Population Policy

What went wrong?

Devaki Jain
18th July 1994

Reply to Dr.Ashish Bose Indian Express 17th July 1994.

The issue at stake is not whether Devaki Jain does not understand Population Science or the English language; or did not have ideas; or whether Dr.M.S.Swaminathan is pro poor, pro woman, and pro nature. The issues are two:

one: the serious discriminatory effects of legislations which bar entry into powerful and elite positions and privileges such as elected positions, organised industry, official services to those who are poor, from soci culturally traditional categories hemmed in by economic and social insecurity. It will also hurt females as a whole as in son-preference cultures, 2-child formula will lead to killing of females till a son is born. Thus by applauding legal strictures, as in page 40 para 13.1,the expert group is launching an attack on the poor SC/ST women.

Two: By moving away from agreed approach which was ethical and practical - the energies of a whole community of organisations engaged in grassroot work will be turned from implementation to resistance.

If the document had stuck to the approach that in my view was agreed upon, then all the hands - offical, PRI, grassroot could have gone into action putting it on the ground. Instead it has now wasted nine months August - May of deliberations and consenus building. Further it has put the organisations working with the poor, and women who could have put a "decent" policy on the ground into taking adversantial roles; and put poor women and SCs & STs into a mode of defending themselves, - rather than enabling themselves.

It is not only tragic, it is reprehensible. Our verbal battles in newspapers are trival, against this great cost - namely loss of productive constructive time. This is my deepest anguish.

At a private level, there is of course anguish as persons like Dr.Ashish Bose, and even more Dr.M.S.Swaminathan are personal friends for about forty years and throughout the working of the group were the strongest supporters of the principles of justice, and the reasoning against a narrow approach, the approach of incentives/disincentives targets, legal sanctions.

Dr.Bose says I ceased to be a member of the group when I went abroad - and I am truly relieved to hear this. We could have completed the document before I left, if not for Dr.Bose. He and I were to bring complete drafts of the final document to an 'Akhand-Path' meeting in Delhi 29th - 30th Where we were to wrangle over our differences, smoothen the corners and bring out a final agreed draft for the Chairman and then the group. I did. He didn't.

Certainly if I was around in April-May, I would not have agreed to the inclusion of the objectionable paragraphs nor to the kind of analysis, emphasis and fragemented nature of the document.

The pity is that we had in fact a freshly designed, cogent and enlightened draft - even if it was in the form of inputs from members. We could have stayed with that and given ourselves the pride of place in India and abroad that we in India, with our ability to review and critique ourselves, can present to Parliament and Public a really just and practical policy on Population.

Here are some of the basic elements of our pre-May agreed approach;

(1) that population policy as a means of ensuring people's well being is not synonymous with Family Planning.

(2) emphasising macro-economic policies which ensure public expenditures to provide basic social and economic security.

(3) taking a non contraceptive approach to population size-reducing strategies: based on the principle of self-determination.

(4) making social and economic development a community based activity, articulated through the PRIs.

(5) providing health care as a basic service through a high quality wide spread net work of PHC's - thus merging the various health departments into an integrated service.

(6) making the birth control programme male addressed and all of this built around an understanding that poverty eradication was the firest step, and should be the single most important effort of the country - for moral and material reasons.

And here are the noxious paras; Page 40, Para 13.1

Rajasthan and Haryana have enacted laws which debar prospectively persons who do not adopt the two child norm from contesting elections for Panchayats, Zilla Parishads and Nagarapalikas. This reflects political commitment. Even if such legislation does not exist, there should be a code of conduct which enjoins on all elected representatives of the people, from parliament to panchayat, to adopt voluntarily the small family norm. Elected people's representatives will then become role models for the public to emulate. Future legislation in this area at central or state level should however safeguard the interests of women, particularly those belonging to the socially and economically underprivileged sections of society.

Devaki Jain/26th March

Draft

HP3:2

NATIONAL POPULATION POLICY

1. Introduction : Goals

1.1 Population is about people and their well-being. Whether populations are fast growing or slow growing, increasingly it is being seen as an issue that contains within it all the major concerns of the world today. The sustainability of economic growth, the relevance of life styles, consumption levels, the role of science and technology, the exercise of human rights; the participation of disadvantaged/subordinated groups in decision making and the quest for a just world order. Thus a policy on population offers the best framework for people-led social engineering for economic advancement; with the strong underpinning of ecological sustainability.

Purpose of population policies is not just family limitation or survival but a satisfactory quality of life for all (MSS)

1.2 The policy will be such that all three elements of nation building will be incorporated.

- a pattern of economic growth which is enabling namely

provides livelihood and food security to the poor and safeguards the natural resources base and the environment.

- a pattern of social development which builds bridges across divides based on class, caste and gender, regional imbalances and urban - rural divides.

- and a pattern of political management which responds to the aspirations of the neglected communities and unreached groups and respects our deeply in-grained principles of democracy.

1.3 It will based on an understanding of poverty and within it poor women, the characteristics of their life situation, their deprivations and capabilities.

It also has to shed any myths and prejudices such as that ignorance and superstition are responsible for large families, that therefore the poor especially women have to be "motivated" through reward and punishment, and scares like the Malthusian argument or the population bomb; or its reverse - that a small family is a happy family, and that money can buy or more aptly dry reproductive capacity.

1.4 Thus [NPP (or the Population Policy)/ or "it is"/recommended that] recommend investment in social and economic security services for the poor as the key to reach the goal of peoples well being, balancing people with resources.

1.5 Today's concerns in Population policy recognises the economic interdependence between macro and micro, and within that the organisation of production and trade and social and political organisation. Social organisation has to take note of individual, family, household and societal, - aspirations and political organisation support self-government with a strong place for the interest of women and other subordinated groups.

1.6 Today's concern is for <u>women's</u> role in decision making not only within the family but also in other arenas of public policy. Not involving women enough in the planning and implementation process has been responsible for distortions and wastage of efforts.

1.7 It is for <u>method</u> more than goal - (the Gandhian approach), that means are as important as ends, means determine ends. This moral approach has gained new legitimacy as it is being found to be more efficient, in that self determined and self designed programmes through being more appropriate, have built in the strength for effective implementation. Thus community based programmes, programmes which begin with local involvement, response to a locally articulated issue; - institutions which bring together self interest group, like rural youth in sports clubs are being found effective.

1.8 It is for youth - especially the adolescent girls and boys, their well being, their knowledge and their aspirations, their sense of security. Following the SAARC region's theme of the girl child population policy recommends rearranging public policy to provide the girl child with security : with food and education, her parents with livelihoods and institutional mechanisms to safeguard their interests - whether disadvantaged because of gender, caste or class.

1.9 It is for moving out of targeting birth control , the demographic approach to user - induced responses, to choice free of coercion.

The adoption of a small family norm with a consequent decline in total fertility should not be viewed only in demographic terms. It means that people, and particularly women, are empowered to take control of their fertility and the planning of their lives. Information and education using all the products of the information age are important for promoting a change in the mind set of the society. The concept of equity has to be extended to the generations yet to be born, i.e. inter-generational equity.(MSS)

A shift from a contraceptive approach to concurrent and integrated attention to services, technologies and government policies, with a view to providing the substrate conditions essential for success. Diversity in culture, language

and religion and national assets. It is important that amidst this diversity, there is unity of purpose in achieving a balance between population and natural resources, particularly land and water and equity in gender and economic terms. (MSS)

1.10 It is for emphasising the greater participation of men and for the strengthening of techniques to be available to men and male youth and not only to mothers and girls.

1.11 It emphasises linkages in delivery of development impulses, to other service programmes; to social & political institutions - not only institutions of self-government but corporate, worker, cooperative, technnical, social & cultural organisations.

2. India's Experience - Positive aspects

2.1 The Indian political and development environment offers an unusually creative opportunity for putting on the ground the kind of wholesome population policy that is suggested in the global, and regional discourse on population and development.

2.2 The traditional democratic framework, multi-party system and freedom of association and speech has encouraged free and frank debate on population policy and programmes between government and the "public" as well as between various interest groups. Further from the very beginning there has been freedom for women to choose to intercept birth - the right to abortion, MTP etc. Anti poverty programmes have been another feature of the development policy, - targetted programmes of food and work especially for the below poverty households and further within them special programmes for the women.

2.3 Indian experience in improving the quality of life of the people, equity building and population stabilisation provides a rich basket of ideas and practices for the new directions/for the future.

2.4 Between 1951-61 to 1992, there has been a dramatic, approximately 50% fall in death rate (22.8 to 10); in infant mor-

tality rate (IMR) a 30% fall from 110 p.1000 to 79. Crude Birth Rate (CBR) has shown a fall of 25% from 41.7 to 29.0, and TFR has also fallen by about 40% from 5.97 to 3.6.

2.5 There has been a remarkable increase in life expectancy, one of the most widely used quality of life indices, from 32 to 58.6.

2.6 There are significant variations between States, and between rural and urban areas. States like Kerala and Tamil Nadu, with crude birth rates of 17.5 and 20.7 in 1992 respectively, have performed very well. On the other hand, the crude birth rates in Assam (30.6), Bihar (32.2), Haryana (31.9), Madhya Pradesh (34.4), Rajasthan (34.7) and Uttar Pradesh (36.2) are higher than the national average of 29.0 per thousand population in 1992. Similar inter-State variations are seen in respect of the infant mortality rates. Kerala has an IMR of only 17 per thousand live births whereas it is as high as 104 in Madhya Pradesh and 114 in Orissa. Total fertility rates in Bihar (4.4), Haryana (4.0) Madhya Pradesh (4.6), Rajasthan (4.6) and Uttar Pradesh (5.1) are significantly higher than the all-India average of 3.6 (SRS 1991).

2.7 The Fertility Rate is lower in urban areas than in rural areas. In Urban India with a total population of over 217 million, the total fertility rate has declined to 2.7 in 1991.

2.8 Kerala State with a population of 29 million in 1991 has already achieved a total fertility rate of 2.0; and allowing for mortality, its fertility has dropped below the replacement level. In other words, its NRR is below 1, with an infant mortality rate of below 20 and a life expectancy at birth of over 70 years. The state Goa with a small population of 1.2 million in1991 has also achieved a below-replacement level of fertility along with low mortality. In Tamil Nadu state with a population of nearly 56 million in 1991, the TFR in 1990 was 2.5, the gross reproduction rate was 1.2 and with an infant mortality rate of 67, the NRR was 1.0.

2.9 The long-term goal of the country is to achieve a total fertility rate of about 2.1, with an infant mortality rate of below 60 and a crude birth rate of 21 and a crude death rate of 12 per thousand.

.10 These changes are significant achievements and reflect the effort made in all directions : the thrust towards poverty removal; investment in infrastructure economic and social, the spread of extension services, as well as diffusion of information, and the role of institutions, social and economic and political including the role of non governmental organisations.

2.11 What this experience reveals is that the goals of policy, can be reached through the democratic process namely without coercion. That the "routes" of approaches need not be the same in every place. That a supportive environment of improved social amenities, information about them, education and capability to access them, a hope of economic security and a sense of equality between people, especially classes and sexes is the critical mass for people to voluntary opt for smaller families.

2.12 However in India there is widespread recognition that these approaches, though legitimate in themselves have not delivered the results - either in removal of poverty and hunger, or improving the social quality of life.

2.13 The Government and civic society in their search for more effective approaches have recognised that there is need to provide the framework for an even more democratic method of economic and social development - and this has led to the 73rd & 74th Amendment to the Constitution which mandates elected bodies at the sub district and district level with 33-1/3% reservation of seats for women.

2.14 This administrative and political framework will provide the space to reflect and accommodate the heterogeneity of Indian society and the Indian economy - regional diversity, apart from ethnic and religious diversity. It will also provide what is critical in any quest for justice within unequal

societies and relationships, namely a system of redressal, which in turn depends on accountability. In a multi party system with periodical national and subnational elections the power to remove from power, that is offered through regular elections provides the best instrument for such redressal.

2.15 Indian development planning has also been built on the concept of area planning - the geographical area, the product area as in silk, or dairy; wheat or sugarcane, or the social backwardness of area. By using area planning with the power to design, given to a locally elected body, many of the needs of inter-sectoral balance, inter-sectoral dependence, or integration, plus heterogeneity of base, culture and opportunity can be accommodated.

2.16 A number of NGOs undertaking innovative community-based programmes specifically targetted to the poor and disadvantaged, have demonstrated dramatic reductions in fertility and mortality.

2.17 The experience of health service provision through NGOs is often cited as an example of correct approaches. The point to be emphasized here is that these programmes have been successful because they have had an organic growth and have not been preconceived programmes. It is likely that the specifity of each successful approach makes it less replicable; but the lesson to be drawn is precisely that we need a

system that permits and contains diversity. It is also worth emphasizing that a programmes which is "handed over" to an NGO for implementation is missing out on the first and necessary condition, that the programmes be developed from bottom up.

2.18 An important lesson that the NGO experience has to offer is that social change, especially where it affects gender, class and caste groups is a slow process and must be approached gradually. While grassroot NGO experiments have not led to major monolithic movements in people's participation and self-reliance and the voluntary sector cannot hope to play a major quantitative role in the national scene, the relative advantage of NGOs has been in the qualitative field by providing a test-bed for new ideas and methodologies and a sounding board for government policies and programmes (Sundar, 1993)

2.19 The experience of NGOs has also drawn attention to the importance of quality of care in the design and implementation of programmes. NGO experience shows that attention to quality of services, particularly from the perspective of the user, can significantly enhance service utilization. The focus of government programmes has largely been on service delivery and on the service provider. The user's perspective has not received much attention in government programmes. Quality of care issues from the user's perspective, have yet to be understood, particularly by those

involved in policy formulation and programme implementation in the public sector (Pachauri, 1993).

2.20 NGO's have recorded the fact that women generally do not wish for larger families but are coerced by social custom and the blind preference for sons. Such coercion can only be countered when safe motherhood, child survival and gender justice prevail. Male involvement in family planning is a desideratum but remains at a low level due to attitudes, and also to the fact that there are fewer male contraceptive choices. The popularisation of the condom may raise that level, especially as protection against diseases and AIDS, but male attitudes and behaviour still remain rooted in backward traditions and a disavowal of women as equal partners.

3. INDIAN EXPERIENCE - Negative Aspects

3.1 Evaluations and studies that not only assess the programmes especially as they affect womens' fertility and health - but also analyse the links between changes in the birth rate, in fertility and variables such as income, education, autonomy and so on seem to converge in the view that the approaches and the programmes have not been able to engineer population stabilisation evenly and wholesomely in a sustainable manner.

3.2 Reasons for this lack of success can be divided into two classes; one, those internal to family planning and health programmes and two, those external to it even if deeply connected to it.

3.3 Internal: One important reason is traced to the delivery systems - the instruments used such as the institutional arrangements at the ground level, the PHC, the MCH outposts, the functionary, namely the ANM and so on.

The method: that the programme is cut off from other programmes addressed to the same client group. That there is no commitment to local needs, conditions : no participation of "users" - etc.

The technologies and the way they are provided and of course the basic flaw of target setting in contraceptive use/and cover : and implicit coercion & corruption in offering incentives and disincentives

3.4 External : The inadequacy of public investment in provision of basic amenities including food and livelihood security : such as elementary education, primary health, apart from reduction in inequality of access to moving assets.

3.5 The population of India is expected to cross the one billion mark by 2001 as per the projections made by the Standing Committee of Experts on Population Projections. The Committee also estimated that the population of the country would be about 1082 million in 2006.

3.6 India's population rose from 36.1 million in 1951, when the planned development effort started, to 846.3 million as per the 1991 Census. On 2.4 per cent of the world's land area, India supports more than 16 per cent of the world's population, and the population is increasing by about 17 million every year. The growth of population has gathered momentum in the last few decades. However, the average annual exponential growth rate has fallen, for the first time after Independence in 1947m, to 2.14 per cent, during 1981-91. Data gathered annually on sample basis also show a decrease in the annual natural increase rate, to 1.90 per cent in 1992. The sex ratio stood at 1079 males per 1000 females in 1991. 37 per cent of the population was aged below 14 years and 6.6 per cent is currently estimated to be over 60 years of age. The death rate is estimated to be 10 and birth rate 29. The Infant Mortality Rate (IMR) is estimated to be 79 per thousand live births in 1992 and Total Fertility Rate (TFR) 3.6 in 1991.

3.7 The country has the dubious distinction of being the first in the world in terms of the absolute number of persons added to its population each year.

3.8 The country has also the unenviable position of being one with a very unfavourable sex ratio (929 females : 1000 men - 1991 census).

3.9 The current patterns of development are first, enhancing the rich-poor divide, with increasing marginalisation of the poor, second joblessness is increasing, i.e. jobless economic growth, third, damage to the life support system of land, water, flora and fauna and the atmosphere is increasing and fourth, there is growing violence in the human heart leading to a situation where there is disproportionate attention to the security of a few than to the misery of the many. (MSS)

3.10 The national level of IMR and female literacy and the inter-state differences in them are high and need attention. If the birthrate does not drop simultaneously, the rate of natural increase in population can rise above the 1.9 per cent reported for 1992. (MSS)

4. Women & Population/or Women-led approach/gender dimensions

1. It is now widely recognised(or recognising that) the wide disparities between men and women in all the key indices of well being and progress - starting with Nutrition through death, to wage rates - inhibits the capability of women to freely make their own reproductive choice, to adopt and access the services. It is recommended that this gap has to be bridged and this bridging requires special attention to reach females from birth to death with the services in specially designed and funded packages.

2. However, this is not enough. Nor it is always perceived in ways which lead to autonomy. Women must be perceived as active agents in leadership and change in the spheres of production & trade as well as social & political spheres. They must be recognised as holding views on the definition and goals of a population policy; on its practice and programme and not only as recepients of social, economic and political services.

3. Poor women, as also other women, want to have reproductive freedom, the power to make their reproductive choice, want the well being of their families and themselves, freedom from the "drudgery" of child bearing (and would like to limit their family size). It must be recognised that the women are best equipped to determine the elements and the instruments of a programmes that helps them towards this goal.

4. Women's groups, formal as in Mahila Mandals, and in Panchayats; informal as in non-governmental organisations, - whether joined together for economic or social purpose, are the most effective and sensitive vehicles for safeguarding women's interest in developing and implementing a reproductive health and fertility management programmes.

5. Gender relations,or the distribution of power between men and women in a society and particularly within a family is is a critical factor in enabling women's status. It is now well established that women's access to decision making and capability to exercise her interest in the social group has strong links to social well being, especially reproductive health and choice.

6. It is also recognised that where there is a measure of equality between men and women, whether because of equality in education and income (Kerala) or culture and custom (tribal communities) or because the programmes have been equally directed to the two sexes, - fertility has shown a greater and more sustainable decline.

7. This reduction of the inequality between the sexes, or sometimes the presence of a more equitable distribution of power between the sexes is in turn traced to education, income, entitlement to resources and also the prevailing culture. Processes that lead to this situation where women have a control over their lives, is called empowerment. Empower-

ment leads to reorganisation of the productive and reproductive roles not only within the family, but also within the society.

8. It is recognised that there is a need to address men not only through health extension, not only through IEC and social marketing of contraceptives, but to enable men to and understand and accommodate their role in fertility management, its psychological and social implications. It is increasingly being recognised that decisions on reproduction, whether taken by the male or the female have implications for self image and status, according to the cultural and the economic context. Thus extension work has to address itself to these implications if it wishes to have durable effect.

9. Another important recognition is the need to address the programmes to the whole life cycle of the woman, (and the man) especially at the stage of child and adolescent - and not only at the reproductive age.

Attending to the women only at the MCH stage often is too late even from the limited goal of family size apart from the more humane goal of wellbeing. For example most of the irreversible contraception used by women has been of women over 30 years with already 3.6 children.

10. From the conception of a girl in the womb to her death there are many threats both to life itself and to health. This

discrimination affects not only health status but power relations, the ability to take decisions, to negotiate and protect herself.

Thus today the concern is for the HARDSHIP that women suffer, from birth to death, through undernutrition, early marriage, unsafe child birth and inadequate health services to follow up morbidity. Population policy thus addresses itself to women's wellbeing of which her entitlement to good health and the capability to choose her reproductive path becomes the critical mass.

11. Nutrition, food, and not only for pregnant and nursing mothers but for children, to build the base of a healthy body has been recognised as basic - whether one looks at it as a basic human right or a need. Thus Food Security has been closely linked to population issues and policies.

12. Education is another critical element that has been pointed out as having an impact in a variety of ways. Less educated, poor and physically exhausted mothers are likely to pass on poverty to their children, while better educated mothers is one of the key factors for improving the situation. Studies have shown that women with seven years or more of education tend to marry on average four years later, and have 2.2 fewer children statistically than women with no schooling.

13. Education levels out power between men and women both in and outside the household (In analysing Kerala, what is not

often emphasised is the equality in educational and wage levels between men and women.

14. But educating little girls also has major demands on the macro economic system. Poor little girls cannot go to school, unless they have not only the usually identified support of creches for their younger siblings, or also the other usually identified element, that is, better household income through higher wage for the adults but relief from time consuming domestic chores such as fetching water and fuel for the home.

15. The gender perspective on population policy then can be translated into the following recommendations, falling into 3 categories:

(A) Organisational

(B) Programme content

(C) Macro-imperatives

(A) Organisational:

16. Health and Family Planning to be seen as one subject namely health - both in Central government and in the new institutions of local self government i.e - one window for health. Health deliveries to be community derived and managed, with higher quality of services, client oriented, providers oriented towards integrating traditional wisdom into services. Health stations to be capable of dealing with males

and females from birth to death as with health education, especially information on the body and its care as part of the service.

This health package to be integrated to the Panchayat Raj Institutions with open ended guidelines. This approach will naturally build in the sensitivity to regional diversity in India. Differentiating both in expenditure and programme elements according to the situation of life and death in a particular place.

The government budget to provide the basic health service as part of Public Expenditure.

(B) Programme Content

17. i) Upgrading of primary health centres to have facilities including OTs, preventive curative and reproductive tract including SID treatment services.

Orienting of health providers to share information, to respond to clients - men & women.

Orienting IEC to strengthen knowledge base on health, reproductive health and contraceptives.

ii) Universalising elementary education - and also strengthening literacy drive both for Males and females. To enable girls to participate provide relief from the 3 -C's child care, from domestic chores

(water fuel fetching, cooking, cleaning), by provision of infant creches as a social basic amenity; making water and fuel accessible through intense investment in water, wood and other energy provision for domestic use on a crash programme scale.

18. Contraceptives & Birth control

Women's groups are of the view that :

a) there should be equal emphasis on birth control devices for men and women - in provision, promotion and research

b) that a wide range of safe contraceptives to be available - but safety ensured. The safety depends on quality of clinical services and information available to recipient. The health centres quality is key to contraceptive adoption

c) that education is to be on the understanding of the body, reproductive processes for men and women from early years.

19. Local level planning and implementation of Employment generation/livelihood safeguarding district and other local level Planning for full employment often requires:

a) safeguarding existing livelihood strategies, even more than generating "new" employment;

b) skill training/credit - markets.

These require both identification/advocacy and investment.

c) Food Security - not only the PDS and the nutrition programmes but hard core food production and export policies; land use, crop selection policies to be re-oriented for food security..

20.. (C) Accountability and Monitoring indices

The arrangements being designed for development management by the local self government bodies would provide accountability if the powers of supervision over teachers and health and other functionaries is given to these bodies. Further the elected representatives themselves would be accountable to the electorate on the basis of some performance indices. It has been suggested that these indices could be

- infant mortality especially female infant mortality
- Attendance at schools of students/ and teachers, especially girl students
- marriage registration and other basic needs should be goaled and the auditing of progress done both

publicly at the grama sabha as well at the Zilla Parishad and Mandal Panchayat meetings so that the representatives be held responsible for achievement of people's well being. This means a shift from CPR, IUD insertions etc as indices to indices of social progress.

21. It is noteworthy that India's decentralisation system 73rd & 74th Amendments) has recognised the crucial importance of women's active involvement in development. Combing as they do concerns for equity, economy and environment - they constitute a much needed and indispensible social force for development. The constitutional Amendment has grasped this fact and provided for a good start to generation of this social force.

22. One third of elected seats in Panchayats (which means about 10 lakh seats) have been reserved for women. This places them initially itself, in a vantage position (and in fairly good strength) to influence pattern and priorities of development. What is need are initiatives/programmes to strengthen the capability/resolve of women to influence decision - making processes in panchayats as well as enhance their (women's) self-confidence.

VI. Think Locally Act Globally

Reviews of population and development programmes, attempted in the past over three decades by the Planning Commission and independent researchers, have highlighted the following as the foremost necessary steps to convert past experience into capital for vastly improved and durable results in the future.

1. Accountable Local Institutions

The establishment of democratic decentralisation or panchayat institutions - which are accountable to the people and where the people have the choice to replace their representatives periodically - must be regarded as the first and the most important step. Their establishment will multiply decision-making centres which is the dire need of the hour for stimulating equitable and sustainable rural development. These institutions will provide for local participation and local contribution - imagination, ideas, information about local situation, priorities and most of all: stake in socio-economic advancement of their own area and population. A responsible role assigned to the local population would also improve the prospects of raising local resources and provide for better care of natural resources of soil, water, forests for sustainable growth.

The 73rd Amendment of the Constitution has now provided the basis and assurance that there will be an orderly network of

elected panchayats extending from village to block and the district levels with a harmonious division of functions.

Simultaneously, the 74th Amendment has mandated corresponding democratic institutional underpinning in the urban areas.

2. Micro-level planning and implementation

The Planning Commission's review of the working of population and other development programmes has also concluded the imperative need for micro level planning without which economic and social services which are vital from the population view point cannot be made to converge in a systematic and fruitful manner.

"Analysis clearly underscores the need of a decentralised, area specific district level planning based on critical and in-depth disaggragated analysis of a constellation of socio-biological indices." (Planning Commission, Dec. 1991).

Local area development plans, starting at the micro (village) level, should be the unit and basis of planning. For this, the present planning process which is top down must be re-modeled to accommodate and assimilate local area plans in the overall State/National plans. The integration of area plans with the State/National Plans is fundamental to the transference of poverty alleviation from the periphery to the core of national development strategy.

HP3:3

KITAKYUSHU FORUM ON ASIAN WOMEN
19-21 November, 1993

WOMEN-LED POPULATION POLICY

- AN ASIAN APPROACH

PANEL PRESENTATION

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Table of Contents

I	INTRODUCTION
II	THE INDIAN POPULATION PROBLEM
III	INDIAN DEMOGRAPHIC DIVERSITY : ITS LESSONS
IV	WOMEN'S AUTONOMY/STATUS
V	THE INDIAN DEBATE
VI	INDIAN WOMEN'S APPROACH
VII	THE NEED FOR SOLIDARITY

List of Tables

Tables from Pravin Visaria's paper - "A Population Policy of India : A draft for facilitating discussion.

Figure 1	:	Crude birth and death rate, India, 1901-1990.
Figure 2	:	Couple protection rate by method, All India : 1971-1991
Figure 3	:	Age specific fertility rates for India, 1970-1990
Figure 4	:	Literacy rates by broad age groups in India, 1961 to 1987-88.

Annexure and Tables from T.V. Antony's paper " The Family Planning Programme : Lessons from Tamil Nadu's Experience.

Annexure	1:	Select indicators influencing birth rate of some major states of India.
Table	1:	Vital rates for Tamil Nadu.
Figure	5:	Trend in Infant Mortality Rate in Tamil Nadu.
Figure	6:	Trend in birth rate in Tamil Nadu.

I INTRODUCTION : THE IMPORTANCE OF THIS MEETING

This can be a very significant meeting because :

a) It gives Asians an opportunity to address the world with an Asian approach.

Asia is the fastest growing economic region in the world today. Asia is also "culturally" self confident and holds the largest population mass.

b) It gives Asian women an opportunity to go beyond the visible data information streams and analysis, and develop serious and useful policy and programmes to basically make women, especially the poorer, low access to - service women more comfortable on what is called <u>population issues</u>

Japan is the largest donor to UNFPA.

c) The world conference on Population and Development is very near : Sept. 94, Cairo.

e) It gives an opportunity for Japan <u>to provide leadership in the field of Population</u>, Development and Environment.

This conference can begin the process of :

a) Bringing Asian women into a focussed platform of solidarity. The SAARC (South Asian Association for Regional Cooperation) is holding a meeting on <u>Women and Family health</u> in Katmandu, Nov. 22 - We could "connect" with this.

b) Using the solidarity to influence the approach to Population, Development, and Environment at the general level i.e. <u>not</u> only gender specific level - and provide an Asian approach and in turn,

c) Influencing <u>global</u> agendas and actions

The background notes and programmes given to us give me this hope, as they were <u>aware, focussed and brief</u>.

I will start by addressing the issues elected for me : The Indian Population "Problem" ; Women's Status - and its link to population - but I will try to reach into the three other issues, addressed by others such as :

- North/South
- Low fertility rates in Japan, Italy and Sweden and
- Environment and Population

THE INDIAN POPULATION "PROBLEM"?

