development. Programmes like Balika Samridhi Yojana, and Maternity Benefit schemes can enable women to access facilities and services to promote small healthy families. Synergies between various schemes aiming at the same target group have to be promoted at the village level through active involvement of peoples' representatives and the people themselves.

To turn the programme for population stabilization into a peoples' movement calls for partnership between various agencies and groups, like village level functionaries of various Government Departments, members of cooperative societies, self help groups, thrift and credit societies, joint forest management groups, Mahila Swasth Sanghs, NSS Volunteers and Nehru Yuvak Kendras

Planners, programme implementers and the people themselves have to bring about synergy and accelerated convergence between ongoing demographic, educational, technological and info tech transitions. With all these efforts, and the active co-operation of the distinguished members of the Commission, I am sure that the country will optimally utilize the demographic opportunity window during the next two decades to achieve rapid population stabilistion, sustainable human and social development and improvement in the quality of life of the people of India.

Points to be made at the Population Commission Meeting

1. Number versus people

Concern concerned about the general tenor in the larger discourse surrounding population implying that the numbers are more important than anything else in the population "problem": that is, if not for the one billion population, India would be much more prosperous today. The facts are otherwise: Indians live longer, produce more, eat more and are less poor than what they were fifty years ago. Painting a Malthusian doomsday scenario may be counter-productive as it happened in 1976-77 when a popular and political backlash drastically slowed down the voluntary contraception programme for about five years.

I like to call this the "we" vs "they" syndrome - "we", the educated/middle class/affluent/urban, are aware and responsible so "we" have small families and contribute to India's progress. On the other hand, "they", the illiterate/poor/rural, are ignorant and irresponsible, so "they" have large families and so "they" are a drag on India's progress towards prosperity. Once again, the facts are otherwise: fertility is falling even among "them" at a fairly rapid rate. What is needed within the health & population sector are good quality and accessible contraception services for adults and couples, especially in view of the fact that there is substantail unmet need for contraception in all parts of India, as shown by the NFHS data. What is NOT needed are Malthusian doomsday scenarios and arguments, because these will inevitably bring a coercive element to the programme with all the undesirable consequences as it happened in 1976-77. Further, both ICPD-1994 and the present National Population Policy of the Govt of India are on humane and sustainable principles; therefore, let us follow those policies and strategies. If we do that and with an annual GDP growth rate of not less than six percent, per capita incomes will rise and poverty levels will decline, eventually resulting in population stabilisation in India.

2. Unmet Need

Traditionally, the concept of unmet need originates from the field of family planning where it has been extensively used to measure the proportion of women/couples who want to limit and/or space their births but are not using any form of contraception. Because family planning is now seen as an integral part of reproductive and sexual health, this concept of unmet need must be redefined as programs make a paradigm shift and begin to implement comprehensive sexual and reproductive health services.

The magnitude of unmet reproductive and sexual health needs in India is daunting. The problems in this deprived region are many. Despite decline in fertility and increase in contraceptive prevalence, infant mortality and maternal mortality rates in India remain unacceptably high. Human deprivation is especially grim for women as low status and poverty has resulted in tremendous increases in gender violence. However, a changing policy environment presents an opportunity to make a difference.

These unmet needs can be met by:

- Getting users perspectives on improving quality of care
- Meeting the needs of adolescents, a neglected group
- Reducing maternal mortality and morbidity which is a neglected tragedy

- Reducing unsafe abortion that is fast becoming a pervasive problem
- Diagnosis and treatment of the silent epidemic of reproductive tract infections
- Looking at cancers of the reproductive system, till now an unaddressed problem, and
- Devising strategies to tackle the challenge of HIV/AIDS

3. Quality of Care

Over the past few decades, significant growth and expansion of the Indian family planning program have been evident. Starting from virtually no infrastructure the Indian program has grown to encompass over 150,000 primary health centres and sub-centres employing more than 300,000 family planning personnel. This network now extends to almost the entirety of India's people, three-fourths of who reside in 600,000 often small and isolated communities. Apart from family planning the program has gradually expanded the range of services it offers to include immunisation, antenatal and delivery care, preventive and curative health care and most recently reproductive health services. Child survival programs have been implemented since the 1980s. Services for promoting safe motherhood have been put in place more recently. Prevention of HIV/AIDs and STIs are also more recent initiatives. These achievements notwithstanding, it is difficult to escape the fact that the Indian family planning/welfare program remains characterised by considerable unfulfilled potential and promise. Its modest progress stands in marked contrast to its neighbours – most notably Bangladesh, Thailand, and Indonesia. Nowhere is this disparity more apparent than in the most populous states – the Hindi belt- which home more than 40% of India's population. The reasons for the limited success of India's program extend far beyond the service delivery system They encompass the social, cultural and economic factors – including low status of women, low levels of literacy among women and extreme poverty which influence the demand for fertility limitation. In recent years though there has been a growing consensus among policy makers, researchers, and experts that the program itself – as reflected in its priorities, emphasis and implementation of services – must be accorded prime responsibility for the limited success of family planning in India.

The challenge today therefore, is to strengthen all these services by expanding their reach, improving their quality and effectively integrating additional reproductive health services within ongoing programs. Although improved quality of care is recognised as a priority to be addressed in programmes, there is still no clear working definition of quality in the Indian context nor tools for monitoring it. Improving quality of care requires a focus on the process of service delivery, including communication and information sharing; establishing minimal standards for procedures and examinations; and ensuring that clients receive the service appropriate to their needs. Some countries, such as Sri Lanka, have make considerable progress, beginning before the ICPD, to provide high-quality, client centred-integrated services.

Studies show that improvements in quality can be made at a reasonable cost; without them, people will not come to or continue using the service. Using various tools[1], family planning providers and supervisors world-wide are being trained to improve quality of care, thereby creating commitment to solve problems as they arise.

---

[1] Ibid

Training in quality of care creates commitment to solve problems as they arise. Principles include treating the client well, providing the client's preferred method, individualising care, aiming for dynamic interaction, avoiding information overload and using and providing memory aids[2].

For reproductive and child health, UNFPA India has worked out a quality framework of nine elements to be used for planning, implementation and assessment. They reflect programme priorities in the Indian context. These elements are:

- Access to services
- Service environment
- Client provider interaction
- Informed decision making
- Equipment and supplies
- Professional standards and technical competence
- Continuity of care
- Integration of services
- Women's participation in decision making

4. THE ROLE OF:

a) Civil society Organizations (CSOs), Non Governmental Organisations (NGOs) and Panchayati Raj Institutions (PRIs)

The emerging vision of civil society

The ICPD process has drawn renewed attention to the variety of and relationships among civil society organisations and the public sector. Civil society takes different forms, but it may be thought of as a range of associations, organisations and institutions that bind people of similar interests together. It includes voluntary membership groups, the private sector and its groups and associations, cultural organisations and advocacy groups. Among its components are co-operatives, trade unions, micro-enterprise and self-help groups, women's groups, health and development advocacy and service groups, business associations, charitable organisations, religious bodies, trade unions, political parties, clans and other family-based systems, lobbying groups, social movements, political parties professional associations, men's groups, youth groups – in short, the whole range of ways people get together to express their views and attain their ends other than through the formal state[3].

The State can be involved, to different degrees in different settings, with a range of such groups (for example, as sponsor, partner, organiser, financier, manager, licenser or regulator), but the special roles and responsibilities of the State are distinct. The term non-governmental organisation (NGO) is often used to refer to groups that are

---

[2] Murphy, E.M., and C. Steele. 1997. "Client-Provider Interactions (CPI) In Family Planning Services." In Recommendations for Updating Selected Practices in Contraceptive Use, vol. 1, by Technical Guidelines/Competence Working Group, USAID. 1997. Chapel Hill, North Caroline: INTRAH

[3] UNFPA. 1998.Civil society and Population and Development. Background document for the Round-table on Partnership with Civil Society in Implementation of the ICPD Programme of action, Dhaka, Bangladesh, 27-30 July 1998.

no part of the State apparatus but is generally understood to be less inclusive than civil-society organisations (CSOs) as a whole[4].

In the years since the ICPD, the relationship between civil-society organisations and governments has continued to mature. In many countries, including many developing countries, NGOs have moved closer to involvement in decision-making. They are often included in discussion of national population policy and in official delegations to international and regional conferences. They are not only advocates for reproductive health and rights and gender equity but are also active in programmes to improve women's status and rights and reproductive health services. The ICPD has marked a turning point for recognition of NGOs as genuine partners of governments in planning, implementing, monitoring and evaluating policies and programmes.

The 73rd and 74th Constitutional Amendments to the Constitution have brought Panchayats and nagarpalikas into the centre of the development debate. These Panchayati Raj institutions can emerge as de facto agents of the development. The challenge facing the nation is how best to enhance the ability of local bodies to take such responsibility.

The PRIs have opened up several opportunities. There is renewed optimism in many areas, especially regarding the greater transparency of Government administration. PRIs provide disadvantaged communities with a voice that can be heard all the way up to the State and national level. A large number of women have been elected to the Panchayats, some as sarpanches (Chiefs). Elected women representatives have been drawn from a wide cross section of society, including many rural animators who had the opportunity to work with NGOs in women's empowerment programmes and in campaigns like those for total literacy, the anti-alcohol movement, and environmental protection.

Ways and means have to be identified to draw upon the widely differing experiences of NGOs, Panchayats and nagarpalikas with a view to merging the initiatives launched by voluntary organisations with the legitimacy and outreach provided by local self-governing bodies.

As a national strategy, NGOs & PRIs in various parts of the country may be involved in the programme in the following manner:

As partners:
For advocacy on the paradigm shift in population and development, reproductive health, and gender.
For enhancing their capacity for reproductive health, with regard to human resources, knowledge, and skills.
For improving the working environment of NGOs by providing more resources to them, simplifying access to resources and approval procedures, and facilitating intersectoral co-operation.

---

[4] NGOs in one narrow sense refer to those organizations accredited by the State to ender into contracts and other formal associations with donors and/or State bodies. Organizations whose operations and management overlap with the State and which operate as agents of the State, such as parastatal enterprises, are often excluded from the common understanding of NGOs.

As a Resource:
NGOs /PRIs in a consultative and planning role: nationally, for the total programme; for district level programmes; and for specific national and regional projects.

NGOs/PRIs as a Recipients of Assistance:
For innovations in reproductive health service delivery; for promotion of gender equality and equity; for programmes for adolescents and youth; and for programmes in border areas designed for women, environment and other relevant population and development issues.

CSOs, NGOs and PRIs should be involved as part of district-based programmes for the provision of primary Health Care, including reproductive health initiatives. Activities carried out in partnership with NGOs and PRIs could include:

- Training and capacity building programmes for elected representatives (including women), Government officials, and NGO partners
- Establishing a community controlled and managed revolving fund for purchasing necessary drugs and emergency care.
- Educating the community about available health services, using young men and women in a process to identify key health problems and information on where to go for various services.
- Training community members, both men and women, on how to access services provided under different Government programmes and by private and charitable institutions.
- Establishing support groups for female village-level health, education and other development workers.
- Creating for a at the district level where elected representatives, opinion leaders, NGOs, and Government officials can come together to discuss local health problems and to provide fund that could be utilised in programmes, interventions, and campaigns planned by these groups.

b) Private Sector
The private sector has the potential to play several important roles in the implementation of the policy.

- Businesses with direct interests in the provision of supplies, services and technical know-how can work with governments to eliminate barriers to access to services and informations and to development of markets for those able to pay.
- They can include family planning and reproductive health services are included in the packages of benefits that are offered to their employees and in the regulatory frameworks governing enterprises
- Provide workers with informations and education on family life and health issues (e.g. Tata Corp of India)
- Business associations and community groups can use their networks to provide a platform to promote greater awareness (e.g. Rotary International)
- Medical associations such as Commonwealth medical association and the Federation of Gynaecologists and Obstetricians and their local affiliates have advocated for expanding reproductive and child health services. They can define national codes of conduct and standards of care that protect basic rights.

c) Communication and Education (Focus on communication rather than role of the media – since media is and could very well be communication tool

Well-designed communication strengthens good programmes, but information without services only produces dissatisfaction. Raising awareness about reproductive health is not the same as increasing the use of the services. In many countries, information campaigns are developed without the involvement of local providers, communities and representatives from the target groups. Messages are usually designed for adult women and ignore key target groups like men, adolescents, newlyweds and opinion leaders.

Communication strategies are not always well linked with services: a campaign may raise awareness of contraception but may not say where to find it; or motivate potential clients before the services are available. Information, education and communication (IEC) strategies about reproductive health must go well beyond sensitisation to provide information about how to avoid reproductive tract infections, unwanted pregnancies and obstetrical complications, for example-Hot lines and radio call-in shows are good for providing accurate and confidential information. Combining several media also reinforces messages[5].

Information and education strategies about reproductive health and population and development issues must advance beyond awareness raising. Policy makers and programme beneficiaries alike need information that will help them to make decisions and act on them. They need information about, for example, the risks of STDs, the danger signs of a difficult pregnancy, and available methods of contraception. They also need information on who can provide assistance, where services are to be found and what kinds of treatment they can expect and have a right to demand.

This information must reach everyone who needs it. The mass media are useful for giving practical information[6], but traditional and local communication channels are also needed. So are non-governmental organisations and community groups.

5. Linkages between social investment, demographic change and development: A broader look at population issues

- Population and development policies which establish broad goals should be clearly linked with the resources to achieve them;
- Institutional structures should be capable of adapting to changing policies;
- There has to be a commitment to gender equity and equality, greater participation of women in policy and decision making roles, partnership with men and action to end gender-based violence;

SHABANA AZMI
MEMBER OF PARLIAME

[5] McCauley, A. P., and C. Salter. 1995. "Meeting the Needs of Young Adults." Population Reports. Series J. No. 41. Baltimore, Maryland: Population Information Program, Johns Hopkings University

[6] An excellent source book of practical advice and case examples concerning health communications in the area of reproductive health is: Piotrow, Phyllis Tilson, et al. 1997. Health Communication: Lessons from Family Planning and Reproductive Health. Westport, Connecticut: Praeger Press (Published under the auspices of the Center for Communications Programs, Johns Hopkins School of Public health).

- Need for a rapid movement towards reproductive health service integration and better referral systems;
- Need for more responsive services, better accountability to the people for whom the services are designed, and intensified attention to staff training, retention and management;
- Determined action to halt the spread of AIDS;
- A commitment to provide quality reproductive health services and information to young people including unmarried women;
- More effective decentralisation;
- Improvements in the quality and use of data;
- Closer collaboration between government and civil society.

6. **Investments in health and education lead to smaller, healthier families.**
Important choices must be made regarding investments in education, particularly of girls and women, and in health, including reproductive health and mortality reduction. Decisions to invest in these areas can initiate dramatic changes in reproductive behaviour, and will shape the demographic future.

Declines in fertility and mortality are mutually reinforcing. Fertility decline is often associated with postponing the first birth, waiting longer intervals between births and having fewer children late in reproductive life.

Women who have been to school understand that proper care for children includes support for their education. The more education women have, the more education their children are likely to have. Educated mothers are more likely to invest in the health of their children and use information and services to protect their children's health.

One of the strongest and most consistent relationships in demography is between mothers' education and infant mortality - the children of women with more years of schooling are much more likely to survive infancy[7]. More educated mothers have better health care, marry later and are significantly more likely to use contraception to space their children. They have better skills for obtaining and evaluating information on health care, disease prevention and nutrition. They also have better access to resources, through earning opportunities and marriage, and can manage them better. They are more likely to recognise the advantages of educating their children.

Women of all levels of education and economic status take steps to choose the number and spacing of their children. Their ability to do so is a function of not only education, but also circumstance, resources and custom. Population programmes help provide the means.

---

[7] This relationship is regularly graphed in the World Education Report series. See, for example: United Nations Educational, Social and Cultural Organization. 1997b. World Education Report 1997. Paris: United Nations Educational, Social and Cultural Organization. See also: Cleland, J., and J. van Ginneken 1988. "Maternal Education and Child Survival in Developing Countries: The Search for Pathways of influence." Social Science and Medicine 27:1357-1368. An important early theoretical discussion of the relationships can be found in: Cochrane, Susan H. 2979. Fertility and Education: What Do We Really Know? Baltimore, Maryland: The Johns Hopkins University Press.

From: Sharad Pawar, MP

ISSUES RELATING TO POPULATION STABILIZATION

The focus of the National Commission on Population for Population Stabilisation should be on three broad areas:

1. Awareness
2. Technology
3. Infrastructure

1. Awareness

Of these the most important is the spread of awareness amongst our people. It is equally necessary to increase the level of awareness on all related issues because population stabilization is a crucial factor of social and economic development. This can only be done through IEC strategies by focusing at the girl child and women.

a) I believe that if any developmental activity is to succeed the Government should specifically earmark plan funds for capacity building in all social sectors i.e. education, health, women and child development, water and sanitation.

b) There should be earmarked funds for training of elected women representatives especially at the grass root level. Training should be decentralized with a cluster approach to enable women to attend these courses. Absenteeism by either trainer or trainees should result in disqualification for the elected Zilla Parishad members, Panchayat Samiti members, office bearers, Mayors, Muncipal Presidents, Sarpanch and Dy. Sarpanch of Gram Panchayats. Population stabilization should be the responsibility of Local Self Government bodies.

c) Adequate funds for capacity building should be allocated by the Centre and States under plan and non-plan expenditures. Utilisation of these funds must be taken into consideration while formulating any scheme for allocation of funds from Centre to State and from State to Local Self Government bodies.

d) At the village level responsibility for implementing the programme must be with Gram Panchayats. Village Population Committee may be

formed consisting of 75% women including all women elected members should be responsible for implementation of the programme.

Funds for this programme should be made available to Local Self Government bodies directly at all three tiers as far as possible.

e) NGO's must be associated at all levels wherever possible. However, the nature and magnitude of the problem is such that it is squarely the responsibility of elected representatives and the government machinaries at all levels to ensure its success. This should not be treated a welfare programme. It is a national crisis and must be dealt with utmost care and urgency.

f) The potential of the print and the electronic media should be fully utilized in this regard. No doubt the reach of electronic media makes it an ideal vehicle for message transmission, however, it is not adequate that a few spots and messages are put on the media. Most of the programmes and advertisements depict women as vulnerable, helpless, decorative and unempowered. Therefore, the role of the media and its utilization should be analysed carefully.

There is an immediate need for a programme and advertisement code to be set in place. A committee of media persons, NGOs, women in public service, women working in management levels in bureaucracy and private sector headed by senior persons from the media be set up to formulate such code. Such codes exists even in free and developed societies like in U.K. The media should evolve a code for self regulation in consultation with leaders and representatives of various sections of our society and work out a commonly agreed code and abide by it in a responsible and transparent manner. I have been the Chairman of the Parliamentary Committee on Broadcasting Bill and I have observed that while every section of the industry cried itself hoarse against regulation and "censorship", not one of them offered to set up any machinery to look into this situation themselves. The broadcasting & entertainment industry has money, intelligence and human resources in abundance. I think the time has come for them to display a sense of responsibility towards the country and society.

The key to population stabilization and socio-economic development of our country lies in the empowerment of women

2. **<u>Technology</u>**

(a) Concentration should be on spacing methods which are hassle free.

(b) Adequately trained counseling must be available at the village level. I would suggest a scheme where young married

women in villages be identified and trained as counselors to advise on method of spacing, as well as on contraception practice. This would include cooperating and alerting the medical staff whenever necessary to specific problems.

(c) There is a need to push for terminal methods of family planning for men. I believe that persons in public life should lead from the front. Political parties should make it a preferred practice amongst younger party-men, who will become leaders tomorrow. The two-child norm for elected posts should not be applicable for women candidates till we are satisfied that women truly have control over how many children they bear.

3. **Infrastructure**

It is necessary that physical infrastructure is available in the country to support the massive programme of population stabilization.

(a) There is need for creating a safe delivery room in every village. This should be top priority for JRY funds. More emphasis on training and equipping Traditional Birth Attended local women is needed till we can ensure that at least 80-90% of all deliveries are done in hospitals.

(b) All weather roads must be built to primary health centers and sub centers from the village – JRY and rural connectivity programme must be allowed to take up other programmes after this requirement is exhausted.

(c) A village to be declared electrified only when health care centre with delivery room has power supply for at least 6 hours a day.

(d) Safe and adequate housing for medical staff at all levels should be the responsibility of the Local Self Government bodies. Failure to provide this should carry heavy penalties.

(e) 75% jobs on the primary health sector should be for women and their performance should be partly rated on their contribution to population stabilization.

(f) The Government must push through the 81st amendment with immediate effect.

HP 5.22

National Population Commission: Some Points for Consideration

Rami Chhabra

The Prime Minister, addressing the Nation in October 99, has said: "A new century demands a new mind-set." He also recalled the philosophy of *Daridranarayan* as a guiding principle for his government and pledged for a rearrangement of development priorities by re-deploying resources and strengthening institutions for providing to all: safe drinking water, primary health services, primary education, rural roads and housing to rural homeless.
The PM's words are most relevant in the context of the population issue.

New Mind-Set: Not Disentitlement but Meeting Basic Human Entitlements

The implementation of the National Population Policy (NPP) demands a new mind set. Notwithstanding, intermediate and long term demographic objectives and goals set out in the NPP, a linear pursuit of the earlier "numbers crunch" approach has to be clearly forsaken, once and for all.
The nation, at all levels, must internalise the counter-productivity of any coercive or manipulative policies that may be conceived in the cause of population stabilisation. Conversely, there is need to unambiguously recognise the criticality for time-bound improvement of the human condition of a large mass of citizens presently below or around the poverty line.

The country carries the stigma of the largest concentration anywhere in the world of the absolute poor; of illiterates; the malnourished and diseased from easily preventable or curable infections – with women and girls disproportionately represented in these deprived ranks.
It may well be argued that the level of economic development does not necessarily correlate directly with the extent of fertility decline. But, a ***concerted effort to provide minimum human entitlements, together with measures to energise the vast, latent talent of the people, particularly women and youth, is the ethical imperative for 21st century India. Indisputably, the synergistic environment that such a sincere developmental effort would generate also makes it one of the soundest strategies for achieving an early eventual equilibrium of population numbers.***

Further, there is need to better appreciate that the strict imposition/canvassing of a two child family norm is not the sole path to slowing rapid population growth.
Effective increase in the age at marriage beyond the teens and the first birth well into the twenties –critical to the health and human development of the girl child – can bring very dramatic demographic change, by extending the period between generations and serving to empower future generations of women to actualise their wishes for delayed/ smaller family formation.
Similarly, immediate servicing of the needs of high parity couples carries both immediate and future dividends, as will be elaborated later. Therefore, the need is to

simultaneously encourage several alternate pathways towards population stabilisation rather than project a monolithic 2-child pattern for everyone.

In particular, efforts that help women to avoid a pregnancy at lifecycle points/situations that are harmful to her/her child – because the mother is too young, too old or too exhausted from repetitive childbearing have now basic public sympathy and support. Birth rates could tumble fairly rapidly and desired family sizes shrink with such humane, people-supportive, women-sensitive, health-focused initiatives delivered with quality of care.

Fertility Decline Trend Not to Be Disturbed

Today, despite manifold problems, the country is well launched into a fertility decline pattern – even in the difficult North Indian states, where the pace is much slower but very evident. Care must now be exercised that this trend is not disturbed by any controversial actions. ***A spirit of consensus-building and political commitment expressed in terms of compassion and concern for the poor – not demographic outcomes – is capable of yielding fairly miraculous demographic changes.***

Family planning awareness and information is reasonably widespread, there is a receptive environment among the people and most women are willing, even eager, to adopt smaller family norms. ***Bridging the gap between awareness and adoption will be fastest through affirmative actions that provide progress towards fulfillment of citizens' basic entitlements to create a win-win situation.***

Planning Commission a Fitting Nodal Point

The Government is to be congratulated for finally breaking many years of impasse in policy formulation and particularly for locating the National Population Commission within the Planning Commission. Population being the subject matter of all development, it is fitting that the Planning Commission is the nodal point for the overseeing mechanism. This serves to bring the issue central to the entire development process and should facilitate the inter-sectoral coordination and convergence of social development services essential to the success of the implementation of the NPP - which was an understandably difficult task for a line Ministry.

Integration of Health & Family Welfare

The Ministry of Health and Family Welfare (MOHFW) now needs to concentrate on streamlining and improving the outreach and delivery of basic health services, including RCH and FP- the crucial and critical, but not exclusive, elements needed for bringing about the required massive change in society. ***An integrated delivery of basic health and RCH in the field will also require integrated direction and functioning of the Health &Family Welfare Depts at the Central level – as also of the National Aids Control Organisation now functioning as an independent entity within MOHFW - to bring about policy cohesion and to conserve and maximise the utilsation of scarce resources, human and fiscal.***

Basic Minimum Needs Investment A Basic Minimum Backdrop for NPP

Alongside, the Planning Commission must rearrange development priorities as indicated by the PM and secure the investments required to fill the gaps in the priority social service sectors as earlier identified by the Ninth Plan. In particular, a functioning primary health care system within which reproductive and child health is embedded, safe drinking water, basic sanitation, universalisation of elementary education and nutrition security must be assured to all. These aspects serve the under-served and voiceless but can be ignored only to the entire nation's peril. They are a minimum backdrop requirement for achieving the NPP objectives and goals.

Creation of A National Population and Social Development Fund

The National Population Commission needs to be supported by a Population and Social Development Fund as envisaged in the Swaminathan Report so that the various fragmented but large sums of moneys being spent under different ministries and different project heads can be pooled to create maximum infrastructure and impact, as also be effectively monitored and evaluated. In particular, external multilateral and bilateral funds should be encouraged to flow through such a central fund so that there is a coherent overview on resources being expended. Further, private sector and philanthropists can be encouraged to join in supporting the provision of basic amenities.

Amplification of NPP Socio-Demographic Goals and Action Plans

At present 10 of the 14 Socio-demographic Goals and much of the concomitant Action Plans are conceptualised as responsibilities mainly within the health sector or in terms of support to the health sector. ***To reflect the broader perspective on population it is necessary to further amplify the NPP list of 14 socio-demographic goals to include other "beyond health and RCH" parameters crucial to its outcome.*** For instance, improvement of women's economic and political participation.

The government has finalised (or is in the process of finalisation) ***Policy Statements on Women, Youth, Older Persons, Aids Control. These need to be reviewed to ensure that they provide a cohesive and complementary framework with NPP. Goals pertinent to population stabilisation efforts need to be further incorporated into the NPP.***

In the present document Socio-Demographic Goal 14 relating to convergence needs stronger articulation to categorically assign responsibility to each social sector Ministry/ agency to reach its particular programme to identified areas/ communities in tandem with the package so that the synergy of coordinated delivery of different social services demonstrably improves the quality of lives within which family welfare acceptance accelerates. Identifying and utilising opportunities to promote/ link served groups with basic health care services, including family planning, must become a two-way responsibility.

For the NPC to function effectively a Steering Committee and Sub Committees as suggested by the Independent Commission on Health need to be formed at the earliest.

Meeting Unmet Needs:

Unmet needs for family planning are largely a result of poor, ineffective/inaccessible service delivery. However, they are also in part the function of social factors that inhibit the actualisation of inner wishes. Further, service delivery itself is hampered in remote and social development deprived areas. Therefore, attention to the allied social aspects will need to be simultaneous with the push to improve the reach of contraceptive services, even within immediate priority plans.

Further, as ***a significant segment of unmet need (nearly half in the most vulnerable states) relates to family limitation, attention to terminal methods and improvement in the delivery of sterilisation services must remain a key priority.*** Unfortunately, currently sterilisation appears downgraded in the system in the anxiety to create a basket of contraceptive choices.

Terminal method adoption by those with higher parity cannot be viewed as inconsequential to NPP goals. Besides fulfilling a critical need for the woman/couple in that situation, it dents low birth weight; infant, child and maternal mortality and morbidity, which is highest for higher parity births particularly when they occur to exhausted, debilitated mothers.

In the vulnerable Northern states fourth order and above births, which are highly dangerous to the mother and child, comprise a third of all births. Therefore, the direct impact is not inconsiderable. It is also the most cost-effective contraceptive service. In the states with low CPR quality sterilisation services could readily mop up pent up demand and in turn become the most effective communication strategy to bring in younger women at lower parity and age –if the older woman leaves as a satisfied customer of the service given her.

Repopularising vasectomy is also a critical programme requirement. But popularising male sterilisation poses a major communication challenge to restructure male perceptions of their masculinity and inculcate a sense of sexual responsibility.

Strategies to promote/reinforce sexual responsibility altogether need primacy in the face of spiraling STD/HIV infections. These cannot be effectively tackled with the current mechanistic "safe sex" approaches. The latter are not only creating a false sense of security but are also leading to mounting expenditures on huge condom promotion and distribution programmes, advocacy of dual contraception approaches etc. while contributing to the breakdown of relational values. There is an urgent requirement to critically examine and reformulate the Aids Prevention strategies which hold grave potential of both destabilising societal norms and

Adolescents: A Most Critical Group

Adolescents are a very significant and neglected population group. With the largest ever cohort of adolescents now maturing to adulthood, the challenges are immense. ***Closer attention to the reproductive health and contraceptive needs of the large number of married adolescents existing presently is a distinct programme requirement for the family welfare programme.***

But the still larger challenge is in implementing the minimum legal age of marriage. Further, in managing to extend the years between puberty and marriage without the

patterns of sexual exposure and indulgence that has marred so many adolescent lives in the industrialised countries and led to an explosion of out of wedlock pregnancies and other social problems.
We need to learn from the experience of China and other Asian countries like Indonesia etc. who in similar circumstances were able to extract a good demographic bonus by investing heavily in the training of the army of youths, involving them in national construction and enhancing national productivity while actively ensuring disciplined abstinence from the young. While there is need to develop specific schemes and programmes (amongst others with NYKs, NSS) to address skill building, vocational training and activities that lead into informal and formal means of employment, the media will need to be separately canvassed for its role and responsibility in this regard.

How we deal with tackling AIDS and how we help our adolescents to develop healthy lifestyles to span the years till they are ready for marriage will determine to a great degree whether we make a demographic transition that is a wholesome equation of low-fertility-low-mortality- and high-social-well-being equilibrium or not. The path is as important to national well being as the ultimate goal of population stabilisation.

Legislation
There is need to debate whether a linear extension, till 2026, of the 42nd Constitutional Amendment freeze of Lok Sabha seats on the basis of 1971 Census population figures is the best solution. There is considerable sentiment in the country that basic tenets of democracy are being denied by both the unwieldy sizes of the constituencies and the considerable differences in population sizes of different constituencies. Nor has the freeze served its original purpose of deterring unbridled population growth in large parts of the country. On the other hand, to defreeze is unfair to those states that have been responsive to the national discipline imposed. At the same time the issue of women's representation hangs unresolved.
It is suggested that any legislation flowing out of the NPP should reflect the new mindset tone and tenor of the new population policy framework–within which fundamental human rights and gender equity need to have primacy. Therefore, this legislation should be examined de novo in order to reflect the new thinking on population issues and to bring about greater justice and equity in representation without penalising those who performed well according to past criteria.

A freeze of number of constituencies at the state level; intra state delimitation to ensure equitable electorate sizes and finally to ensure the principle of dual membership – one man, one woman – in every constituency could be one configuration that meets several demands and creates an effective new instrument.

We need imaginative new breakthroughs, not a linear extension of the past. The above needs to be seriously examined.

सत्यमेव जयते

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

Speech

of

Dr.C.P.Thakur,

Hon'ble Minister of Health and Family Welfare

at the

Meeting of National Commission on Population

on

22 July, 2000

Respected Prime Minister ji, Learned Deputy Chairman, Hon'ble Chief Ministers, Distinguished members of the Population Commission, Ladies and Gentlemen.

I consider myself uniquely privileged to be in charge of the Ministry of Health and Family Welfare at a time, when after years of deliberation, the country has adopted a holistic and comprehensive Population Policy for achieving "Commanding Heights" in human development, especially social sector development.

I stand before you not to give a sermon on population or a big lecture. Each one of you know more on population than me. I stand before you to welcome you to this Meeting as well as to request you for total commitment to the programme and action plan for population stabilization. The National Population Policy, 2000 not only seeks to stabilise our population but is also an approach to improve the total quality of life of the nation.

Sir, this country starting from the First Plan has so far spent Rs. 19,516 crores on the Family Welfare programmes only to achieve a population of one billion in 2000. You will agree with me that it is not the programme, which has failed, it is we who have failed. The saying of William Shakespeare is very much applicable in this situation " the fault, dear Brutus, lies in ourselves and not in our stars". After 50 years of independence and after 9 Five Year Plans more than 400 women per one lakh life births die. Why should a women die during delivery or delivery related problem? A serious disease like Toxemia of pregnancy also has become preventable now. Our women die of anaemia, malnutrition and due to inadequate obstetric care. We must combine to reverse this trend. Why should a single infant or a newborn child die? They die because they are born of mothers with anaemia, malnutrition and have immunological system which is underdeveloped because of the malnutrition of the mother.