In India the rate of natural increase has remained around 2.1-2.2 percent now for almost three decades (since 1961). However, the provisional data for 1991 (birth rate : 29.3; and death rate : 9.8) suggest a decline in the rate of natural increase to a little below 2 percent. **(1)**

According to the international experience, we expect that this process of a fall in the growth rate will continue and accelerate in the years ahead, even though the number of couples in reproductive ages 15-44 is expected to increase from about 141 million in 1990 to 170 million in 2000. It is necessary to recognise that the stability of the growth rate is itself an important achievement; it is a grave mistake to misinterpret it as either stagnation or failure of the family planning programme. (Visaria also Anirudh Jain and Judith Bruce 1993) **(2)**

III INDIAN DEMOGRAPHIC DIVERSITY : ITS LESSONS

While the national birth rate remains above 29, there are sizeable inter-state differences which have highlighted the need to examine separately the factors of fertility and mortality underlying a NRR of 1. For example apart from Kerala with its population of 29m in 1991, TFR of 2.0 and NRR below 1 there is Tamil Nadu with a population of nearly 56 million and NRR of 1.0; Goa with a population of only 1.2m, also NRR less than 1.

The diversity reminds us :

a. that inspite of varied historical, cultural and other characteristics demographic "goals" can be reached. For example, Goa is predominantly Christain and Roman catholic. Tamil Nadu has a literacy rates of 63.72% which is 25.87% lower than Kerala. Tamil Nadu never had the 'equalising' political direction of Kerala (Communist Party) nor the older history of a widespread health care system introduced by the monarch (pre-independence). However Tamil Nadu did have free feeding programme for children and lactating mothers (Antony) **(3)**. It had a popular leader extolling women's status.

b. That there are many many routes to reaching the NRR of 1. or below 1. Each area has its own impulses, "keys" to developing an approach to population growth and most of these lie outside a contraceptive approach.

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(1) The data for this piece has been taken from a paper by Dr. Pravin Visaria prepared for the Expert group on Population Policy, currently in process in India. I am also a member of this committee.

(2) Visaria, Pravin : A Population Policy of India : A draft for facilitating discussion. August 1993.
Bruce, Judith : Objectives and efficacy of Family Planning Programme. Prepared for SIDA volume on Population Reconsidered : Health, Empowerment and Rights.
Jain, Anirudh K : Revising the role and responsibility of the Family Welfare programme in India. Economic and Political Weekly, Dec. 7, 1992. p 2729-2737

(3) The Family Planning Programme - Lessons from Tamil Nadu's Experience by Shri T.V.Antony.

90 districts of a total of 452 districts in India have been identified as requiring focussed attention. In these districts IMR and MMR is high. (Jairam Ramesh) **(4)**

India wishes to launch a programme to reduce this harsh phenomena. It hopes to achieve a NRR of 1 by 2000 A.D. with an effective couple protection rate of 60% and an infant mortality rate of below 60 and this would imply a crude birth rate of 21 and a crude death rate of 12 per thousand (Pravin Visaria) **(5)**. It is not the case that India 'has failed' there is a plateau and various demographic analysis (Vasant Gowariker **(6)** predict that there will be a strong self perpetuated downward trend even if no harsh measures are taken.

IV WOMEN'S AUTONOMY/STATUS

It cannot be a simple linear argument that Kerala's literacy rate for women of 66%, and women's labour force participation of 35%, reveals that women have high "status" in Kerala and that reveals female tonomy, which in turn yields the remarkably low TFR and NRR (Gita sen) **(7)** is a result of high literacy.

Women's autonomy cannot be seen as an independent variable. It is a function of the degree of equality between men and women in a family of gender relation in a household. Mere education or even legal status or even "advanced" economy, does not necessarily determine reproductive decisions. If it were so then would the women of Italy "resist" male domination by refusing to provide "reproduction"? . Or would Swedish women return to higher fertility rates once the men begun to share the nuturing roles?..

It is gender balance of power that is the key factor - this factor not only permits women to make choices but it also makes men more psychologically capable of accepting "joint" decisions. It also means shared spaces and responsibilities in family or partnership of child care.

THE INDIAN DEBATE:

Population Policy issues are being widely actively and intensively debated and formulated in India today.

What is emerging in brief from the Indian discourse is

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(4) Ramesh,Jairam : Social backwardness : Criteria and ranking of districts in India.

(5) Visaria, Pravin : A Population Policy of India : A draft for facilitating discussion. August 1993.

(6) Gowariker, Vasant : The inevitable billion plus. New Delhi. July 1993.

(7) Sen, Gita : Women, Poverty and Population : Issues for the concerned environmentalist. 1992.

. Symposis of "Women's Health and Family well-Being" Meeting. New Delhi, Feb. 1-2, 1993.

.. International SYmposium on Research on the regulation of human fertility. Stockholm, Sweden. Feb. 1993.

Population Policy is not to be women centered - but women led. There is a world wide tendency spread across all disciplines to over-associate womens fertility with the birth rate, with reproduction and thus make all efforts at population management entirely womb focussed. For example the measure, TFR (Total Fertility Rate) which is measured from the births per women of reproductive age, which is widely used in demographic discourse tends to also focus on women's organs only.

Women do not hold the key to their fertility. Men and women hold it and thus it is wrong to make the measures and policies womb focussed.

(b) Birth Control, reproductive health needs to be equally male addressed. Male also to be responsible for reproduction and what follows.

(c) Health, well being of population to be goal and not population control. Health, Life (as different from death) must be the important issue which means a concern for all elements of supporting life. (A. K. Sen)

(d) Information, high quality service, choice, right to choose, are key issues in birth control services.

(e) In poor areas the primary goal should be the reduction of IMR and Maternal mortality and not fertility control.

(f) There should be no target setting, and no incentives. These are both inefficient and unjust. No small family message without back up.

(g) To broaden health services, to integrate all health service delivery into good PHC's or delivery points upto the village "outputs". Increase investment in Health.

(h) To lay emphasis on process rather than goal, to give space to listen, build self confidence, to introduce the traditional, indigenous wisdom in health care.

(i) To take a life cycle approach and deal with men and women in a wide spectrum not only in reproductive stage.

VI INDIAN WOMEN'S APPROACH

It is now widely understood and largely agreed that Indian Women, including those who are poor, not educated, unemployed, rural and so on, would like to have the power to control their fertility. That they would like to have few children and at the same time ensure good health and longevity for their children and themselves.

The problem arises only when the discussion moves from what women want, to how this desire or need is met.

Those who work with women, especially with those who are poor, living in very inadequate habitats, with no water or sanitation, with uncertain economic base know that for women to have reproductive choice, it is now not only insufficient, but inefficient, to offer only a cafeteria or wide range of contraceptives.

Their reasons for holding this view arises from :

1. Their knowledge that the choice of how many children to have depends on many factors external to the availability of contraceptives. For example; the survival of children, the need for hands of labour, the need for a son, the self image of the male partner whose virility is substantiated by the women's pregnancy and so on.

2. Their understanding of the dangers of some of the new invasive contraceptives especially when implanted into malnourished bodies, in bodies which have no access to medical care in case of trouble, and in health service structures where there is the danger of infections. This makes them wary of 'needles' and 'knives' - especially in view of the entry of AIDS as an epidemic.

3. Their understanding that womens fertility is not a function of only her body but the power of men and that gender relations determine freedom of choice; and that these relations have also to undergo change for choice to be exercised.

4. Their experience of the current family planning services through the States, where incentives and targets have made poor women victims of coercion and neglect.

They ask Society and the State to take a wholesome view of this problem and to address themselves to the broader needs as well as to the focussed needs.

VII THE NEED FOR SOLIDARITY

There is urgent need for convergence, for an agreed approach which could provide a broad based platform for advocacy from those involved with poor women and knowledgeable on reproductive health matters.

Responding to the issues raised above, I would like to make a proposal to this conference, especially to Japan and especially to Japan's influence on the UNFPA.

World Wide Consultations by women are revealing that broadly the women's movement whether it is placed in the North or the South has the following concerns, and the following proposals.

First, as said earlier, they are concerned that the blame for environmental devastation is being put on "poor people".

Second, that the response which is to control numbers is being put entirely on what is called the women's womb or the tubes (Shanti Ghosh) (8).

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(8) Ghosh, Shanti : Whither Health Care for Women and Children.

Third, that due to these concerns that population somehow must be controlled and reduced, technologies which have developed are being brought and with subsidies and political pressure, being put into use especially on women in developing countries. The constructive response to these is :

One, for the lobbies of Asian women broadening to World wide women to show that the problems of the environment are not necessarily the problem generated by population. The problems of environment are generated by waste generation, (DJ, Berlin/SID) (9) over consumption of natural resources, both in the production and consumption styles of what is called modern industry. Therefore, it cannot be brought into a population agenda but has to be taken into what is called the economic development agenda.

Two, that decision making on birth is taken by men and women. Men have to be brought into responsibility for birth as much as women. Men's problem, psychological and material need to be dealt with. Women's decision making capability which is called reproductive choice leading to reproductive rights has to be strengthened.

Since women are seen as the perpetrators of high population, those who are not aware of the technological devices and their requirements are often made victims of the implantation of technology and often induced through monetary incentives. These monetary incentives are given both to the victims as well as the motivators. It is now shown that if the money spent on what is called the propaganda, is transferred to provide more care in preparation for birth, reproductive choice, reproductive health no further resources are required. (Sonal Desai) (10)

Therefore, they appeal that the UNFPA should put more emphasis on quality of care, better facilities for broad based health, much more information sharing, and redressal mechanisms for those who are victims of careless contraception than support mainly the technological devices.

Three, that women's organisations who have the capability to reflect and be sensitive to the needs of women need to be much more involved in providing care and safeguards to women who go for birth control.

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(9) Sustainable Development and Environmental Challenges. Keynote address at International Congress of Scientists and Engineers. "Challenges Science and Peace in a Rapidly Changing Environment". Berlin 29 Nov. - Dec. 1, 1991. Published in Challenges Science and Peace in a Rapidly Changing Environment. Edited by Rainer Rilling and others, 1992 Volume 1.

Women, Waste and Planet Safety : Proposal for North South Alliance. Prepared for UNCED, Rio de Janerio, June 3-11, 1992. Published in the Hindu, June 7, 1992, WIDE Bulletine 1992, Women in Action, No. 4/92 & 1/93.

(10) Jain, Devaki and Desai, Sonal De : Maternal employment and changes in family dynamics : The social context of women's work in Rural South India. Working paper no. 39. Population Council, 1992. 43p.

The issues that are being flagged by the women of the South are greater investment in health care, the merging of general health with maternal health, the provision of basic amenities, they would also like to suggest that the State should be responsible for a minimal basic service of health, literacy and decision making spaces. Privatisation of health care can only be on top of that. Therefore, the ideology that all health care has to be privatised while population control strategies are sent through the State Machineries, are rejected.

They have shown how "disincentives" like not being allotted land, housing, ration cards, electoral positions, jobs in organised sector because of family size tend not to be disincentives only; they tend to create inequalities within social strata. For example very often it is the large masses in India who might have many children to start with at a very early age. By barring them entry to various decision making, powerful forums due to number of children they have borne, one would automatically be shifting the power equation to the elite. Therefore, disincentives of this kind cannot be pushed on to a very equal society.

Targets have not worked in India nor any where because target tend to shift the focus of interest of the providers of health from providing health services to achieving goals. Much of the havoc caused by the Indian Family Planning experience has been due to the target approach.

One must understand that in very poor societies with acute unemployment, providers, grassroot functionaries and the men and women "target" population can easily be induced to undertake various tasks with small bits of money. Thus by providing constant cash incentives, one may not be designing appropriate policies.

Finally, the whole issue of health care to be designed at the community level, to integrate itself with other care and with local needs, has been brought up in the Indian debate. Accountability : being proximate to the people who receive the health care so that the redressal mechanisms are immediate and accessible.

India will be going into a form of decentralised political management in the 73rd Amendment to her constitution. According to this Bill, not only will local govt. be elected but 33 1/3% have been reserved for women. Already in 4 States 70,000 women have already been drawn into these political governing councils. India has also given many of the individual sectoral subjects for designing and management, implementation and monitoring to these local bodies. Health and family welfare is therefore, an agenda on local self government bodies.

It is most important therefore, that the world takes note of this new trend which will soon come into many other countries. e.g (Philippines, Bangladesh in Asia, Ghana, Cote d'Ivoire etc. in Africa) and facilitate women and men to goal their own objectives in terms of population, size and its quality.

The UNFPA and Japan could take a leadership in addressing these issues and to ask that women in the local community be assisted in developing health care systems which suits their bodies and their needs, that advocacy and responsibility is shared between men and women and that institutions are built which have accountability and redressal mechanisms.

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2 Visaria, Pravin : A Population Policy of India : A draft for facilitating discussion. August 1993.

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4 Jain, Anirudh K : Revising the role and responsibility of the Family Welfare programme in India. Economic and Political Weekly, Dec. 9, 1992. p 2729-2737

5 The Family Planning Programme - Lessons from Tamil Nadu's Experience by Shri T.V.Antony.

6 Ramesh, Jairam : Social backwardness : Criteria and ranking of districts in India.

7 Visaria, Pravin : A Population Policy of India : A draft for facilitating discussion. August 1993.

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REDUCING POPULATION GROWTH

Dr. Devaki Jain

28 February 2000

By a curious and perhaps auspicious coincidence, the Government of India released its Population Policy 2000 on the same day that the Indian Association for the Study of Population was closing a three day colloquium on Population called The Millennium Conference on Population 2000. Over the three days, demographers, social scientists, academics specialising in various aspects of Indian economic growth and development, personnel from the network of Population Research Centres supported by the government, State and Centre, were taking a close look at the changes that were taking place at the ground level in the Indian development landscape, especially as it impacted the quality, the size and other aspects of the composition of the Indian population.

Whatever the perspective from which any individual scholar or researcher was looking at the characteristics of the Indian population whether in relation to elements such as the natural resource base, the economic situation, the profile of poverty and unemployment/employment, the social relations between gender, between castes, the disparity between regions and categories of people, a few propositions or findings seem to have emerged.

One, that the relationship between availability of food and the growing population is not alarming. In fact a couple of speakers suggested that a growing population acts as a stimulus to growth. Second that poverty was neither on the increase nor was consumption expenditure across different income deciles changing significantly. They were by and large stationery across these segments. Three, that every prediction or forecast of population size made in the last 50 years had been disproved by India's population growth – it was in each case lower than that which was anticipated, thereby arguing that there was a down turn across the board in the rate of growth of India's population largely due to a lowering of the birth rate. So to some extent, the alarm bells that had been ringing were muted.

Some of the papers broke new ground, showing that more than any other causal factor, location, namely geographical location had been the strongest determinant of a particular fertility rate. This could be tautological in that certain areas in India have embedded, entrenched convergence of poverty, unemployment, high rates of mortality and high rates of fertility. But the paper had gone beyond those areas which I like to call the 'black heart of Mother India', and found that by and large these rates were locationally constant despite interventions like education, better health aspects etc.

A paper from Kerala showed how the public health centres had more than half of the posts of service providers were unfilled, apart from not having most of the hardware including notebooks for running a private primary health centre. And this is in the socially advanced State of Kerala a leader in social development. These says cannot be overcome by better management, but require flow of funds. This and other papers which described the condition of the public health system, the reasons for such large numbers in what is called unmet needs for contraception, the papers describing birth rates as differentiated between castes and classes revealed an alarming neglect of what can be called the health and social development services sector. The Conference was calling attention to the importance of state expenditure on health sector and in turn far great

attention to public health, both in terms of financial support and in terms of streamlining the delivery.

One issue that came up during the Millennium Conference and in some sense burnt holes in the overall debate was the reference to women, their location in the debate and the way data was collected and used. The issue in some sense not only electrified the gathering, but also received positive response across the diversity in the hall

Almost all the detailed papers, i.e. the sub theme papers had to refer to what is called gender. The difference between men and women in terms of outcomes of literacy or health or mortality or morbidity. Some papers had to refer to women's unmet need for contraception, others to achievements in contraception in terms of means towards the end. The issue that was raised which seemed to have a resonance amongst the women academics and researchers in the conference was that ultimately the real issue between men and women was one of relations of power. Men by and large still had control over women's lives. Reference was made to the study of the prevalence of violence against women where most respondents have suggested that the prime cause is disobedience to male authority. A study on unmet needs showed that across class, caste, location, differences in awareness, education, income levels, availability of contraceptes the one agreement that was common to all categories when it came to the reason why they could not fulfil their need or desire to contracept was male authority.

This identification of power over woman which inhibited her from reproductive choice, asserting her reproductive rights, but also asserting other forms of rights, rights against violence, pointed to the importance of shifting the relations of power, giving the women the capacity to say no. This power seemed even more relevant given the AIDS epidemic, where women are not able to insist on safe sex due to the male reluctance to use the condom and in turn the violence that he exhibits if she insists. This led to the identification of an issue which had not been given sufficient attention, namely redressing or rearranging the power relations between men and women within communities, in order to give them the opportunity to affirm their will, especially in relation to their bodies.

Dealing with this might require collective affirmation by women of rights which can either be translated into their presence in the panchcyati raj institutions, their presence in structures of power, structures which had control over finance. Money is associated with power and it was pointed out that in the panchayati raj institutions, women hardly had any access to spending power since all the social development schemes were ultimately delivered by functionaries of departments. A suggestion was made that it might be important to look at the administrative procedures of local self government, and suggest that women's committees are formed not only to look at women's issues, but for providing basic social amenities and funds such as the funds allocated in the component plan would be put in the hands of women led committees for spending the allocations. Thus attention was called for institutional arrangements for enabling women to have power in society, power in financial and political matters such that they may then translate this power into power in the domestic theatre which would enable them to have a right over their own reproduction.

Community health groups are able to bridge the various sectoral and departmental and sub departmental divides which plague the health delivery system. In an exercise done in Karnataka by a sub committee of the state planning board on district level social development, it was found that out of 75 schemes that were operating in a district under

different heads of expenditure, there were 25 schemes which under the broad heading of health and equal number under the broad heading of education. There is need to look at such anachronisms and do what is called rationalisation of financial assistance patterns with a greater emphasis on untied funds given with some specific outcomes as the role of the --- against which the funds should be spent, rather than the items for which it needs to be spent. Outcomes such as reduction in female infant mortality, increase in enrolment of girls into secondary schools, reduction of maternal mortality, percentages of marriages where the couples are over the age of 18 and so forth could be a much more valuable monitoring devices than expenditure heads or targets. But to put a monitoring module like that on the ground not only requires designing of measuring frameworks, but also the arrangements to collect such data at short intervals in meaningful ways, so that the district or village level government can audit the change with data which is differentiated across gender and caste.

However, other alarm bells were being rung throughout the conference, calling attention to the macro economic policy and its neglect of social development as well as environment and food security, and how this would impinge on the quality of the population and social justice. The Millennium Conference revealed what a large resource of individuals India has, who have interest and knowledge and commitment to stabilising India's population and to link it to the protection of environment, protection of people's rights, the protection of food security

Interestingly the New population policy document released by the Government of India pays detailed attention to the need for increasing finance and the need for increasing attention to delivery of health services and its convergence with other services which could be called basic social amenities. It also pays attention to devolving this power both to deliver, manage and hold accountable to the local self government institutions and draws attention to the need to pay attention to what is called human resource development, enormous orientation and training to service providers, linking them to the new approach which is target free and underlines reproductive health.

The new Population Policy moves away from the incentive-disincentive approach of limiting access to leadership roles or to the goodies such as house plots or jobs according to the two family norm. Thus giving us hope that the state is not entirely deaf and blind to the information that comes from those who are working diligently in the field of enabling people to improve their own state of well being by having families which are manageable, given their resources and their goals.

One of the problems about the Indian public opinion and the Indian media is that there is a knee jerk reaction to public statements. If the policy had brought in the ugly clauses of conditionality or of technologies of contraception which are dangerous such as invasive contraceptives, there would have been an uproar. On the other hand when there was a policy statement which renegotiates the approach and excludes conditionality and exclusion, many newspapers labelled it as a population policy without teeth, knowing fully well that population policies with conditionalities put their teeth into the worst off and the most powerless.

Another Indian and perhaps international fallacy is that a policy statement is required on every issue and that national structures with Prime Ministers leading them will give it the importance, attention, money, political and social support to get it through. This had never been the case, whether it is a policy statement on industry or on child, taking two

extreme ends of what can be called subjects of national interest. Policy statements, it is said, provide a framework within which the state and what is called civil society, can perform. But over the last 50 years, one has not only seen that policy statements remain as pieces of good worked out knowledge, but even five year plans have had the same fate in that ultimately the major portion of the government's expenditure ever during the heyday of planning was outside of the plan. Political interventions and other circumstances have had often to bypass the intention.

Structures which required the Prime Minister to chair have invariably found themselves hampered in performance or in speed of action as the Prime Minister's time is scarce and had to be ceremonially used and therefore such structures and committees can only meet once a year, if at all. The National Committee on Women for example which was put in the Prime Minister's lap, thinking that that is where the power to transform lay, never took off. Policy on children, signed at the Children's Summit has not been able to walk longer.

The one advantage of making a declaration like the national population policy is that it might set an ethic or an approach which could be used by advocacy groups as a peg to critique and deconstruct the retrogressive policy approaches taken by some of the States. Since this is a State subject, the capacity of the Central government to influence the State is limited. However, it might trigger the energy of the public opinion to remove the blots from some other state level policies which are using ideas like restrictive entry knowing very well that it not only discriminates between classes, but it has the most minimal impact on fertility.

It is detailed exercises, and skills to make such exercises come into systems of district level governance that can enable a wise and informed approach to population stabilisation, which is more or less reflected in the new population policy, to become a valuable exercise. The National Population Policy needs to have a deeper look at administrative structures and procedures apart from the major issue mentioned above of finances for public health and the attention to the devolution of power to communities and local self government.

If it has to have what can be called a dramatic impact, then the effort to lay a base of social and economic security for the poor, to lay a base for institutional arrangements for women's empowerment, laying a base of auditing frameworks should be initially undertaken in the States which are showing highest rates of reproduction. Such an approach would enable those States and the people in them to achieve their own goals, which they might have set in their own self interest - but it will also reduce the deep deprivation in those districts which I have called the Black heart of Mother India. Instead of once more playing foot ball with the Population Policy that has just been declared, it would be wise for both the State and civil society, to address how it can be worked out in the detail and by joining forces to press on the national and state level budgets, the importance of investing in public health and using the community based approach which has worked very well in India. This would have value for both removing the 'pop scare' (like the bomb scare) and the hysteria associated with that as well as bring a minimum of well being to highly incarcerated social groups.

UNFPA
United Nations
Population Fund

Millennium Conference on Population, Development and Environment Nexus

February 14 - 16, 2000

Population and Economic Development : Political Systems and Gender Equity

A historical narrative and update

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Bangalore

HP3:5

Theme : Population and Economic Development : Political Systems and Gender Equity

Subject : Population and Gender Equality and Equity

Title of Paper : A historical narrative and update

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POPULATION AND GENDER EQUALITY AND EQUITY

BY

DEVAKI JAIN

ABSTRACT

This paper basically summarises the outcome of two valuable exercises conducted by official committees of the Government of India on gendering population policy. It commends these two exercises as containing in them well debated, carefully researched women sensitive approaches to a population policy for India. The author was a member of both these Committees.

The paper then goes on to describing the particularly distressing if not devastating trends that are noticeable in the demographic profile of women in India in the millennium and suggest that while specific approaches and strategies and operational mechanisms can be designed to enable a gender just and effective population policy for India, the crucial issue for transforming the particularly vicious situation that exists today, is for a change in the power relations, for a reduction in disparities – at the macro level as well as at the household level, not only in economic and social indicators, but in indicators of power.

The paper suggests that these changes in power relations can be brought about by strengthening the presence of women in political structures not only by arrangements like quota, but by the affirmative, collective pressures of the women's movement. It argues that women as a social force, transforming power relations across the board is a crucial element in any population policy advice.

SECTIONS

- First Tracings – individual events
- Second Tracings – The working groups
- The emerging values
- Women design population policy
- Retrospect
- Annexures

Population and gender equality and equity

A historical narrative and update

Devaki Jain

In this presentation, I am suggesting that there is enough received wisdom on gender equity and its links to a just and effective population stabilisation programme. However, I am also suggesting that by itself "gender-equity" as a concept is a limited and limiting approach towards the goal.

Valuable work has been done on probing gender-equity, and its effect on fertility. From the flat statements that leveling of difference offers a better chance for Joint decisions if not self-determination ,to the detail of what needs levelling, viz., physical items like control over resources, education, health and economic,- there has been immense analysis of data, going over age cycles, locations, ethnicity and so on.

The Human Development Reports have added useful dimensions to this quest for equity, by locating the disparities context of poverty1997, growth 1996, consumption 1998
And globalisation 1999. This has has provided additional fire power for those who are concerned with inequality – its causes and consequences. The GDI and GEM , basically gender inequity measures, have provided useful monitoring tools for the achievement of equality in these measures or indicators.

However, as Lady Macbeth lamented "All the perfumes of Arabia cannot wash there hands clean" – so too all the material indicators – and the attempts to level them through measures, evaluations, programmes have not been able to break through the embedded hard rock of patriarchal power / further strengthened by "custom". And hence terms like gender – and gender equity, arranging the balance in external variables, equal shares, are not the language and preoccupation of those working for social justice Relations of power, perhaps even unequal relations – in the sense of women or dalits having the upper hand - has became the idiom , born out of experience.

Hence , instead of reviewing the recent, useful technical work – on gender equity, I decided to review the work done,- what I call a historical narrative-of the available ideas towards woman – sensitive population policy.

The paper is in five parts

The first traces the evolution of gender sensitivity
The second traces the work of two major papers, on population policy, where women's knowledge and ideas were integrated.
The third points to the values that emerge from this view.
The fourth summarises how women would design policy
And the fifth is a retrospect.

Just as there has been an evolution in the last 10-15 years in the demographic trends – a decline in several key variables, like mortality, and in some pockets the TFRs are comforting. (***Population Growth in 21st Century" – India, Population Foundation of India, 1999***) so too there has been a healthy and comforting evolution in the consideration of the link between Women, Population and Development in the last 15 years. The evolution in the understanding, perspective and prescription is based on deeper analysis of the data emerging from research on population, and greater participation by women scholars and women activists in drawing attention to the complexity of relationship and to ground level phenomena.

I have called my paper ***a historical narrative***, as I hope to reveal that there have been major achievements in building wise, wholesome approaches to enabling a decline in population growth in which, women's role in the cruoial zones of reproduction, and advice thereof, have been accommodated and what the arena needs now is moving forward from such platforms – and not returning either to the obsolete or adversarial positions. What these are will be spelled out in the course of the paper.

First Tracings : individual events

I remember the time 25 years ago in 1973, when I went to Dr. Ashish Bose at IEG to persuade him to do a statistical profile of women for the book that I was editing called "Indian Women" *(Devaki Jain edit Indian Women GOI 1975)* After strenuous efforts to build the data (the very first time I think it was done) Ashish Bose along with his research assistant drew up some tables , and then called me to share the shocking phenomena of the declining sex ratio, between 1901 and 1961.*(It is this same chapter exercise that went into the CSWI report "Towards Equality". that was being put together at ICSSR at that time)* The sex ratio has since been one of the most crucial and pungent variables that are being used to determine the inequality between males and females **from the womb to the tomb as** the saying goes.

From then on - in my own work and in the work and participation of a large number of informed and skilled researchers and activists ,- and in dialogue with demographers, statistical systems, health and family welfare departments and organisations ,there have been valuable forward moves .

For example the work of those who are probing the household , the family as a stratified social formation, not the ideal even-handed "Safe" place for women and girls; as well as the related work of those who were looking at gender disparities across the class and caste categories , whether in the area of ***work or nutrition or hospital care***[1] led to pressure to gender disaggregate the data and reject the household as the lowest unit for data collection, among other achievements.

I remember one conference (*Population Trends and Family Planning in South Asia, 1989)* where the R-G (at that time Mr. Padmanabha) had displayed maps of India and coloured the zones according to infant mortality disaggregated across sex . Dr Shanthi Ghosh and I were seeing the exhibition together and noticed that District Salem seemed unusually pink , indicating intense death of female infants, therefore it was decided to recommend a further study of the district under the special studies scheme of the R-Gs office. Now we know all about the prevalence of female foeticide and infanticide and its special presence in Salem. *(Revaluing Women's Roles", Paper Presented in the Conference of Population Trends and Family Planning in South Asia, 1989.)*

The growing awareness of the difference between women's poverty and men's poverty, apart from the external characteristics of this poverty, as expressed in labour force participation profiles , in health and nutrition and educational profiles-led to immense changes in policy documents apart from academic discourse. The sixth plan, had a chapter on women's employment reflecting these "new" statistical probes: and later all plans have chapters on women and development, insisting on gender differentiated bases for data analysis and action. (*VIth Plan, Yojana Bhavan, 1980 + all other five year plans).* This type of information and its translation into programmes for

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1. *Banerjee, Nirmala, : "Household Dynamics and Women's Position in a Changing Economy" - Paper presented at the International Conference on Gender Perspectives in Population, Health and Development in India, New Delhi,1996.*

Jeejeebhoy, Shireen J : "Family Size, Outcomes for Children, and Gender Disparities - Case of Rural Maharashtra", Economic and Political weekly, 1993

Sen, Amartya : "Population and reasoned agency: food fertility and economic development", Paper Presented at the Population –Environment _ Development Seminar at the royal Academy of Sciences and the Beijer Institute,1993.

Jain, Devaki : "In equality within the household. The neglected factor",1977.

Jain, Devaki : "Household Food Security, A Production Consumption Link',1985.

Anant,Suchitra : "Women at work in India, A Bibliography ",ISST, Sponsored by Ministry of Labour, Government of India, Sage Publications,New Delhi,1986.

Jain, Devaki :The Household Trap : Report on a field Survey of Female Activity Patterns, Vikas Publication, 1985.

Jain, Devaki, Banerjee, Nirmala : "Tyranny f the Household" – Investigative Essays on Women's Work, Vikas Publication,1985.

Jain, Devaki "Are women a separate issue", in Populi, Journal of the United Nation's fund for population activities, New York, Nov, 1978.

Dandekar, Kumudini

Swaminathan, Madhura

Batliwala, Srilatha

attention to the issue of gender inequality has been enlarged and made into a discipline of its own, by the HDRs starting with HDR 95 ***(Human Development Report – 1995, UNDP)*** and translated into new indices called the GDI and GEM specifically to measure inequities between men and women based on gender differences. GEM, relates to Power and GDI to development. This work has led to the birth of several State Level HDRs and one which I would commend is the Karnataka HDR brought out in 1999 where the chapter on women is somewhat different from the usual and one on which I will be basing some of my proposals and analysis. Karnataka has also taken the District as its unit for building GDIs and GEMs, responding to PRI (73rd Amendment).

At the same time knowledge and advocacy began to appear on the difference between men and women ***in choices*** . The work of Anil Aggarwal CSE *Ask the women first* The Chipko Movement *(Anupam Mishra, GPF)* and the work of many of us began to reveal that women had a different perspective and preferences in development priorities even within a class or caste or location. This kind of information is becoming vivid in the written and spoken information that is now emerging from the PRI system. Books and articles are emerging which reveal that women have different priorities methods and capabilities in their role in governance from men.

Therefore a crucial milestone that we passed was moving the difference between men and women from merely the physiological , biological to the area of choice which could be called mental or Intellectual

For my presentation flagging these milestones is important because what I would be making a case for is that the focus on women , in the approach to any policy, especially population policy ,which is so embedded in ***body parts***, shifts from the body to the mind, to the political , social and economic presence of women in the overall system .

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2. Devaki Jain, "Minds Not Bodies – Expanding the notion of gender in development", Bradford Morse Memorial Lecture, UNDP, Beijing, September 5th, 1995

Jain, Devaki : " Leadership Gap: A Challenge to Feminists, Indian Association for women's Studies sixth National Conference Lecture ,Mysore,1993

Jain, Devaki : "Women and Governance", UNDP, September 1996.

Human Development in Karnataka ,1999 "Human development and the second sex", Planning Department, Government of Karnataka, Bangalore.

Jain, Devaki : "India in the new Millennium: the Challenges Ahead –Challenges for women in India in the new Millennium". January 19th, 1998. Publisher,Dr Bruce .P. Corria. Associated Prof of Economics, Managing Director, International Policy Review.

Jain, Devaki "Women's Quest for Power – five Indian case studies", 1980, Vikas Publication, Ghaziabad..

Updates

There has been much progress in India in the detailed analysis of the links between fertility and external variables in the last 5 years which also needs mention and attention. Many of these studies would like to argue that the factors influencing fertility are not linear, as for example that an input of education will deliver an out put of lower fertility . Land rights, ownership of assets, work status, location of housing apart from broader "macro" elements like the overall level of satisfaction of basic needs, the prevalence of gross disparities, including the embeddedness of patriarchy and tradition the existence of women's collective strength either as in mass based women's organisations or struggles, are only some of the items that are being pointed to in analysis. Most of these ultimately land in the area of relations of power between groups and individuals: how much power have women to control their life, to control their lives, to lead in a particular situation?

What we find when we scan both the information analysis and outcome of collectivities like the working group, on gender adjusted population policy - or the detailed analysis, is to the importance of seeking the leadership and participation of women in evolving an approach, as well as for reducing the TFR, for demographic transition as well as the **partnership and advise of women's organisations.**

This is not to say that the programme has to be **"women-focussed"** in the sense of seeing women as objects to be manipulated, but **women led** in the sense of seeing women as subjects who would direct not only their bodies, but social relations, gender relations which ultimately is a relations of power. The power to have self determination or autonomy or reproductive freedom or reproductive rights.

This is why in the elements or the pillars or the analysis framework that was evolved by the Swaminathan Committee in its deliberations, an element was added called "social force". We recognised that since demographic transitions requires transformation, transformation cannot be brought about merely by delivery of a programme as a scheme or an extension service, transformation requires a movement ethic and at one time we even coined the term 'the population movement' just as during the more idealistic days of the panchayti raj system, we wanted to call it a "panchayati raj movement" or a movement for devolution of power.

It is not uncommon to find that idealism that was present during the birthing of an idea tends to wear off and a movement approach gets corrupted into a delivery of development approach. This is quite a normal and natural phenomena. Even so, it is important, in my view, to recall that these ideas and attitudes were part of the thinking and designing process that went into what can be called official policy deliberations.

Jain, Devaki and Sonalde Desai: : "Maternal Employment and Changes in Family Dynamics: The Social Context of Women's Work in Rural South India" - The Population Council, Working Papers 1992, No. 39.
Desai, Sonalde "Land Distribution and fertility", EPW.
Agarwal, Bina "Gender and Command over Property: A critical Gap in Economic Analysis and Policy in South Asia" paper on World Development, Vol. 22, No. 10
Agarwal, Bina. *"Gender and Legal Rights in Agricultural Land in India"*, in: Economic and Political Weekly, 25.03.1995..
Gulati,Leela : "Women's role infertility decline in Kerala State,1995.

Other findings are being highlighted almost every week revealing to us that the perspective on population have to change from one of panic as is being shown in the ads by Sahara India Pariwar . For example, Prof C H Hanumantha Rao in a recent (*January 22-28, 2000 Vol XXXVNo4, article in EPW*)says "Demand for foodgrains in India has been declining and some of this decline indicates an increase in consumer welfare. The decline has been sharper in the rural areas where improvements in infrastructure make other food items and non-food commodities available. Though cereals (used here as proxy for foodgrains) consumption has increased among the poorest 30 percent of the population, even this group is near the saturation"

In the pages that follow, I would have spent quite a good deal of time in quoting passages from the sub committee of the National Committee towards preparing India's country paper for Cairo, and some time in putting forward the framework that was being built up as drafts for the Swaminthan Committee.

I could as well have taken these ideas out of those processes and presented them as a list of important findings generated from data as well as ideas generated from practise which would be the core of a paper on ***gender equality, gender equity and population.***

But the reason I am opting for the ***recall approach*** rather than the ***recycle approach*** is because I am overwhelmed by the wastage that is being generated and will be generated, by our not using milestones both for information and for prescription. During the course of my research for providing an input both to the sub committee and the Swaminathan Committee, I was overwhelmed by the depth of analysis and understanding that had been generated by the many "powerful" technically competent meetings that the U.N. Population office had called prior to Cairo. There was a meeting at Botswana, a meeting in Bangalore and each was of different categories of those working in the field of population. It could be demographers, it could be scientists, it could be academic, it could be health officials. In each of these meetings, papers were generated, which scanned the available experience and put it forward.

One paper which I refer to again and again in my paper and which I will quote, and which was written in 1993 could have been written today.

It is particularly pertinent, as it refers to the dangers of what I call a women focussed policy in relation to HIV/AIDS. It talks of the trap that awaits women who will be having to bear the burden of the number of sick as well as the number of orphans that would be generated by the AIDS epidemic. She said this in 1993, whoever is the author, and it was a stark reality that was faced by the communities in South Africa, whose conferences on AIDS I attended in 1998, who, as you would have seen in the papers, are being faced with 3 million AIDS generated orphans as of today and more to come with no capacity to absorb the orphans into orphanages. But a further burden or stress on already over stressed women led households because of the culture in South Africa as in India, of families taking the burdens of social displacement. South Africa will also have a new demographic profile with life expectations as well as other variables showing extra ordinary disjunctions, and retrogression in an era of millennium progress hype.

It is this same wastage that I wish to avoid by pointing to processes and committees which in fact drew on the most radical at that time 'new information' the articulation of those who are protecting and expanding the horizon of women's rights. To say that there has been this kind of process which has not just built consensus, but which has integrated knowledge to come out with a wholesome policy, - and it would be wasteful and retrogressive not to take ourselves forward from there.

With each day bringing out new punitive and careless and therefore inefficient proposals on population policy, it is crucial that this Conference takes note of the fresh water that has passed under the bridge and pick up from there. There is a possibility that the 2001 census would probably reveal another 'missing women' phenomena because of the prevalence of female infanticide and foeticide. Therefore it is not Malthus, who stalks populations, but it would be discrimination against women patriarchy and custom and AIDS which might be a significant factor in demographic change in India.

Working groups

1. The report of the sub group of the National Committee set up by the Govt. of India in 93-94 , in preparation for the Cairo Conference. I was the Convenor of this sub committee (as a member of the National Committee) and worked with a team of ten person; each representing a different track record ; an ideal group with an academic, an official of H&FW, a grassroot activist, an ngo, UNFPA. (see Annexe for coverage of report and membership).

2. The Expert Group on Population Policy chaired by Dr M.S Swaminathan 94

Excersise I, (the subcommittee called its report ***Beyond Family Planning: Towards Social Policy***
and I quote some of its paras

Traditionally, population programmes have been influenced by the basic demographic variables, birth, migration and death. These have tended to be treated separately and, in view of the impact the rate of population growth can have on development in general, priority has been given to the issues surrounding fertility. This has meant that, after studying the more immediate relationships, efforts have spread to the exploration of more abstract relationships and therefore to identifying possible linkages between fertility and the status of women defined by variables such as **level of education and salaried employment.**

However of late more importance is being given to just, humane and effective development policies which have **at their centre the well-being** of all people. This has led to advice that population policies, designed and implemented under this overall objective, should take into account a wide range of phenomena including access to and distribution of resources; health status; gender relations and sexuality; aging; urbanisation and migration; political; racial, ethnic, religious, class and **other societal factors that directly affect women's and men's ability to exercise their reproductive health.**

Each of these phenomena has significant ***gender dimensions reflecting not only biological differences between males and females, but also power imbalances between women and***

nen. Thus, to assure human well-being, in particular women's well-being population policies and programs must be framed within and implemented as a part of broader ***development strategies that will redress the unequal distribution of resources and power between and within countries, between racial and ethnic groups, and between women and men.***

Historically, however, population policies and programs have been ***driven more by demographic goals than by quality of life goals.*** *Women's fertility has been the primary object of both pro-natalist and anti-natalist population policies.* ***Women's behaviour rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision making.***

There needs to be fundamental revision in the design, structure and implementation of population policies, so that focus is on the empowerment and well-being of all women. This implies that ***changes are needed in the design of family planning and health services and information; the ways in which these are provided; the technologies they promote; the biomedical and social research that is done; and the process for involving women in all levels of decision making and implementation.*** *(Extract from Women's voices '94. January 15, 1992.)*

It is also recognised that where there is a measure of equality between men and women, whether because of equality in education and income (Kerala) or culture and custom (Tribal communities, (Survival Strategies of the Poor – the role of traditional wisdom" Sreenivasan Foundation, 1986, Bangalore) or because the programme has been equally directed to the two sexes, - fertility has shown a greater and more sustainable decline.

This reduction of the inequality between the sexes, or sometimes the presence of a more equitable distribution of power between the sexes is traced to education, income, entitlement to resources and also the prevailing culture. Processes that lead to this situation where women have a control over their lives, is called empowerment.

"Empowerment leads to reorganisation of the productive and reproductive roles not only within the family, but also within the society. To simply recommend more equal sharing within the family is to a large extent illusory if the society is not organised in a way which permits it: for example, in developing countries, sharing has a cost which is luxury when the strategy is focussed on survival. It is thus apparent that the "advancement" of women cannot be added dimension to other development activities as is often believed, but a process at the core of society that has an impact on all development activities". *(Extracts from gender perspective on population issues, United Nations Office at Vienna. Gaborone, 22-26 June 1992.*

It is recognised that there is need **to address men** "the forgotten 50 percent of family planning" not only through health extension, not only through IEC and social marketing of contraceptives, but to enable men to understand and accommodate their role in fertility management, its psychological and social implications. It is increasingly being recognised that decisions on reproduction, whether taken by the male or the female have implications for

self image and status, according to the cultural and the economic context, thus extension work has to address itself to these implications if it wishes to have durable affect.

"Men have always been involved". "They were the key element in the demographic transitions in many developed countries to smaller families, using condoms and coitus interrupts prior to the widespread use of the pill in the 1960's." (*Extract from Getting More Men Involved. Network, published by Family Health International V13(1), Aug. 1992).*

In the last generation, however, a female orientation has been at the forefront of family planning. The introduction of "modern" female methods – the pill, IUDs, injectables, and recently Norplant, among others – coincided with the establishment and growth of family planning programs in developing countries. "We know how to provide family planning services to women better than men, and there's been limited funding for male-only programs."

Three factors in the 1980s triggered more focus on the male role in the population equation. The coming of AIDS and its rapid spread through heterosexual contact has caused new attention and resources to be devoted to the condom and to understanding sexual health.

Another important recognition is the need to address the programme to the whole lifecycle of the woman, (and the man) especially at the stage of child and adolescent – and not only at the reproductive age. Some of the issues family planning programmes need to look into are: how to intervene at all stages of a woman's life cycle; how to improve the status of women, in a life-course approach; how to proved sex education and girls / women's higher level of economic dependence. These, and other questions need to be looked into from a gender perspective.

A common criticism to health efforts for women is that they are mostly centred on "MCH" i.e. mother, child health. Operationally, such a package has made good sense, often corresponding to existing reality and, furthermore, integration with family planning has given important results. Motherhood however, although fundamental, is but one aspect of a women's health. A greater concern for the health of women throughout their life might lead one to explore the possibility of breaking down the concept "child" into its gender dimensions in order to avoid families later on reacting differently to the sickness of daughters compared to that of sons and limiting the expectations for girls to their reproductive role. Attending to her only at the MCH stage often is too late even from the limited goal of family size apart from the more humane goal of wellbeing. For example most of the irreversible contraception used by women has been of women over 30 years with already 3.6 children (Anirudh Jam)

From the arrival of a girl in the womb to her death there are many threats both to life itself and to health. This discrimination affects not only health status but power relations, the ability to take decisions, to negotiate and protect herself.

Another example can be provided in relation to the AIDS epidemic. Models have shown that variables such as the difference of age between partners can play a significant role in increasing the risk of infection of the women. The difference of age between partners is a typical expression of differences in wealth and power. In such circumstances, traditional

information, education and communication (IEC) campaigns and the provision of condoms, although indispensable, might not be sufficient for women to insist on "safer" sex if they are not sufficiently empowered. Responses to the epidemic tend to rediscover the "caring" role of women, thus increasing their burden and endangering any advance in their status. Worse, the future of the daughters of overburdened or sick mothers can be definitively mortgaged by enrolling their assistance, rather than that of boys. One has therefore to be careful that "community" responses to the epidemic do not turn out to be gender traps for women. These few examples illustrate the fact that a gender analysis could have important organizational consequences on existing programmes as well as considerable positive impact on their outcome. (Extract from A Gender perspective on Population Issues, United Nations Office at Vienna, Gaborone, 22-26 June 1992.)

Lack of opportunities early in life will mortgage a woman's potential through all stages of her life. When that happens to a generation, this could mortgage future national development for several decades. Early pregnancies and continued births throughout the productive years, with or without emotional, practical and financial support from the father, leave many women in an economically dependent position, from youth to old age. Family planning, but also the age perspective; the different stages of a woman's life which determine her possibilities to make decisions related to fertility.

Thus today concern is for the HARDSHIP that women suffer, from birth to death, through under nutrition, early marriage, unsafe child birth and inadequate health services to follow up morbidity. Population policy thus has to address itself to women's wellbeing, of which her entitlement to good health and the capability to choose her reproductive path becomes the critical mass.

Nutrition, food, and not only for pregnant and nursing mothers but for children; to build the base of a healthy body has been recognised as basic – whether one looks at it as a basic human right and need or from a narrow point of view of introduction of contraception (the iud, norplant another technologies work better on a well nourished body sic) Thus Food security has been closely linked to population issues and policies (T.N. Krishnan)

This in turn, is dependent on may macro policies and programmes – for example, (land use and export import policies determine availability of food at the aggregate level. At the local level, prices, the food distribution system (PDS), purchasing power to buy the food, which in turn depends on availability of employment, and then the distribution of power between the sexes which will determine division of food within the household. (A.K. Sen) Agricultural production programmes, land use (food or cash crops) which in turn is dependent on prices, and these on turn on the trading policies, international food prices, export compulsions, or import compulsions, will affect food availability to vulnerable groups (IFPRI)

Thus a simple input like nutritional justice to children would need the back up of macro policy – both food security and employment, or livelihood. Safeguarding these two securities it is found would affect population growth as deeply and strongly as providing contraceptive incentives; and perhaps with a more durable impact.

Education is another critical element that has been pointed out as having an impact in a variety of ways.

Less educated, poor and physically exhausted mothers are likely to pass on poverty to their children, while better educated mothers is one of the key factors for improving the situation. Studies have shown that women with seven years of more of education tend to marry on average four years later, and have 2.2 fewer children statistically than women with no schooling. (*) *Sadik, Nafis: State of World Population Report, New York, United Nations Population Fund, 1990. P 15*

Education raises the age of marriage of girls which has a very strong impact on birthrate (Anirudh Jain), It levels out power between men and women both in and outside the household. The other links that education gives knowledge on health and opportunity and thus impacts fertility is well known.

But educating little girls also has major demands on the macro economic system. Poor little girls cannot go to school, unless they have (not only the usually identified support of creches for their younger siblings, or also the other usually identified element better household income through higher wage for the adults very but relief from time consuming domestic chores such as fetching water and fuel for the home. In a national seminar on the new education policy (NIEPA) the final consensus recommendation was that piped water and gas were as important, as much a necessary condition for girls to go to school as a black board was for the school. (Extract from National Seminar on Education in an integrated planning framework. March 2-4 1992.)

The paper from the sub committee then gave the following proposals as a response to the review:

The Action plan for revamping the Family Welfare Programme in India addresses these issues and the approach suggested is consistent with many of the recommendations emerging from a women's perspective. These include for example, a consolidation of existing infrastructure, more attention to practical problems of field workers, and an ending of the "target" approach.

A holistic approach to women's health is needed, and not one that limits itself to reproductive health. This means we need a system that responds to all the following: occupational health; reproductive health; maternal health; mental health; nutrition.

Close attention needs to be given to the quality of service and follow up. One way of ensuring this is to give primacy to the 'perspective of the client' (1)

Looking at population issues from this perspective, it becomes clearer that demographic questions cannot be understood without going beyond the boundaries of family welfare and structure and of facilities, in particular drinking water, sanitation and education is a pre condition for sensible population decisions. This is well borne out by theories of the demographic transition and in the Indian context Kerala provides an illuminating example (*S. Pachauri, "A reproductive health approach to the population problem", Demography India, Vol 20, No 2 (1991) pp155* 162).*

The experience of health service provision through NGOs is often cited as an example of the correct approaches. The point to be emphasized here is that these programmes have been

successful because they have had an organic growth and have not been pre conceived programmes. It is likely that the specifity of each successful approach makes it less replicable; but the lesson to be drawn is precisely that we need a system that permits and contains diversity. It is also worth emphasizing that a programme which is "handed over" to an NGO for implementation is missing out on the first and necessary condition, that the programme developed from bottom up.

The essence of the NGO approach has been to mobilize, empower and conscientization, the people. Through their work on conscientization, struggle and protest, NGOs have taught the disadvantaged to put pressure on the government and have complied the system to become more responsive to their needs.

The Working group (II)

The Swaminathan group Exercise 2

The second milestone was the work done by the expert group on population policy set up under the Chairmanship of Dr. M.S.Swaminathan. This group also had the benefit of by a remarkably skilled group of diverse professionals from scientists to civil servants, demographers and officials. As well as interaction with experiences both of grassroot feminist organisations, evolved experts in this field such as Dr. Sundari Ravindran, Dr. Shanti Ghosh, and many others. The dialogue and discussions between the proponents and this team during the process of preparing the report brought in almost all the insights on women's role and participation, in responding to a population policy, as well as designing and implementing the population policy. Naturally, the valuable diverse streams that enabled the earlier subcommittee's work flowed into the process also.

The Expert Group on National Policy reviewed the experience of India's 45 years of Family Planning interventions, and made a **turn about** from the old approach. **Unanimously.** Some of its key recommendations were:

(i) Scrap all incentives, disincentives, target orientation – including legal conditionalities like making individual or institutional benefits dependent on family size or birth rate performance – from the approach.

(ii) At the structural level merge the Family Welfare department with the Health Department and make it **one** line of administration all the way down to the village. In other words, to remove the Family planning Department so that the emphasis on **health** does not get deflected to "family planning". This is a "Revolutionary" change of approach for India as she has prided herself on being a pioneer, first in the world to have an FP intervention. In fact the group decided not to even use the word "FP" any more but call it **contraceptive** services.

(iii) To change the IEC from (as Avabai Wadia put it) bombarding and exhorting people to limit their families to one of giving information on the body, on various aspects of health.

(iv) To set up a National committee to review the ethics of introducing drugs especially the new high tech contraceptives – especially the transparency and full satisfaction of the trials before introduction.

The reasons the Group were so strong and clear in rejection of the old was the fact that in a context of deprivation and also insecurity, in a context of diversity and difference (pluralism) appeals on family size were un-receivable- or to put it another way could not be landed safely on the ground. It was necessary even for efficiency to respond to poor communities on the basis of their pre-occupations. This led to a strong support for local self government, to decentralized management of health systems.

However, since we recognised that the number of people and their rate of growth was a serious mater and needed to be restrained and established, (towards a goal of TFR in the rage 2.0 to 2.1; we decided to abandon the NRR as a measure) we the group, decided that at the macro level we should pressurise the leadership to make investment, resource allocation choices, and administrative choices which otherwise they would find difficult in the current Structural Adjustment Atmosphere (SAP) of resource shortage – arguing that this is the most effective intervention for a sustained lowering of TFR.

In one of its earlier drafts the Swaminathan Committee on population policy, had crystallised the main pillars of a policy as

First the provisioning of basic economic and social security to all sections of Indian society especially the poverty sets; - which meant universally available high quality elementary education alongside with schemes for provisioning of creches, clean drinking water, sanitation and maternity care. Eminent scientists had given simple solutions to ensure that pregnant mothers do not suffer from anemia which in turn reduces the survival rate as well as the capacity of children and so forth.

The **second** pillar was to use the existing institutions of governance namely the Panchayati Raj system to advantage, to facilitate the design implementation and monitoring of high quality social development services. The idea of locally designed and implemented and monitored services with accountability provided by the elected body was to ensure that delivery is proximate to users. Words like user oriented, locally designed, women designed have all been enshrined as the second pillar of that expert group's proposal.

Third the expert group also had negated the idea of incentives and disincentives, the utility of what was called the propaganda machinery of supporting the two family norm but instead asked for more effort on involving young men especially in community based activities which also give them information on not merely birth control but reproduction. So rather than propaganda on the two family norm, it was suggested that information be given on reproductive organs, which would both facilitate their understanding of fertility but also enable them to protect themselves from sexually transmitted diseases etc.

Fourth, the enormous rich experience of non-governmental organisations in enabling communities to exercise restraint on birth rate, in fact to exercise their own preference to have a few children was also flagged. And it was suggested that if the quality of service and

the user oriented approach of many of the successful non-governmental organisations was widely disseminated and prompted there would be a far greater impact.

We felt that it was possible, even within the current resources position to give a strong financial support to a crash programmes of mass employment, accompanied by feeding programmes and elementary education, with the same "adrenaline", or feverish energy and funds as is applied to the strong propaganda about the Population bomb : and that this would be a more effective way of ushering in a "quality" Population.

This would require very strong political will in countries going through Globalisation where social sector investment is seen as "unproductive". Leveling inequalities between social categories and regions in access to material benefits shifting and allocations of resources and pin pointing users, also requires political strength.

In both these processes I had the opportunity to learn a great deal from the technical experts and an opportunity to draw their attention to facts, analysis and propositions which has been the experience of those who have done research on women especially women in poverty, especially women in the economy and politics.

Emerging Values:

The reason I elaborate on this experience is two fold.

i) Almost all the elements of the Indian approach and strategy exactly match what the Indian women's movement- and in fact the international women's movement – recommend and has been high-lighting on the grounds of justice and efficacy. (See Annex-1).

ii) To show that the articulation of the Women's movement is not thetoric and ideology alone, it translates itself to practical elements of a National Policy.

The crucial aspect of these experiences which needs to be noted by any process which wants to speak to a national population policy for India, including the Bimaru states, is that Indian women, including those who are poor, not educated, unemployed, rural and so on, would like to have the power to control their fertility. That they would like to have few children and at the same time ensure good health and longevity for their children and themselves.

The problem arises only when the discussion moves from ***what women want*** to, ***how this desires or need is met.***

Another very important aspect of women's advice or articulation is that on the same facts their analysis is different from mainstream. Further they reveal "new", "hidden" facts which are so critical for formulating effective policy, and finally they emphasize the method as much as, if not more than the goal.

The richness of this was dramatically revealed to me during a visit to Japan to participate in an Eminent Persons Group of the UNFPA prior to Cairo. The Japanese women had registered a new organisation called "Japanese Women for Health Cairo 94" and prepared factual papers on different issues. Their explanation of Japan's "success" (Japan's stable low birth rate) is that women refused to have babies, "satyagraha" – as there is o support to their role from men, law or the state. They have very few methods of contraception available (male condom and for women abortion even that in a concealed way) so to achieve this low TFR they used abortion. Hence while the Prime Minister of Japan claimed the "success" as the effect of policy, the women revealed that it was not policy, but their own resistance to manipulation.

Those who work with women, especially with those who are poor, living in very inadequate habitats, with no water or sanitation, with uncertain economic base, know that for women to have reproductive choice,. it is now not only insufficient but inefficient to offer only a cafeteria or wide range of contraceptives.

Their reasons for holding this view rises from:

1. Their knowledge that the choice of how many children to have depends on many factors external to the availability of contraceptives. For examples, the survival of children, the need for hands of labour, the need for a son, the self image of the male partner whose virility is substantiated by the woman's pregnancy and son.

2. Their understanding of the dangers of some of the new invasive contraceptives especially when implanted in malnourished bodies, in bodies which have no access to medical care in case of trouble, and in health service structures where there is the danger of infections. This makes them wary of "needles" and "knives" – especially in view of the entry of AIDS as an epidemic.

3. Their understanding that womens fertility is not a function of only her body but the power of men and that gender relations determine freedom of choice; and that these relations have also to undergo change for choice to be exercised.

4. Their experience of the current family planning services through the State, where incentives and targets have made poor woman victims of coercion and neglect

They ask Society and the State to take a wholesome view of this problem and to address themselves to the broader needs as well as the focussed needs.

Women design population policy:

In several meetings whose location moves from New York where the UNFPA had their advisory Committee meeting on Women Pop and Dev (New York, May 31 - June 3, 1993) to meetings in Mysore at the National Conference on Women Studies, from a Meeting convened by the Health organisations in the govt's programme of providing reproductive health services to women, to a meeting in Bangalore called by the Centre for Women Development Studies (CWDS), the approach and the thrusts coming on from the womens organisations are the same.

Women are interested in the detail. If nutrition is required as a basic pre-condition of health, then they have advice on land use; they draw attention to the role of commodity prices and international trade agreement elements which may shift this use to less food oriented uses or raise costs. They have similar interest in water use which in turn leads to view on production technologies, on power generating technologies, irrigation systems and so on.

When women recommend education for girls, they recommend piped water and gas to be introduced in every home – as they know that as long as water has to be fetched from ponds and rivers and wells; even far away queue-lined taps, as long as fuel hs to be brought from far away woods or collected form the bush, girls cannot go to school – and now with the break down of self control in most societies every here there is the thereat of rape, violence against even little girls as they walk to school across fields. So to reach low fertility rates they start with security from violence, investment in social infrastructure go on to piped water and gas to be available like black boards and teachers; and then on to school hours to suit climatic and occupational needs of poor working families, then on to ensuring that village teachers teach and village nurses, nurse by wanting local accountability for the grass root functionaries.

Consulting women, treating them as reasoned agency (to use AK Sen's words) as subjects leads to another kind of public policy across all sectors, and in institutions – what is called a paradigm shift.

United Nations Population Fund, New York.