Our infant mortality rate revolves round 72. We can improve this by providing better warming conditions for the newly born, preventing infections and arranging for better nutrition. We are not able to cover all the children with routine immunization in most of the States. But there are States in this country like Kerala, whose demographic profile is approaching that of Sweden. When one of the States of India can achieve such demographic profile why not UP? Why not Bihar? Why not Rajasthan? Why not Madhya Pradesh? Why not Orissa? You would agree with me that what a man has done, another man can also do. What a State has achieved I am confident that other States can also achieve.

Sir, now we have decided to converge all the programmes of Department of Health, Department of Family Welfare and Department of Indian Systems of Medicine & Homeopathy in my Ministry and would approach the people with a common and united effort to remove the drudgery of the weaker sections. With concerted and coordinated effort involving all the Departments like Human Resource Development, Rural Development, Women and Child Development etc. and your support, we will turn the table on the population boom.

Even with this inadequate investment, Government spending on health care does not always targets the right priorities. Being a clinician myself, I know as well as anybody else that the tertiary level health care facilities in this country need both modernization and expansion. However, given our resource constraints we recognize that our primary duty lies in improvement of basic primary and secondary levels of health care; of the health status of women and children and in controlling communicable diseases. We must recall that during the early days of economic liberalization (early 90s) both the Central Government and many State Governments had to resort to cutbacks on expenditure on health care. One important consequence of this cutback was the re-emergence of diseases that were considered extinct like Malaria and Plague. Currently, after the initial success of the immunization programme, we have been witnessing a decline in the standards of routine immunization and in fact of other routine health programmes. This is particularly evident again in the large North Indian States. Countrywide, the decline in IMR has already been slowing down. Maternal Mortality Ratio in the country is still unacceptably high. Pregnancy is not a disease; there is no reason why women should die during or soon after pregnancy. Women will not die, if we succeed in disseminating proper health information and providing basic minimum services for essential and obstetric care. We find, however that in many Indian States the standards of these services have been steadily declining throughout the '90s. Bihar's immunization record used to be much better in the early '90s. UP does not present any significant difference, in the status of safe and institutional deliveries between NFHS-I 1992-93 and NFHS-II 1998-99. The fact that poor people are resorting to local and often unscientific methods of contraception, demonstrates our inability to match the growing demand for contraceptive services of reasonably good quality.

A recent landmark in the health sector has been a major consultation by the Ministry with the professional associations in the medical sector - IMA, FOGSI, IAP, Indian Association of Anesthetists, etc. It was heartening to see that the long felt need for statutory bodies like Medical Council of India, Nursing Council of India to ease the stringency of some of their norms for making medical services of basic kind available to the poor people was

also strongly voiced by the leaders of these associations. Absence of anesthetists and gynecologists is one of the major reasons for our continuing inability to set up a credible referral system and, in fact to handle emergency conditions of any kind. I would, therefore, strongly urge the medical professional bodies to take into account the need of the country in totality and to provide for a certain degree of liberalisation for rural hospitals.

Another significant suggestion was made by FOGSI in this consultation was that a special mid-wifery cadre needed to be developed everywhere in the country and more clinical responsibilities entrusted to trained mid-wives. FOGSI had pointed out that in several countries obstetric care is actually being provided by mid-wives. Even if it is not possible for the Government to create a new cadre of Government employed mid-wives, it would certainly be possible to train and equip mid-wives for working in a private capacity in every village or in groups of villages. We should look at the success of Sri Lanka and other South-East Asian countries, who have wisely invested on building up a strong cadre of mid-wives as providers of health care in rural areas.

Main streaming of the vast body of Indian System of Medicine practitioners in the health sector and using their services for certain essential public health activities was another important recommendation of the consultation which the government intends to follow up vigorously. The Ministry has already made an important beginning in this direction by including Ayurvedic/unani drugs for basic health care needs for women and children, in the drug kits supplied by the Family Welfare Department at the sub-centre level. The States too should supplement this effort vigorously through their State specific schemes.

It is true that the current public sector expenditure on health at 1.2% of GDP, is meager compared to that of other countries. I request the Prime Minister, Finance Minister, Deputy Chairman of Planning Commission and in fact all the agencies of Government who have a role in deciding upon financial allocations for government business, to accord higher priority to investment in the Health, Family Welfare and population related sectors.

There is an urgent need to consider new and unorthodox solutions for tackling this chronic problem. Did Mahatma Gandhi have enough resources to start a war against slavery? Did Lord Rama had enough resources or an organised army to win the war against the Ravana? The answer is NO. It was their Will and Determination and the fighting spirit for a noble cause that led to their victory. I request everyone present here to fight for the noble cause of population stabilization. This time we are determined to make good the shortcomings of the programme like shortage of condoms,

pills, iron and folic acid but from our side. I would request the State Governments to ensure the presence of Doctors at PHCs and Hospitals and to make the services of Doctors and health workers available to the target groups. State governments also need to frame imaginative and firm policies for managing and motivating the work force in the health sector-doctors, para medicals and all other categories of employees. The problem of absenteeism and indiscipline can be tackled by firm and even handed policies. Above all, the experience of many States has shown that in the health sector, devolution of managerial and financial responsibilities to the elected bodies at district and sub-district levels does pay in terms of increased accountability and improved functioning. Where the arm of the government does not reach, we must not fight shy of enlisting the support of the NGOs. My Ministry would whole-heartedly compliment and support your noble efforts.

This is a country where we worship Durga, we worship Kali and we worship Saraswati. A very renowned poet of Hindi Shri Jay Shanker Prasad said about women "Nari Tu Kewal Shradha". But this is a country where woman is killed before she is born, just after the birth and even after marriage for not bringing enough dowry. These are the heinous practices prevailing in this country and can best be controlled by educating and empowering the women.

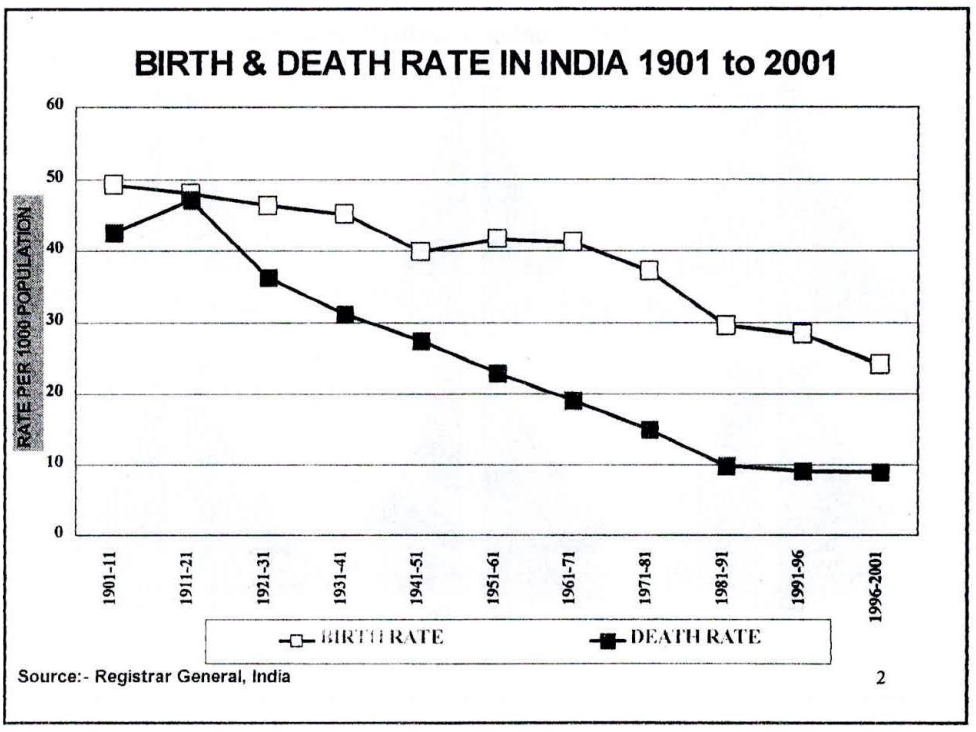
We have targeted certain States, which are lagging behind and with your help they can be brought at par with other States. The state of the health care facilities in most of the urban slums and peri-urban areas is often appallingly poor. We have been neglecting, far too long, the special needs of our tribal population and vulnerable segments of our population like the adolescents and the aged. With the increasing longevity of the average Indian, chronic diseases cannot be neglected any longer. Nevertheless, the fact remains that in large parts of the country the primary task is the effective control of communicable diseases, diarrhoea, enteric diseases, vector borne diseases like Malaria, Kala Azar, TB and HIV/AIDs. Control and treatment of STIs/RTIs is an important strategy for not only improving maternal health, but also for controlling HIV/AIDs in the community. The Family Health Awareness Campaign now being conducted by the Ministry twice a year is an excellent example of what can be achieved by converging the efforts of various Departments.

There has already been too much delay in completing our basic tasks. Time has now come to reorient our strategy and to take on the challenging tasks set before us by the National Population Policy resolutely. With your whole hearted cooperation and the support of Hon'ble Prime Minister and the Planning Commission we will convert this war against population from a possible victory to a certain victory.

✦ ✦ ✦

POPULATION SITUATION AND NATIONAL POPULATION POLICY 2000

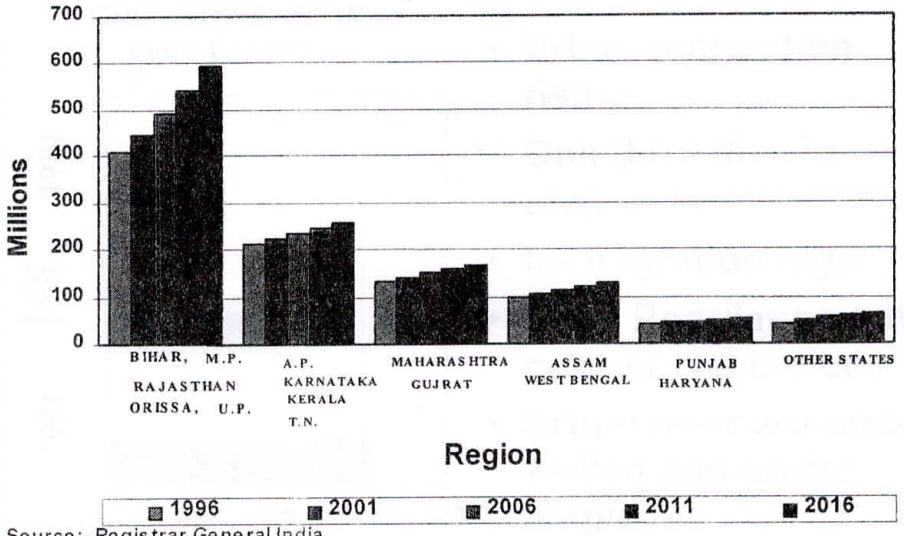
National Commission on Population
22nd July, 2000



Source:- Registrar General, India

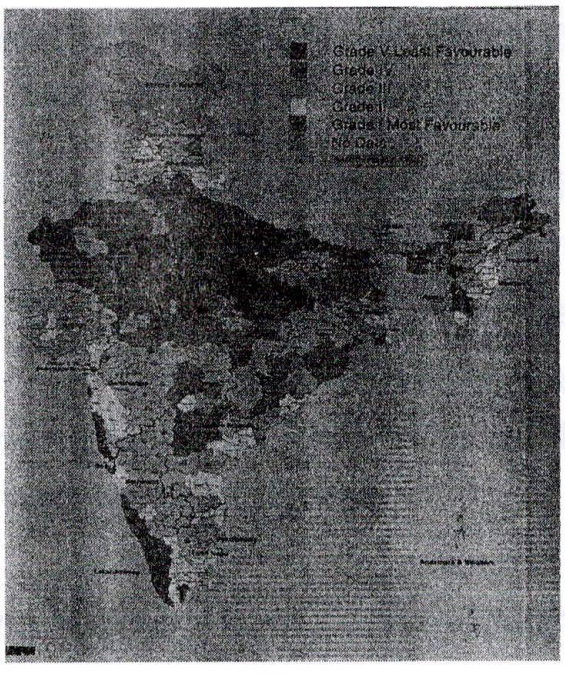
2

Population Projections



Source:- Registrar General India

5



6

NATIONAL POPULATION POLICY 2000

Requirements for rapid Population Stabilisation

- Primary Health Care
- Reproductive Health care accessible and affordable
- Coverage and outreach of education
- Empowering women
- Housing, safe drinking water and sanitation
- Transportation and communication

10

Immediate Objectives

- Address the unmet needs of contraception, health infrastructure and trained health care personnel
- Provide integrated service delivery for basic reproductive and child health care

11

Medium Term Objective

- Achieve Replacement Level Fertility (TFR of 2.1) by 2010.

Long Term Objective

- To bring about population stabilisation by 2045

12

Strategic Themes

- Decentralise planning & implementation
- Convergence of services
- Empower women
- Promote child health and survival
- Address unmet needs
- Utilise diverse health care providers

13

Strategic Themes (contd.)

- Target under-served groups
- Promote Indian Systems of Medicine
- Collaborate with NGOs & private sector
- Promote R & D
- Provide for the older population
- Upscale IEC

14

STRATEGIES FOR CONSIDERATION

DECENTRALISATION, CONVERGENCE AND PARTNERSHIPS

Population is not an issue of any one sector - it is of concern to everyone

- Convergence of services
- Cluster services
- Partnerships with NGOs & private/corporate sector
- Strengthen Panchayati Raj Institutions
- Make Decentralisation and people's participation a reality

16

HEALTH – WHAT TO DO?

A healthy population is a pre-requisite for better quality of life

- Reduce maternal and infant mortality
- Universal immunization
- Prevent & control diarrhea, ARI, malaria, T.B., and AIDS

17

HEALTH – HOW TO DO?

- Ensure quality of care
- Increase out-reach
- Use Indian Systems of Medicine & Homeopathy effectively
- Restructure health infrastructure
- Rationalize costs of health care

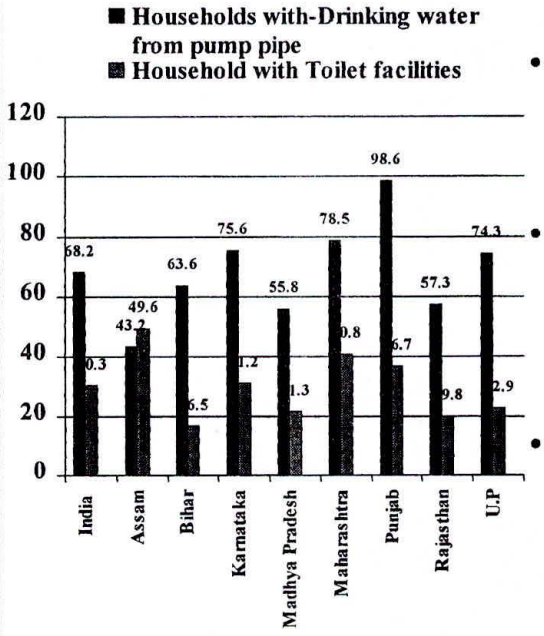
18

NUTRITION

- 20% of the world's children, but over 40 % of the under-nourished
- No decline in under nutrition in pregnant women and 6-24 month children
- No change in birth weight.
- Though severe under nutrition reduced by 50%, reduction in mild under nutrition is marginal
- To be tackled by convergence of health & ICDS services

19

WATER AND SANITATION



- About 200 million people do not have access to safe drinking water.
- 1.5 million children under 5 die annually due to water borne diseases
- 200 million person-days of work lost annually due to water-borne diseases.

20

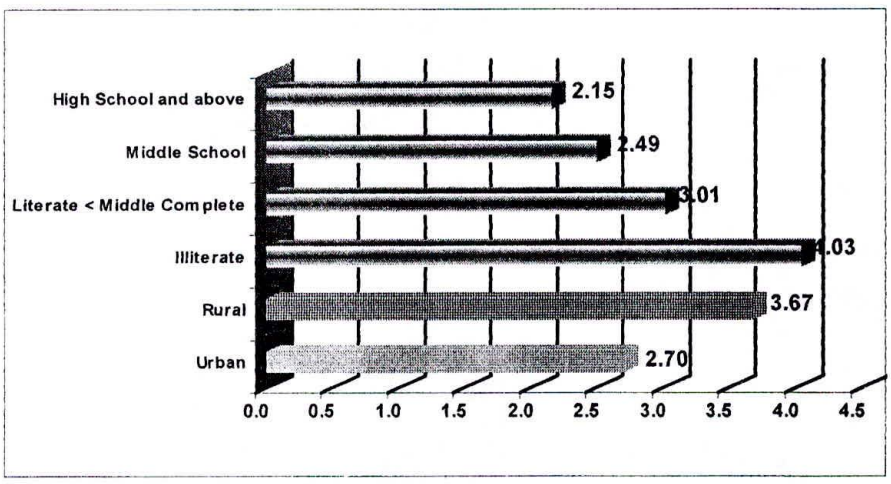
WOMEN'S EMPOWERMENT

Fertility decline and quality of life depend on status of women

- Increase female literacy
- Enhance political participation
- Promote women's health in totality
- Facilitate income generation by women
- Eliminate violence against women (foeticide, infanticide, dowry related etc.)