Statement on Population Policy – Centre for Women's Development Studies Dated 17.01.1993
Council for Social Development

The Hindu dated 11.1.1994
The Pioneer on Sunday dated 16 January, 1994
Devaki Jain

Project for Consultations with poor women towards "Evolving a Woman-Sensitive Population Policy" ISST 1994
A Population Policy for the Twenty First Century – perspective from the Women's Movement.
Summary Report and Recommendations
Policy in India organised by the council for Social Development, New Delhi on 14 January, 1994.
Is population the real problem?
Women as guinea-pigs
Women Led Population Policy Kitakyushu Forum on Asian Women November, 1993

When it comes to health they see health, especially reproductive health as something that has to start being attended to from earliest age of people and of both sexes, to level up their knowledge and responsibility. They recommend that the "departmental approach" to social inputs be changed to a one line, one window and multiple services across age and gender.

Women all over the world are emphasizing participation in decision making and leadership. In our consultations with poor rural women in India, in a project funded by the UNFPA we were impressed to find that they identify capability to make decisions as key to their advancement, and of course key to making informed reproductive choice.refs

But decision making to them does not emerge form literacy or income alone, but from a sense of balance in power or what can be called equality between themselves and their men. Taking us back to the old concept of equality between men and women not at the macro statistical level but at the household and community level – a very different kettle of fish.

The women's Groups that worked on these consultations for the UNFPA constructed a whole national policy on population and strategies thereof from the seed or root of decision making, which is now possible in India due to the 73rd Amendment to our Constitution which reserves 33-1/3 % seats for women in local self government.

When there is a plea of "no funds" / resource crunch, they recommend choice between groups in education, e.g., universal elementary education before higher education. They say teach us about our bodies and give us information, we will choose, even buy the contraceptive.

Literature is full of case studies of women capabilities in innovative institutional endeavors and also in resistance to threats to life and livelihood. Most of these endeavors indicate choice of issues and method of leadership, challenge the theories of economic growth and social change.

The choice is usually supportive of conservation – whether of natural resources or other forms of resource. The method is usually one of collective action and consultative process.

I attach the summarized version of the proposals that emerged from the wide range of consultations listed along with the proposals

Macro Chart

MACRO SUPPORT	
SOCIAL SUPPORT	*LITERACY* *EDUCATION* *HEALTH* *(especially towards the GIRL CHILD)*
ECONOMIC POLICY	*FOOD SECURITY* *EMPLOYMENT* *(especially towards the poorest people)*
RESOURCE ALLOCATION	*ON SOCIAL AMENITIES* *WATER* *COOKING ENERGY* *SANITATION* *ON CHILD CARE INFRASTUCTURE* *Thus taking note of the 3 "C" s in which women are involved – Cooking, Cleaning and Child Care.*
FORM OF ADMINISTRATION	
LOCAL SELF GOVERNMENT	*Accountable elected bodies with representation ensured for women and other subordinate sections.*
LOCAL INSTITUTIONS	*Based on binding categories especially youth*
COOPERATION WITH NGO'S	
FOCUS	
YOUTH	*Girls and boys but especially girls*

Going into the details, to the elements requiring attention and which can be superimposed over the existing systems, they would suggest:

Long-Term Elements:

1. Investing in health: The percentage of GNP needs to increase from current 2% of GNP to 5% of GNP.
2. Building social infrastructure – especially revising allocations of scarce resources. As give more to public investment in water and cooking fuel access to rural households.
3. A life-cycle approach – with a focus on the girl child in the health system. Strengthening the primary health centres, broadening their base to include health services across age and gender.
4. Addressing males from adolescence through all stages on health and reproduction.
5. Building local accountable institutions as a prerequisite for community-defined health systems and providing technical services to women in local government as well as other forms of local community leadership on health.

Immediate Compulsions:

1. Merging the 'family welfare' budget into health budget – so that the flow of funds directed towards reduction of population growth can be used for better and under health facilities currently.
2. Recasting the MCH to be part of health service system, namely the PHC, to provide quality services for all.
3. Making available to local government as well as to other people's institutions some open-ended methods of attaining quality of life and demographic goals through humane ways such as facilitating the replication of effective, sensitive, successful endeavours in health with a component on reproductive health.
4. Intensive education on contraception addressed to boys and girls as well as adults through all forms of organisation, traditional and modern.
5. Developing schemes to postpone the age of marriage of girls offering vocational training, savings, income earning etc.
6. The raise the status, through a wide network of agencies, for the community health worker and health providers <u>especially the mid-wife</u>.

There is urgent need for convergence, for an agreed approach which could provide a broad based platform for advocacy from those involved with poor women and knowledgeable on reproductive health matters.

The above lists are offered only as a skeleton on which more opinions and ideas need to be built. There is urgency not only because population especially its control has come up high on the Agenda of the State but because there is also a dominant view point that the factors which are most influential in reducing fertility lie outside .....

Retrospect

The horrors of the Millennium: The new millennium - the 21st century - these terms as they are thought or uttered have a ring of promise, adventure, modernity, scientific age. Within that vision there can be ideas on how to land social segments like women onto cloud seven or a grand future.

The millennium has been anticipated and characterized in many ways - positive and negative. Information technology has crossed over all barriers - national boundaries, corporate empires, intellectual empires. So in a sense it has leveled. It has also seen an increase in social fragmentation apart from affirmation of social diversity – and its acceptance. Difference, pluralism, multiple identities and self-determination are the key words. However, there are other aspects of the millennium which are horrific and look as if they cannot be contained. What are these horrors?

Threatening erosion of nature - and therefore greater disease/imbalance between soil, air, water and humans. The possibility of new mutants in humans and plants, the fragmentation of society and its old foundations - family, community, class –individualization of a 'lonely kind'. The overpowering economic influence of unaccountable finance & its warlords - hence an abrogation in national sovereignty, and hence abrogation of the accountability of nations to their citizens. A world order without a world; footloose-ness of all people and cultures, economic giants and lilliputs, and therefore a blurring of purpose and responsibility. And last but not least, increase in disparities between people - rich and poor, men and women, place and place, leading often to conflict. Hence a more warring society even if wars are little and local.

In such a situation where disparities and conflicts are increasing; where national resources are under assault; and where power has moved into unchallenged spheres such as IFI's and MNC's; and two women's decades with action plans and follow up mechanisms have made attempts to usher in justice to women in a unipolar world. women's situation cannot be redressed merely by social inputs, merely by trying to level them up with men. In fact women themselves - if their voice in local as well as worldwide forums are taken as 'witness', as evidence, - have recognized that their situation as well as the nature of the world can change only when they lead; only when relations of power change. So even they are moving out of the mode of 'demands' to claiming power or gender-equity, as it is called.

Why this shift even in the aspirations of the World Wide Women's Movement? Why this shift from 'demands', to **power** ?

Any review of progress made in terms of women's position in society vis a vis any indicator - political economical or social - shows that change, if any has been slow, and

partial. The UNDP/HDR-1995 marshalled data from all over the world to starkly illustrate that after two decades of global attention women are still deeply discriminated against and whatever measures of outcome are used - women's contribution to society and economy is still ignored - as indeed their voice in governance.

This review at the global level is matched at the national level. In India over the last 3-4 years as secondary and primary data began to reveal the sharp disparities between males & females in everything from survival,- living and dying - to participation in decision-making , whether within the households or at the global level, many researchers were engaged both in trying to define 'status' of women; measure it, give the measures a hierarchy of importance and then try to assess the progress made in women's quest for equality and justice. According to the latest ground level reports – females are under assault, with foeticide on one hand, sale of girls into the sex trade on the other, and the intensification of domestic violence against women.

It is anticipated that the infant female/male ratio may reflect foeticide and female infanticide (sudha : Intensification of Masculinity at birth, CDS, 1998). The hold of patriarchy and tradition seems stronger than all the humane economic interventions.

It is here therefore that the link between gender equality i.e. a reduction in disparities and the introduction of the rights language – making the violation of women's control over her reproduction, a human rights violation seems to offer hope.

The language of rights has always been a problem* in poor unequal countries where instruments to enforce legal safeguards are muted or blunted by the very poverty and inequality of the situation. But as globalisation strides along and inequality hurts harder, - almost as hard if not harder than poverty and deprivation – people are mobilising around rights even in developing countries.

A recent example of this mobilisation is the newly formed National Alliance of People's Movement (NAPM) which is an alliance of 9 struggle based organisations. The alliance has drafted a declaration from which I quote only their slogan:

"HAMARA BEEJ, HAMARI BHOOMI
HAMARA KHAD, HAMARA PANI"

These responses can be traced to the gradual reduction of people's rights to what was earlier a free public utility – namely rivers, oceans, forests, grazing land etc. these natural resources are beginning to be contracted for production, for trade by agencies which are once removed if not many times removed from the people in these areas, who used to access them.

In another area namely the area of violence against women, which is now at the top of all the agendas, rights and their protection has come to be accepted as necessary condition for beginning to turn around the terrible situation of women in India and South Asia. The situation of women in India and South Asia where the household authority and conventional

* Jain Devaki –" The role of language of rights in population, health and development – An exploratory paper" NCAER Seminar, IIC, 1997.

models of women's roles and behaviour is so deeply embedded that recourse to the language and instrument of right, it is believed, might provide at least one enabling mechanism for fighting there millions of battles in millions of homes.

Another extension of the use of rights initiated through 73rd and 74th Amendment is the right to participate in political structures. Many of the women in local politics talk of their rights, "haq" to be in larger and larger access of politics.

And so we come to ***reproductive rights*** : the effective expression of reproductive rights is dependent on a broader acceptance of the language of rights, in a broader set of areas such as mentioned above – the right to natural resources, the right to protest, the right to leadership and to information. Expanding the concept of reproductive health to include the concept of social and economical security for women would bring us directly to notions of ***development rights***, to the rights of the poor to livelihoods, food and so on.

Again ground swell movements in India including parts of the women's movement, are adopting this language as it links them to constitutional and judicial mechanisms which seem to have more potential to provide justice than the government or even civic society – apart from the market of course.

Some of the older institutions such as trade unions and cooperatives have always used the language of rights. Being representative bodies most of their "procedures" and rules are based on elections, on voting and therefore on rights of the members. The reasons these institutions like cooperatives and trade unions need to be seen with greater interest in the landscape of globalisation and liberalisation is not only because of their representative nature which engages itself in rights (even if women are not yet visibly present in the current scenario of these institutions) but because in the context of large corpora tions, large scale financial institutions coming in to play in the fields of India, the only possible source of counter-vailing power is to build alternative economic organisations, federate them.

In drawing attention to this phenomenon of economic institutions, and modes of resistance, the purpose is to argue that if ideas and actions in the field of ***population and health and development,*** have to be shaken out of their current cruelty, discrimination and assault on women, ***the language of rights*** and the building up of representative institutions, are key instruments, perhaps more key or more valuable than more research, or more advocacy on policy, or more programmes by government.

Thus I come back to where I began the link between political structures, economic development and gender equity. The core issues is self determination, - a woman's right to choose a reproductive path. This entitlement needs "capability" – circumstances which enable the exercise if that right – which is basic economic and social as well as the collective strength to over throw break out if patriarchs and tradition. This requires, a strong political presence of women – not gender equity.

ANNEX 1

Draft for discussion
Section E 4.
Country Paper (India)
(Cairo Conference, 1994)

CONTENTS:

I. Introduction (Approach).

II. Main Elements.

III. Towards Social Policy.

IV. Indian Facts and Experience.

V. Future Strategy and Summary Package.

ANNEXURES:

1. From Vineeta Rai (data)
2. Tables – T.N. Krishnan
   Anuradh Jain
3. Rural Health Infrastructure
4. Distribution of Contraceptives

REFERENCES: References on PG
Newspaper articles

Including a monitoring framework for a non target approach contributed by Ena Singh and supplemented by Dr. Chitra Naik

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Members

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Ms. Ena Singh, UNFPA

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HP 3:6

International SID Programs

POPULATION POLICY
GENDER PERSPECTIVES

Reproductive Rights, Gender and Empowerment Programme

Reproductive Health, Empowerment and Population Policy

Project Background

This project is undertaken by SID in collaboration with its partner organizations in Brazil, El Salvador, Ghana, India, Kenya, Morocco, Pakistan, Tanzania and Thailand.

The project investigates the resources and communication tools through which three ages of women - adolescent, reproductive and third age - acquire knowledge of their reproductive health needs in the context of their local community and to identify what type of services are needed to enhance their capacity to make self-defined choices. It follows broadly the framework of the ICPD Programme of Action's stated aims to shift population policies away from an exclusive focus on demographic concerns and targets to one that puts the well-being of women at the centre of human sustainable development.

In each national context, local women's groups act as a focal point to help formulate activities which, through participatory research, advocacy and dissemination of ideas, would best ensure the provision of quality reproductive health services for the three ages of women as defined by the women themselves, thus acting as subjects and not objects of population programmes.

The project examines three questions:

1. How women of different ages and social positions contribute to the knowledge and practice of reproductive health and how women and men interrelate according to the particular configuration of gender relations;
1. How women's reproductive choices also change according to their different stages of the life cycle as they assume different roles and status levels through adolescence to old age, daughter to grandmother;
2. How to take global decisions on reproductive health back to the local level through a dynamic process of interaction between understanding local conditions and interpreting policy decisions and activities which meet local needs while reflecting the broad principles reached.

Achievements to date

To date partners have:

- reviewed the ICPD Programme of Action in consultation with other women's groups, government, education and health authorities;
- undertaken the case studies (the case studies have been completed in eight countries) with NGOs and local community groups;
- presented and discussed the results of the project's first phase in a workshop held in Santiago de Compostela (Spain) on May 20, 1997 on the occasion of 22nd SID World Conference;

- initiated a process of local consultations with women's groups, civil society groups, intergovernmental and government departments in order to draw up strategy plans which will identify, at the community and national level, the services and resources required to meet different ages of women's reproductive health needs.

Future activities

- ***Advocacy***

  For advocacy purposes, by May 1998, in each local context the partners will organize a national workshop where women's groups leading the projects and SID Chapters will activate their contacts with civil society groups, the private sector, media, parliamentarians and UN agencies, to bring broader awareness of reproductive needs as defined by the community women and the ICPD Programme of Action.

- ***Dissemination***

  The findings of the project will be disseminated at the local level as well as at the international level in print and through electronic communication. A special issue of SID Quarterly Journal *Development* will be published in 1999, on the occasion of the ICPD+5, and will be translated in local languages in order to serve as an educational and awareness building tool for distribution to education, health and NGO institutions working at the community and national level as well as to the international community.

Local Activities

Brazil

Research coordinator:
Jacqueline Pitanguy - Citadania, Estudo, Pesquisa, Informação e Ação (CEPIA)

Special focus:
The Brazilian case study focuses on women domestic workers living in Rio de Janeiro and on their relation to media . Specifically the research team has investigated: how media deals with issues such as gender, reproductive health, sexuality and environment; and how women domestic workers are pictured by TV and Radio programmes.

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El Salvador

Research coordinator:
Ilja Luciak - Virginia Polytechnic Institute and State University

Special focus:
The Salvadorian case study focuses on poor women living in 31 marginal households located in San Marcos and Antiguo Cuscatlán (neighbourhoods in the capital city San Salvador) as well as in Panchimalco (a marginal area in Quezaltepeque).

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Ghana

Research coordinator:
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Special focus:
The Ghanaian case study focuses on adolescent women living in three regions of Greater Accra and women of different ages living in the Eastern Regions of Ghana.

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India

Research coordinator:
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Special focus:
The Indian case study focuses on young married women living in a slum area of Jaipur and in a village from the Alwar district of Rajasthan.

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Kenya

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Cecilia Kinuthia-Njenga - Environment Liaison Centre International (ELCI)

Special focus:
The Kenyan case study focuses on women of different ages living in Kibera, Korogocho and KM, three urban poor neighbourhoods of the capital city Nairobi.

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Pakistan

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The Pakistani case study focuses on women of three age groups living in Baja Lines, a low income neighbourhood of the capital city Lahore.

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Tanzania

Research coordinator:
Leila Sheikh Hashim - Tanzania Media Women's Association (TAMWA)

Special focus:
The Tanzanian case study focuses on women and men of different ages living in Ilala, Temeke and Kinondoni, three districts of the capital city Dar-es-Salaam.

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Thailand

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The Thai case study focuses on migrant women from Myanmar living in the fishing community of Ranong, in the South of Thailand.

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Morocco

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Special focus:
The Moroccan case study focuses on unmarried young mothers who, after having left the rural areas, live in a poor area of Casablanca.

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POPULATION AND FAMILY PLANNING POLICY

A CRITIQUE AND A PERSPECTIVE

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AUGUST 1994.

POPULATION AND FAMILY PLANNING POLICY : A Critique and a Perspective

Ravi Duggal

The Department of Family Welfare, Delhi says "The Family Welfare Program in India is being promoted on voluntary basis as a people's movement in keeping with the democratic traditions of the country. The program seeks to promote responsible parenthood, with a two child norm - male, female or both - through independent choice of the family planning method best suited to the acceptor. For conveying message of small family norm to the masses, motivational, educational and persuasive efforts are made without any resort to any form of coercion" (Family Welfare Program in India - Year book 1989-90, Department of Family Welfare, GOI, New Delhi, pg 48)

This is how the government views its family planning program, which it never tires highlighting that it was the first official program of population control in the world! I have deliberately begun with the above quote because not only is it full of lies but it also drives in many home truths about the governments' perceptions.

RETROSPECT

The Official Population Policy and Program is based on the Malthusian belief that poverty in the 3rd world countries is due to the large population of these countries. Each Five Year Plan (5 YP) in India has thus never failed to comment that India's development or growth has been the best possible with the given resources but uncontrolled population growth has acted as a retrogressive force. Thus, each 5 YP raised substantially allocations for the Family Planning program in the hope that the fruits of development were not eaten away by unchecked population growth. (Note : In India the term family planning has the same meaning as population control.)

Further, India's Family Planning program has been almost wholly directed by international pressures. In the initial years (fifties and early sixties) when the program was truly voluntary in nature it operated mainly through FPAI with substantial assistance and influence from IPPF, FPA of Britain and the Population Council.

When these efforts failed to elicit any significant acceptance of Family Planning, pressures were exerted on the Government of India to take a larger interest in checking population growth. Ford Foundation took the initiative and helped the Government of India in changing the approach from a 'clinical' and Voluntary one to a camp approach with a more aggressive attitude and the introduction of incentives. Thus from an expenditure of Rs 22 million in the second 5 YP the allocation was enhanced to a whopping Rs.270 million (actual expenditure Rs.249 million) in the third 5 YP to accommodate this new approach which continues upto the present. And today the eighth 5 YP has allocated Rs.65,000 million for the Family Planning program.

Table 1 gives plan-wise expenditure on the Family Planning program and the achievements made. The achievements have definitely not been worth it considering the last column in the Table. Today the cost of improving the Couple Protection rate by one percent is about Rs.3 billion (or US $ 100 million). The yield from an alternative investment, say better maternal health services in rural areas, social security for school going children, etc. will be more productive.

Table 1 : Expenditure and Achievement in Family Planning

Five Year Plan	Family Planning Expenditure: Current Prices (Rs. million)	Family Planning Expenditure: 1990-91 Prices (Rs million)	Family Planning Performance: Sterilizations (Lakhs)	IUDs (Lakhs)	CPR % of couples	Cost of increasing CPR by 1% at current prices (Rs million)
First	2	20	--	--	0 2	--
Second	22	220	1 53	x 11	2 7	99 6
Third	249	2075	13 73	20 57	7 9	135 6
Plan Holiday (3 years)	705	3920	43 92			
Fourth	2844	12400	90 04	21 89	14 7	418 2
Fifth	5166	13600	147 17	74 95	22 4	670 3
Sixth	13952	27900	174 44	71 72	32 1	1338 5
Seventh	33292	45885	237 44	283 53	43 3	2972 5
Eighth	65000 (Budget)	65000	---		--	--

Note : 1 The 1990 prices have been calculated by using the purchasing power index of the Rupee from CMIE's Basic Statistics

2 The last column has been computed by dividing the first column by the difference in CPR of each plan period with its preceding period Example for the 3rd Plan Rs 249/(2 7-0 2)= Rs 99 6

Sources : Family Welfare Year Book 1989-90 and Eighth Five Year Plan

Further it is well known that the Couple Protection Rate (CPR) is a highly suspect figure. Correlation of CPR with fertility rates clearly shows that something is wrong. Thus a high cpr in a given population doosn't necessarily mean that fertility is declining. Many studies in India have amply demonstrated this. For instance, an increase in sterilizations does not necessarily mean that fertility will decline because it is well established that acceptors of sterilization have on an average a completed family size of 4 to 6 living children, with at least 2 sons. This only makes a mockery of the target oriented Family Planning program! Thus, the cost of raising the CPR could be much more than what we have computed

This limitation of sterilization was realized at the end of third 5 YP itself but it still continues to constitute the largest accepted method of Family Planning. At the end of the third 5 YP a United Nations team pressurized the Indian government into initiating a very large scale IUD program at the cost of other health programs "The Directorate of Family Planning should be relieved from other responsibilities such as maternal and child health (MCH) and nutrition. It is undoubtedly important for family planning to be integrated (it had been integrated with MCH in 1963) with MCH in the field, particularly in view of the 'loop' program, but until the family planning campaign has picked up momentum and made real progress in the states, the Director General concerned should be responsible for Family Planning only. This recommendation is reinforced by the fear that the program may be otherwise used in some states to expand the much needed and neglected Maternal and Child Welfare services" (UN Advisory Mission Report of the FP Program in India, NY 1966)

The IUD campaign did not shape up as anticipated and was more or less a failure. Mainly because its prime concern was fulfilling targets and that the necessary medical and social backup support and followup was not available to women. In fact an Estimates Committee of the Lok Sabha (Parliament) was critical of the blind acceptance of foreign advise. "The Committee regrets to note that the IUD

program was formulated and implemented on the advise of foreign advisors without analyzing its pros and cons and without exercising an independent judgement on its suitability in Indian conditions and without establishing any proper infrastructure for the same. The Committee suggests that a critical evaluation of the foreign assistance rendered so far be undertaken" (Thirteenth Report of the Estimates Committee of the Lok Sabha, 1971-72, pg 191)

Since the third 5 YP Family Planning has occupied a central place within the public health sector Whatever programs have been designed the Family Planning objective has always been kept in the forefront. Thus under the Minimum Needs Program (MNP), started during the fourth 5 YP, the health sector received assistance to expand the rural health infrastructure (PHCs and SCs) so that the network for Family Planning work could be expanded and made closer to the people. The Community Health Volunteer (CHV) Scheme, though garbed as a barefoot doctor scheme, ultimately became an adjunct of the Family Planning program. In the 6th and 7th 5 YP the child survival and safe motherhood programs, undertaken with international support and guidance, intended for reduction in IMR and MMR, had the objective of Family Planning as got demonstrated in implementation of this program whereby all women getting registered for antenatal (ANC) and postnatal care (PNC) were subjected to a hard sell of Family Planning leading to declining acceptance of ANC and PNC by mothers and newboms ! This obsession with the Family Planning program has discredited the entire effort put into building up a network for primary health care in the underserved rural areas. All the investment in the health sector in rural areas, thus remained grossly underprovided and underutilised because of the pushing of F P. target, by the health and other staff.

The above historical brief is important to understand how Family Planning as a program was built up and how it's obsession with target has led to the destruction in the credibility of the rural health services.

A NEW PERSPECTIVE

It is important to note that the official Family Planning program is directed largely at the rural population. In the urban areas the State does not have to exert pressure on the people to pursue a small family norm. The pressures of urban living induce higher acceptance of contraception.

Basicaily the rural-urban difference arises out of the fact that children among agricultural families are assets whereas for urban dwellers a liability

Why Fertility Remains High?

The small and marginal peasant and the landless laborer constitute 80% of the rural population and most of which exists at the subsistence level. In rural India, employment is largely confined to the months beginning with monsoon and ending with Diwali - this is the kharif season on which most of our agriculture is dependent. These five to six months hold the maximum employment potential. The more working hands that a household has the greater its chance to avail of employment opportunities that are limited seasonally. The greater the number of family members who are able to seek gainful employment the larger the amount of savings a household will be able to generate to tide them over lean (employment) seasons. Secondly, family labor is an important means of saving costs of production for subsistence farmers. Even children make their contribution to household productivity by

contributing their labor to household maintenance that frees adults (the working age-groups), especially women, to participate more in income generating activities. Children contribute not only to housework and in caring of younger siblings but also as a helping hand in home-crafts, cattle rearing, fetching fuel and water, as farm labor on family holdings and quite often as paid workers. Therefore, in a

predominantly subsistence agricultural economy family labor assumes a highly significant place if advantages from production are to be maximized for the household; and as a consequence high fertility becomes a necessary associate.

With the household still as the main production unit in India the family bonds and traditional socio-cultural practices have remained intact. Extended family households or extended family relations make the cost of raising children negligible because the down payment (cost of pregnancy, child birth, upbringing etc) of having children is very low as the cost and responsibility of raising children is most often shared in such families.

Further, such a family structure invariably encourages early marriages because the newly weds do not have to set up a separate home nor have they to bear the responsibility of rearing children on their own. Thus, an early age of entry into marriage and an absence of contraception practice (a practice which such a family structure discourages) results in an extended fertile period for the woman leading to high fertility. Also, in such families the status of women is low. Women are not allowed to take advantage of educational and employment opportunities outside the home and village. As a consequence they are married at a younger age; the gap between their age and their husbands' is wide, resulting in a relationship of total subservience, one of which is an uninterrupted series of births for which the only regulating mechanism are socio-cultural practices that may exercise some control over coital frequency. Another reason for low age at marriage in India is that the female child is considered a burden as long as she remains unmarried and, therefore, parents seek an early marriage. Also in such a family system women are sought at an early age as daughter-in-law so that they can be moulded easily into the new family and share its burden of drudgery and family maintenance with other women folk of the household.

The role of education in raising consciousness of a people, and especially of women is undisputable. The subsistence nature of the economy prevents the majority from seeking education, especially at the secondary level and beyond. When women do not receive education they are married early, and that too to someone eight or ten years older, and have to take on household responsibilities without adequate development of a mind of their own As a consequence they become a cog of the patriarchal social structure alienating themselves from their own self as well as from the collective woman, their sexual and reproductive function being outside their control. Education liberates women from this vicious circle to a large extent and consequently they can also seek productive employment (non-domestic). Working women find child bearing a burden as it has serious economic consequences eroding their independence by engaging them in child-raising. The end result of this (when the woman has the choice) is a greater willingness to accept contraception and a small family norm. In fact our interviews with rural and tribal women in various studies have brought forth the fact that these women desire to control their own bodies and reproduction but the social structure prevents it. In a patriarchal structure (and especially so in a backward society) the control of womens' sexual and reproductive function vest with males for whom production of children, especially sons, is viewed as a reaffirmation of their superiority and control. Therefore fertility control becomes the function of the social structure itself. It is ironical that inspite of this women constitute the main target in population control programs.

Another reason for high fertility in India is the nature and structure of the workforce itself. As indicated earlier agriculture involves a very large majority of the workforce and we have seen how this within the given setting contributes to a high fertility rate. Related to this is the fact that opportunities for non-agricultural work are not growing at a fast enough pace. A runaway development of the non-agrarian sector generates population mobility and displacement, denting and eventually splintering family ties and traditional bonds. But this has not happened in India. Infact, the industrial labor force even in a metropolis like Bombay has organic links with the countryside that helps retain tradition and alongwith it values supportive of high fertility. The living conditions in urban-industrial centers (slum and street dwelling) indirectly contribute to retention of old value systems because they (living conditions) don't provide a security and sense of permanancy to the migrant. As a result he seeks comfort and security back in his village, the city becoming only an extension of his rural-scape. Therefore, even the non-agricultural worker in India does not, most often, have a small family.

Besides, overall poverty, high infant mortality, poor health, education and housing facilities and a total lack of non-family based social security makes an overwhelming majority of Indians, and their counterparts in rest of the third world, opt for a family size that in the long run is beneficial for the family's survival and growth.

Our policy makers fail to see these basic socio-economic facts and continue to be influenced by Father-Malthus and his descendant experts from the West and design programs and allocate resources which do not produce expected results in this case reduced birth rates.

Is there a Population Problem ?

The Malthusians believe in the resource constraint theory and hence are obsessed with the exploding population bomb in the 3rd World. Does reality support this ?

If viewed superficially one can hear the bomb tick (to make it visible every major city has a population clock on which millions of rupees have been spent, the PMs office has a clock donated by UNFPA and Doordarshan every morning alongwith Vande Mataram reminds us of this growing menace!).

The stark poverty, malnutrition, illiteracy, high infant and maternal mortality all tend to indicate that we don't have enough resources to give basic amenities to all. Hence with a smaller population the given resources would have been better distributed. Sounds' pretty convincing!

The question here is what is a smaller population ? What is the quantum of resources that each person should consume ? How should the population size be measured - in terms of land : person ratio, in terms of agricultural production, in terms of energy / resource consumption etc..?

The developed countries hate these 'dirty' questions because if we start answering them the population bomb myth is exploded.