21

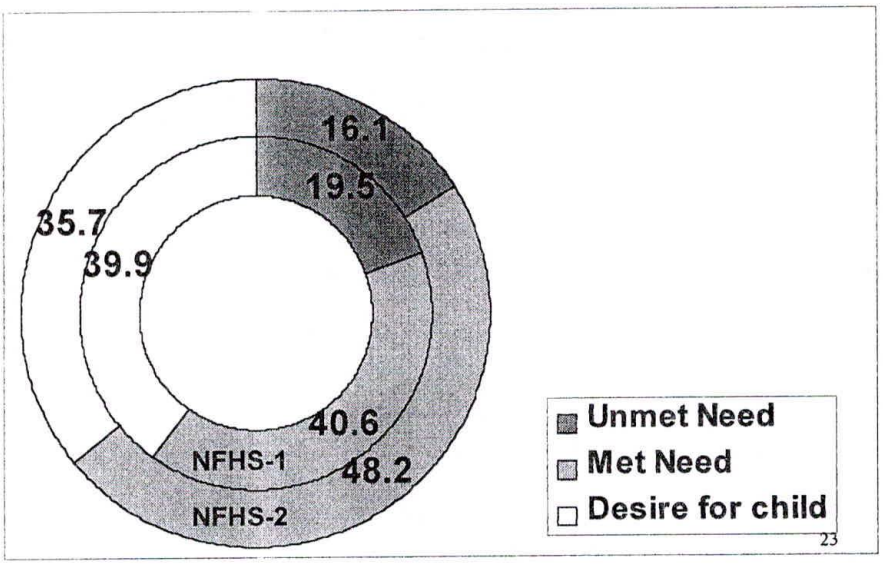
Total Fertility Rate by Education and Residence



22

Source-NFHS-1(1992-1993)

Met and Unmet Need for Family Planning



23

INFORMED CHOICE & MEETING UNMET NEEDS

Two third Indians use or want to use contraception. Coercion not required.

- Meet felt needs of families
- Enable them to achieve their RH goals
- Don't push method specific targets
- Ensure availability and provide quality services
- People will enable realisation of national goals

24

ADDRESSING MEN

Reproduction and child care traditionally seen as woman's burden

- Educate, inform and counsel men to:
  - Plan small families
  - Use contraceptives (sp. NSV)
  - Care for women's health
  - Be caring & responsible fathers
  - Say no to sex determination tests & dowry
  - Educate daughters
  - Treat sons and daughters equally

25

ADOLESCENTS

The next two decades will witness the largest ever increase in the number of adolescents.

- Devise suitable strategies for meeting health, economic and social needs
- Reduce teenage pregnancies
- Sensitize adolescents - break gender stereotypes and respect women

26

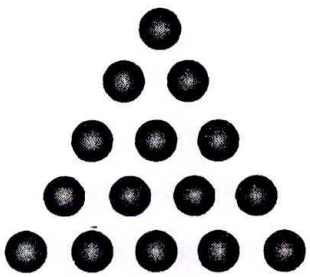
BUILDING PUBLIC OPINION

Demonstration of support by political & religious leaders

- Debate and discuss in print and audio-visual media
- Media to project the concepts of small family, gender equality and discourage objectification & stereotyping of women
- Promote innovative, participatory and interactive IEC

27

Thank you



Speech of Prime Minister, Shri Atal Bihari Vajpayee at Inaugural Meeting of National Commission on Population
New Delhi, 22nd July, 2000

My colleagues
Deputy Chairman of Planning Commission, Shri K.C. Pant,
Minister of Health, Dr. C.P. Thakur,
Chief Ministers,
Members of the National Commission on Population,
Ladies and Gentlemen:

I am happy to be with you at the first meeting of the National Commission on Population. Many of you have taken time off from your busy schedules to be here. This reflects emerging universal concern over the problem of runaway population growth.

The solution to this problem lies in stabilising our population at a sustainable level. Achieving this stabilisation is a challenge. But once we overcome the challenge, we can truly develop our national human resource into a formidable force that will propel India towards all-round prosperity.

It is expected of the state to look after the basic minimum needs of its people. But, as I had pointed out the day we crossed the one billion mark, it is virtually impossible for any state to meet the legitimate requirements of its people if its population continues to gallop from one high to another. As a result, with the best of intentions, the state fails in its primary task: Ensuring a better quality of life for the largest possible number of its people.

It is, therefore, the state's responsibility to prevent its population from exploding to unmanageable limits.

This was realised by India much before any other developing country faced with a similar problem. Indeed, we were the first country to formulate and adopt a National Family Planning Programme way back in 1952. The objective of that programme was to "reduce birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy".

Nobody can fault the intention behind that programme; indeed, it was a courageous step forward, given the cultural, social and traditional realities of Indian society five decades ago.

But, a reality-check on how effective that programme and various policies framed subsequently have been in preventing a runaway population growth, reveals rather disturbing facts. Today, India is the second most populous country in the world. With only 2.5 per cent of global land, it is home to nearly 17 per cent of the world's population.

Every year, more than 15 million children are born here to an unsure future. For, India is among those countries that have a high child mortality rate. As many as 100 of every 1,000 of our children aged under five and more than 200 of every 1,000 of our children aged under 15, risk dying a premature death.

No less disturbing are the facts that more than half our children aged under four are undernourished; 30 per cent of our newborns are underweight; 60 per cent of our women are anaemic. Forty per cent of the world's malnourished children are to be found in our country.

It is indeed paradoxical that this dark reality is in sharp contrast to the progress made by us in food production, disease control and overall socio-economic development. These harsh realities persist in spite of numerous population-related programmes and despite huge sums of money being spent by Government.

Obviously there were flaws in these programmes as well as lapses in their implementation.

If I were to list the reasons why despite elaborate family welfare programmes and huge spending, India's population has shot up to one billion from 240 million in the last hundred years, they would broadly be:

- *Lack of universal access to basic health care facilities;*
- *High child mortality rate;*
- *Low literacy rates, especially among women;*
- *Persistence of high levels of rural and urban poverty;*
- *Inadequate awareness of options and unmet needs for contraception services;*
- *And, of course lack of political as well as popular will to squarely face the problem and overcome the challenge.*

Indeed, the success stories of countries like China, Bangladesh, Malaysia and Indonesia show that given the political will, backed by adequate popular response, the apparently impossible task of checking population growth can be achieved.

However, one need not necessarily look for examples outside India.

At home we have the examples of Kerala, Goa, Tamil Nadu and Andhra Pradesh. Each of them has shown exemplary performance in containing the growth of their respective population. The fertility and mortality rates of Kerala and Goa are nearly similar to those of developed countries. These States are reaping the benefits of investing in literacy, especially women's education, health care services and awareness campaigns.

At the other end of the spectrum are Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh. These States have very high mortality as well as fertility rates. They also lag behind in providing adequate access to health care services, investing in education and empowering women -- factors that ultimately play a decisive role in determining family size.

Ironically, there are pockets within these States where investing in health and education, involving voluntary associations and encouraging community participation have yielded good dividends. I would urge these State Governments to take a cue from the success stories of States within the country as well as areas within their own territories.

The Central Government, on its part, is determined to ensure that flaws in programmes are removed and lapses in implementation do not recur. As a first step, the Ninth Plan recognises the need for a strategy to achieve rapid population stablisation by:

- *Reducing infant and maternal mortality;*
- *Meeting felt needs for contraception.*

The Ninth Plan also aims at investing more in the social sector and in synergising health, literacy and women's empowerment programmes. To ensure that these objectives are fulfilled, and to focus attention on the problem of runaway population growth, we took two subsequent decisions.

The first was the adoption of the *National Population Policy 2000* that provides the policy framework for improving the quality and coverage, as well as for monitoring the delivery, of family welfare programmes. The policy focuses both on society as a whole as well as the primary building block of society, the family -- it targets overall population stabilisation; it aims at encouraging families to achieve sustainable reproductive goals.

Simultaneously, the policy promotes synergy among various social welfare and economic development programmes. It rests on the wisdom that population stabilisation is the *key* to sustainable development which is the *key* to improvement in the quality of life of the masses.

Our second move was to set up the National Commission on Population. This is a broad-based body that includes representatives of both Government and non-government organisations, as well as individuals who can influence society.

Your mandate is to:

- *Review, monitor and give directions for the implementation of the National Population Policy so that the goals that we have set for ourselves can be achieved;*
- *Promote synergy between health, education and related development programmes so that population stabilisation can be achieved by the year* [redacted]; 2045
- *Encourage inter-sectoral coordination in both planning and implementing programmes with the help of different sectors and agencies of both the Union and the State Governments; and,*
- *Build up a people's movement in support of this national effort.*

The goals set by the National Population Policy are no doubt difficult, but by no means impossible, to achieve. I am confident that with the help of the National Commission on Population, and through you the people of India, Government will be able to achieve:

- *Universal access to quality family planning services so that the two-child norm becomes a reality;*
- *Total coverage of registration of births, deaths and marriages;*
- *Full access to information on birth limitation methods and freedom of choice, especially to women, for planning their families;*
- *Reduction of Infant Mortality Rate to below 30 per thousand live births, incidence of low birth weight and maternal mortality rate;*
- *Immunisation against preventable diseases;*
- *Elimination of incidence of girls being married below the age of 18;*
- *Increase in the percentage of deliveries conducted by trained persons to 100 per cent;*
- *Contain Sexually Transmitted Diseases, especially AIDS;*
- *Universalisation of primary education and reduction in the dropout rates at primary and secondary levels to below 20 per cent both for boys and girls.*

To facilitate the attainment of these goals by the National Commission on Population, my Government proposes to set up an **Empowered Action Group** and a **National Population Stabilisation Fund**.

The Empowered Action Group, attached to the Ministry of Health, will be charged with the responsibility of preparing area-specific programmes, with special emphasis on States that have been lagging behind in containing population growth to manageable limits and will account for nearly half the country's population in the next two decades.

The Group will also concentrate on involving voluntary associations, community organisations and Panchayati Raj Institutions in this national effort. It will explore the possibility of expanding the scope of 'social marketing' of contraceptives in a manner that makes them easily accessible even while raising awareness levels.

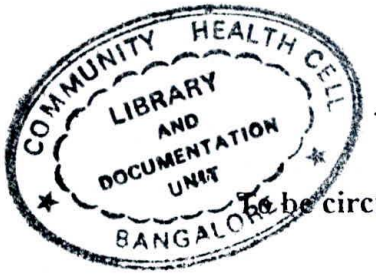
The National Population Stabilisation Fund, which will provide a window for canalising monies from national voluntary sources, is being set up to specifically aid projects designed to contribute to population stabilisation. I appeal to the corporate sector, industry, trade organisations and individuals to generously contribute to this fund, and thus contribute to this national effort.

To give it a kick-start, the Planning Commission may consider making a seed contribution from resources available with it. We will associate non-government representatives in the management of the National Population Stabilisation Fund.

Friends, I look forward to the National Commission on Population playing an active role, not only by generating ideas but also helping in their implementation in the coming years.

I began by saying that India's runaway population growth is a challenge that stares the nation in the face. I would like to conclude by saying that together we *can* overcome this challenge.

Thank you.



To be circulated to the Members of the National Commission on Population

Some key isues brought to the attention of the Members of the Commission at its first meeting on 22nd July 2000 for urgent action

1. There is an urgent need for raising the budget allocation for all the social sectors impinging on population stabilisation programmes envisaged in the National Population Policy document. This will include raising budgetary provisions for the Departments of Education, Family Welfare, Women and Child Welfare, selected aspects of Rural Development including empowerment of Panchayati Raj Institutions and Self-Help Groups for women. The budget for the Department of Family Welfare, as a percentage of Government budget should be immediately raised from 1.8 to 3.6 per cent.

2. The budgetary provisions for primary education should be doubled immediately from this year onwards in order to ensure universal education for all children below the age of 14. The earlier promises made by the Government to increase the provisions for education to 6 per cent of GDP by 2000 (from 3.8 per cent in 1996-97) should be fulfilled at least by 2005.

3. The infrastructure facilities for delivery of Primary Health Care should be considerably expanded and improved, and the gaps in the availability of sub-centres, Primary Health Centres and Community Health Centres should be filled in immediately by necessary constructions, provision of equipments and personnel.

4. The Technology Mission contemplated in NPP 2000 for the six backward States of Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh, Assam and Orissa should be immediately set up under the leadership of a dynamic management specialist with a group of experts drawn from different disciplines of administration, reproductive health, primary health care and monitoring and evaluation. The additional budget envisaged for these six States should be made available to the Technology Mission for spending on these States on directions listed in the National Population Policy 2000.

5. In order to have effective programme implementation in these States, it will be useful to set up State-level Corporations which will oversee the implementation of reproductive health, family planning and primary education and Self-Help Groups (SHG)for women's programmes in these States.

6. We have successful experiences of such Corporations in Uttar Pradesh. Corporations such as U.P. Bridge Construction Corporation has made good name and their work has been recognised in other States. If they can do so in other States, why can't they do in their own State?

7. There should be close monitoring of the programmes of population stabilisation implemented throughout the country. A separate cell under a senior person should be set up in the Population Commission on the progress of the programmes in different States of the country.

8. The data on Couple Protection Rate estimated by the Department of Family Welfare has come to be questioned in terms of its credibility and usefulness. These data do not match with independent estimates obtained from carefully conducted sample surveys such as the National Family Health Survey. It is essential that a Committee is immediately set up to revamp the estimation procedure of Couple Protection Rate calculated by the Ministry and developing the data-base on which they have to be computed.

9. The extension of freeze on the number of seats to Parliament from each State on the basis of 1971 census (42nd Constitution Amendment) until the year 2026, approved by the Cabinet and included in para 37 of NPP 2000 is a laudable step. It should be brought up for legislation in the forthcoming monsoon session of Parliament. This will serve as a powerful motivational measure for the State Governments to fearlessly and effectively pursue the cause of population stabilisation.

Dr K Srinivasan
Member, National Commission on Population
Executive Director, Population Foundation of India

DH 4/6/94

Over one-third of Indian population below poverty line

DH News Service

NEW DELHI, June 3

As per the latest information available with the government, 320.37 million people, or 35.97 per cent of the total population, are estimated to have been living below the poverty line in 1993-94. Of these, 15.65 million people were living below the poverty line in Karnataka the same year, Minister of State for Planning and Programme Implementation Ram Naik informed the Lok Sabha in written answers.

The minister said that from time to time, the government had reviewed the implementation of the rural poverty alleviation and employment generation programmes including the Integrated Rural Development Programme (IRDP), the Jawahar Razgar Yojana (JRY) and the Employment Assurance Scheme (EAS) in the Central Level Co-ordination Committee (CLCC), State-Level Co-ordination Committee (SLCC) and at the district-level by the governing body of the District Rural Development Agencies (DRDAs).

These programmes were also reviewed through an intensive regime of field inspections by officers of the Centre, state and implementation agencies. Periodic, review meetings with state secretaries the incharges of rural development and conferences of project directors of DRDAs were also held to review the progress of implentation of these schemes. Monitoring and vigilance committees had been set up at the state, district and block levels in which elected representatives of the people had been associated to monitor the implementation of these schemes.

Besides, to assess the overall impact of various poverty alleviation programmes, in relation to their specific objectives, the Ministry of Rural Areas and Employment undertook periodic concurrent evaluation of their major schemes through independent recognised organisations.

Some of the positive points listed among the main findings of the latest concurrent evaluation report on IRDP (September 1992-August 1993) were: (a) while 15.96 per cent of the families helped crossed the poverty line of Rs 11,000 per annum, the additional annual income of more than Rs 2,000 was generated to a large percentage (57.34 per cent) of families. The annual income from the assets was more than Rs 6,000 in 29 per cent of the cases; (b) 95 per cent of the beneficiaries felt that the help given to them was according to their choice.