For instance, if resource availability is a constraint then population should be measured in terms of resource consumption. Vasant Pethe, an eminent Indian economist has constructed a paradigm which shows that population growth is not the cause but rather the effect of poverty the blame of which he puts on the inequitous international economic order. He has calculated that if population size must be measured in terms of resource consumption then USA's population will not be 250 million as measured by the census but 25,000 million because the average U.S consumer uses resources 100 times that of the average world consumer. Hence by this measure India's population would be about one-third of its census count or just about 300 million !

One is not arguing here that resources are not limited. One is aware of that but what we want to establish is that the numerically larger 3rd world population is not the one responsible for depletion of especially the non-renewable resources. Infact, this question was surreptitiously glossed over at the Rio Earth Summit held in 1992. It is time that we said NO to this **numbers mania** and demand that people in the under developed countries be viewed as a resource for development. If the West must insist on counting numbers in under developed countried then they should not object to counting of their consumption volume (by saying that consumption is a personal matter). The United Nations in that case must complement the population policy initiatives in countries which the west regards as population bombs, with a policy for consumption in the wasteful West. Like targetted growth rates for fertility and reproduction there must be targetted ceilings for consumption of goods and services in the West. In the global context both (the population policy and comsumption policy) must go together. **If this complementarity is not acceptable then the entire focus on the population issue must be shifted to investing in people. If peoples basic needs and aspirations - employment, housing,**

education,health, old age security, etc. are provided for people will naturally become more socially responsible. If people are *given* a stake in the system they will *have* a stake in the system.

So, now we know where the population problem lies !

Can We Change this Perspective ?

The Indian state is sold over to the population bomb perspective. How do we bring about a change in this ? What follows is not a prescription for change but only issues that, if highlighted, could contribute to efforts to bring about a new perspective.

Firstly the 'population problem' should not be viewed in a single country's context alone. One has to place it in the context of the global economic order. Resource generation, distribution and use should be the focus of such a perspective. It is not a simple economic question but a strongly political one.

Secondly, one must question the aggressive and imposing stance of agencies from the West to chart out population policies and design FP programs in 3rd World countries. The West views the large and growing population of the unerdeveloped countries as a threat to their own survival. For instance, their own technologies are Capital intensive which cannot be adopted on a large scale in under developed countries because it would exacerbate the unemployment problems. Therefore the only way the West can dominate is by reducing numbers in these countries so that their (West's) technological dominance stays intact and the vicious cycle of dependence is perpetuated. Hence the West is obssessed with population control. But their ideas emerge from an understanding from within their own socio-cultural and politico-economic system and hence are doomed to failure in societies which are very different. In India most rural development, health and FP programs have been designed with foreign assistance and almost all have either failed or have generated contradictions with a new series of problems.

Thirdly, following from the above mentioned, the local socio-cultural, economic and political conditions are important determinants of peoples' actions. Why they accept or not accept a small family norm most often has very sound reasons, as we discussed in an earlier section. One cannot impose a FP program from above if it conflicts with peoples' reasoning. Only changes in their socio-economic conditions (for instance, the professional middle class in India) which change their **objective reality** will ultimately change their reasoning vis-a-vis family size. India's flirtation with open coercion during the "Emergency" demonstrates how no amount of hard sell or force can change human behaviour. The focus should thus be on changing the objective reality.

Fourthly, the ultimate determinant of change in reproductive behaviour is acceptance of contraception. Only a radically changed objective reality will bring about this acceptance. Until then the State's efforts with regard to reproductive behaviour should be limited to assuring that **safe contraception** is freely available to those who feel the need to control their reproduction. This changed perspective will greatly improve the image of the public health sector, especially in the rural areas and restore the faith of the people in primary health care services whose credibility has been thoroughly damaged due to the obssession with the numbers mania under the family planning program.

To conclude, we would like to emphasise that there is an urgent need to evolve a new global understanding on the issue of population and development. **Let us not count people. Let us invest in them.**

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INDIA'S 'FAMILY WELFARE' PROGRAM IN CONTEXT OF THE WORLD BANK ENGINEERED REPRODUCTIVE & CHILD HEALTH APPROACH

A Critique and a Viewpoint

Ravi Duggal, CEHAT

This note was presented at a meeting in Washington in December 1995 where a review of India's family welfare program was done in the context of the 'new' reproductive and child health approach which is being promoted by the World Bank. At the meeting were present representatives of the Government of India from the Department of Family Welfare, experts from the World Bank, from a number of US NGOs, afew from Indian NGOs and some from other international agencies concerned with health and population issues. At the meeting the World Bank document Report No. 14644-IN titled 'India's Family Welfare Program : Towards a Reproductive and Child Health Aprroach' was the main agenda item to be debated. The meeting was organised by the Health and Development Policy Project of the Tides Foundation and the Population Council.

During th[illegible]st decade or so the women's movements the world over, and especially . the west, have brought to centrestage womens' reproductive health concerns, the origins possibly being the abortion debate in the United States of America. Add to this the threat from Acquired Immuno Deficiency Syndrome (AIDS) and the population control lobby's supposed population bomb ticking away in third world countries and you have a new health policy prescription for countries who are seemingly endangering the world with their high fertility. India is one such country whose health policy is being reshaped in this new global context.

Another set of global programming for the third world countries is the cutting down of state expenditures for welafre like health, education, social security etc... The prescription here for the state is to narrow down its focus to providing essential services only and that too for a select population of the extremely poor. Thus, in the health sector there has been a descaling of goals from basic health care for all in fifties and sixties to primary health care for all in the seventies and eighties and now in the nineties it is selective essential health care for a selective population. The consequence has been that the health policy in the third world countries is increasingly being narrowed down to fertility reduction.

This development and its consequences are of crucial concern because even in India adverse affects are very visible. Health care investment and expenditures in the public sphere are declining and people are increasingly being pushed into seeking c[illegible]n the private sector even if they can't afford it.

India's Family Welfare Program

At the outset it must be stated that 'family welfare' as a title is highly misleading because the entire effort of the concerned department is family planning, and that too mostly tubectomies. Other concerns of this department like child immunisation, antenatal care, abortions, deliveries, postnatal care etc.. are only marginal -

occasional spurts of activity like universal immunisation using a mission approach did change things temporarily but as routine set in it could not be sustained and is again marginalised. One doesn't have to give the gory details of statistics to show how miserable health care in general and specifically for women and children is. It should suffice to mention that access to basic services like basic medical care, facilities for child birth, abortion services, contraceptive services, pregnancy care, immunisation etc.. are just not there when clients visit the primary health centres or other provider units.

While in the nineteen fifties the state did put in efforts at building an infrastructure to deliver basic health care, these were abandoned sometime in the sixties when population control started to become the cornerstone of India's health policy. The first casualty of this new approach was the maternal and child health program with which the family planning program was integrated on the advise of a United Nations Advisory Mission to accomodate the loop program (the first ever IUCD program). The mch program had at that time just taken off in the rural areas with the setting up of subcentres and a large scale appointment of auxiallary nurse-midwives but both were hijacked by the newly created family planning department. From then on there was no looking back and population control kept getting an ever increasing share of attention of health policy, planning and resource allocations. This might appear to be an exaggeration because 'only' about 15% of the budget of the ministries of health goes to family planning, and hospitals and medical care get about 'as much as' 40% of the budget share. But it is not, because 80% of the 15% on family planning is spent in the rural areas and 85% of the 40% on medical services goes to the urban areas which have only one-fourth of the country's population. Further, the entire health team working in the rural health infrastructure (as also those from other government departments who have FP targets to fulfil) spend an overwhelming proportion of their time on family planning related activities - this means they are forced to encroach on their time for other health care tasks.

The fate of all subsequent programs, like the minimum needs program and integration of health workers under the multipurpose worker scheme, the child survival and safe motherhood program, the community health volunteer scheme, universal immunisation program etc... was the same - all ended up serving more the interests of the population control program than adhering to its own objectives. And it is this that makes up the misery and tragedy of health care, and specifically womens' health, in India. If each of these programs had been implemented genuinely as vertical programs like the small pox eradication program or the malaria control program of the sixties (even though I am against the concept of vertical programs) some significant achievements in women and child health care would have taken place. I fear that the fate of the proposed reproductive and child health approach will not be different and it will end up being a mere change in nomenclature. Also, given the fact that it will be directed largely at women it is in all likelihood going to further strengthen the targetting of women for fertility reduction and again keep men outside the frame of responsibility for reproduction.

Further, it is said by many supporters of the familiy planning program that if it were not for the agressive family planning program fertility would have been much

higher in India. While one recognises the contribution of the family planning department in promoting contraception and increasing people's awareness about them it is too far fetched to give the credit of fertility reduction to the program. Fertlity reduction has its own logic and worldwide it has come about only with change in people's objective reality, that is improved conditions of living, livelihood and social security. Conditions of poverty and large-scale inequities will normally not lead to the desired demographic transition. History bears witness to this !

Saying No to a Separate Reproductive Health Approach

While the elements defined in the package for reproductive and child health services are essential and must be provided it cannot by itself be an essential program. It must of necessity be part of a basic health and medical care program. Good quality basic health and medical care must be the starting point for meeting health care needs of a population and it must be made available universally and not linked in anyway to the ability to pay for it. One must also move away from the tendency of romanticising health care as was done with the community health approach (demystification, peoples health in peoples hand, non-medical model etc...) A basic medical model is essential and desireable (not over-medicalised as in the USA) and its social components must be constructed on such a base - doctors and nurses must form the base and paramedics and others must provide the support to give it a social and people-centred character, that is standing the classical community health model on its head ! I will come back to this later.

Thus, while recognising the importance of reproductive health, especially in a country like India which still has relatively high fertility, an overwhelming proportion of deliveries being conducted at home, often under unhygienic conditions, a supposed unconcern for gynaecological morbidities, an embarrasingly high proportion of abortions being done outside the legal framework, etc... it becomes even more important to emphasise the need for making available comprehensive health services to all, and especially to women as a group for their special needs. And as mentioned earlier the danger of beginning with reproductive health (as a separate or special program) is narrowing down the focus to the uterus, precisely what the women's health movement wants to avoid. Thus the demand must begin with provision of easily accessible and free of cost (at the point of care) comprehensive health care for all, with a clear recognition and provision for special needs of women, as well as of other vulnerable groups like children, the aged, tribals etc...

Thus, fitting the suggested reproductive health services, which have been well thought out, within a comprehensive basic health system should be the essential goal and not fitting it into the current family welfare framework. Hence one cannot but agree with the recommendations in the report about five specific actions to be taken - define a package of essential services; improve access to good quality services; make services more responsive to client needs; make sure that the frontline workers have the skills, support and supplies they need; and strengthen the referral system. But such a package, we emphasise again, must be one of

comprehensive basic health care in which the package suggested by the report becomes an essential part.

It is important to emphasise a comprehensive package of total health and medical care because India's experience with separate programs for each major area of health problem has not only shown major failures but also resulted in wastage of the already small amount of resources which the public health sector is allocated from the state finances. Hence, its time that structural changes are made in provision and financing of health care and not by adding another set of special programs for a select group of population. We have done the latter for too long and wasted public money on programs which have been not only unable to fulfill their objectives but also have alienated people from the public health system, especially in the rural areas.

Basic Health Care

While this is not the forum to discuss a detailed plan of action we can atleast define the provisions which should go into this comprehensive package in the context of the five specific actions stated in the Report under review. First, a list of services which a comprehensive primary (or basic) care should include :

-general practitioner / family physician services for personal health care
-first level referral hospital care and basic specialist services - paediatrics, gynaecology and obstetrics, general medicine, general surgery, dental services and opthalmology, including special diagnostics
-immunisation services for vaccine preventable diseases
-maternity services for safe pregnancy, abortion, delivery and postnatal care
-pharmaceutical services - supply of only rational and essential drugs as per accepted standards
-epidemiological services, including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures
-contraceptive services
-health education and information
-ambulance services

The above must be viewed as a single package of minimum care which must be available universally and without any direct payment. They must be supported by secondary and tertiary levels of care which are already quite well developed in India and only need to be reorganised in the new context. The provision of such care of necessity has to be a public-private mix (given the fact that India probably has the world's largest private health sector), with monopoly buyer/s which need not be the state alone. This also means regulation, control and audit, none of which presently exist vis-a-vis the private health sector. And it goes without saying that special needs of women, including their reproductive health needs as discussed in the World Bank document will be an integral part of this package with each service available at the appropriate level.

Alternate : *Drop Family Planning as a separate program and strengthen provision for basic health care under a universal organised health care system to meet needs and demands of people (in which reproductive and child health care and contraception will be important components).*

Policy Recommendations

World Bank : Eliminate method specific contraceptive targets and incentives. Replace them with broad reproductive and child health goals and measures. Increase the emphasis on male contraceptive methods and broaden the contraceptive method mix.

Alternate : *Restructure and organise the public health system to provide universal basic health care with supportive referral services in basic specialities, which would be sensitive to special needs of vulnerable groups like children, women, elderly, tribals etc.. Remove targets from all health programs and introduce measures of social audit and accountability.*

Public Sector Recommendations

World Bank : Improve access to reproductive and child health services. Respond more effectively to client needs, for example, by listening to clients' preferences, and by imroving service quality. Increase support for the frontline workers, for example, by enhancing the quality of training, and providing adequate supplies. Improve the referral system, especially for essential obstetric care, by strengthening the Primary Health Centres and First Referral Units.

Alternate : *Improve access to basic health care by strengthening provision, especially of non-salary inputs. Respond more effectively to client needs by making available basic services which they need and by improving service quality. Strengthen basic medical humanpower in primary care and increase support for them and other frontline workers through provision of adequate supplies, improved training, better working conditions, removal of targets etc.. provide opportunities for staff to upgrade their skills, for example, ANMs could undertake intensive courses to become full fledged nurses, and nurses similarly could become doctors, which in the long run would help women to get both better access to health care and better attention of their health needs as women. Improve the referral system by strengthening the Primary Health Centres as above, as well as strengthening the basic specialities at the First Referral Unit (Rural Hospital or Community Health Centre).*

Private Sector Recommendations

World Bank : Increase the role of the private sector, especially by : a) revitalising the social marketing program and adding health and nutrition products, b) expanding the use of private medical practitioners in the provision of reproductive and child health services, and c) continuing to encourage experimentation with an

The Private Health Sector

The private health sector as it exists today is not fit for collaboration in such a venture but its sheer size necessitates its planned and regulated involvement. The state has to start a process of planning for and involving the private health sector in the same manner in which it does with regard to many areas of economic activities. The myth of the private health sector being more efficient and of providing better quality care has already been adequately exploded in India and the time is ripe now to start the overdue need for its regulation, control and audit. In an organised public-private mix of health care services the private sector will play a dominant but regulated role at the first level of care, that is family physician services, as also participate in terms of its capacity at other levels.

Financing

With regard to financing it must be pointed out that vis-a-vis the overall budget the amount allocated to family welfare (over 17%, in 1994-95 Rs. 13.5 billion or $ 0.42 billion) is a subsatntial amount. And we must remember that with the current orientation of health services, resources from other sub-sectors of the public health system are also used for the family planning program, especially human resources. It is understandable that this amount is far less than what is required for the suggested reproductive health approach, but what is worse is that the overall health care budget is far far more inadequate than what is needed to meet peoples' basic health care demands. We have to demand the overall increase of resources for the public health sector close to the WHO recommendation of 5% of the GDP. And we must remember that any provision within the limit of this ratio can in no way be termed as high cost. And we must also emphasise that presently all this cannot come from tax revenues and hence other avenues of financing, especially from the organised sector (employers and employees), farm incomes of the middle and rich peasntry etc.. need to be tapped through insurance, social insurance, health care taxes and cesses etc.. and not user charges which is by now an ancient concept. Thus the role of the state in organising the finances for such a system will be crucial and its responsibility of prime importance especially for the poor.

Alternate Recommendations Vis-a-Vis The World Bank

To sum up the discussion above we list out our recommendations as against those of the World Bank being pedalled with the government of India.

Overall Recommendations

World Bank : Reorient the Family Welfare Program, as quickly as possible, to a reproductive and child health approach that meets individual client health needs and provides high quality services.

expanded role for the private sector in implementing publicly funded programs; monitoring the experiments and identifying best-practice for dissemination system-wide.

Alternate : *Involve the private sector by : a) organising them under a single umbrella to provide basic health care under a public-private mix system, b) linking them with various preventive and promotive public health programs in a socially meaningful way, and c) creating mechanisms to regulate them as a measure for social accountability and public benefit.*

Finance Recommendations

World Bank : Increase the budget for reproductive and child health, to meet the staffing and other critical gaps, to enhance service quality, and to offer an essential reproductive health package; and use funding as a performance incentive to reorient the program towards a reproductive and child health approach by taking steps to improve state level finances.

Alternate : *Increase the overall budget for basic health care to meet basic health needs / demands of people and use monopoly financing as a tool to both regulate the system as well as integrate the public and private provision of health care. The allocations to various program heads should be based on expressed demands of the people, especially those in presently underserved areas. Using innovative methods to enhance resources by targetting indirectly people with capacities to pay and doing away with all forms of user-charges at the point of seeking care.*

HP 3:9

THE NATIONAL POPULATION POLICY: PROBLEMS AND POSSIBILITIES

By Imrana Qadeer

The National Population Policy (NPP) announced by the government indicates that, at least on paper, the oscillation between a coercive and a voluntary approach has been settled in favour of the latter. The document unambiguously states that it strives for a welfare strategy that is voluntary, target-free, and integrated with key components of the welfare sector. It also states that the "overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society".

Looking at past population policy guidelines, the present policy appears to be a step forward. The policy makers have arrived at this public position only after repeated failures of earlier strategies, and not necessarily because of their enlightened collective assertion. It is therefore problematic as it comes at a point of time when the very components with which the strategy is to be integrated are being dismantled by rapidly receding State initiatives.

The population policy fixes a goal of population stabilisation by 2045. It envisages that population replacement levels will be achieved by 2010. To achieve these goals a range of objectives have been set up. These include:

- effective coverage with reproductive and child care services to reduce infant mortality rates, maternal mortality rates, and total fertility rates;
- education up to secondary level;
- delay in age of marriage;
- registration of vital statistics;
- control of communicable diseases, with a special focus on AIDS; and
- a commitment to convergence of social sector programmes.

To achieve these objectives a set of twelve strategies is spelt out. Many of these are continuation of previously accepted strategies. Such as decentralised planning fo reproductive and child health (RCH), education up to 14 years of age, convergence welfare services, empowerment of women, insuring child health, providing for the unm need for family welfare and for the basic needs of the under-served. Special needs adolescents and men, use of diverse health care providers (NGOs and private secto mainstreaming Indian system of medicine, strengthening contraceptive research, effecti information education and communication strategies, and providing for the old population are also not new. Notable among the new steps is the proposal to revive system of licensed medical practitioners to fill in the gaps in clinical care and to conve

services at the village level. While these are welcome strategies, their content leaves much to be desired.

The policy document raises two sets of questions. Firstly, how consistent is the content of the policy document with its overall perspective? Secondly, how will the challenge of convergence (of the welfare sectors) be interpreted by the States, which will actually be implementing the policy? This paper attempts to explore these questions. It is our belief that if the inherent contradictions within the NPP and the potential of coercion in the implementation of this policy are not corrected right at the beginning, and strict guidelines not provided, the policy will fail to realise its potential.

INTERNAL IN CONSISTENCY OF THE POPULATION POLICY

There are some very obvious inconsistencies in the NPP, which need to be addressed if the policy has to acquire a positive edge. Some key areas for consideration lie in the dissonance between the NPP's welfarist approach and the reality of the government's disinvestment plans, between primary health and reproductive health, between convergence of welfare services and the available structures, and between voluntarism and coercion.

Conflicting Population and Development Policies:

If the population policy's expressed concern for quality of life and well being is genuine, then structural issues cannot be under-emphasised, even when it is accepted that population number is an important factor in development. The NPP document, however, neither talks of land reforms or strategies for employment generation and food security systems, nor of ensuring the celebrated 'safety net'. But it does reiterate that, "stable population is an essential requirement for promoting sustainable development with more equitable distribution", thus making it a one-way process. It warns, "if current trends continue" India's population may overtake China's by 2045! And it adds that, "at the current growth rate, the additions 'neutralise' efforts to conserve resources and environment!"

These demographic fears are not new. They reflect a mind-set rather than a real new threat - a mind set that is unable to accept the complexity of the problem and that must hide behind these linear projections. In India, for example, despite the perpetual failure of the family planning programme for population control, birth rates have steadily fallen over the 20th century (1). Interestingly enough, in 50 years of planning, the programme targets have never been achieved at the end of a Plan period (except during the Emergency!). As things stand, there is nothing different as far as the present projections go. But over the later half of the 90s, the rate of decline of infant mortality rate (IMR) has slowed down and, over 1996-98, the Sample Registration Scheme shows its reversal in at least eight major States (2). Thus, the not-so-improbable danger that population growth rate may come down, but because of the added factor of rising mortality rather than declining fertility rates, has not been taken note of by the NPP.

The above trends, along with the increasing pressure on land, ensuing migration and the unmet need for contraception, indicate that, instead of using hypothetical situations to justify the so called 'dangers' inherent in India's demographic status, there is an urgent need to look at the processes behind demographic shifts. By blaming future population growth for the "neutralisation of efforts to conserve the resource endowment and environment", the policy, at best, protects processes such as liberalisation and Structural Adjustment that ensure a kind of development which sustains only certain sections at the cost of others. The NPP yet again refuses to accept that population stabilisation requires efforts to create well-being, which is a necessary prerequisite of, or an instrument for, population stabilisation, rather than the exercise of demographic goal fixing!

Just the issue of utilisation of natural resources shows that it is the international market-oriented model of development and its strategies that cause mindless destruction and waste and certainly not population numbers, even when they are increasing. For example, the pattern of industrial growth is characterised by large-scale closure, privatisation, and displacement of workers, in a way that the worsening employment situation affects their well-being (3). Despite adequate growth rates, poverty levels have not changed much. Rural poverty, in particular, shows stagnation over the 90s (4). There is also evidence of severe destruction of life and livelihood. In Andhra, 300 cotton growers committed suicide, as they could not sustain their livelihood within the shifting policies that generated a systemic crisis (5). At the Narmada Dam site, the so-called development created death traps of malaria and human displacement (6), which have become key contributions of development projects in independent India (7). These projects are meant to "adjust" Third World economies to suit the hi-tech markets and for the promotion of distorted development.

Even when we look at those above the poverty, there is sufficient evidence to show that majority of them are negatively affected by the ongoing social and economic processes. For examples in late 90s, total employment has declined - especially among the literate and the educated - who seek employment other than manual (8). Similarly, the contraction of the unorganised sector in the late 90s has pushed a large number of rural people into relatively low productivity areas. Added to this is the shrinking social sector that reduces employment opportunities (9), and makes services inaccessible as private sector hikes prices of health, education and other necessities.

These examples illustrate that the conflict is not simply between the "population added" across classes and the resources generated by those classes, but between sections of population with respect to control over resources, irrespective of the population added. The issue is more of livelihoods for the poor, and their basic rights to survival with dignity, against the rights of other classes to further enrich themselves. The inability of the NPP to focus on the broader linkages is also reflected in its narrow approach to under- nutrition. It clings to Integrated Child Development Services (ICDS) alone and to distribution of micro-nutrients when studies in the past have shown the inadequate coverage and the

inability of the feeding programmes to impact nutritional status of the population (10). These programmes were actually short-term strategies, initiated in the 60s and 70s to tackle a crisis situation. The assumption was that with long term planning, these would become redundant.

As it is now, the NPP does not mention any concern either about the failures of the Public Distribution System (PDS), nor of the process of commercialisation of agriculture that is undermining the food security system (11). Employment opportunities for the unemployed, ensuring minimum wages, public distribution system for food grains and electrification are not important issues for the NPP. By avoiding a review of the nature of the developmental process that burdens the weak and forces them to wait for relief and not defining concrete shifts in structure for the benefit of the marginalised, the NPP creates a myth of perfect choices and opportunities. This fits the demographic requirements of the globalisation process that demands the profitable use of hi-tech but not of human labour.

Conflicting RCH and Primary Health Care Policies

While the NPP proposes an integrated approach to basic health care, it in fact reduces basic health to RCH. This is at the cost of general health care, especially for women. In the absence of an explicit health policy, the NPP sends a clear message about the priority being placed on population control as against Primary Health Care (PHC). The previous health policy, that had committed itself to achieving PHC by 2000 AD, has not merited even a reference in the NPP document. It talks only of "primary level care". The supportive secondary and tertiary care essential for PHC is ignored, as is the notion of comprehensive development of communities. The result is that Primary Health Centres and Sub-Centres have been totally identified with the Family Welfare Programme in the NPP. This will only further alienate people from the peripheral institutions.

The NPP, instead of strengthening PHC, appears to initiate a quiet process of appropriation of the basic infrastructure for RCH, while simultaneously condemning the existing infrastructure for lacking 'supervision' and 'motivation' and for being limited and over burdened! The policy, in fact, goes out of its way to declare that the last 50 years have demonstrated "the unsuitability of these yardsticks" for assessing health care infrastructure, particularly for remote, inaccessible, or sparsely populated regions. According to the NPP we need to promote, "a more flexible approach, by extending basic RCH care through mobile clinics and counselling services". In other words, experiments such as mobile clinics that were proven to be costly and a failure in the 70s (12) are being revived at the cost of that very infrastructure that needs resources for its rejuvenation. There is not a word to explain why RCH cannot remain a component of PHC and why the available infrastructure (among the best in South Asia) cannot provide comprehensive PHC (i.e. including RCH), fully supported by secondary and tertiary level care.

There is much talk of "partnerships" and mobilising a variety of service providers to overcome the need for infrastructure. However, what would be the State's share of

responsibility in the areas identified and how much would the partners contribute, remain- any one's guess. The "partners" seem to be free to bargain with the government on this issue. At the same time, with cuts in subsidies and plans to privatise welfare sector services, the access of those who need the services most will necessarily be marginalised further.

While the NPP emphasises quality of RCH care, it also proposes, "elimination of the current cumbersome procedures for registration of abortion clinics"! This is counter to all notions of strengthening and enforcing mechanisms for standardised services. Registration is a means to assess the adequacy of the institutional infrastructure and its quality. Any dilution of conditions for registration will have a direct effect on the quality of services provided by institutions. Laxity in registration will ensure only profiteering by unscrupulous providers and not add to expansion of effective services in the real sense.

As a part of its integrated strategy, NPP does mention control of communicable diseases but does not comment on their vertical structures, their inefficiency and inappropriateness (13). With their exclusive single purpose workers, who travel to the same places and multiply travel costs as well as waste people's time by increasing the number of visits per family, the present vertical programmes enhance inefficiency. This was recognised by the government itself in early 1970s when the Ministry of Health and Family Welfare introduced the concept of multipurpose workers (14).

The NPP's exclusive focus on AIDS control programme is due to the perception of a shared interest in promoting condoms and treating reproductive tract infections and sexually transmitted diseases. The policy does not recognise the dangers of poor infrastructure for PHC that makes the population vulnerable to contacting AIDS through the use of inadequate facilities such as unsterilised syringes. The programme records 24% of the AIDS cases come from among professional blood donors, drug users, recipients of blood transfusion and others (15), which are indicative of laxity of services. Yet, there is no accurate assessment of the implications of the inadequacy of the PHC services for AIDS. It is evident that improving the quality of PHC (including blood banks) will contribute to AIDS control. An aid amount of Rs. 1425 crores from the international funders for the second phase of the programme seems only to enhance its vertical nature (16). The NPP ignores the social situation that was conducive to the spread of AIDS. As a result people remain victims of their conditions, as well as of the very system of health care that was to protect them.

This deliberate undermining of PHC services and the NPP's linear approach to RCH is damaging to the cause of reproductive health itself. The problems of maternity and infant health are the outcome of a continuum of ill health for women. Over 40% of deaths among girls under 14 years of age are caused by communicable disease (17), and anaemia and malnutrition are prevalent in about 60-70% of the women (18). Therefore, no amount of reproductive health services alone can be effective. The reproductive system is a part of the body and a sick woman can hardly sustain a healthy reproductive system. It is well known that a significant part of maternal mortality is due to sickness. Any isolated

approach to RCH can, therefore, only be self-defeating. Thus, it is very significant that the NPP rejects the positive ideas evolved by an earlier draft that had called for "a restructuring of the ministry", in a manner that its two departments are actually merged, and vertical programmes are integrated into the general health services (19).

Conflicts Between Conceptual and Structural Needs of Convergence

Just like the professed policy for integration of RCH, the stated strategies for converging welfare services to strengthen RCH are vague, weak, and ill defined. It is also not clear that, if the prescribed services (such as primary and secondary education, housing, drinking water etc.) are to be provided to the needy, then how are the respective departments going to define their tasks and restructure themselves so as to be able to deliver these services. A policy of inter-sectoral convergence can be successful only when the ministries have clear guidelines and mechanisms for delivery of the required services. These guidelines are missing in the NPP. In which case simply putting bureaucrats from the concerned ministries on to the Population Commission may not help. These services can be supportive of RCH only when they are operative in the field and cover both the rural and urban poor. For this the respective departments need to undertake very clear-cut financial and structural reforms.

By adding a hundred member National Population Commission to oversee the implementation, the policy does not actually set up an efficient mechanism for implementation of policies. The Commission's members are from different walks of life. They may be imbued with excellence in their own area of expertise but they are bound to have varying competencies in assessing issues of implementation of the NPP. These issues range from technological, administrative, financial, organisational, to social and ethical ones. At best the Commission can work towards evolving a consensus on issues. To oversee implementation a more cohesive group will be required, with clearly set evaluation mechanisms and working on a continuous basis. The policy does not visualise any such rigorous mechanism. It neither sets up an internal assessment mechanism within the Ministry, nor an independent external monitoring mechanism through the Planning Commission. In the past the Planning Commission has provided excellent monitoring services for the family welfare programme (20). But the NPP only proposes to use the Planning Commission as a co-ordinating unit.

The reasons for the absence of rigorous mechanisms are not difficult to identify. The health sector has to function as a sop to get soft loans and international aid to keep up the trickle of foreign currency to correct the balance of payments! As a result, the tags attached to developmental programmes have to be accepted. Consequently, the distortions in the welfare sector have to be ignored rather than remedied. It is not surprising then that, despite so much emphasis on Panchayati Raj, both the devolution of power and disbursement of funds remain inadequate.

It is apparent that plans evolved by international funding agencies like the World Bank cannot be over-ruled, despite all the wisdom buried in the shelves of the Ministry of

Health and Family Welfare and government institutions. The forgotten report of the Planning Commission's Working Group on Population (21), and the ICMR-ICSSR Report on PHC (22), reflected the official understanding of population stabilisation as a function of well-being. PHC for the underprivileged was seen as much more than simple mid-way correctives in the delivery system. And, for all this, major restructuring was envisaged. Today, all that has become a thing of the past. The NPP, on the face of it, appears to be striving for a broad comprehensive approach, but is actually trapped in the demographic compulsions of the prevailing economic policy. A policy that reduces, rather than increases, investments in the welfare sector (except for population control) and forces restructuring to promote markets for the planned benefit of a handful.

The lack of legal structures to support the policy is yet another aspect of the conflict between strategies and structures. The NPP's treatment of women's empowerment reveals not only a lack of sensitivity towards the issue but also a poor understanding of it. For example, empowerment is to improve "nutrition related capabilities that become crucial to a woman's well being, and through her, to the well-being of children". How this empowerment will happen is not clear except that Panchayats are expected to provide them employment. In the absence of resources within the Panchayats, this remains a hypothetical proposition. Only one thing is clear: according to NPP, women's health and nutrition problems can be largely prevented or mitigated through "low cost interventions designed for low income settings". Thus, while one is not sure of their empowerment, women's destiny to stay in "low income groups" is assured.

Except for extending the legal freeze on the 42nd Amendment to 2026 AD, so that the states may "fearlessly and effectively pursue the agenda of population stabilisation", no other legal provision is offered that might be supportive of women. The legislative requirements for ensuring women's right to information, property rights, political participation, and safety etc. all are missing. Women's empowerment is thus seen as a programmatic intervention from above that promotes fertility control rather than creates enabling conditions for them.

Conflict of Voluntary Acceptance and Coercion

The NPP courageously rejects force and coercion. It is therefore critical that the same does not re-enter the programme through the back door of motivational strategies. This is imminent in three steps being included in the policy proposals. There is a proposal to start national health insurance coverage for hospitalisation costs for children below 5 years of age. It is however linked to acceptance of terminal methods of contraception and small family norm by the family. The policy thus proposes to deny help to a child for the acts of its parents! Should a NPP working towards well being do so, when that child invariably will be a little girl who is dispensable in families waiting for the arrival of a son?

The second proposal is for those below the poverty line. A health insurance scheme, again for hospitalisation not exceeding Rs. 5000, and again linked to acceptance of the two-child norm. The spouse accepting sterilisation is also given a personal accident

insurance cover. Shouldn't those below the poverty line be given assured services and better coverage without arm-twisting, so that well being induces acceptance of a small family and population stability, rather than denying basic amenities? The third proposal is to honour and award the Panchayats and Zila Parishad for successful performance on the basis of services provided, excluding sterilisation and harmful contraceptives. However, such incentives may induce pressure for achievement and we have the experience to foresee which section will bear the brunt of this pressure.

The NPP lacks trust in the people. It assumes that they do not think of their welfare and hence a certain amount of pressure and conditional incentive are required. This is dangerous because the limits of these pressures are very ill defined. Perhaps this attitude is born out of the knowledge that, in the present policy for overall development, there is no scope for well being of the poor. They have to bear the burden of the Structural Adjustment Policies and hence must be coerced, coaxed and pushed, not through well-being and expanding opportunities, but through pressure and coercion.

Interestingly, the lack of trust in people is not limited to the common people alone - it extends beyond. The NPP proposes to set up two technology missions outside the purview of the existing national research institutions. One of these is for neonatal care and the other for the assessment of new contraceptives. While the first is to be composed of Indian obstetricians and paediatricians, and is called the National Technical Committee, the second is called the Technology Mission and will have international experts on it! Thus, in the name of high-powered commissions the NPP brings in international interest groups on national planning commissions. This Technology Mission will be within the department of Family Welfare itself and will work towards the incorporation of "advances in contraceptive technologies". This is an extremely retrogressive step. It undermines our own scientific community that has worked with diligence within research institutions like ICMR, and saved the programme from incorporating harmful contraceptives such as Depo-Provera and Quinacrine pellets. All of these were proven to be damaging to women in India and elsewhere (23,24,25), but were being pushed by corporate experts. It also unnecessarily duplicates institutions while there is resource scarcity.

The case of Quinacrine is particularly alarming, where ethical concerns have collapsed altogether. Despite WHO's advice to stop all trials, unscrupulous doctors have - taking advantage of weak control systems and free market mechanisms - promoted the use of this unapproved contraceptive among unsuspecting women. This drug has not even cleared the required stages of testing necessary before a human trial and yet First World academic journals have chosen to publish the unethical human trials on Third World women as scientific research (26).

We therefore need to ask, why do we need foreign experts in our National Technology Missions? What role did the foreign experts play in the past; be it the Family Welfare Programme, the National Malaria Programme, the Tuberculosis Control Programme or the AIDS Control Programme? In the Family Welfare Programme they advised to keep maternity and child health services out of the scope of the programme, as

the poor state of health of women and children would exhaust all resources (27). India was pushed into accepting a National Malaria Eradication Programme without any preparatory phase, a necessary component of the programme design (28), and paid a heavy price for it when hit by resurgence of the disease. Similarly, Directly Observed Treatment Schedule (DOTS) has been thrust on the Tuberculosis Control Programme against the advice of national experts who had clearly outlined a more economic and context specific alternative strategy (29). "Experts" have also made projections of AIDS for India that promoted panic and ignored the specificity of the Indian population. They ARE also shifting attention towards treatment OF AIDS without at all considering the problem of its control (30). Without a rational strategy for control, AIDS becomes yet another means for expansion of foreign markets in technology and dependence of the Third World. What role are the technical experts in the mission going to play now and whose interest will they represent?

Hints of vested interests are visible in the pressure on the Third World to do away with stringent safety guidelines in research and take up more of the so-called "essential research". This research will be funded by international agencies but will be conducted in the Third World for the benefit of humanity (31). There is a view that life is cheap in the Third World, hence it can be used as a dumping ground (32). The increasing use of Third World populations as cheap human material for experimenting with new technologies (33) are indications of a trend. It is, therefore, extremely critical to understand who provides the technical expertise and for whose benefit.

PROBLEMS OF IMPLEMENTATION

The implications of these contradictions are evident in the State Population Policy documents circulated by Uttar Pradesh and Madhya Pradesh. Both these states join Maharashtra, Haryana and Rajasthan in enacting laws that debar people from elections to the local bodies (but not to Parliament!). The thrust of their Population Policy is fertility control through the RCH approach. The two policies barely articulate their broader developmental strategies. Also, little is said about enhancing opportunities, capabilities, or convergence of inter-sectoral development.

Uttar Pradesh (34) for example, proposes to:

(i) Refuse government services to those who marry before the legal age of marriage.

(ii) Sterilisation will continue to play a critical role in its strategy.

(iii) Hold sterilisation and RCH camps! It does mention "periodic reviews" and "follow ups" to diffuse the damaging image the word "camps" elicits (35). At the same time, it confesses that camps are not the best way to provide high quality services on a regular basis. Yet it hopes to "improve access to and quality of services".

(iv) Performance appraisal of medical officers will be based on their "contribution to meeting RCH needs"! This means that if they do not perform other duties it does not matter!

(v) People will be "encouraged to utilise services of the private institutions" at all levels of the district. These will be identified by the State and given support both in terms of equipment and resources. This not only means that the tax payer's money is diverted into the private sector, but also that those 36% people who are below the poverty line (36) may not get any secondary or tertiary level care even for RCH.

(vi) Train its workers & upgrade their skills and knowledge in modem research with newer technologies. However, there is not a word of caution about the use of contraceptives that are not suitable for Indian conditions. In fact, the State proposes to incorporate material on injectable contraceptives in its training and hopes to conduct operations research to assess the possibility of introducing injectables and other new technologies in family planning services. It needs to be pointed out that operations research helps optimise a system. The choice of technology should depend upon epidemiological studies. The fact that the Ministry has not included injectable contraceptives in the National Family Welfare Programme, and epidemiological studies have shown that they are inappropriate, is totally ignored (37).

(vii) Despite the fact that the Centre has created a special fund for population stabilisation and the NPP considers RCH a basic service, Uttar Pradesh proposes to introduce user fee even for RCH. This is proposed despite the evidence that user fee excludes the poorest from services (38).

The State of Madhya Pradesh (39), chooses education and Panchayati Raj as its main social sector programmes that will support its population stabilisation strategy. The rest of the welfare sector does not enter the debate nor does the document state the share of resources to be provided for the Panchayats for the social sector programmes. Along with these, the policy proposes that:

(i) Persons having more than two children after January 26th, 2001 would not be eligible for contesting elections to Panchayats, local bodies, or co-operatives in the State.

(ii) Legal age of marriage will be made a criterion for employment.

Thus, on the one hand there is talk of empowering women, and on the other hand policies like the above negatively affect women. The majority of women are hardly in a position to either decide the age at which they are married or the number of children they bear. If these State policies are any indication of future possibilities, then it is clear that coercion is there to stay. Child marriage, for which the social and economic conditions of parents are responsible, will further deprive an already hopeless youth (especially girls) from seeking opportunities.

In addition to these two States, the Maharashtra government is reported to have put up a most draconian bill for the approval of the Governor. It not only refuses families with more than two children all welfare facilities (housing, land for housing or agriculture,

free studentship, loans etc), but also denies the third child rationed food grains and even health care for the mother and the infant! Even the poorest are not spared the wrath of this policy (40) and the Minister of Food and Civil Supplies is reported to have justified the decision as being "in the national interest" (41).

Thus we see that, in the interpretation of the national policy, the States reflect a single-minded pursuit of the demographic goal. Whatever was left of the public sector health services is going to be fully appropriated and peripheral health institutions will be transformed into RCH service outlets. As a result, the workers may not have time for the rest of the services for which they were earlier responsible. The poor will be further marginalised and sucked into the vortex of a free market for health care being formally promoted by the States by providing space and formal financial assistance to the private sector. What then, is different about this NPP except its liberal camouflage?

It is evident that the NPP yet again falls short of striking a balance between well being, through increased human productivity, and population numbers. The latter by itself makes little sense unless seen in terms of integration into or alienation from the economic and social processes. The NPP, unfortunately, is too preoccupied with demographic targets to provide that balance. The States have taken their cue and are going to alienate a big chunk of the population from the mainstream socio-economic process, labeling them as undesirable and an obstruction to development. We seem to be losing sight of the fact that the level of poverty in the country is stagnating. Even those who are above the poverty line are increasingly facing greater insecurities due to shrinking employment opportunities, under employment and a failing service sector. The IMR is not only stagnating but also giving hints of a rise in some of the major States (42). In such a situation, should demographic achievements of fertility control alone be considered the need of the hour?

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Engagement + Nadgir
National Pop Commn

भारत सरकार
राष्ट्रीय जनसंख्या आयोग
योजना भवन, संसद मार्ग
नई दिल्ली - 110001
फोन : 3710051, फैक्स : 3717681
Government of India
National Commission on Population
Yojana Bhavan, Parliament Street
New Delhi-110001
Tel. : 3710051, Fax : 3717681

I SHNA SINGH
Member Secretary

D.O.No. N-11011/25/2000-NCP

October 4, 2000

Dear Ms Jain,

In pursuance of the decision taken in the first meeting of the National Commission on Population held on 22nd July, 2000, Working Groups as described in the Order enclosed have been constituted. While constituting these Groups, we have tried to take into consideration options / preferences given by the Members and their area of specialisation. I am glad to inform you that you have been nominated to the Working Group(s) detailed in the Order enclosed.

The first meeting of your Working Group(s) is likely to be convened shortly.

With regards.

Yours sincerely,

Krishna Singh

(Krishna Singh)

Ms Devaki Jain
Singamma Sreenivasan Foundation
"Tharanga" 10th Cross,
Rajmahal Vilas Extension
Bangalore.

No N-11011/25/2000-NCP
Government of India
National Commission on Population

Room No.243, Yojana Bhavan,
Sansad Marg, New Delhi – 1.

Dated 4th October, 2000.

ORDER

Subject: Working Groups of the National Commission on Population.

(1) In pursuance of the decision taken in the first Meeting of the National Commission on Population held on 22nd July, 2000, the following Working Groups are constituted:

I) **WORKING GROUP ON STRATEGIES TO ADDRESS UNMET NEEDS :**

a) Sub-group on strategies to address unmet needs for contraception
b) Sub-group on strategies to address unmet needs for maternal and child health
c) Sub-group on strategies to address unmet needs for public health, drinking water, sanitation and nutrition
d) Sub-group on strategies to address unmet needs for empowerment of women and development of children

a) Sub-group on strategies to address unmet needs for contraception

i) Mr. K. Srinivasan, Ex. Health Secretary - Chairman
Members:
ii) Dr. Nina Puri , President, FPIA
iii) Dr. Saroj Pachauri, Regional Director, South and South East Asia Population Council
iv) Prof. Sunder Lal, Rohtak Medical College, Indian Association of Preventive and Social Medicine
v) Shri K. Gopalakrishna, President, JANANI
vi) Shri Alokendu Chatterjee, President, Federation of Obst. & Gyna. Society of India, (FOGSI)
vii) Prof. Ranjeet Rai Choudhary, Scientist, National Institute of Immunology
viii) Dr. D. Takkar, Head of Department, Deptt. Of Gynaecology, AIIMS,
ix) Representative of Birla Management Corporation Ltd's Community Initiatives and Rural Development, Mumbai.

x) Representative from Hindustan Latex.
xi) Representative of National Commission on Population
xii) Secretary, Family Welfare, Government of Bihar
xiii) Secretary, Family Welfare, Government of Rajasthan
xiv) Representative of Department of Family Welfare - Convenor.

Special Invitees

i) Dr.(Ms.) Banu Coyaji, Director, KEM Hospital, Rastapet
ii) Dr. Sharad Iyengar, ARTH, Udaipur
iii) Representative of Department of Indian Systems of Medicine & Homeopathy
iv) Sudha Tiwari, Parivar Seva Sanstha.

Terms of Reference

i) To identify gaps and
ii) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
iii) To consider any other matter related with or incidental to the above terms of reference.

i) Sub-group on strategies to address unmet needs for maternal and child health

Secretary, Health, Government of India, Chairman
Members
i) Shri Dileep Kumar, Indian Nursing Council
ii) Shri Abhay Bang, SEARCH, Gadchiroli
v) Dr. T.N. Mehrotra , President, IMA
) Dr. (Ms.) Manorma Singh, Ram Manohar Lohia Hospital
) Shri Alok Mukhopadhyay ,Chairman, VHAI
i) Mrs. Neidonud Angami, President, Naga Mothers' Association
ii) Dr. Badri N. Saxena, Centre for Policy Research
iii) Representative of Department of Family Welfare
x) Representative of Department of Women & Child
) Representative of Department of Social Justice
i) Representative of National Commission on Population
ii) Secretary, Family Welfare, Government of Madhya Pradesh
iii) Secretary, Family Welfare, Government of Uttar Pradesh
lv) Adviser Health, Planning Commission
v) JS (FW/RCH).
vi) Department of Health - Convenor

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

c) Sub-group on Sub-group on strategies to address unmet needs for public health, drinking water, sanitation and nutrition

i) Dr. H. Sunderasan, Ex-Vice Chancellor (Madras University) - Chairman
Members:
ii) Ms. Imrana Qadir, Professor, Population Studies, JNU
iii) Dr. B.K. Tiwari, Nutrition Adviser, DGHS
iv) Prof. K.J. Nath, All India Institute of of Hygiene & Public Health, Calcutta
v) Mr. Bindeshwar Pathak, Sulabh International
vi) Representative of Department of Rural Drinking Water
vii) Representative of Department of Urban Drinking water
viii) Representative of Department of Women & Child development
ix) Representative of Department of Environment
x) Representative of Department of Health
xi) Representative of National Commission on Population
xii) Dr. Prema Ramachandran, Adviser (Health), Planning Commission
xiii) Adviser or Representative, Drinking Water/Sanitation/Planning Commission - Convenor.

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

d) Sub-group on strategies for empowerment of women, development of children and issues relating to adolescents

i) Mrs. Margaret Alva, Member of Parliament - Chairperson
Members:
ii) Ms. Ela Bhatt, SEWA, Ahmedabad
iii) Dr. Swapna Mukhopadhyay, IEG, Institute of Social Studies Trust

iv) Ms. Devki Jain, Sangamma Foundation
v) Ms. Aaditti Mehtta, Rashtriya Mahila Kosh
vi) Dr. Suroj Pachauri, Regional Director, Population Council
vii) Dr. Tyagi, Indian Academy of Paediatrics, Department of Tele Medicine, AIIMS
viii) Dr. Sunil Mehra, MAMTA
ix) Representative of Department of Women and Child development
x) Representative of Department of Youth Affairs
xi) Representative of National Commission on Population
xii) Representative from IGNOU
xiii) Adviser or Representative, Social Welfare, Planning Commission - Convenor.

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

II) WORKING GROUP ON PRIMARY AND SECONDARY EDUCATION IN RELATION TO POPULATION STABILIZATION.

i) Dr. K. Venkatasubramanian, Member (Education), Planning Commission - Chairman.

Members :

ii) Dr. (Mrs.) Usha Nayyar, NCERT
iii) Prof. Mohd. Amin, Ex- Vice Chancellor, Jamia Hamdard
iv) Dr. Ketan Desai, President (MCI)
v) Dr. Digvijay Singh, Ex-M.P.
vi) Ms. Jaya Jaitley, President, Samata Party
vii) Mr. B.G. Deshmukh, Ex-Cabinet Secretary/Pr. Secretary to PM
viii) Principal Adviser (Education), Planning Commission
ix) Representative of Department of Family Welfare
x) Representative of National Commission on Population
xi) Representative of Department of Education - Convenor

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

III. WORKING GROUP ON REGISTRATION OF BIRTHS, DEATHS AND MARRIAGES

i) Registrar General of India - Chairman

Members:

ii) Dr. Pai Panandiker, Centre for Policy Research
iii) Shri K.Srinivasan, President, Indian Association for Study of Population
iv) Shri Ashish Bose,
iv) Representative of Department of Statistics
v) Representative of Department of Family Welfare
vi) Representative of National Commission on Population
vii) Adviser, Health/Planning Commission - Convenor.

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.
d) Both legislative and implementational issues should be addressed.

IV. WORKING GROUP ON MEDIA FOR INFORMATION, EDUCATION & COMMUNICATION (IEC) AND MOTIVATION :

i) Shri H. K. Dua, Press Adviser to PM - Chairman

Members:

ii) Shri Alyque Padamsee, President, AP Associates,
ii) Shri Rajiv Shukla - M.P. (Rajya Sabha)
iii) Dr. J.K. Jain, Jain TV
iv) Ms. Sharmila Tagore, MP
v) Shri Ajit Bhattacharya, Press Institute of India
vi) Ms. Rami Chhabra, Member NCP
vii) Dr. Mahip Singh Member NCP
viii) Dr. K. Jaipal, Principal, Siddha Medical College, Chennai, Tamil Nadu
ix) Shri Narendra Mohan, MP
x) Ms. Usha Rai, Editors Guild of India
xi) Shri Qari M. M. Majari, Urdu Secular Qayadat
xii) Representative of Department of Family Welfare
xiii) Representative of Department of Ministry of IB
xiv) National Commission on Population - Convenor.

Terms of Reference

a) To identify gaps and

b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.

c) To consider any other matter related with or incidental to the above terms of reference.

d) Aspects of inter-sectoral co-ordination should be given special attention.

2. The Working Groups may co-opt any official or non-official as a special invitee to one or more sittings of the Group.

3. The expenditure on TA/DA of the non- official members, in connection with the meeting of the Working Group will be borne by the National Commission on Population, as per rules and regulations of TA/DA applicable to Grade I officers of Government of India or as otherwise decided by the Vice Chairman NCP. The expenditure on TA/DA of the official members, in connection with the meeting of the Working Group will be borne by their respective Departments/Ministries.

4. All the Working Groups will submit their final reports to the National Commission on Population within six months from the date of issue of this order.

R.K. Parmar

(R.K. Parmar)
Under Secretary,
National Commission on Population

To

1. All Members of the National Commission on Population
2. All Members of the Working Groups.

Copy to :

1. JS, Prime Minister's Office,
2. PS to Deputy Chairman (Planning Commission)
3. PS to Member Secretary (National Commission on Population)
4. PS to Joint Secretary (National Commission on Population)

HP 3:10

http://www.maharashtra.gov.in/english/gment/policyfr.htm.

MAHARASHTRA STATE POPULATION POLICY

An Extract

Maharashtra is one of the Progressive States in the country. The State however, has not been able to control its population as per expectations. The first doubling of the population occurred in 60 years between 1901-1961. The next doubling occurred only in 30 years. The present birth rate of the State is 22.3 and we rank 5th in the country. The State is declaring its population policy with an intention to bring down the rate of population growth.

The objectives of this policy are:

(1) Reducing Total Fertility Rate to 2.1 by year 2004;
(2) Reducing Birth Rate to 18 by year 2004;
(3) Reducing the Infant Mortality Rate to 25 by year 2004;
(4) Reducing the Neonatal Mortality Rate to 2- by year 2004.

Following schemes will be introduced under this population policy: -

1.. Accepting concept of two child norm as "Small Family Norm";
2.. For obtaining subsidies under various Government schemes acceptance of "Small Family Norm" would be considered essential.
3.. In order to propagate the concept of Small Family Norm amongst the Government and semi-Government employees this condition will be included in the service rule. Schemes such as House Building Advance, Vehicle Advance and Medical Reimbursement will be admissible those who limit their family to two children;
4.. Performance in Family Welfare to be part of assessment of officers at various levels;
5.. Strict implementation of existing acts and policies such as Child Marriage Act, Prenatal Sex Determination Act, Birth and Death Registration Act etc.;
6.. Organisation of Family Welfare Camps with the financial assistance from Cooperative Societies, Sugar factories and other industrial establishments;
7.. Acceptance of small policy norm as a condition for qualifying for elections to various bodies such as Zilla Parishad, Panchayat Samiti, Corporation, Co-operative Societies etc.;
8.. Constitution of Mahila Vikas Group under the Chairmanship of Hon. Chief Minister's wife at State level and under the Chairmanship of Minister or Guardian Minister's wife at District level;
9.. Enhancing involvement of Panchayat Raj Institutions in implementation and monitoring;
10.. Village Level Scheme based on achievements in various Family Welfare Indicators;
11.. Schemes for motivating the health infrastructure for improving quality of care;
12.. Training of Dais to ensure self delivery practices;
13.. A population council under the Chairmanship of Chief Minister and a Coordination Committee under the Chairmanship of Chief Secretary to monitor the implementation of policy; and,
14.. An incentive of Rs. 10,000/- in the form of fixed deposit for 18 years to Below Poverty Line couples accepting terminal method after one or two daughters (with no male child) (If two daughters an amount of Rs.5000/- for each daughter). This daughter(s) will be given an additional incentive of Rs.5000/- each as fixed deposit for 5 years when she completes her schooling unto 10th standard and does not get married before completing the 20 years of the age.

HP-3.

Subject: **Men's involvement in population**
Date: Thu, 23 Mar 2000 20:28:13 +0530
From: "DOLKE" <aaasn@nagpur.dot.net.in>
To: "Medico Friend Circle" <mfriendcircle@netscape.net>

http://www.timesofindia.com/140300/14mbom8.htm

Experts attempt to rope in men to defuse population bomb
By Rupa Chinai

The Times of India News Service

MUMBAI: With India's population poised to cross the one-billion mark, desperate policy-makers and programme managers have now hit upon a new formula to approach the vexed problem of population control.

Realisation has now dawned that Indian male involvement is crucial for change, because they are the prime decision-makers within all relationships.

While admitting that this half of the species has been ignored in five decades of the planning process, experts are now trying to understand how men can be sensitised to become responsible sexual partners, husbands and fathers; how they can be made to value women and see them as equal partners in the decision making process; and how to involve their help in the country's reproductive and child health programme.

At a workshop on `Reaching out to men as supportive partners in reproductive and sexual health', held in Mumbai recently, secretary level health officials from Rajasthan, Madhya Pradesh, Gujarat and Maharashtra, academics, researchers and NGOs struggled to formulate strategies that might work double-quick in creating such enormous societal and mindset changes. The need for this new approach is also highlighted in the recent `Population Policy of India' that was announced a week ago. The workshop was organised by the Population Council and International Institute for Population Studies.

Emerging from the workshop was the recognition that men also have health needs, and in particular sexual health needs, that are not being met through the current emphasis on programmes geared at women and children. In the absence of a ``basket of curative services'' being offered at primary health centres, government health workers have no way of reaching out to men and talking to them about preventive health issues. Personalised counselling at this level is vital, along with generalised information campaigns.

(Studies show that 70 per cent of India's population seek curative services from the private sector, because they do not get the services they require from the government system.)

In fact, during informal discussions, senior bureaucrats bluntly criticised the continued circumvention of the comprehensive primary health care approach. ``Family planning is not a technology issue. Delhi's failure in understanding this complexity is leading to the same mistakes being made again and again,'' a senior health official said.

Referring to government claims of having sought the `community's perception and participation' in health planning, officials said that in reality it is doctored by a questionnaire that refers to the government's set agenda.

``When a person cannot get treatment for a disease, he has no confidence in the health worker. Perception of health needs are based on individual experience and priority, and when the villager is only asked about safe delivery or maternal death, it may not be a major issue he sees, because so many women are delivering their babies safely at home through the

16/8

To JPJ | SDR | PA
lib. population policy file.

To TN 27/3

To RN 24/3

28/3

traditional `dai' (midwife). At the grassroots, health cannot be divided into compartments, and has to be wholistic. If this verticalisation of programmes does not stop we will do more damage,'' a senior secretary of health said.

NGOs from Gujarat presented studies showing that men readily respond to having small and healthy families, and are supportive when sensitised. The `entry point' to men's involvement, however, started with the NGO offering them a package of curative services that established channels of communication on issues of preventive health. Now the men accompany their wives for pre and post natal check-up, makes sure she rests and consumes her iron folic tablets during pregnancy. Antenatal clinics now see 85 per cent attendance, says Anupa Mehta of Deepak Charitable Trust, Vadodara.

Cultural constraints were recognised as being a major deterrent in the decision making process between husband and wife and the attainment of the latter's health. For instance, in a Rajput village community of Vadodara district, there is no communication between couples on such issues, and health seeking decisions are often made by elders in the family. Couples cannot go out alone. Consequently, when women do come for referral services, they often come too late.

According to Ramachandran Kaza of Maulana Azad Hospital, Delhi, the successful outcome of the `No scalpel vasectomy' (NSV) campaign in several states, was restricted elsewhere. ``Its not because men are not coming forward, but because service providers are not providing the services,'' he says. In Karim Nagar, Andhra Pradesh, 40,000 cases treated with NSV in seven months, was achieved because of the strong commitment of the district administration who assured them good quality services and follow-up of each case.

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Arun Dolke
Tel. : (91-712) 260709
Email : aaasn@nagpur.dot.net.in

RECOMMENDATIONS

Following the essence of the recommendations of NDC Committee on Population & Implementation, the Family Welfare Programme has undergone a paradigm shift from 1996-97. The Centrally fixed methods specific targets have been replaced by a system of assessing needs at grassroot level which will take into accounts local needs, ensure community participation and close monitoring implementation through Panchayati Raj Instituitions and other local bodies.

Approach during the X Plan

The objective during the X Plan period should be:

a) to ensure that the all the felt need for contraception is fully met;

b) reduce the infant and maternal mortality and morbidity so that there is a reduction in the desired level of fertility and the consequent increased felt need for contraception, especially by birth order based approach.