A large number of beneficiaries found the assets to be of good quality. On the other hand, the areas of concern were (a) a very poor linkage of the IRDP with the Training of Rural Youth for Self-Employment (TRYSEM) and Development of Women and Children in Rural Areas (DWCRA); and that (b) in 45 per cent of the cases, the settlement of claim preferred by the beneficiaries for perished assets remained unsettled.

PM to call all-party meet on poverty

NEW DELHI, June 3 (PTI)

Prime Minister Atal Behari Vajpayee would be convening an all-party meeting to elicit their opinion on how they could play a more effective role in proper utilisation of funds for anti-poverty programmes.

Intervening during question hour in Lok Sabha today, Mr Vajpayee admitted that elected representatives were unable to participate effectively in such a serious matter.

HP-3.

National Population Policy, 2000

ACTION PLAN

Operational Strategies

(i) & (ii) Converge Service Delivery at Village Levels

1. Utilise village self help groups to organise and provide basic services for reproductive and child health care, combined with the ongoing Integrated Child Development Scheme (ICDS). Village self help groups are in existence through centrally sponsored schemes of: (a) Department of Women and Child Development, Ministry of HRD, (b) Ministry of Rural Development, and (c) Ministry of Environment and Forests. Organise neighbourhood acceptor groups, and provide them a revolving fund that may be accessed for income generation activities. The groups may establish rules of eligibility, interest rates, and accountability for which capital may be advanced, usually to be repaid in installments within two years. The repayments may be used to fund another acceptor group in a nearby community, who would exert pressure to ensure timely repayments. Two trained birth attendants and the aanganwadi worker (AWW) should be members of this group.

2. Implement at village levels a one-stop integrated and coordinated service delivery package for basic health care, family planning, and maternal and child health related services, provided by the community and for the community. Train and motivate the village self-help acceptor groups to become the primary contact at household levels. Once every fortnight, these acceptor groups will meet, and provide at one place 6 different services for (i) registration of births, deaths, marriage and pregnancy; (ii) weighing of children under 5 years, and recording the weight on a standard growth chart; (iii) counseling and advocacy for contraception, plus free supply of contraceptives; (iv) preventive care, with availability of basic medicines for common ailments: antipyretics for fevers, antibiotic ointments for infections, ORT /ORS[1] for childhood diarrhoeas, together with standardised indigenous medication and homeopathic cures; (v) nutrition supplements; and (vi) advocacy and encouragement for the continued enrolment of children in school up to age 14. One health staff, appointed by the panchayat, will be suitably trained to provide guidance. Clustering services for women and children at one place and time at village levels will promote positive interactions in health benefits and reduces service delivery costs.

3. Wherever these village self-help groups have not developed for any reason, community midwives, practitioners of ISMH , retired school teachers and ex-defence personnel may be organised into neighbourhood groups to perform similar functions.

---

[1] Oral Rehydration Therapy /Oral Rehydration Salts

4. At village levels, the Aanganwadi Centre may become the pivot of basic health care activities, contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school activities. The aaganwadi centre can also function as depots for ORS/basic medicines, and contraceptives.

5. A maternity hut should be established in each village to be used as the village delivery room, with storage space for supplies and medicines. It should be adequately equipped with kits for midwifery, ante-natal care, and delivery; basic medication for obstetric emergency aid; contraceptives, drugs and medicines for common ailments; and indigenous medicines/supplies for maternal and new-born care. The panchayat may appoint a competent and mature mid-wife, to look after this village maternity hut. She may be assisted by volunteers.

6. Trained birth attendants as well as the vast pool of traditional dais should be made familiar with emergency and referral procedures. This will greatly assist the Auxiliary Nurse Midwife (ANM) at the subcentres to monitor and and respond to maternal morbidity/emergencies at village levels.

7. Each village may maintain a list of community mid-wives, village health guides, panchayat sewa sahayaks, trained birth attendants, practitioners of indigenous systems of medicine, primary school teachers, and other relevant persons, as well as the nearest institutional health care facilities that may be accessed for integrated service delivery. These persons may also be helpful in involving civil society in monitoring availability, quality and accessibility of reproductive and child health services; in disseminating education and communication on the benefits of smaller and healthier families, with emphasis on education of the girl child; and female participation in the work force.

8. Provide a wider basket of choices in contraception, through innovative social marketing schemes, to reach household levels.

Comment: *Meaningful decentralisation will result only if the convergence of the national family welfare programme with the ICDS programme is strengthened. The focus of the ICDS programme on nutrition improvement at village levels and on pre-school activities must be widened to include maternal and child health care services. Convergence of several related activities at service delivery levels with, in particular, the ICDS programme , is critical for extending outreach and increasing access to services. Intersectoral coordination with appropriate training and sensitisation among field functionaries will facilitate dissemination of integrated reproductive and child health services to village and household levels. People will willingly cooperate in the registration of births, deaths, marriages, and pregnancies if they perceive some benefit. At the village level, this community meeting every fortnight, may become their most convenient access to basic health care, both for maternal and child health, as well as for common ailments. Households may participate to receive integrated service delivery, along with information about ongoing micro-credit and thrift schemes.*

Government and non-government functionaries will be expected to function in harmony to ensure integrated service delivery. The panchayat will promote this coordination and exercise effective supervision.

(iii) Empowering Women for Improved Health and Nutrition

1. Create an enabling environment for women and children to benefit from products and services disseminated under the reproductive and child health programmes. Cluster services for women and children at the same place and time. This promotes positive interactions in health benefits, and reduces service delivery costs.

2. As a measure to empower women, open more child care centres in rural areas, and in urban slums, where a woman worker may leave her children in responsible hands. This will encourage female participation in paid employment, reduce school drop-out rates, particularly for the girl child, and promote school enrolment as well. The aanganwadis provide a partial solution.

3. To empower women, pursue programmes of social afforestation to facilitate access to fuelwood and fodder. Similarly, pursue drinking water schemes for increasing access to potable water. This will reduce long absences from home, and the need for large numbers of children to perform such tasks.

4. In any reward scheme intended for household levels, priority may be given to energy saving devices such as solar cookers, or provision of sanitation facilities, or extension of telephone lines. This will empower households, in particular women.

5. Improve district, sub-district, and panchayat level health management with coordination and collaboration between district health officer, sub-district health officer and the panchayat for planning and implementing activities. There is need to:

- Strengthen the referral network between the district health office, district hospital and the community health centres, the primary health centres, and the subcentres in management of obstetric and neo-natal complications.
- Strengthen community health centres to provide comprehensive emergency obstetric and neo-natal care. These may function as clinical training centres as well. Strengthen primary health centres to provide essential obstetric and neo-natal care. Strengthen subcentres to provide a comprehensive range of services, with delivery rooms, counseling for contraception, supplies of free contraceptives, ORS, and basic medicines, together with facilities for immunisation.
- Establish rigorous problem identification mechanisms through maternal and peri-natal audit, from village levelupwards.

6. Ensure adequate transportation at village level, subcentre levels, zilla parishads, primary health, and at community health centres. Identifying women at risk is meaningful only if women with complications can reach emergency care in time.

7. - Improve the accessibility and quality of maternal and child health services, through:

- Deployment of community mid-wives and additional health providers at village levels; cluster services for women and children at the same place and time, from village level upwards, e.g. ante-natal and post-partum care, monitoring infant growth, availability of contraceptives and medicine kits; and routinised immunisations at subcentre levels.
- Strengthen the capacity of primary health centres to provide basic emergency obstetric and neo-natal health care.
- Involve professional agencies in developing and disseminating training modules for standard procedures in the management of obstetric and neo-natal cases. The aim should be to routinise these procedures at all appropriate levels.
- Improve supervision by developing guidance and supervision checklists.

8. Monitor performance of maternal and child health services at each level by using the maternal and child health local area monitoring system; which includes monitoring the incidence and coverage of ante-natal visits, deliveries assisted by trained health care personnel, and post-natal visits, among other indicators. The ANM at the subcentre should be responsible and accountable for registering every pregnancy and child birth in her jurisdiction, and for providing universal ante-natal and post-natal services.

9. Improve technical skills of maternal and child health care providers by:

- Strengthening skills of health personnel and health providers through classroom and on the job training in the management of obstetric and neo-natal emergencies. This should include training of birth attendants and community midwives at district level hospitals in life saving skills, such as management of asphyxia and hypothermia.
- Training on integrated management of childhood illnesses for infants (1 week – 2 months).

10. Support community activities such as dissemination of IEC material including leaflets and posters, and promotion of folk jatras, songs and dances to promote healthy mother and healthy baby messages, along with good management practices to ensure safe motherhood, including early recognition of danger signs.

11. Programme development, comprising:

- Partnership in family health and nutrition. The aanganwadi worker will identify women and children in the villages, who suffer from malnutrition and/or micro-nutritional deficiencies including iron, vitamin A, and iodine deficiency; provide nutritional supplements; and monitor nutritional status.
- Convergence, strengthening, and and universalisation of the nutritional programmes of the Department of Family Welfare and the ICDS run by the

Department of Women and Child Development, ensuring training, and timely supply of food supplements and medicines.

- Include STD/RTI and HIV/AIDS prevention, screening and management, in maternal and child health services.
- Provide quality care in family planning, including information, increased contraceptive choices for both spacing and terminal methods, increased access to good quality and affordable contraceptive supplies and services at diverse delivery points, counseling about the safety, efficacy and possible side effects of each method, and appropriate follow-up.

12. Develop a health package for adolescents.

13. Expand the availability of safe abortion care. Abortion is legal, but there are barriers limiting women's access to safe abortion services. Some operational strategies are:

- Community level education campaigns should target women, household decision makers, and adolescents about the availability of safe abortion services, and the dangers of unsafe abortion.
- Make safe and legal abortion services more attractive to women and household decision makers by (i) increasing geographic spread; (ii) enhancing affordability; (iii) ensuring confidentiality; and (iv) providing compassionate abortion care, including post abortion counseling.
- Adopt updated and simple technologies that are safe and easy, e.g. manual vacuum extraction not necessarily dependant upon anaesthesia,, or non-surgical techniques which are non invasive.
- Promote collaborative arrangements with private sector health professionals, NGOs, and the public sector, to increase the availability and coverage of safe abortion services, including training of mid-level providers.
- Eliminate the current cumbersome procedures for registration of abortion clinics. Simplify and facilitate the establishment of additional training centres for safe abortions in the public, private, and NGO sectors. Train these health care providers in provision of clinical services for safe abortions.
- Formulate and notify standards for abortion services. Strengthen enforcement mechanisms at district and sub-district levels, to ensure that these norms are followed.
- Follow norms-based registration of service provision centres, and thereby switch the onus of meticulous observance of standards onto the provider.
- Provide competent post-abortion care, including management of complications and identification of other health needs of post-abortion patients, and linking with appropriate services. As part of post-abortion care, physicians may be trained to provide family planning counseling and services such as sterilisation, and reversible modern methods such as IUDs, as well as oral contraceptives and condoms.
- Modify syllabus and curricula for medical graduates, as well as for continuing education and in-house learning, to provide for practical training in the newer procedures.

- Ensure services for termination of pregnancy at primary health centres and at community health centres.

14. Develop maternity hospitals at sub-district levels and at community health centres to function as FRUs (FRUs) for complicated and life threatening deliveries.

15. Formulate and enforce standards for clinical services in the public, private, and NGO sectors.

16. Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing, as well as commercial sales.

17. Create a national network consisting of public, private and NGO centres identified by a common logo, delivering reproductive and child health services *free to any client*. The provider will be compensated for the service provided, on the basis of a coupon, duly counter-signed by the beneficiary, and paid for by a system to be devised. The compensation will be identical to providers, across all sectors. The end-user will choose the provider of the service. A group of management experts will devise checks and balances to prevent misuse.

(iv) Child Health and Survival

1. Support community activities, from village level upwards to monitor early and adequate ante-natal, natal, and post-natal care. Focus attention on neo-natal health care and nutrition.

2. Set up a National Technical Committee on neo-natal care, to align programme and project interventions with newly emerging technologies in neo-natal and peri-natal care.

3. Pursue compulsory registration of births in coordination with the ICDS Programme.

4. After the birth of a child, provide counseling and advocacy about contraception, to encourage adoption of a reversible or a terminal method. This will also contribute to the health and well-being of both mother and child.

5. Improve capacities at health centres in basic midwifery services, essential neo-natal care, including the management of sick neo-nates outside the hospital.

6. Sensitise and train health personnel in the integrated management of childhood illnesses. Standard case management of diarrhoea and acute respiratory infections must be provided at subcentres and primary health

centres, with appropriate training, and adequate equipment. Besides, training in this sector may be imparted to health care providers at village levels, especially in indigenous systems.

7. Strengthen critical interventions aimed at bringing about reductions in maternal malnutrition, morbidity and mortality, by ensuring availability of supplies and equipment at village levels, and at sub-centres.

8. Pursue rigorously the pulse polio campaign, to eradicate polio.

9. Ensure 100 percent routine immunisation for all vaccine preventable diseases, in particular tetanus and measles.

10. As a child survival initiative, explore promotional and motivational measures for couples below the poverty line who marry after the legal age of marriage, to have the first child after the mother reaches the age of 21, and adopt a terminal method of contraception, after the birth of the second child.

11. Children form a vulnerable group, and certain sub-groups merit focussed attention and intervention, such as street children and child labourers. Encourage voluntary groups as well as NGOs to formulate and implement special schemes for these groups of children.

12. Explore the feasibility of a national health insurance covering hospitalisation costs for children below 5 years, whose parents have adopted the small family norm, and opted for a terminal method of contraception after the birth of the second child.

13. Expand the ICDS to include children between 6–9 years of age, specifically to promote and ensure 100 percent school enrolment, particularly for girls. Promote primary education with the help of aanganwadi workers, and encourage retention in school till age 14. Education promotes awareness, late marriages, small family size, and higher child survival rates.

14. Provide vocational training for girls. This will enhance perception of the immediate utility of educating girls, and gradually raise the average age of marriage. It will also increase enrolment and retention of girls at primary school, and likely also at secondary school levels. Involve NGOs, the voluntary sector and the private sector, as necessary, to target employment opportunities.

(v) Meeting the Unmet Needs for Family Welfare Services

1. Strengthen, energise and make publicly accountable the cutting edge of health infrastructure at the village, subcentre and primary health centre levels.
2. Address on priority the different unmet needs detailed at Appendix IV, in particular, an increase in rural infra-structure, deployment of sanctionned and appropriately trained health personnel, and provisioning of essential equipment and drugs.
3. Formulate and implement innovative social marketing schemes to provide subsidised products and services in areas where the existing coverage of the public, private, and NGO sectors is insufficient in order to increase outreach and coverage,
4. Improve facilities for referral transportation at panchayat, zilla parishad, and primary health centre levels. At subcentres, provide ANMs with soft loans for purchase of mopeds, to enhance their mobility. This will increase coverage of ante-natal and post natal check-ups, which, in turn, and will bring about reductions in maternal and infant mortality.
5. Encourage local. entrepreneurs at village and block levels to start ambulance services through special loan schemes, with appropriate vehicles to facilitate transportation of persons requiring emergency as well as essential medical attention.
6. Provide special loan schemes and make site allotments at village levels, to facilitate the starting of chemist shops for basic medicines and provision for medical first aid.

(vi) Under Served Population Groups

(a) Urban Slums

1. Finalise a comprehensive urban health care strategy.
2. Facilitate service delivery centres in urban slums to provide comprehensive basic health, reproductive and child health services by NGOs, and private sector organisations, including corporate houses.
3. Promote networks of retired government doctors, and para-medical and non-medical personnel who may function as health care providers for clinical and non-clinical services on remunerative terms.
4. Strengthen social marketing programmes for non-clinical family planning products and services in urban slums.
5. Initiate especially targeted information, education and communication campaigns for the urban slums, on family planning, immunization, ante-natal, natal and post-natal check-ups and other reproductive health care services. Integrate aggressive health education programmes with health and medical care programmes , with emphasis on environmental health, personal hygiene and healthy habits, nutrition education and population education.
6. Promote inter-sectoral coordination between departments / municipal bodies dealing with water and sanitation, industry and pollution, housing, transport, education and nutrition, and women and child development, to deal with

unplanned and uncoordinated settlements.

7. Streamline the referral systems and linkages between the primary, secondary and tertiary levels of health care in the urban areas.
8. Link the provision of continued facilities to urban slum dwellers with their observance of the small family norm.

(b) Tribal Communities, Hill Area Populations and Displaced and Migrant Populations

1. Many tribal communities are dwindling in numbers, and may not need fertility regulation. Instead they may need information and counseling in respect of infertility.

2. The NGO sector may be encouraged to formulate and implement a system of preventive and curative health care that responds to seasonal variations in the availability of work, income and food for tribal and hill area communities, and migrant and displaced populations. To begin with, mobile clinics may provide some degree of regular coverage and outreach.

3. Many tribal communities are dependent upon indigenous systems of medicine which necessitates a regular supply of local flora, fauna, and minerals, or of standardised medication derived from these. Husbandry of such local resources and of preparation and distribution of standardised formulations should be encouraged.

4. Health care providers in the public, private, and NGOs sectors should be sensitised to adopt a "burden of disease" approach to meet the special needs of tribal and hill area communities.

(c) Adolescents

1. Ensure for adolescents access to information, counseling and services, including reproductive health services, that are affordable and accessible. Strengthen primary health centres and subcentres, to provide counseling, both to adolescents, and also to newly weds (who may also be adolescents). Emphasise proper spacing of children.

2. Provide for adolescents the nutritional package of services available under the ICDS programme .

Comment: *Improvements in health status of adolescent girls has an inter-generational impact. It reduces the risk of low birth weight and minimizes neo-natal mortality. Malnutrition is a problem that seriously impairs the health of adolescent and adult women and has its roots in early childhood. The causal linkages between anaemia and low birth weight, prematurity, peri-natal mortality,and maternal mortality has been extensively studied and established.*

3. Enforce the Child Marriage Restraint Act, 1976, to reduce the incidence of teenage pregnancies. Preventing the marriage of girls below the legally permissible age of 18 should become a national concern.

Comment: *It will promote higher retention of girls at schools, and likely also encourage participation in the paid work force.*

4. Provide integrated intervention in pockets with unmet needs in the urban slums, remote rural areas, border districts and among tribal populations.

(d) Increased Participation of Men in Planned Parenthood

1. Focus attention on men in the information and education campaigns to promote the small family norm, and to raise awareness by emphasising the significant benefits of fewer children, better spacing, better health and nutrition, and better education.

2. Currently, over 97 percent of the sterilisations are tubectomies. Repopularise vasectomies, in particular, the no-scalpel vasectomy as a safe, simple, painless procedure, more convenient and acceptable to men.

3. In the continuing education and training at all levels, there is need to ensure that the no-scalpel vasectomy, and all such emerging techniques and skills are included in the syllabi, together with abundant practical training. Medical graduates, and all those participating in "in-service" continuing education and training will be equipped to handle this intervention.

(vii) Diverse Health Care Providers

1. At district and sub-district levels, maintain block-wise, a data base of private medical practitioners whose credentials may be certified by the Indian Medical Association (IMA). Explore the possibility of accrediting these private practitioners for a year at a time, and assign to each to a satellite population, not exceeding 5000 (depending upon distances and spread), for whom they may provide reproductive and child health services. The private practitioners would be compensated for the services rendered, through designated agencies. Renewal of contracts after one year may be guided by client satisfaction. This will serve as an incentive to expand the coverage and outreach of high quality health care. Appropriate checks and balances will safeguard misuse.

2. Revive the earlier system of the licensed medical practitioners who, after appropriate certification from the IMA, may participate in the provision of clinical services.

3. Involve the non-medical fraternity in counseling and advocacy so as to

demystify the national family welfare effort, such as retired defence personnel, retired school teachers, and other persons who are active and willing to get involved.

4. Modify the under/post-graduate medical, nursing, and paramedical professional course syllabi and curricula, in consultation with the Medical Council of India, the Councils of ISMH, and the Indian Nursing Council, in order to reflect the concepts and implementation strategies of the reproductive and child health programme and the national population policy. This will also be applied to all in-service training and educational curricula as well.

5. Ensure the efficient functioning of the First Referral Units i.e. 30 bed hospitals at block levels which provide emergency obstetric and child health care, to bring about reductions in Maternal Mortality Ratio/ Rate (MMR) and Infant Mortality Rate (IMR). In many states, these FRUs are not operational on account of an acute shortage of specialists i.e. gynaecologist / obstetrician, anaesthetist, and pediatrician. Augment the availability of specialists in these three disciplines, by increasing seats in medical institutions, and simultaneously enable and facilitate the acquisition of in-service post-graduate qualifications through the National Board of Medical Examination and open universities like IGNOU in larger numbers. As an incentive, seats will be reserved for those in-service medical graduates who are willing to abide by a bond to serve for 5 years at First referral Units after completion of the Course. States would need to sanction posts of Specialists at the FRUs. Further, these specialists should be provided with clear promotion channels.

(viii) (a)Collaboration with and Commitments from the Non-Government Sector

1. There remain innumerable hurdles that inhibit genuine long term collaboration between the government and non-government sectors. A forum of representatives from government, the non-government organisations, and the private sector may identify these hurdles, and prepare guidelines that will facilitate and promote collaborative arrangements.
2. Collaboration with and commitments from NGOs to augment advocacy, counseling and clinical services, to access village levels. This will require increased clinic outlets as well as mobile clinics;
3. Collaboration between the voluntary sector and the NGOs will facilitate dissemination of efficient service delivery to village levels. The guidelines could articulate the role and responsibility of each sector;
4. Encourage the voluntary sector to motivate village level self help groups to participate in community activities;
5. Specific collaboration with the non-government sector in the social marketing of contraceptives to reach village levels will be encouraged.

(viii) (b) Collaboration with and Commitments from Industry

1. The corporate sector and industry could for instance, take on the challenge of strengthening the management information systems in the seven most deficient states, at primary health centre and subcentre levels. Introduce electronic data entry machines to lighten the tedious work load of ANMs and the multi-purpose workers at subcentres and the doctors at the primary health centres, while enabling wider coverage and outreach;
2. Collaborate with non-government sectors in running professionally sound advertisement and marketing campaigns for products and services, targeting all segments of the population, from village level upwards, in other words, strengthen advocacy and IEC, including social marketing of contraceptives;
3. Provide markets to sustain the income generating activities from village levels upwards. In turn, this will ensure consistent motivation among the community for pursuing health and education related community activities;
4. Help promote transportation to remote and inaccessible areas up to village levels. This will greatly assist the coverage and outreach of social marketing of products and services;
5. The social responsibility of the corporate sector in industry must, at the very minimum, extend to providing preventive reproductive and child health care for its own employees (if >100 workers are engaged).
6. Create a national network consisting of voluntary, public, private and non-government health centres, identified by a common logo, delivering reproductive and child health services, free to any client. The provider will be compensated for the service provided, on the basis of a coupon system, duly counter signed by the beneficiary and paid for by a system that will be fully articulated. The compensation will be identical to providers, across all sectors. The end user exercises choices in the source of service delivery. A committee of management experts will be set up to devise ways of ensuring that this system is not abused.
7. Form a consortium of the voluntary sector, the non-government sector and the private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education to its 1 billion citizens.
8. In the area of basic education, set up privately run/managed primary schools for children up to age 14 – 15. Alternately, if the schools are set up/managed by the panchayat, the private corporate sector could provide the mid-day meals, the text –books and/or the uniforms.

(ix) Mainstreaming Indian Systems of Medicine and Homeopathy

(1) Provide appropriate training and orientation in respect of the RCH programme for the institutionally qualified ISMH medical practitioners (already educated in midwifery, obstetrics and gynaecology over 5-1/2 years), and utilise their services to fill in gaps in manpower at appropriate levels in the health infrastructure, and at subcentres and primary health centres, as necessary.

(2) Utilise the ISMH institutions, dispensaries and hospitals for health and population related programmes .
(3) Disseminate the tried and tested concepts and practices of the indigenous systems of medicine, together with ISMH medication at village maternity huts and at household levels for ante-natal and post-natal care, besides nurture of the newborn.
(4) Utilise the services of the ISM and H 'barefoot doctors' after appropriate training and orientation towards providing advocacy and counseling for disseminating supplies and equipment, and as depot holders at village levels.

(x) Contraceptive Technology and Research on RCH

(1)Government will encourage, support and advance the pursuit of medical and social science research on reproductive and child health, in consultation with ICMR and the network of academic and research institutions.

(2)The International Institute of Population Sciences and the Population Research Centres will continue to review programme and monitoring indicators to ensure their continued relevance to strategic goals.

(3) Government will restructure the Population Research Centres , if necessary.

(4)Standards for clinical and non-clinical interventions will be regularly issued.

(5) A constant review and evaluation of the community needs assessment approach will be pursued, to align programme delivery with good management practices and with newly emerging technologies.

(6) A Committee of international and Indian experts, voluntary and non-government organisations and government may be set up to regularly review and recommend specific incorporation of the advances in contraceptive technology and in particular, the newly emerging techniques, into program development.

(xi) Providing for the Older Population

(1) Sensitize, train and equip rural and urban health centres and hospitals towards providing geriatric health care.
(2) Encourage NGOs and voluntary organizations to formulate and strengthen a series of formal and informal avenues that make the elderly economically self reliant.
(3) Tax benefits could be explored as an encouragement for children to look after their aged parents.

(xii) Information Education and Communication

1. Converge IEC efforts across the social sectors. The two sectors of Family Welfare and Education have coordinated a mutually supportive IEC strategy. The Zila Saksharta Samitis design and deliver joint IEC campaigns in the local idiom, promoting the cause of literacy as well as family welfare. Optimal use of folk media has served to successfully mobilize local populations. The state of Tamil Nadu made exemplary use of the IEC strategy by spreading the message through every possible media, including public transport, on mile-stones on national high-ways as well as through advertisement and hoardings on roadsides, along city / rural roads, on billboards, and through processions, films, school dramas, public meetings, local theatre and folk songs.

2. Involve departments of rural development, social welfare, transport, cooperatives, education with special reference to schools, to improve clarity and focus of the IEC effort, and to extend coverage and outreach. Health and population education must be inculcated from the school levels.

3. Fund the nagarpalikas, panchayats, NGOs and community organizations for interactive and participatory IEC activities.

4. Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behavior and response patterns of individuals and communities. This serves to enthuse communities to be attentive towards the quality and coverage of maternal and child health services, including referral care. Public leaders and film stars could spread widely the messages of the small family norm, female literacy, delayed marriages for women, fewer babies, healthier babies, child immunization and so on. The involvement and enthusiastic participation of elected leaders will ensure dedicated involvement of administrators at district and sub-district levels. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional, and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout society.

5. Utilise radio and television as the most powerful media for disseminating relevant socio-demographic messages. Government could explore the feasibility of appropriate regulations, and even legislation, if necessary to mandate the broadcast of social messages during prime time.

6. Utilise dairy cooperatives, the public distribution systems, other established networks like the LIC at district and sub-district levels for IEC and for distribution of contraceptives and basic medicines to target infant / childhood diarrhoeas, anaemia and malnutrition among adolescent girls and pregnant mothers. This will widen outreach and coverage.

7. Sensitise the field level functionaries across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, cooperatives) to the strategies, goals and objectives of the population stabilisation programs.

8. Involve civil society for disseminating information, counseling and spreading education about the small family norm, the need for fewer but healthier babies, higher female literacy and later marriages for women. Civil society could also be of assistance in monitoring the availability of contraceptives, vaccines and drugs in rural areas and in urban slums.

DEMOGRAPHIC PROFILE

India is following the demographic transition pattern of all developing countries from initial levels of `high birth rate - high death rate' to the current intermediate transition stage of `high birth rate - low death rate' which leads to high rates of population growth, before graduating to levels of `low birth rate - low death rate'.

1. Age Composition

1. (i) The age distribution of the population of India is projected to change by 2016, and these changes should determine allocation of resources in policy intervention. The population below 15 years of age (currently 35 percent) is projected to decline to 28 percent by 2016. The population in the age group 15 - 59 years (currently 58 percent) is projected to increase to nearly 64 percent by 2016. The age group of 60 plus years is projected to increase from the current levels of 7 percent to nearly 9 percent by 2016.

Table 4 : Age Composition as Percentage of the Total Population[2]

Year	Below 5 years	Between 0-15	Between >15 – 59 years	+ 60 years
1991	12.80	37.76	55.58	6.67
2001	10.70	34 33	58.70	6.97
2011	10.10	28.48	63.38	8.14
2016	9.7	27.73	63.33	8.94

2. Inter State Differences

2. (i) India is a country of striking demographic diversity. Substantial differences are visible between states in the achievement of basic demographic indices. This has led to significant disparity in current population size and the potential to influence population increases during 1996-2016. There are wide inter-state, male-female and rural-urban disparities in outcomes and impacts. These differences stem largely from poverty, illiteracy, and inadequate access to health and family welfare services, which coexist and reinforce each other. In many parts, the widespread health infrastructure is not responsive.

2. (ii) At least 10 states and union territories in India have already achieved replacement levels of fertility. These are ranked in accordance with their total

[2] Technical Group on Population Projections. Planning Commission.

fertility rates. Additionally, in each of the three tables below, the current population of each state / union territory, the ratio of this population to the country population, the infant mortality rate and the contraceptive prevalence rate of the state / union territory is also indicated:

Table 4 : Population Profile of 10 States and Union Territories of India

State	Population Size (in millions) as on 1 March 1999*	Percent of Total Population	Total Fertility Rate 1997	Infant Mortality Rate 1998	Contraceptive Prevalence Rate 1999
INDIA	981 .3		3.3	72	44 %
Group A (TFR =2.1)					
Goa	1.5	0.2	1.0@	23	27.1
Nagaland	1.6	0.2	1.5@	NA	7.8
Delhi	13.4	1.4	1.6@	36	28.8
Kerala	32.0	3.3	1.8	16	40.5
Pondichery	1.1	0.1	1.8@	21	56.9
A&N Islands	0.4	0.04	1.9@	30	39.9
Tamil Nadu	61.3.	6.2	2.0	53	50.4
Chandigarh	0.9	0.09	2.1@	32	35.0
Mizoram	0.9	0.09	NA	23	34.6

Source: Registrar General of India

@ Three year moving average TFR1995-97

*Population Projections by Technical Group on Population Projections,1996

2.(iii) There are 11 states and union territories that have a total fertility rate of more than 2.1 but less than 3.0, ranked accordingly :

Table 5 : Population Profile of 11 States and Union Territories of India

State	Population Size (in millions) as on 1 March 1999*	Percent of Total Population	Total Fertility Rate 1997	Infant Mortality Rate 1998	Contraceptive Prevalence Rate 1999
Group B (TFR = > 2.1 and< than 3.0)					
Manipur	2.21	0.2	2.4@	25	20.1
Daman & Diu	0.1	0.01	2.5@	51	30.2
Karnataka	51.4	5.2	2.5	58	55.4
Andhra Pradesh	74.6	7.6	2.5	66	50.3

Himachal Pradesh	6.5	0.7	2.5	64	48.2
Sikkim	0.5	0.06	2.5	52	21.9
West Bengal	78.0	7.9	2.6	53	32.9
Maharashtra	90.1	9.2	2.7	49	50.1
Punjab	23.3	2.4	2.7	54	66.0
Arunachal Pradesh	1.2	0.1	2.8@	47	14.0
Lakshadweep	0.07	0.01	2.8@	37	9.1

Source: Registrar General of India

@ Three year moving average TFR1995-97

*Population Projections by Technical Group on Population Projections,1996

2. (iv) However, there are at least 12 states and union territories that have a total fertility rate of over 3.0. These have been listed below:

Table 6 : Population Profile of 11 States and Union Territories of India

State	Population Size (in millions) as on 1 March 1999*	Percent of Total Population	Total Fertility Rate 1997	Infant Mortality Rate 1998	Contraceptive Prevalence Rate 1999
Group C(> 3.0)					
Orissa	35.5	3.6	3.0	98	39
Gujerat	47.6	4.8	3.0	64	54.5
Assam	25.6	2.6	3.2	78	16.7
Haryana	19.5	2.0	3.4	69	49.7
Dadra & Nagar Haveli	0.2	0.02	3.5@	61	29.1
Tripura	3.6	0.3	3.9@	49	25.2
Meghalaya	2.4	0.2	4.8@	52	4.6
Madhya Pradesh	78.3	8.0	4.0	98	46.5
Rajasthan	52.6	5.4	4.2	83	36.4
Bihar	98.1	10.0	4.4	67	19.7
Uttar Pradesh	166.4	17.0	4.8	85	38.2
Jammu & Kashmir	9.7	1.0	NA	45	15.0

Source: Registrar General of India

@ Three year moving average TFR1995-97

*Population Projections by Technical Group on Population Projections,1996

2.(v) The five states of Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar

Pradesh that currently constitute nearly 44 percent of the total population of India, are projected to comprise 48 percent of the total population in 2016. In other words these states alone will contribute an anticipated 55 percent increase during the period. 1996 -2016. Demographic outcomes in these states will determine the timing and size of population at which India achieves population stabilisation.