The programme will be directed towards

a) bridging the gaps in essential infrastructure and manpower through a flexible approach and improving operational efficiency through investment in social, behavioral and operational research.

b) providing additional assistance to poorly performing districts identified on the basis of the 1991 census and RCH Surveys.

c) ensuring uninterrupted supply of essential drugs, vaccines and contraceptives of appropriate quality and quantity.

d) promoting male participation in the planned parenthood movement and increasing the level of acceptance of vasectomy, particularly through no scalpel vasectomy techniques.

Attempts will be made to enhance quality and coverage of Family Welfare services through:

i) participation of general medical practitioners engaged in voluntary, private and joint sector and active cooperation of the practitioners of ISM&H;

ii) involvement of Panchayti Raj Institutions for ensuring intersectoral coordination, community participationat at grassroot level in planning, monitoring and management;

iii) involvement of corporate sectors, agriculture workers and labour representatives.

The Programme will take up the following initiatives during the Tenth Plan period:

1) Assess the needs for Reproductive and Child health Services at PHC/CHC/FRU level.

2) Undertake area specific need assessment at the grassroot level to fulfill the felt needs for Reproductive and Child Health Services.

3) Provide need based, client centred, demand driven, integrated Reproductive and Chi. Health Service so that there is:

   i. improvement in the maternal and child health indicators.

   ii. increased contraceptive acceptance to prevent unwanted pregnancies; and

   iii. reduction in the birth rates.

4) Provide essential infrastructure through a flexible approach, strengthen the existing manpower and provide key personnel required, provide essential drugs, devices and other consumables essential for running the programme

5) Increase the operational efficiency of the Programme through training, improved utilisation of the Management Information System (MIS), improved first line supervision, increase in involvement of the state Govt public health infrastructure in the sub district level and improved integration of different sectors at village level.

6) Improve community participation in implementation and monitoring of the programme through involvement of the Panchayati Raj institutions and other local bodies/institutions.

7) Improve the existing mechanisms for concurrent and independent monitoring and evaluation of the ongoing programme and initiating appropriate mid course corrections.

8) Undertake IEC programme through all channels of communication so that the population understands the paradigm shift and makes optimum utilisation of the available facilities.

9) Components of the RCH Services to be implemented include:

I Increased access to effective Contraception

a) Balanced presentation of the contraceptive options and enabling the couple to choose the method most appropriate to them;

b) Improving availability of family planning services to prevent unwanted pregnancies .

c) Improving male participation in the Family welfare programme, popularisation of vasectomy including newer techniques like no scalpel vasectomy.

II. Increased access to safe legal abortion facilities under MTP Act for management of unwanted pregnancies.

III. Universal screening of all pregnant women for risk factors and appropriate management of problems detected in pregnancy, labour and post natal period so that there is reduction in the maternal, perinatal and neonatal morbidity and mortality.

IV. Effective nutritional services to vulnerable groups.

V. Improved child health care through detection and management of the health problems in child hood and adolescence.

VI. Proper treatment of reproductive tract infections and sexually transmitted infections in men and women .

VII. Prevention and treatment of gynaecological problems including infertility, menstrual disorders and prolapse uterus, malignancies including cancer cervix and breast.

To review the present status of involvement of organised and unorganized sectors of Industry and trade/labour unions in the Family Welfare Programmes and recommend ways and means for increasing their participation in the Programmes.

Managerial capability of corporate bodies will go a long way in improving efficiency in the field of social marketing of contraceptives. The problem solving approach of corporate sector can be of use in improving operational efficiency of the health care infrastructure.

Possibilities may be explored to deliver health care services in unserved urban area through public, private and/or joint sector as the case may be.

Other issues and recommendations

To make the CNA approach a success, role of each person in the health care system has to be clearly defined. A holistic thinking has to be developed for appreciating this approach. Both administrative structure and professional culture have to be integrated and internalised in such a manner that the functionaries are made to learn the modus operandi of what is to be done.

SRS has provided reliable and useful information for planning as well as impact assessment in Health and Family Welfare. The SRS needs further strengthening for rapid collection and reporting of vital indices according to felt needs.

Now that three-tier local self-government has come into being, the letter and spirit of self governance has to be inculcated in the sub-centres as well as Primary Health Centres. The decentralised approach would require sharing of responsibility at various stages - PHC being th unit of micro-planning of the Panchayati Raj System.

The doctors and other functionaries of the health care delivery system have to know their role and activities as well as explain it to the Panchayats for effective planning and implementation of the ongoing programmes and a well increased community participation at grassroot level.

The Family Welfare Programme has to meet the requirements of contraception for spacing in the younger age couple and permanent methods - vasectomy, tubectomy for those who have completed their families.

Villages with small population size, which are generally backward in basic infrastructural facilities, poor literacy and poor utilisation of existing services, need special attention. Additional staff, if necessary, may be provided. It is estimated that a large number o. paramedical staff may be required to meet the MCH/FP needs specially in urban slums and poorly performing districts.

Even during Tenth Plan, some Sub-Centres may have to be established to serve needs of remote rural and tribal areas which are underserved. For establishing new sub-centres, it is desirable to take into consideration a distance criteria (say, a sub- centre within a radius of 10 kms) besides size of population, in the inaccessible areas. Population, distance and access to

Family Welfare needs of the population will be used as criteria for determining the manpower as well as infrastructural needs. The Family Welfare Programmes will utilize differential areas specific micro planning to assess the needs for family welfare services.

The content, quality of services for antenatal, natal, and neonatal and post natal care will be improved. Necessary equipment for identification of risk of mothers, neonates will be provided (e.g BP apparatus, weighing scales, urine testing kits). Universal serving of all pregnant women and neonates at birth will be the goal for 2001.

The success of the programme depends upon the personnel operating it, who shall be provided with the necessary knowledge, skills to meet the requirements of the population at Primary Health Care Institutions. Periodic inservice training utilising multi-professional approach has to be taken up to update their knowledge and skills.

Distance education and multi-professional education should be the focus for training the lower level functionaries like ANMs, Male Health Workers, and Anganwadi workers etc. in order to attain optimum utilisation of resource. The Departments of FW, WCD and Human Resource Development may have to join hands for discharging this onerous task.

Tenth Plan strategy in FW programme would be to meet the unmet need for MCH & FP Services to enable the couples to achieve their reproductive goal so that the national goal of reduction in under 5 mortality and birth rate are achieved through adequate primary, secondary and tertiary care with appropriate linkages.

Urban Migration over the last decade has resulted in rapid growth of urban slums. There has not been any well planned and organised effort to provide primary, secondary and tertiary care services in geographically delineated urban areas. In some cities, the health status of urban slum dwellers is worse than that of rural population. During the Tenth Plan period, the initiatives taken in Ninth Plan will be further strengthened by a well structured organisation of urban primary health care services to all inhabitants within 1 - 2 Kms of their dwellings. Appropriate referral linkages between primary, secondary and tertiary care facilities in defined geographic area will be established to promote optimal utilisation of Nagar Palikas in the implementation of health, water supply and sanitation programmes.

Following the essence of the recommendations of NDC Committee on Population, the Implementation of Family Welfare Programme has undergone a paradigm shift in 1996-97. The Centrally fixed methods specific targets have been replaced by need assessment at grassroot level which will take into accounts local needs, ensure community participation and close monitoring through Panchayati Raj Instituitions and other local bodies. The RCH approach will address the reproductive needs of the population. The family welfare programme during the Tenth plan is to be geared up to meet the un-met need for contraception and achieve rapid reduction in IMR, maternal mortality and under 5 mortality. If these programmes are fully implemented specially in the States/ Districts which currently have high IMR and high fertility, rate, there may be substantial reduction in IMR, CBR, TFR and population growth rate.

Strengthening and operationalisation of the FW infrastructure

The focus since the 8th Plan has been on strengthening and operationalising existin infrastructure for delivering of primary health care through improvement in physical facility,filling up of vacant posts, ensuring supply of essential drugs and improving referral services. To some extent this has been possible; however, there are still some key posts like specialists at CHC, lab technicians at PHC/CHC and male multipurpose worker at the sub centre which are either not sanctioned or continue to remain vacant, which, to some extent was overcome through RCH initiatives.

The main approach of the Family Welfare programme during the Tenth Plan should be:

i) To assess the needs for reproductive and child health at PHC/CHC/FRU etc. level and undertake area specific microplanning.

ii) To provide need based, client centered, demand driven integrated Reproductive and chil health care.

TABLE-1

TOTAL FERTILITY RATE (TFR) - PROJECTED LEVEL 2007

Sl. No.	State/UT	No. of eligible couples 2001 in 000's	Total Fertility Rat SRS (98)	Estimated TFR 2007
	INDIA	176,647	**3.2**	2.3
I.	MAJOR STATES			
1	Andhra Pr	14,161	2.4	1.8
2	Assam	4,049	3.2	2.3
3	Bihar	14,752	4.3	2.8
4	Gujarat	8,854	3.0	2.1
5	Haryana	3,563	3.3	2.2
6	Karnataka	8,912	2.4	2.0
7	Kerala	5,190	1.8	1.6
8	Madhya Pr	10,749	3.9	2.6
9	Maharashtra	16,641	2.7	2.1
10	Orissa	6,130	2.9	2.4
11	Punjab	3,886	2.6	2.1
12	Rajasthan	10,052	4.1	2.7
13	Tamil Nadu	10,807	2.0	1.7
14	Uttar Pr	27,897	4.6	2.7
15	West Bengal	13,557	2.4	2.1
II.	SMALLER STATES			
1	Arunachal Pr	169	2.8	2.4
2	Chattisgarh	3,702	NA	3.0
3	Delhi	2,343	1.6	1.8
4	Goa	194	1.0	1.6
5	Himachal Pr	1,015	2.4	2.0
6	Jharkhand	4,790	NA	3.0
7	J & K	1,571	NA	2.3
8	Manipur	315	2.4	2.2
9	Meghalaya	332	4.0	2.6
10	Mizoram	117	NA	2.4
11	Nagaland	233	1.5	2.3
12	Sikkim	78	2.5	2.2
13	Tripura	501	3.9	2.6
14	Uttaranchal	1,425	NA	2.4
III.	UNION TERRITORIES			
1	A&N Islands	59	1.9	1.7
2	Chandigarh	155	2.1	1.9
3	D&N Haveli	39	3.5	2.8
4	Daman & Diu	24	2.5	2.1
5	Lakshadweep	165	2.8	2.4
6	Pondicherry	165	1.8	1.6

TABLE-II

% of Girls Marrying Below 18 Years - NFHS and Rapid Household Survey(98-99) and Literacy Rate(% Female)2001 Census

Sl. No.	State/UT	% of Women Ages 20-24 Married Before Age 18 NFHS (98-99)	% of Girls Marrying Below 18 Years of Age preceeding 3 Yrs. Of survey(98/99)	Literacy Rate % Female (7 years & above) 2001 Census
	INDIA	**50.0**	**36.9**	**54.2**
I.	**MAJOR STATES**			
1	Andhra Pr	64.3	37.3	32.7
2	Assam	40.7	28.7	43.0
3	Bihar	71.0	58.2	33.6
4	Gujarat	40.7	25.2	58.6
5	Haryana	41.5	31.6	56.3
6	Karnataka	46.3	35.4	57.5
7	Kerala	17.0	9.1	87.9
8	Madhya Pr.	64.7	58.6	50.3
9	Maharashtra	47.7	30.9	67.5
10	Orissa	37.6	32.2	51.0
11	Punjab	11.6	11.2	63.6
12	Rajasthan	68.3	57.1	44.3
13	Tamil Nadu	24.9	19.1	64.6
14	Uttar Pr	62.4	49.3	43.0
15	West Bengal	45.9	51.1	60.2
II.	**SMALLER STATES**			
1	Arunachal Pr	27.6	32.8	44.2
2	Chattisgarh	NA	41.9	52.4
3	Delhi	19.8	6.4	75.0
4	Goa	10.1	3.5	75.5
5	Himachal Pr	10.7	3.0	68.1
6	Jharkhand	NA	50.8	39.4
7	J & K	22.1	1.5	41.8
8	Manipur	9.9	10.2	59.7
9	Meghalaya	25.5	9.1	60.4
10	Mizoram	11.6	16.0	86.1
11	Nagaland	22.9	29.5	61.9
12	Sikkim	22.3	15.7	61.5
13	Tripura	NA	34.5	65.4
14	Uttaranchal	NA	12.4	60.3
III.	**UNION TERRITORIES**			
1	A&N Islands	NA*	20.6	65.5
2	Chandigarh	NA	0.0	75.3
3	D&N Haveli	NA	50.6	43.0
4	Daman & Diu	NA	17.6	70.4
5	Lakshadweep	NA	18.2	81.6
6	Pondicherry	NA	5.0	74.1

TABLE - III

Fertility and Contraceptive Preferences NFHS-I & NFHS-II

India/states	Ideal No. of Children		% of couple with two children want no more child (including Str.)		% of couple with three children want no more child (including Str.)		% couple not using any method		Preferred Method for future use						% who discussed FP during Home visit
									Male Str.		Female Str.		Spacing Method		
	1992-93	1998-99	1992-93	1998-99	1992-93	1998-99	1992-93	1998-99	1992-93	1998-99	1992-93	1998-99	1992-93	1998-99	1998-99
INDIA	**2.9**	**2.7**	**59.8**	**72.3**	**76.9**	**84.2**	**59.4**	**51.8**	**0.9**	**0.7**	**58.6**	**65.2**	**29.0**	**22.4**	**14.4**
North															
Delhi	2.5	2.4	78.2	85.3	89.4	94.7	39.7	36.2	1.0		34.0		45.3		23.1
Haryana	2.6	2.5	63.4	81.4	86.8	88.2	50.3	37.6	0.7		61.7		20.8		17.4
Himachal Pr.	2.4	2.2	77.1	91.5	90.8	94.7	41.6	32.3	3.8		59.4		26.7		17.8
J&k	2.8	2.7	60.0	65.6	49.2	87.5	50.6	50.9	0.2		62.1		18.3		8.0
Punjab	2.6	2.3	75.4	89.0	89.1	96.4	41.3	33.3	1.3		55.4		25.9		27.3
Rajasthan	3.0	2.8	44.2	61.1	71.2	79.4	68.2	59.7	1.0	0.5	79.6	78.1	13.6	15.8	22.0
Central															
Madhya Pr.	3.1	2.9	47.4	59.6	70.2	83.6	63.5	55.7	1.7	1.0	64.3	78.4	27.3	15.5	26.5
Uttar Pr.	3.4	3.1	32.3	47.9	57.2	70.5	80.2	71.9	0.9	0.5	25.5	33.5	58.2	35.6	25.4
East															
Bihar	3.4	3.3	35.1	44.4	38.5	69.5	76.9	75.5	0.9	1.1	60.5	68.0	32.3	26.3	20.8
Orissa	3.0	2.7	60.7	70.9	79.5	88.6	63.7	53.2	1.3	1.4	46.1	67.3	39.3	22.6	12.2
West Bengal	2.6	2.4	74.2	87.7	86.8	93.0	42.6	33.4	0.3		43.0		32.0		14.2
Northeast															
Arunachal Pr.	4.7	3.2	29.0	48.0	34.7	59.4	76.4	64.6	1.3		45.0		36.9		20.9
Assam	3.2	2.9	53.4	66.3	76.3	82.4	57.2	56.7	0.2		23.9		38.5		11.0
Manipur	3.7	3.6	36.5	47.2	63.3	65.9	65.1	61.3	3.0		14.5		66.7		18.5
Meghalaya	4.6	4.7	21.9	26.8	34.1	50.6	79.3	79.8	0.7		21.6		41.7		23.3
Mizoram	4.3	4.0	50.0	38.5	66.9	77.5	46.2	42.3	0.8		47.6		50.8		6.9
Nagaland	4.0	4.0	31.6	51.2	40.6	57.8	87.0	69.7	3.6		34.8		40.2		32.4
Tripura	2.6	NA	74.5	NA	94.5	NA	43.9	NA	*		32.1		36.6		NA
Sikkim	NA	2.2	NA	90.0	NA	94.4	NA	46.2	NA		NA		NA		33.9
West															
Goa	2.7	2.3	70.2	76.4	87.7	86.4	52.2	52.5	*		44.5		30.8		17.9
Gujarat	2.6	2.5	71.9	75.9	81.3	85.7	50.7	41.0	0.9		79.4		12.3		14.2
Maharashtra	2.5	2.3	70.9	81.7	85.9	91.9	46.3	39.1	0.5		68.3		25.7		10.2
South															
Andhra Pr.	2.7	2.4	64.8	83.9	84.2	92.1	53.0	40.4	2.2	1.8	88.5	87.0	7.2	5.8	14.0
Karnataka	2.5	2.2	67.3	80.1	83.9	89.8	50.9	41.7	0.3		81.9		13.7		6.4
Kerala	2.6	2.5	84.0	86.5	90.2	88.7	36.7	36.3	0.5		76.3		15.1		12.2
Tamilnadu	2.1	2.0	79.4	86.4	91.9	93.6	50.2	47.9	0.4		78.8		15.4		15.2

* Less than 0.05%

TABLE-IV

Status of IMR,TFR & Higher Order of Birth - SRS, NFHS & District Rapid Household Survey

Sl. No.	State/UT	IMR		TFR		Contribution of higher order of births 3 & above (%)		Districts with more than 40% birth order 3 and above (RHS. 98-99)	
		SRS (99)	NFHS-II (98-99)	SRS (98)	NFHS-II (98-99)	RHS (98-99)	NFHS (98-99)	No.	Total Distt. Covered
	INDIA	**70**	**67.8**	**3.2**	**2.9**	**45.8**	**45.2**	**312**	**504**
I.	MAJOR STATES								
1	Andhra Pr	66	65.8	2.4	2.3	28.8	31.5	0	23
2	Assam	76	69.5	3.2	2.3	45.6	43.8	16	23
3	Bihar	66	72.9	4.3	3.5	57.1	54.6	30	30
4	Gujarat	63	62.6	3.0	2.7	37	41.1	8	19
5	Haryana	68	56.8	3.3	2.9	40.9	41.6	5	17
6	Karnataka	58	51.5	2.4	2.1	35.3	33.6	5	20
7	Kerala	14	16.3	1.8	2.0	17.1	21.1	0	14
8	Madhya Pr	91	86.1	3.9	3.3	53.6	52.8	36	38
9	Maharashtra	48	43.7	2.7	2.5	34.5	39.2	7	30
10	Orissa	97	81.0	2.9	3.5	45.3	42.9	26	30
11	Punjab	53	57.1	2.6	2.2	35.8	39.6	4	17
12	Rajasthan	81	80.4	4.1	3.8	51.9	52.9	30	30
13	Tamil Nadu	52	48.2	2.0	2.2	23.6	23.2	0	23
14	Uttar Pr	84	86.7	4.6	4.0	59.4	58.1	58	58
15	West Bengal	52	48.7	2.4	2.3	38.9	36.5	7	19
II.	SMALLER STATES								
1	Arunachal Pr	43	63.1	2.8	2.5	56.7	46.0	13	13
2	Chattisgarh	NA	NA	NA	NA	47.0	NA	5	7
3	Delhi	31	46.8	1.6	2.4	32.3	39.3	0	1
4	Goa	21	36.7	1.0	1.8	21.4	24.9	0	2
5	Himachal Pr	62	34.4	2.4	2.1	31.4	33.3	2	12
6	Jharkhand	NA	NA	NA	NA	54.2	NA	13	13
7	J & K	NA	65.0	NA	2.7	50.6	50.3	8	13
8	Manipur	25	37.0	2.4	3.0	46.2	47.1	7	8
9	Meghalaya	56	89.0	4.0	4.6	57.1	60.1	7	7
10	Mizoram	19	37.0	NA	2.9	40.0	46.0	2	3
11	Nagaland	NA	42.1	1.5	3.8	61.1	59.6	6	6
12	Sikkim	49	43.9	2.5	2.8	43.3	42.1	3	4
13	Tripura	42	NA	3.9	NA	34.7	NA	1	3
14	Uttaranchal	NA	NA	NA	NA	50.8	NA	10	10
III.	UNION TERRITORIES								
1	A&N Islands	25	NA	1.9	NA	20.3	NA	0	2
2	Chandigarh	28	NA	2.1	NA	20.2	NA	0	1
3	D&N Haveli	56	NA	3.5	NA	44.9	NA	1	1
4	Daman & Diu	35	NA	2.5	NA	35.4	NA	1	2
5	Lakshadweep	32	NA	2.8	NA	44.6	NA	1	1
6	Pondicherry	22	NA	1.8	NA	21.1	NA	0	4

Source - Registrar General, India, NFHS and Rapid Household Survey

TABLE - V

Status of Maternal Care - Rapid Household Survey (98-99) and N.F.H.S.(98-99)

Sl. No.	State/UT	Any ANC		Full ANC		Safe Delivery		Districts with less than 40% Full ANC Visits (RHS, 98-99)	
								No.of districts	Total Distt. Covered
		RHS	NFHS-II	RHS 3 check-up TT+IFA	NFHS-II 3 or More checkup	RHS	NFHS		
	INDIA	65.3	65.4	31.8	43.8	40.4	42.3	267	504
I.	MAJOR STATES								
1	Andhra Pr	94.2	92.7	63.4	80.1	60	65.2	0	23
2	Assam	56	60.1	24.8	30.8	31.1	21.4	18	23
3	Bihar	26.4	36.3	10.1	17.8	18.8	23.4	30	30
4	Gujarat	79.1	86.4	42.7	60.2	56.3	53.5	3	19
5	Haryana	77.7	58.1	23.9	37.4	32.8	42.0	7	17
6	Karnataka	88.9	86.3	60.1	71.4	60	59.1	0	20
7	Kerala	84.5	98.8	86.1	98.3	97.4	94.0	0	14
8	Madhya Pr	53.9	61.0	20.2	28.1	27.5	29.7	31	38
9	Maharashtra	87.8	90.4	54.8	65.4	61.4	59.4	0	30
10	Orissa	72.9	79.5	32.5	47.3	32.9	33.4	23	30
11	Punjab	87.2	74.0	24.5	57.0	55.0	62.6	5	17
12	Rajasthan	62	47.5	16.6	22.9	32.5	35.8	30	30
13	Tamil Nadu	98.4	98.5	75.3	91.4	82.5	83.8	0	23
14	Uttar Pr	48.0	34.6	11.2	14.9	21.9	22.4	55	58
15	West Bengal	84.1	90.0	33.4	57.0	45.6	44.2	10	19
II.	SMALLER STATES								
1	Arunachal Pr	44.4	61.6	19.8	40.5	28.2	31.9	12	13
2	Chattisgarh	52.2	NA	27.1	NA	22.4	NA	5	7
3	Delhi	89.5	83.5	73.1	68.2	73.8	65.9	0	1
4	Goa	98.3	99.0	80.3	95.7	95.1	90.8	0	2
5	Himachal Pr	87.1	86.8	52.7	60.9	36.4	40.2	0	12
6	Jharkhand	42.8	NA	18.9	NA	19.9	NA	10	13
7	J & K	58.0	83.2	23.8	66.0	46.8	42.4	5	13
8	Manipur	77.0	80.2	30.9	54.4	50.0	53.9	4	8
9	Meghalaya	55.0	53.6	30.9	31.3	35.7	20.6	6	7
10	Mizoram	80.3	91.8	43.7	75.8	62.9	67.5	1	3
11	Nagaland	45.7	60.4	15.6	23.1	25.1	32.8	5	6
12	Sikkim	63.1	69.9	31.9	42.6	36.8	35.1	3	4
13	Tripura	69.1	NA	34.8	NA	48.4	NA	1	3
14	Uttaranchal	40.6	NA	17.5	NA	22.3	NA	3	10
III.	UNION TERRITORIES								
1	A&N Islands	95.9	NA	84.4	NA	67.2	NA	0	2
2	Chandigarh	79.6	NA	62.9	NA	71.6	NA	0	1
3	D&N Haveli	90.6	NA	62.0	NA	27.9	NA	0	1
4	Daman & Diu	95.1	NA	71.1	NA	70.7	NA	0	2
5	Lakshadweep	99.4	NA	91.4	NA	74.1	NA	0	1
6	Pondicherry	99.8	NA	83.8	NA	93.5	NA	0	4

TABLE-VI

Status of Immunisation - Rapid Household Survey(98-99) and NFHS(98-99)

Sl. No.	State/UT	Full Immunisation		No Immunisation		ORS packets for Diahhorea		Districts with Full Immunisation less than 40% (RHS, 98-99)	
		RHS	NFHS-II	RHS	NFHS-II	RHS @	NFHS $	No.	Total Distt. Covered
	INDIA	54.2	42.0	18.7	14.4	11.2	26.8	151	504
I.	MAJOR STATES								
1	Andhra Pr	74.7	58.7	2.4	4.5	25.2	39.6	0	23
2	Assam	46.7	17.0	11.6	33.2	17.1	37.1	9	23
3	Bihar	20.1	11.0	53.1	16.8	8.6	15.4	30	30
4	Gujarat	58.2	53.0	10.2	6.6	13.8	28.9	2	19
5	Haryana	66	62.7	10.4	9.9	4.8	25.7	0	17
6	Karnataka	71.6	60.0	5.7	7.7	15.0	34.3	2	20
7	Kerala	83.8	79.7	1.8	2.2	24.3	47.9	0	14
8	Madhya Pr	47.3	22.4	13.3	13.9	7.9	29.8	16	38
9	Maharashtra	79.5	78.4	1.9	2.0	10.4	33.2	0	30
10	Orissa	57.4	43.7	10.0	9.4	24.8	35.1	2	30
11	Punjab	72.6	72.1	9.7	8.7	2.4	42.3	0	17
12	Rajasthan	36.9	17.3	33.6	22.5	4.7	20.3	19	30
13	Tamil Nadu	91.5	88.8	0.4	0.3	16.6	27.9	0	23
14	Uttar Pr	44.5	21.2	27.3	29.5	4.9	15.8	26	58
15	West Bengal	51.3	43.8	14.0	13.6	23.5	40.5	6	19
II.	SMALLER STATES								
1	Arunachal Pr	30.4	20.5	22.9	28.7	13.7	40.2	10	13
2	Chattisgarh	59.1	NA	7.8	NA	NA	NA	1	7
3	Delhi	84.8	69.8	2.4	5.1	NA	39.1	0	1
4	Goa	88.3	82.6	0.0	0.0	13.8	55.6	0	2
5	Himachal Pr	80.5	83.4	2.4	2.8	17.2	45.6	1	12
6	Jharkhand	30.8	NA	34.1	NA	NA	NA	9	13
7	J & K	52.8	56.7	1.0	10.4	12.0	47.5	2	13
8	Manipur	50.6	42.3	20.5	17.2	13.6	50.7	4	8
9	Meghalaya	32.7	14.3	18.0	42.3	10.4	22.4	5	7
10	Mizoram	66.7	59.6	5.7	10.4	23.5	44.7	1	3
11	Nagaland	26.2	14.1	8.8	32.7	30.9	29.7	5	6
12	Sikkim	65.4	47.4	4.2	17.6	40.3	27.0	0	4
13	Tripura	45.4	NA	16.9	NA	14.1	NA	1	3
14	Uttaranchal	62.8	NA	19.4	NA	NA	NA	0	10
III.	UNION TERRITORIES								
1	A&N Islands	77.4	NA	1.8	NA	29.8	NA	0	2
2	Chandigarh	61.6	NA	1.8	NA	35.7	NA	0	1
3	D&N Haveli	77.3	NA	2.7	NA	7.9	NA	0	1
4	Daman & Diu	72.0	NA	4.2	NA	17.3	NA	0	2
5	Lakshadweep	94.8	NA	0.3	NA	3.1	NA	0	1
6	Pondicherry	95.3	NA	0.1	NA	16.9	NA	3	4

@ Percntage mothers whoes children got ORS packets as treatment of diahhorea
$ Percentage of children who suffered diahhorea and got ORS packets as treatment.