3. MATERNAL MORTALITY

3.(i) With 16% of the world's population, India accounts for over 20% of the world's maternal deaths. The maternal mortality ratio, defined as the number of maternal deaths per 100,000 live births, is incredibly high at 408 per 100,000 live births for the country (1997), which is unacceptable when compared to current indices elsewhere in Asia.

Table 5: Maternal Mortality Ratios in Asia [3]

Sri Lanka	China	Thailand	Pakistan	Indonesia	India	Bangla-desh	Nepal
30	115	200	340	390	437	850	1500

3.(ii) Within India, the inter-state differentials are a matter of concern.

Table 6: Inter-State Differences within India in Maternal Mortality Ratios[4]

Kerala	Bihar	Madhya Pradesh	Rajasthan	Uttar Pradesh	Orissa
87	451	498	607	707	739

4. INFANT MORTALITY

[3] UNFPA " The State of World Population, 1999 - 6 Billion. A Time for Choices
[4] Registrar General of India.

4. (i) It is estimated that about 7% new born infants perish within a year. Poor maternal health results in low birth weight and premature babies. Infant and childhood diarrhoeal diseases, acute respiratory infections and malnutrition contribute to high infant mortality rates. Additionally, in India, across the board (rural or urban areas), there are more female deaths in the age group of 0-14 than elsewhere[5]. Although the Infant Mortality Rate (IMR) has decreased from 146 per 1000 births in 1951 to 72 per 1000 births (1997), and the sex differentials are narrowing, again there are wide inter-state differences recorded in 1998, as is clear from Table 2 on Page 3-4. In comparison, we note the infant mortality rates in South Asia and elsewhere:

Table 7: Infant Mortality Rates in Asia [6]

Sri Lanka	Thailand	China	Indoneisa	India	Pakistan	Bangla-desh	Nepal
18	29	41	48	72	74	79	83

5. SEX RATIO

5. (i) India shares a distinctive feature of South Asian and Chinese populations as regards the sex ratio, with a century's old deficit of females[12]. The (female to male) sex ratio has been steadily declining. From 1901 to 1991, the sex ratio has declined from 972 to 927. This is largely attributed to the son preference, discrimination against the girl child leading to lower female literacy, female foeticide, higher fertility and higher mortality levels for females, in all age groups up to 45.

[5] UNICEF (1995) "The Progress of Indian States, 1995. India Country Office, New Delhi.
[6] UNFPA "The State of the World Population, 1999, 6 Billion - A Time for Choices"

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), ೧೯೯೧ನೆಯ ಜನಗಣತಿಯ ಅಂಗವಾಗಿ, ಅಂಗವಿಕಲತೆಯುಳ್ಳ ವ್ಯಕ್ತಿಗಳ 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 ಸಂಸ್ಥೆಯಾದ NCPEDP 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 ರಾಜ್ಯಮಟ್ಟ, 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 ಕೇಂದ್ರೀಕೃತವಾಗಬೇಕು. 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.

- ಸ್ಥಳೀಯ ಭಾಷೆಯಲ್ಲಿ ಶಿಕ್ಷಣ/ಮಾಹಿತಿ/ಸಂದೇಶ ವಾಕ್ಯಗಳನ್ನು ಸಾರುವ ಕಲಿಕಾ ಸಾಮಗ್ರಿಗಳ ತಯಾರಿಕೆಗಾಗಿ, ಕಾರ್ಪೊರೇಟ್ ಉದ್ಯೋಗ ಸಂಸ್ಥೆಗಳ ಹಾಗೂ ಇನ್ನಿತರ ಸಂಸ್ಥೆಗಳ ಸಹಾಯವನ್ನು ಪಡೆಯಬೇಕು.

- ಜನಗಣತಿ ಕಾರ್ಯಕರ್ತರ ತರಬೇತಿ; ವಾರ್ತ ಮತ್ತು ಪ್ರಚಾರ ಇಲಾಖೆ, ಪತ್ರಿಕೆ ಹಾಗೂ ಪ್ರಚಾರ ಮಾಧ್ಯಮಗಳಿಗಾಗಿ ಸಭೆಗಳನ್ನು ಏರ್ಪಡಿಸುವ ಸಲುವಾಗಿ, ಹಚ್ಚುವರಿ ಹಣವನ್ನು ಕಾಯ್ದಿರಿಸಬೇಕು.

- ಭಿತ್ತಿ ಪತ್ರಗಳನ್ನು ಹಂಚುವುದರ ಮೂಲಕ ಹಾಗೂ ಸಭೆಗಳನ್ನು ಕರೆಯುವುದರ ಮೂಲಕ, ಕೇಂದ್ರ ಹಾಗೂ ರಾಜ್ಯ ಸರ್ಕಾರಗಳ ಎಲ್ಲ ಇಲಾಖೆಗಳಿಗೂ, ಅಂಗವಿಕಲತೆಯ ಬಗ್ಗೆಯ ಮಾಹಿತಿ ಸಂಗ್ರಹಣೆಯ ಕಾರ್ಯ, ಈ ಜನಗಣತಿಯಲ್ಲಿ ಸೇರ್ಪಡೆಯಾಗಿರುವ ವಿಷಯ ತಿಳಿಯುವಂತೆ ನೋಡಿಕೊಳ್ಳಬೇಕು. ಇದನ್ನು ಹಳ್ಳಿಯ ಪಂಚಾಯತಿಗಳಲ್ಲಿ ಇರುವ ಪ್ರತಿನಿಧಿಗಳಿಗೂ ತಿಳಿಯುವಂತೆ ವ್ಯವಸ್ಥೆ ಮಾಡಬೇಕು.

- ಡಿಸೆಂಬರ್‌ನಲ್ಲಿ "ಅಂತರಾಷ್ಟ್ರೀಯ ಅಂಗವಿಕಲರ" ದಿನಾಚರಣೆಯನ್ನು ಮಾಡಲಾಗುತ್ತದೆ. ಈ ಜನಗಣತಿ ಕಾರ್ಯದಲ್ಲಿ ತೊಡಗಿರುವವರ ಸಂಪೂರ್ಣ ಭಾಗವಹಿಸುವಿಕೆ ಇರುವಂತೆ, ದೇಶದ ಎಲ್ಲೆಡೆ, ಪಂಚಾಯತಿ ಟ್ಟದಲ್ಲಿ ಸಮುದಾಯ ಶಿಕ್ಷಣ ಸಭೆಗಳನ್ನು, ಡಿಸೆಂಬರ್ ಮೊದಲನೆಯ ವಾರದಲ್ಲಿ ನಡೆಸಬೇಕು.

- ಮುಂಬರುವ ಜನಗಣತಿಯಲ್ಲಿ ಅಂಗವಿಕಲತೆಯ ಮಾಹಿತಿ ಸೇರ್ಪಡೆಯ ಬಗ್ಗೆ, ಸಂದೇಶವನ್ನು ಸಾರುವ ವಾಕ್ಯಗಳನ್ನು ಜನವರಿ ೨೦೦೧ ಹಾಗೂ ಫೆಬ್ರವರಿ ಆರಂಭದಲ್ಲಿ ಉಪಯೋಗಿಸುವ ಪೋಸ್ಟ್‌ಕಾರ್ಡ್, ಒಳನಾಡು ಅಂಚೆ ಪತ್ರ (Inland letter) ಗಳ ಮೇಲೆ ಮುದ್ರಿಸುವಂತೆ ಅಂಚೆ ಇಲಾಖೆಯನ್ನು ಕೋರಬೇಕು.

ಅಂಗವಿಕಲತೆ ಇರುವ ವ್ಯಕ್ತಿಗಳಿಗೆ ಇದು ಒಂದು ಒಳ್ಳೆಯ ಅವಕಾಶ

ಈ ಕಾರ್ಯಚರಣೆಯಲ್ಲಿ ಪಾಲುದಾರರಾದ ಸರ್ಕಾರ, ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು, ಅಂಗವಿಕಲರ ಅಭಿವೃದ್ಧಿ ಸಂಸ್ಥೆಗಳು, ಹಾಗೂ ಇದರೊಂದಿಗೆ ಇಡೀ ಸಮುದಾಯ, ಸರಿಯಾದ ಮಾಹಿತಿಯನ್ನು ನೀಡಿ, ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸುವ ಮೂಲಕ, ಯಶಸ್ವಿಯಾಗಲು ಸಾಧ್ಯ..

ಪೃಥ್ವೀಶ್ ಎಸ್.
ಸಂಯೋಜಕರು
ಅಂಗವಿಕಲತೆ ತರಬೇತಿ ಮತ್ತು ಸಂಶೋಧನಾ ವಿಭಾಗ
ನಂ 3, ರೆಸ್ಟ್ ಹೌಸ್ ರೋಡ್
ಬೆಂಗಳೂರು - 560 001

ಹರ್ಷ್ ಮಂದಿರ್
ರಾಷ್ಟ್ರೀಯ ನಿರ್ದೇಶಕರು
ಆಕ್ಷನ್ ಏಡ್ ಸಂಸ್ಥೆ
ನಂ 1, ಉದಯ ಪಾರ್ಕ್
ನವದೆಹಲಿ

ಕೃತಜ್ಞತೆಗಳು

ಇದು ದಾವಣಗೆರೆಯಲ್ಲಿ ನವೆಂಬರ್ 26 ಮತ್ತು 27, 2000 ದಲ್ಲಿ ನಡೆದ ಜನಾರೋಗ್ಯ ಸಭೆಯಲ್ಲಿ ಚರ್ಚಿಸಿದ ವಿಷಯಗಳಲ್ಲಿ ಒಂದು. ಬೆಂಗಳೂರಿನ ಅಪರ್ಣ ಅವರು ಈ ಕರೆಯನ್ನು ಕನ್ನಡಕ್ಕೆ ಭಾಷಾಂತರಿಸಿ ಉಪಕಾರಿಗಳಾಗಿದ್ದಾರೆ. ಹಾಗೂ ಭಾರತೀಯ ಜ್ಞಾನ ವಿಜ್ಞಾನ ಸಮಿತಿಯವರು (ಬಿಜಿವಿಎಸ್) ಈ ವಿಷಯದ ಚರ್ಚೆಗೆ ವಿಶೇಷವಾದ ಅವಕಾಶವನ್ನು ಮಾಡಿಕೊಟ್ಟರುತ್ತಾರೆ.

INDEBTEDNESS - AND ILL HEALTH

A. **HOUSEHOLD ILL HEALTH** → **INDEBTEDNESS** → **POVERTY CYCLE**

PUBLIC SECTOR MEDICAL/ HEALTH CARE → **POVERTY ALLEVIATING EFFECT**

B. **NATIONAL / INTERNATIONAL DEBT**

- **Lowered Life Expectancy**
- **Debt Repayment 3-4 times health expenditure**

(BMA, 2000)

INDEBTEDNESS - AND ILL HEALTH (Contd.)

C. **NET RESOURCE TRANSFER $ 2000 billion**

From Poor to industrialized countries (UNICEF 1999)

D. **IMPACT OF SAPS**

- **Unemployment**
- **Shift to informal sector without social security**
- **User charges**
- **Downsized Public Social Sector**
- **Reduced access to care**
- **Lowered nutrition status, nutrition insecurity**

BRIDGING IMPLEMENTATION GAPS IN PUBLIC POLICY

1. GOOD, HUMANE GOVERNANCE

   with local governance systems

2. LEADERSHIP

   at different levels

3. MANAGEMENT

   of human and financial reserves, with accountability, transparency

4. STRENGTHEN CAPACITIES, FOSTER HUMANE ATTITUDES, RELATIONSHIPS

   AT INTERFACE BETWEEN PEOPLE, PATIENTS and PROVIDERS

5. INVOLVE WOMEN, NGOs, Stakeholders

INDIGENOUS SYSTEMS OF MEDICINE AND HEALING TRADITIONS

MODERN MEDICINE

- SCIENCE AND TECHNOLOGY BASED
- INDUSTRIAL AND COMMERCIAL LINKS

INDIGENOUS SYSTEMS

- LOCAL HEALTH AND CARING TRADITIONS
- TRADITIONAL KNOWLEDGE BASED
- SELF RELIANCE
- LOCAL CONTROL
- COMMUNITY RIGHTS

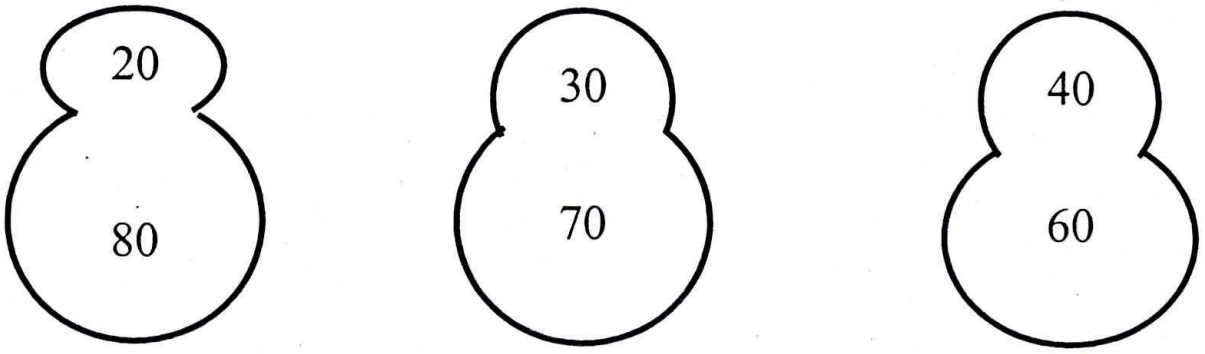
RECOGNITION

- **Involvement in Health Planning and Programmes**
- **Increased Budgetary, Legal and Institutional Support**
- **Openness to Different World views, Philosophies, Approaches**

COMMUNITY INVOLVEMENT

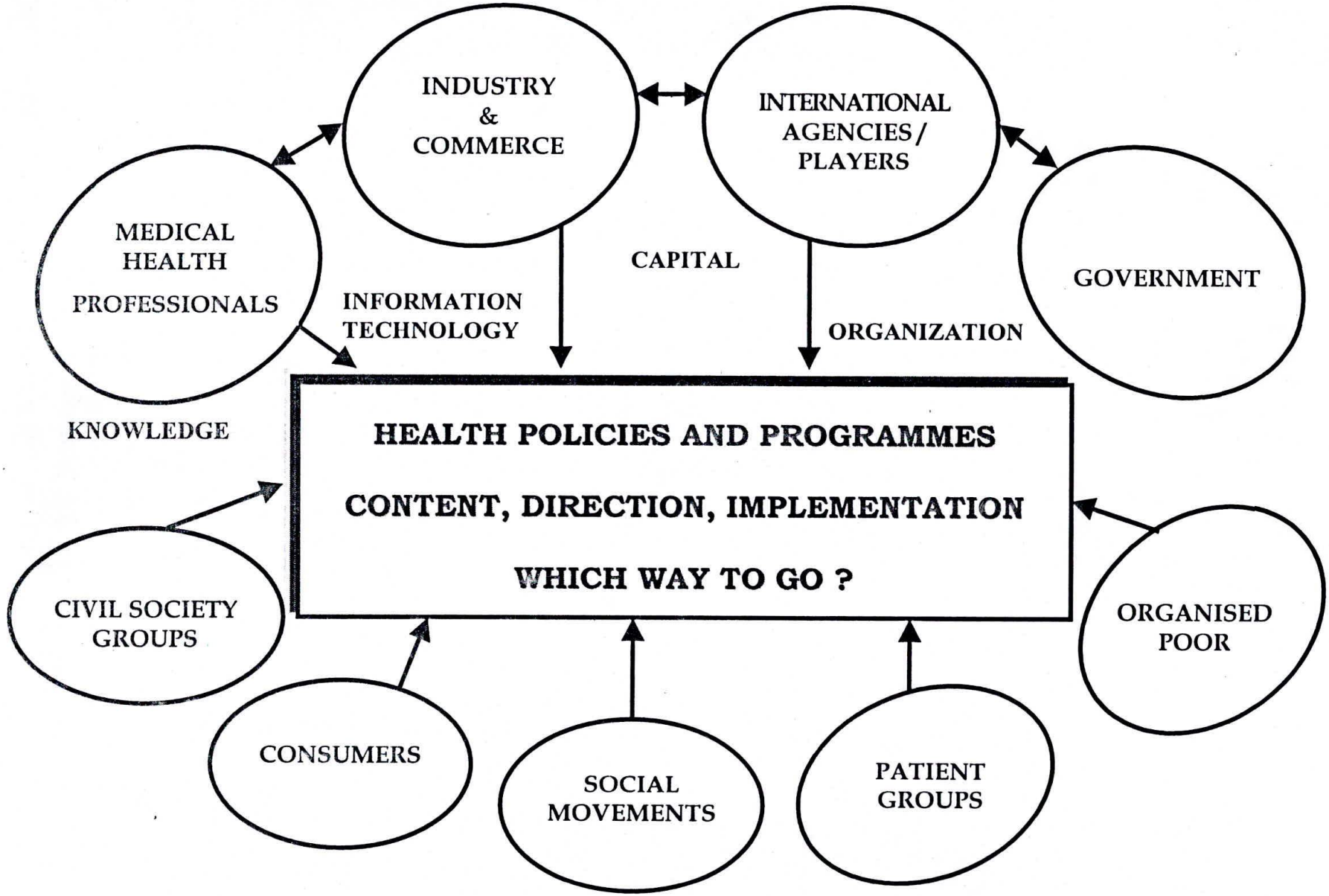
THE POOR

SOCIAL MINORITY OR SOCIAL MAJORITY



DOES IT 'MAKE A DIFFERENCE'?

WHO DECIDES, ANYWAY?


INDUSTRY & COMMERCE
INTERNATIONAL AGENCIES / PLAYERS
MEDICAL HEALTH PROFESSIONALS
GOVERNMENT
CAPITAL
INFORMATION TECHNOLOGY
ORGANIZATION
KNOWLEDGE
HEALTH POLICIES AND PROGRAMMES
CONTENT, DIRECTION, IMPLEMENTATION
WHICH WAY TO GO ?
CIVIL SOCIETY GROUPS
ORGANISED POOR
CONSUMERS
SOCIAL MOVEMENTS
PATIENT GROUPS

REACHING THE POOR

MEDICAL CARE

DOCTORS

DIAGNOSTICS

DRUGS

HIGH TECH

HIGH COST

HEALTH CARE
PUBLIC HEALTH
COMMUNITY HEALTH, HEALTH PROMOTION, PREVENTION, CURE & REHABILITATION.
PRIMARY HEALTH CARE
DETERMINANTS OF HEALTH

- NUTRITION
- SAFE WATER
- SANITATION
- CLEAN AIR
- HOUSING
- EMPLOYMENT/LIVELIHOOD

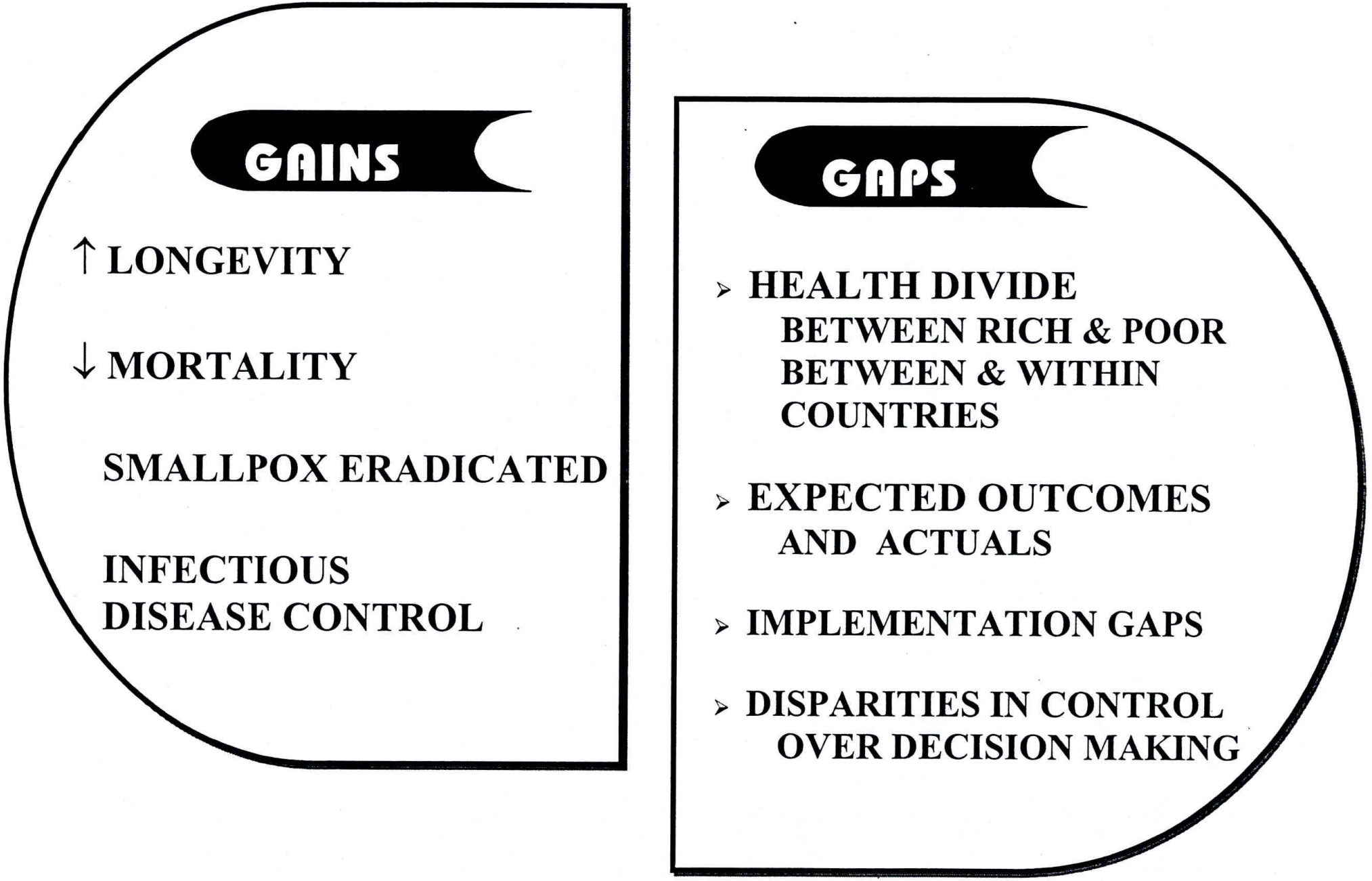
- **Which inputs have greater gain?**
- **How do governments, international agencies and donors prioritize?**
- **How are resources distributed?**
- **Why did we abandon intersectoral coordination and the primary health care approach?**

A PRESCRIPTION FOR ATTAINING THE HEALTH FOR ALL GOAL

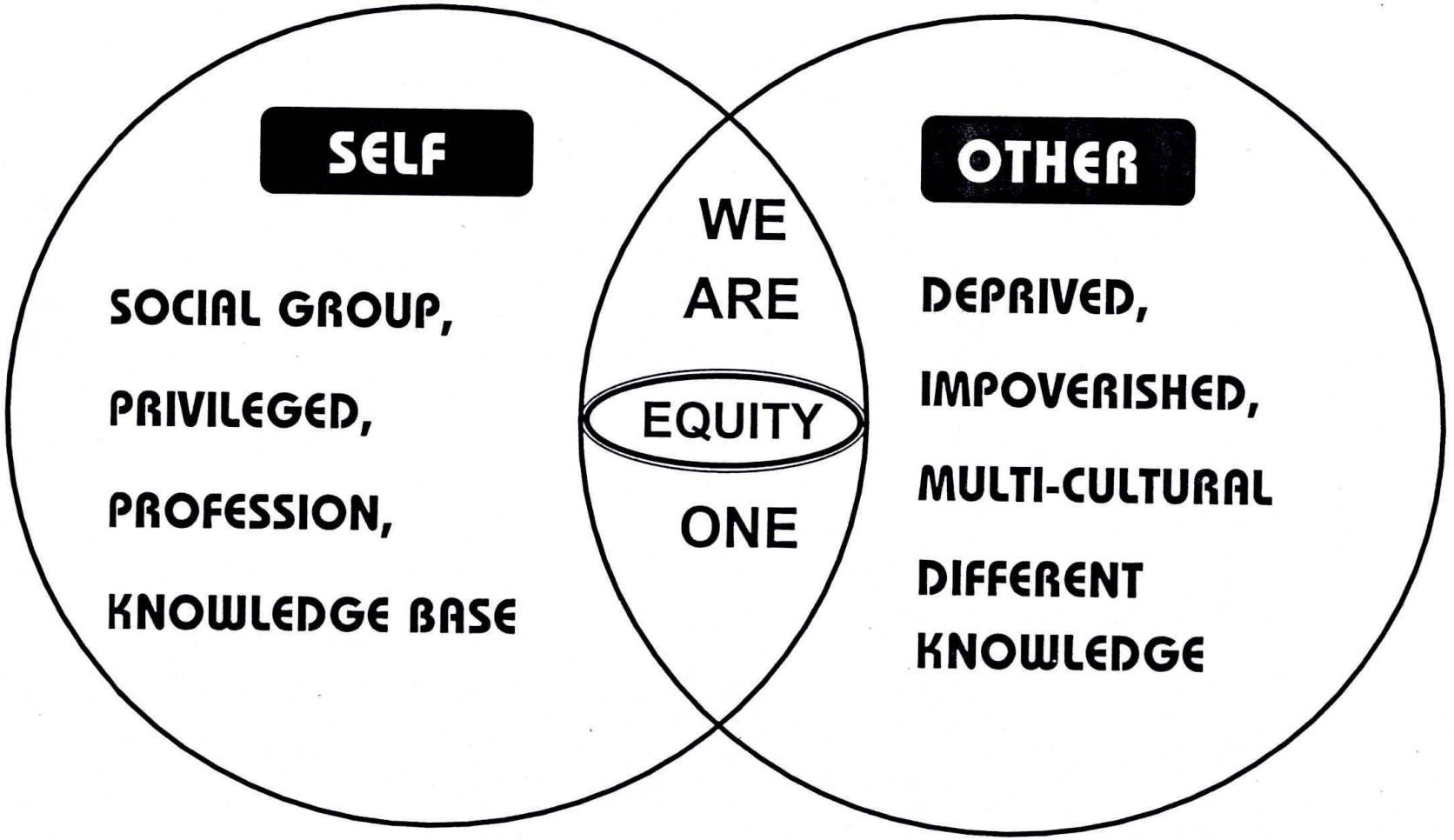
A MASS MOVEMENT TO

- REDUCE POVERTY, INEQUALITY AND SPREAD EDUCATION
- ORGANISE THE POOR AND UNDERPRIVILEGED TO FIGHT FOR THEIR BASIC RIGHTS.
- MOVE AWAY FROM COUNTER – PRODUCTIVE CONSUMERIST WESTERN MODEL OF HEALTH CARE, AND REPLACE IT BY AN ALTERNATIVE BASED IN THE COMMUNITY.

BY
Indian Council of Social Sciences Research (ICSSR), and
Indian Council of Medical Research (ICMR), 1981


GAINS
↑ LONGEVITY
↓ MORTALITY
SMALLPOX ERADICATED
INFECTIOUS DISEASE CONTROL
GAPS
➢ HEALTH DIVIDE BETWEEN RICH & POOR BETWEEN & WITHIN COUNTRIES
➢ EXPECTED OUTCOMES AND ACTUALS
➢ IMPLEMENTATION GAPS
➢ DISPARITIES IN CONTROL OVER DECISION MAKING

RE - VISIONED RELATIONSHIPS



SHIFT

ATTENTION, ANALYSIS AND ACTION

FROM

REACHING THE POOR AND DISADVANTAGED THROUGH CHARITY, WELFARE, AND EXTENSION OF EXISTING PARADIGMS.

TO

ADDRESSING POVERTY, INEQUALITY AND HEALTH, SOCIETAL AND BEHAVIORAL PROCESSES.

STRATEGIC APPROACHES TO IMPROVED HEALTH FOR THE POOR

- Promoting Indigenous systems of Medicine and Healing Traditions
- Fostering Community Involvement, using the Primary Health Care Approach
- Bridging Implementation Gaps
- Addressing Political Process & Power
- Preventing Distortions due to Privatization
- Responding to Indebtedness and Ill-health.

PREVENTING DISTORTIONS DUE TO PRIVATISATION

POLICIES PROMOTING PRIVATE FOR PROFIT SECTOR & PUBLIC – PRIVATE MIX

- COST EFFECTIVENESS, QUALITY OF PRIVATE MEDICAL CARE
- PRIVATE SECTOR ROLE IN HEALTH PROMOTION, PREVENTION, REHABILITATION
- WILLINGNESS VS. ABILITY TO PAY
- ECONOMIC CONSEQUENCES

- ACCESS – GEOGRAPHICAL & ECONOMIC
- EQUITY
- EVIDENCE BASE AND ETHICS OF SUCH POLICIES
- WTO IMPACT – RISING COSTS OF DRUGS AND MEDICAL CARE, NEW DEVELOPMENTS OUT OF REACH OF POOR

- REASSERTING ROLE OF THE STATE
- RECOGNISING ROLE OF COMMUNITIES, CIVIL SOCIETY, NGOs, VOLUNTARY SECTOR
- QUALITY ASSURANCE & ACCREDITATION OF PRIVATE SECTOR

State population to cross 5.33 crore by year-end

By Anupama GS

Bangalore, Oct 12: On Tuesday, e World population crossed the six billion mark.

In Karnataka, the population is poised to cross 5.33 crore by the year-end, as compared to 5.22 crore in 1998. And by the end of 2000, it is expected to exceed 5.45 crore.

All this, because very few people in the State believe in practising birth control, according to a study. This is especially true of backward districts in the Hyderabad-Karnatak area.

As per the study, only about 30 per cent of people of the Hyderabad-Karnataka region use contraceptives though the average rate of acceptance of contraceptives in the State is about 60 per cent. The Hyderabad-Karnataka region incl Gulbarga, Bidar, Bijapur, Raichur, Koppal and Bellary districts.

The survey titled *The study of Family Welfare Performance in Karnataka* was conducted by the Population Research Centre of the Institute for Social and Economic Change (ISEC).

According to Prof P Bheemarayappa of the Centre, the low rate of acceptance of contraceptives in the region was in tune with development indicators. "Karnataka's peculiarity lies in its regional variations and imbalances. In the North-Karnataka region, population has continued to grow rapidly, people are resistant towards the use of contraceptives, immunisation and the age of a girl's marriage is still very low," he said.

Projected district-wise population

DISTRICT	1999	2000
Bangalore	65,21,000	67,70,000
Bangalore(R)	18,80,000	19,08,000
Chitradurga	15,52,000	15,86,000
Davangere	18,88,000	19,35,000
Kolar	25,21,000	25,62,000
Shimoga	16,41,000	16,67,000
Tumkur	26,49,000	26,97,000
Belgaum	41,45,000	42,21,000
Bijapur	18,21,000	18,60,000
Bagalkote	16,52,000	16,87,000
Dharwad	15,92,000	16,22,000
Gadag	9,97,000	10,16,000
Haveri	14,77,000	15,04,000
Uttar Kannada	13,59,000	13,78,000
Bellary	20,51,000	21,07,000
Bidar	15,44,000	15,84,000
Gulbarga	31,16,000	31,90,000
Raichur	17,13,000	17,65,000
Koppal	12,03,000	12,38,000
Chikmagalur	11,15,000	11,28,000
DakshinKannada	18,50,000	18,81,000
Udupi	11,75,000	11,90,000
Hassan	17,89,000	18,19,000
Kodagu	5,09,000	5,11,000
Mandya	18,65,000	18,95,000
Mysore	27,35,000	27,99,000
Chamrajnagar	10,33,000	10,55,000

The performance of the rest of the State including Bangalore, Chitradurga, Davanagere, Kolar, Shimoga, Tumkur, Belgaum, Bagalkot, Dharwad, Gadag, Haveri, Uttara Kannada, Chikmagalur, Dakshina Kannada, Udupi, Hassan, Kodagu, Mandya, Mysore and Chamarajanagar districts in practicing birth control measures was satisfactory, Bheemarayappa said.

The professor also pointed out that the study had revealed a few startling facts. "Though it is not a new trend, the study found that participation of men in birth control measures is very low, as low as one per cent. Women are sterilised and are forced to follow spacing methods. There is a need for an attitudinal change to involve men in the process", he said.

The Family Planning Association of India (FPAI) also voiced a similar opinion. "Something should be done to involve men in practicing birth control methods. In rural areas, it is pathetic to see women suffering for lack of adequate health care", FPAI-Karnataka branch Director Shanthi Baliga said.

The Director also wanted the Government and the political parties to take up the task of educating people on family planning.

Bheemarayappa emphasised the need for the Government to concentrate on the development of the Hyderabad-Karnataka region. "The Government should concentrate on all-round development. Patchy development of a State will result in regional imbalances and Karnataka is a perfect example of this", he said. The professor also suggested that the Government provide orientation to all the members of the State Assembly on family welfare.