TABLE-VII

CRUDE BIRTH RATE (CBR) & DEATH RATE(CDR) - PROJECTED LEVEL 2007

Sl. No.	State/UT	Population Census 2,001	CBR SRS (99)	CDR SRS (99)	Exp. Level of CBR 2007
	INDIA	1,027,015,247	26.1	8.7	21
I.	MAJOR STATES				
1	Andhra Pr	75,727,541	21.7	8.2	17
2	Assam	26,638,407	27.0	9.7	22
3	Bihar	82,878,796	30.4	8.9	23
4	Gujarat	50,596,992	25.4	7.9	20
5	Haryana	21,082,989	26.8	7.7	22
6	Karnataka	52,733,958	22.3	7.7	20
7	Kerala	31,838,619	18.0	6.4	15
8	Madhya Pr	60,385,118	30.7	10.4	23
9	Maharashtra	96,752,247	21.1	7.5	17
10	Orissa	36,706,920	24.1	10.7	21
11	Punjab	24,289,296	21.5	7.4	18
12	Rajasthan	56,473,122	31.1	8.4	22
13	Tamil Nadu	62,110,839	19.3	8.0	16
14	Uttar Pr	166,052,859	32.1	10.5	24
15	West Bengal	80,221,171	20.7	7.1	22
II.	SMALLER STATES				
1	Arunachal Pr	1,091,117	22.3	6.0	20
2	Chattisgarh	20,795,956	NA	9.6	22
3	Delhi	13,782,976	19.4	4.8	16
4	Goa	1,343,998	14.3	7.2	12
5	Himachal Pr	6,077,248	23.8	7.3	20
6	Jharkhand	26,909,428	NA	8.9	22
7	J & K	10,069,917	NA	NA	22
8	Manipur	2,388,634	18.6	5.4	16
9	Meghalaya	2,306,069	28.7	9.1	23
10	Mizoram	891,058	17.0	5.5	16
11	Nagaland	1,988,636	NA	2.3	15
12	Sikkim	540,493	21.6	5.8	17
13	Tripura	3,191,168	17.0	5.7	16
14	Uttaranchal	8,479,562	NA	6.5	23
III.	UNION TERRITORIES				
1	A&N Islands	356,265	18.1	5.5	15
2	Chandigarh	900,914	17.9	3.9	14
3	D&N Haveli	220,451	32.4	6.6	23
4	Daman & Diu	158,059	26.9	7.1	16
5	Lakshadweep	60,595	25.1	4.7	20
6	Pondicherry	973,829	17.7	6.9	16

TABLE-VIII

INFANT MORTALITY RATE - PROJECTED LEVEL 2007

Sl. No.	State/UT	Children 0-6 2001 census	IMR		IMR 99 (Average SRS & NFHS-II) 1998	Estimated IMR 2007
			SRS (99)	NFHS-II (98-99)		
	INDIA	157,863,145	70	67.8	68.9	42
I.	MAJOR STATES					
1	Andhra Pr	9,673,274	66	65.8	65.9	40
2	Assam	4,350,248	76	69.5	72.8	45
3	Bihar	16,234,539	66	72.9	69.5	40
4	Gujarat	6,867,958	63	62.6	62.8	35
5	Haryana	3,259,080	68	56.8	62.4	40
6	Karnataka	6,826,168	58	51.5	54.8	40
7	Kerala	3,653,578	14	16.3	15.2	9
8	Madhya Pr	10,618,323	91	86.1	88.6	55
9	Maharashtra	13,187,087	48	43.7	45.9	36
10	Orissa	5,180,551	97	81.0	89.0	60
11	Punjab	3,055,492	53	57.1	55.1	35
12	Rajasthan	10,451,103	81	80.4	80.7	45
13	Tamil Nadu	6,817,669	52	48.2	50.1	35
14	Uttar Pr	30,472,042	84	86.7	85.4	55
15	West Bengal	11,132,824	52	48.7	50.4	35
II.	SMALLER STATES					
1	Arunachal Pr	200,055	43	63.1	53.1	40
2	Chattisgarh	3,469,774	NA	NA	NA	50
3	Delhi	1,923,995	31	46.8	38.9	20
4	Goa	142,152	21	36.7	28.9	9
5	Himachal Pr	769,424	62	34.4	48.2	30
6	Jharkhand	4,796,188	NA	NA	NA	35
7	J & K	1,431,182	NA	65.0	2.7	40
8	Manipur	312,691	25	37.0	31.0	30
9	Meghalaya	457,442	56	89.0	72.5	35
10	Mizoram	141,537	19	37.0	2.9	20
11	Nagaland	280,172	NA	42.1	NA	30
12	Sikkim	77,170	49	43.9	46.5	30
13	Tripura	427,012	42	NA	3.9	30
14	Uttaranchal	1,319,393	NA	NA	NA	35
III.	UNION TERRITORIES					
1	A&N Islands	44,674	25	NA	1.9	20
2	Chandigarh	109,293	28	NA	2.1	30
3	D&N Haveli	39,173	56	NA	3.5	35
4	Daman & Diu	20,012	35	NA	2.5	25
5	Lakshadweep	8,860	32	NA	2.8	25
6	Pondicherry	113,010	22	NA	1.8	16

TABLE - IX

COUPLE PROTECTION RATE - PROJECTED LEVEL 2007

Sl. No.	State/UT	No. of eligible couples 2001 in 000's	Couple Protection Rate as per programme data			Contraceptive Prevalence Rate NFHS (98-99)			Contraceptive Prevalence Rate Any (%) RHS (98-99)			CPR (Average Programe, NFHS,RHS)		Expected Level 2007	
			Total March,2000	By Ster.	Spacing (Modern)	Total	By Ster.	Spacing (Modern)	All Method	By Ster.	Spacing (Modern)	By Ster.	Spacing (Modern)	Permanent	Spacing (Modern)
	INDIA	176,647	46.2	29.0	17.2	48.2	36.0	8.3	42.5	34.9	7.6	33.3	11.0	49.3	15.9
I.	MAJOR STATES														
1	Andhra Pr	14,161	52.8	44.5	8.3	59.6	57.0	1.8	58.7	57.7	1.0	53.1	3.7	65.0	10.0
2	Assam	4,049	15.2	12.3	2.9	43.3	16.7	10.0	28.5	13.5	15.0	14.2	9.3	35.0	16.9
3	Bihar	14,752	21.2	16.7	4.5	24.5	20.2	2.2	23.3	21.1	2.2	19.3	3.0	30.0	10.0
4	Gujarat	8,854	52.8	35.4	17.4	59.0	45.3	8.1	52.0	42.6	9.4	41.1	11.6	60.0	21.2
5	Haryana	3,563	49.4	32.3	17.1	62.4	40.8	12.5	52.7	39.4	13.3	37.5	14.3	56.3	26.0
6	Karnataka	8,912	56.3	44.8	11.5	58.3	52.2	4.4	57.9	52.8	5.1	49.9	7.0	60.0	12.7
7	Kerala	5,190	39.6	34.5	5.1	63.7	51.0	5.1	57.7	50.3	7.4	45.3	5.9	60.0	10.7
8	Madhya Pr	10,749	45.9	28.0	17.9	44.3	37.9	4.7	43.4	38.0	5.4	34.6	9.3	55.0	17.0
9	Maharashtra	16,641	49.3	40.0	9.3	60.9	52.2	7.6	58.3	50.6	7.7	47.6	8.2	60.0	14.9
10	Orissa	6,130	37.6	26.5	11.1	46.8	35.6	4.7	39.5	34.0	5.5	32.0	7.1	55.0	12.9
11	Punjab	3,886	65.5	35.2	30.3	66.7	30.9	23.0	53.6	31.0	22.6	32.4	25.3	55.0	30.0
12	Rajasthan	10,052	36.1	22.9	13.2	40.3	41.8	5.8	39.0	32.4	6.6	32.4	8.5	45.0	15.5
13	Tamil Nadu	10,807	50.4	39.3	11.1	52.1	46.0	4.3	49.9	45.5	4.4	43.6	6.6	65.4	12.0
14	Uttar Pr	27,897	38	17.3	20.7	28.1	15.6	6.4	21.6	14.1	7.5	15.7	11.5	35.0	21.0
15	West Bengal	13,557	32.2	27.2	5.0	66.6	33.8	13.5	45.4	31.9	13.5	31.0	10.7	50.0	19.4
II.	SMALLER STATES														
1	Arunachal Pr	169	14.0	9.7	4.3	35.4	20.7	12.2	33.8	16.0	17.8	15.5	11.4	30.0	20.8
2	Chattisgarh	3,702	NA	NA	NA	NA	NA	NA	40.1	NA	NA	38.0	5.0	45.0	10.0
3	Delhi	2,343	27.0	17.0	10.0	63.8	28.6	27.7	68.3	28.8	39.5	24.8	25.7	40.0	30.0
4	Goa	194	23.9	21.1	2.8	47.5	28.2	7.7	38.9	28.9	10.0	26.1	6.8	45.0	12.4
5	Himachal Pr	1,015	46.9	34.8	12.1	67.7	52.4	8.4	62.4	50.6	11.8	45.9	10.8	65.0	19.6
6	Jharkhand	4,790	NA	NA	NA	NA	NA	NA	27.8	NA	NA	21.0	2.0	30.0	3.6
7	J & K	1,571	14.4	12.1	2.3	49.1	30.7	11.1	47.0	29.9	17.1	24.2	10.2	36.4	18.5
8	Manipur	315	17.8	11.3	6.5	38.7	15.5	10.3	19.4	10.1	9.3	12.3	8.7	30.0	15.8
9	Meghalaya	332	4.7	2.8	1.9	20.2	10.7	9.1	13.2	6.4	6.8	6.6	5.9	30.0	10.8
10	Mizoram	117	34.6	28.9	5.7	57.7	45.3	11.7	47.5	39.3	8.2	37.8	8.5	56.8	15.5
11	Nagaland	233	8.2	6.3	1.9	30.3	12.3	12.0	21.6	12.3	9.3	10.3	7.7	30.0	14.1
12	Sikkim	78	21.5	14.8	6.7	53.8	24.8	26.6	36.7	22.9	13.8	20.8	15.7	31.3	28.5
13	Tripura	501	23.4	17.0	6.4	NA	NA	22.8	40.4	NA	NA	20.0	20.0	30.0	36.4
14	Uttaranchal	1,425	NA	NA	NA	NA	NA	NA	39.9	NA	39.9	30.0	10.0	40.0	18.2
III.	UNION TERRITORIES														
1	A&N Islands	59	38.4	32.2	6.2	NA	NA	NA	58.2	44.7	13.6			50.0	15.0
2	Chandigarh	155	33.5	23.3	10.2	NA	NA	NA	57.0	21.1	35.9			40.0	35.0
3	D&N Haveli	39	37.5	25.8	11.7	NA	NA	NA	35.4	29.7	5.7			35.0	10.0
4	Daman & Diu	24	29.3	23.0	6.3	NA	NA	NA	50.7	44.4	6.3			50.0	10.0
5	Lakshadweep	165	7.2	3.3	3.9	NA	NA	NA	11.5	7.4	4.1			30.0	10.0
6	Pondicherry	165	58.4	51.2	7.2	NA	NA	NA	56.8	50.6	6.2			65.0	10.0

Sl. No.	State/UT	CPR(in %) 31.3.2000			CPR(in %) NFHS I (92-93)		CPR(in %) NFHS II (98-99)		CPR Any (in %) RHS (98-99)		
		By All Meth.	By Ster.	spacing	By Ster.	spacing	By Ster.	spacing	By Ster.	spacing	All Methods
	INDIA	**46.2**	**29.0**	**17.2**	**30.8**	**5.5**	**36.0**	**8.3**	**34.9**	**7.6**	**42.5**
I.	MAJOR STATES										
1	Andhra Pr	52.8	44.5	8.3	44.7	1.8	57.0	1.8	57.7	1.0	58.7
2	Assam	15.2	12.3	2.9	14.6	5.4	16.7	10.0	13.5	15.0	28.5
3	Bihar	21.2	16.7	4.5	17.7	3.2	20.2	2.2	21.1	2.2	23.3
4	Gujarat	52.8	35.4	17.4	41.0	5.8	45.3	8.1	42.6	9.4	52.0
5	Haryana	49.4	32.3	17.1	34.8	9.6	40.8	12.5	39.4	13.3	52.7
6	Karnataka	56.3	44.8	11.5	42.7	4.8	52.2	4.4	52.8	5.1	57.9
7	Kerala	39.6	34.5	5.1	48.3	6.1	51.0	5.1	50.3	7.4	57.7
8	Madhya Pr	45.9	28.0	17.9	31.7	4.0	37.9	4.7	38.0	5.4	43.4
9	Maharashtra	49.3	40.0	9.3	46.5	6.4	52.2	7.6	50.6	7.7	58.3
10	Orissa	37.6	26.5	11.1	31.6	10.0	35.6	4.7	34.0	5.5	39.5
11	Punjab	65.5	35.2	30.3	34.0	17.4	30.9	23.0	31.0	22.6	53.6
12	Rajasthan	36.1	22.9	13.2	26.2	3.3	41.8	5.8	32.4	6.6	39.0
13	Tamil Nadu	50.4	39.3	11.1	39.6	5.8	46.0	4.3	45.5	4.4	49.9
14	Uttar Pr	38	17.3	20.7	13.1	5.3	15.6	6.4	14.1	7.5	21.6
15	West Bengal	32.2	27.2	5.0	30.6	7.0	33.8	13.5	31.9	13.5	45.4
II.	SMALLER STATES										
1	Arunachal Pr	14.0	9.7	4.3	10.7	8.5	20.7	12.2	16.0	17.8	33.8
2	Chattisgarh	NA	NA	NA	NA	NA	NA	NA	NA	NA	40.1
3	Delhi	27.0	17.0	10.0	23.2	31.2	28.6	27.7	28.8	39.5	68.3
4	Goa	23.9	21.1	2.8	30.5	7.3	28.2	7.7	28.9	10.0	38.9
5	Himachal Pr	46.9	34.8	12.1	45.8	8.5	52.4	8.4	50.6	11.8	62.4
6	Jharkhand	NA	NA	NA	NA	NA	NA	NA	NA	NA	27.8
7	J & K	14.4	12.1	2.3	29.7	10.0	30.7	11.1	29.9	17.1	47.0
8	Manipur	17.8	11.3	6.5	13.8	10.3	15.5	10.3	10.1	9.3	19.4
9	Meghalaya	4.7	2.8	1.9	10.0	5.1	10.7	9.1	6.4	6.8	13.2
10	Mizoram	34.6	28.9	5.7	44.6	8.3	45.3	11.7	39.3	8.2	47.5
11	Nagaland	8.2	6.3	1.9	6.4	6.2	12.3	12.0	12.3	9.3	21.6
12	Sikkim	21.5	14.8	6.7	NA	NA	24.8	26.6	22.9	13.8	36.7
13	Tripura	23.4	17.0	6.4	NA	NA	NA	22.8	NA	NA	40.4
14	Uttaranchal	NA	NA	NA	NA	NA	NA	NA	NA	39.9	39.9
III.	UNION TERRITORIES										
1	A&N Islands	38.4	32.2	6.2	NA	NA	NA	NA	44.7	13.6	58.2
2	Chandigarh	33.5	23.3	10.2	NA	NA	NA	NA	21.1	35.9	57.0
3	D&N Haveli	37.5	25.8	11.7	NA	NA	NA	NA	29.7	5.7	35.4
4	Daman & Diu	29.3	23.0	6.3	NA	NA	NA	NA	44.4	6.3	50.7
5	Lakshadweep	7.2	3.3	3.9	NA	NA	NA	NA	7.4	4.1	11.5
6	Pondicherry	58.4	51.2	7.2	NA	NA	NA	NA	50.6	6.2	56.8

Status of Contraceptive Acceptance - Programme, Rapid Household Survey and N.F.H.S.

TABLE - XI

Sl. No.	State/UT	Total Population (in '000) 2001	No. of Eligible Couples in 000's March,2001	Accepted Terminal Method			Districts with less than 30% Couples Sterilised (RHS, 98-99)	
				Programme	NFHS 98-99	RHS 98-99	No.	Total Distt. Covered
	INDIA	**1,027,015**	**176647**	**29.0**	**36.0**	**34.9**	**223**	**504**
I.	**MAJOR STATES**							
1	Andhra Pr	75,728	14161	44.5	57.0	57.7	0	23
2	Assam	26,638	4049	12.3	16.7	13.5	22	23
3	Bihar	82,879	14752	16.7	20.2	21.1	29	30
4	Gujarat	50,597	8854	35.4	45.3	42.6	1	19
5	Haryana	21,083	3563	32.3	40.8	39.4	2	17
6	Karnataka	52,734	8912	44.8	52.2	52.8	0	20
7	Kerala	31,839	5190	34.5	51.0	50.3	0	14
8	Madhya Pr	60,385	10749	28.0	37.9	38.0	7	38
9	Maharashtra	96,752	16641	40.0	52.2	50.6	0	30
10	Orissa	36,707	6130	26.5	35.6	34.0	7	30
11	Punjab	24,289	3886	35.2	30.9	31.0	7	17
12	Rajasthan	56,473	10052	22.9	41.8	32.4	15	30
13	Tamil Nadu	62,111	10807	39.3	46.0	45.5	0	23
14	Uttar Pr	166,053	27897	17.3	15.6	14.1	57	58
15	West Bengal	80,221	13557	27.2	33.8	31.9	8	19
II.	**SMALLER STATES**							
1	Arunachal Pr	1,091	169	9.7	20.7	16.0	12	13
2	Chattisgarh	20,796	3702	NA	NA	NA	0	7
3	Delhi	13,783	2343	17.0	28.6	28.8	1	1
4	Goa	1,344	194	21.1	28.2	28.9	1	2
5	Himachal Pr	6,077	1015	34.8	52.4	50.6	0	12
6	Jharkhand	26,909	4790	NA	NA	NA	11	13
7	J & K	10,070	1571	12.1	30.7	29.9	7	13
8	Manipur	2,389	315	11.3	15.5	10.1	8	8
9	Meghalaya	2,306	332	2.8	10.7	6.4	7	7
10	Mizoram	891	117	28.9	45.3	39.3	1	3
11	Nagaland	1,989	233	6.3	12.3	12.3	6	6
12	Sikkim	540	78	14.8	24.8	22.9	4	4
13	Tripura	3,191	501	17.0	NA	NA	3	3
14	Uttaranchal	8,480	1425	NA	NA	NA	4	10
III.	**UNION TERRITORIES**							
1	A&N Islands	356	59	32.2	NA	44.7	0	2
2	Chandigarh	901	155	23.3	NA	21.1	1	1
3	D&N Haveli	220	39	25.8	NA	29.7	1	1
4	Daman & Diu	158	24	23.0	NA	44.4	0	2
5	Lakshadweep	61	10	3.3	[illegible]	[illegible]	[illegible]	[illegible]
6	Pondicherry	974	165	51.2	NA	50.6	0	4

TABLE - XII

Rate of Contraceptive Acceptance - Performance of States

Sl. No.	State/UT	Estimated No. of Eligible Couples March,2001 (in 000's)	Estimated No. of Unsteriiised Couples March,2001 (in 000's)	Performance (2000-01 Upto Jan.)		Performance Rate per 10,000 unsterilised couples	
				Terminal	Spacing method	Terminal	Spacing method
	INDIA	176,647	125,419	3,236,556	24,109,615	258	1922
I.	MAJOR STATES						
1	Andhra Pr	14,161	7,859	487,883	982,177	621	1250
2	Assam	4,049	3,551	8,844	90,493	25	255
3	Bihar	14,752	12,288	54,622	220,771	44	180
4	Gujarat	8,854	5,720	200,042	1,343,368	350	2349
5	Haryana	3,563	2,412	77,212	520,753	320	2159
6	Karnataka	8,912	4,919	346,234	708,528	704	1440
7	Kerala	5,190	3,399	124,200	218,515	365	6
8	Madhya Pr	10,749	7,739	243,616	2,089,349	315	2700
9	Maharashtra	16,641	9,985	530,040	1,098,592	531	1100
10	Orissa	6,130	4,506	60,624	557,820	135	1238
11	Punjab	3,886	2,518	67,613	779,901	269	3097
12	Rajasthan	10,052	7,750	193,901	1,787,455	250	2306
13	Tamil Nadu	10,807	6,560	310,352	764,967	473	1166
14	Uttar Pr	27,897	23,071	260,251	3,821,379	113	1656
15	West Bengal	13,557	9,869	157,281	729,111	159	739
II.	SMALLER STATES						
1	Arunachal Pr	169	153	1,028	4,617	67	303
2	Chattisgarh	3,702	NA	NA	NA	NA	NA
3	Delhi	2,343	1,945	27,556	239,847	142	1233
4	Goa	194	153	4,292	5,443	280	356
5	Himachal Pr	1,015	662	22,538	116,511	341	1761
6	Jharkhand	4,790	NA	NA	NA	NA	NA
7	J & K	1,571	1,381	10,578	33,574	77	3
8	Manipur	315	279	496	5,772	18	207
9	Meghalaya	332	323	1,727	5,217	54	162
10	Mizoram	117	83	2,545	3,177	306	382
11	Nagaland	233	218	NA	NA	NA	NA
12	Sikkim	78	66	588	2,846	88	428
13	Tripura	501	416	5,151	32,068	124	771
14	Uttaranchal	1,425	NA	NA	NA	NA	NA
III.	UNION TERRITORIES						
1	A&N Islands	59	40	1,348	3,374	337	843
2	Chandigarh	155	119	2,069	16,146	174	1358
3	D&N Haveli	39	29	267	401	92	139
4	Daman & Diu	24	13	442	1,602	239	867
5	Lakshadweep	10	10	38	676	39	699
6	Pondicherry	165	81	9,552	14,538	1186	1806

Table XIII

Indicators	NFHS-I (1992-93)	NFHS-II (1998-99)
1. Female Literacy	43.3	51.4
2. Percentage of Girls married below 18	54.2	50.0
3. Children fully immunized (%) (BCG, Polio 3, DPT 3, Measles)	35.4	42.0
3(a) Coverage of Individual Antigens		
BCG	62.2	72.0
Polio 3	53.4	63.0
DPT	51.7	55.0
Measles	42.2	51.0
4. Infant Mortality Rate	78.5	67.6
5. 3 or more Ante Natal Check up for women.	44.0	44.0
6. 2 or More doses of TT	55.0	67.0
7. Iron Folic Acid Supplementation	52.0	58.0
8. % Safe Delivery	34.2	42.3
9. Percentage of births of order 3 and above.	48.5	45.2
10. Contraceptive Prevalence Rate	40.6	48.2
11. Sterilisation	31.0	36.0
12. Spacing Methods (Modern)	6.0	7.0
Spacing Methods (Traditional)	4.0	5.0
13. Total Fertility Rate	3.4	2.9
14. % of Women with any anaemia	NA	52.0
15. % of Children with any anaemia	NA	74.0

Table-XIV

Position of Districts - Acceptance of RCH - *District Surveys-I and II*

S.No.	Characteristics		Very Good	Good	Satisfactory	Poor
1	Contribution to birth by birth order 3 & above	Status(%)	<10	10-20	20-40	>40
		No. of districts	6	21	164	313
2	Pregnant women who had IFA tablets	Status(%)	>75	50-75	30-49	<30
		No. of districts	41	88	109	266
3	Three ANC check-ups	Status(%)	>75	60-75	40-59	<40
		No. of districts	95	42	102	265
4	Institutional deliveries	Status(%)	>75	50-75	30-49	<30
		No. of districts	46	62	109	287
5	Safe deliveries	Status(%)	>75	50-75	25-49	<25
		No. of districts	97	128	137	142
6	Children diarrohea treated by ORS	Status(%)	>75	50-75	25-49	<25
		No. of districts	0	9	82	413
7	Children fully immunised	Status(%)	>75	60-75	40-59	<40
		No. of districts	144	90	118	152
8	Sterilisation	Status(%)	>50	40-50	30-39	<30
		No. of districts	75	101	105	223

population stabilization, the indicators of maternal & child care should be 100% by the the terminal year. Unless this is achieved, the indicators of fertility above can't show any improvement.Maternal mortality rate in India is 540 per 100,000 live births (NFHS-98).Post Partum Hamorrhage (PPH) and severe anemia are among the important causes of high maternal mortality. As per NFHS-98,35% of pregnant women did not receive antenatal care,67% received 2 dosesT.T and 58% received Iron and folic acid and two-thirds deliveries took place at home.Even though the infant mortality rate has declined from 146 in 1950s to 72 per 1000 live births in 1998;it has remained static since early 90sand neonatel mortality continues to be high.

Maternal and Child Health target should be 100% without which population stabilization cannot be achieved.

CHAPTER -7

Terms of reference- ***To assess the current status and future requirement (short, medium and long term) of demographic, bio-medical, social and behavioural research aimed at meeting*** the ***felt needs for health care of women and children and contraception during the Tenth Plan:***

Research is an important component of the Family Welfare Programme. Major focus of the research activities during the last three decades include:

1) Basic research aimed at better understanding of the physiology of reproduction in women and men, development of newer contraceptives and newer drug delivery systems so that couples in the 21st century will have wider choice of contraceptives.

2) Clinical testing of newer drugs and devices to determine their suitability for use in the National Family Welfare programme; research studies to investigate the safety and efficacy of available contraceptives in presence of undernutrition, anaemia and prolonged lactation.

3) Operational research aimed at introducing wider contraceptive choices in the National Programme and to improve quality and coverage of family planning services within the existing health care system so that there is increased acceptance and continued use of the contraceptive methods.

4) Socio-demographic, psycho-social and communication research so that there is better understanding of the behavioral factors governing contraceptive acceptance and adoption of the small family norm, and testing of newer innovative approaches to provide the knowledge, promote attitudes and practices that could result in improvement in acceptability and continued use of contraception.

Research studies in Family Planning and Population Stabilisation are being carried out by the Indian Council of Medical Research, its permanent institutes, its collaborating centres; and

academic and Research Institutions supported by research grants from the ICMR, DBT, DST and UGC. The National Institute for Health and Family Welfare carries out operational research studies; the IIPS Bombay and the network of Population Research Centres also carry out research and evaluation studies in Family Planning and allied fields. Many of these institutions are undertaking collaborative studies funded by National Agencies and by International agencies such as WHO, UNFPA, UNICEF, etc.

Research studies in India have shown that:

1. Puerperal sterilisation is safe and effective contraception in lactating women.
2. IUD insertion in the immediate post partum period is associated with high expulsion rates. Insertion of IUD in the hyper involuted uterus during lactational amenorrhea might be associated with a increased risk of perforation of uterus. Taking these factors into consideration it would appear that the optimal time for IUD insertion might be soon after return of menstruation in lactating women.
3. IUDs and sterilisation have no adverse effect on lactation and hence are the contraceptives of choice in lactating women.
4. There may be women who find that these methods are not suitable and opt for hormonal contraceptives. Available data indicate that progestogens only contraceptives are free from any adverse effect on lactation. Combination of pills containing low dose estrogens have been shown to reduce the duration of lactation and milk output when initiated early in lactation. However, if low dose of Oral Contraceptive use is begun after 6 month of lactation, there was no adverse effect on duration of lactation, milk output, infant growth or development. It is well known that contraceptive steroids are excreted in breast milk. So far there are no reports about any adverse effect attributable to steroid ingestion through breast milk. Taking all these into account and as a measure of abundant precaution, Government of India has issued a guideline that hormonal contraceptives use in the Family Planning Programme should initiate only after 6 months of lactation.

Demographic research studies should include testing and validation of relationship between reduction of infant mortality rate and the parameters in the States at different levels of demographic transition.

Population Policy and Family Planning Paradigm has shifted in the recent past from demographic issues to quality of life issues. Emphasis has been put on the reproductive rights of women, adolescent care, gender equity and greater male participation in family life and family planning. These are closely linked with women's health and status of their development. In order to provide conceptual clarity on researchable issues on reproductive issues on reproductive and child health care, several research projects are being undertaken in the category of bio-medical research studies, as well as fertility regulation, infertility, safe abortion, reproductive tract infections (RTIs)and sexually transmitted diseases(STCs), adolescent reproductive health, old age problems etc.

The Division of Reproductive Health and Nutrition of the ICMR has been engaged in promoting, conducting and coordinating research and development activities in the nationally important area of reproductive health and related nutritional issues. The activities of the Division in reproductive health have a major focus on program relevant operational researches as well as on applied clinical and basic research. This is being carried out through its intramural set up namely Institute for Research in Reproduction (IRR), Mumbai, National Institute of Nutrition Hyderabad and through extramural research largely being conducted by a nation-wide network of Human Reproduction research Centre (HRRCs), National Nutrition Monitoring Bureau and other non ICMR collaborating institutions/medical colleges.

Interstate/ intrastate differences in fertility and mortality

There are marked differences in the performance under the Family Welfare Program between states Some of these attributable to the differences in the availability and access to services; socioeconomic factors including educational especially of women also play an important role. Even though the norm for expenditure is uniform there are substantial difference between States both in terms of utilization of the funds and impact as assessed by IMR CBR and CPR. States like Kerala have achieved low CBR and IMR at relatively low cost . On the other hand states like Haryana and Punjab have not achieved substantial reduction in IMR and CBR in spite of higher expenditure per eligible couple. In states like Bihar, the expenditure is low and performance is poor.

District data on higher order births available from district surveys shows that there are marked differences in these indices not only between States but also between districts in the

same state.. The Family Welfare Program, therefore, has been re-oriented to (a) remove or minimise the inter and intra- State differences (b) undertake realistic PHC based decentralised area specific microplanning tailored to meet the local needs and (c) involve Panchayati Raj institutions in the programme development and monitoring at local level to ensure effective implementation of the programme and effective community participation.

Kerala, the first State to achieve TFR of 2.1 did so in spite of relatively low per capita income; in spite of having substantial higher per capita income Punjab and Haryana are yet to achieve TFR of 2.1. Obviously in Indian context, economic development and increase in per capita income are not essential prerequisites for achieving reduction in fertility. Tamil Nadu was the next State to achieve TFR of 2.1. The State did so in spite of higher IMR and lower female literacy rate than Kerala; Maharashtra, which has similar IMR and is yet to reach substantial decline in TFR. This shows that in some States decline in IMR is not also a critical determinant of decline in fertility. Andhra Pradesh is the State which has shown lower growth as per census 2001. The State has shown a steep decline in fertility in spite of relatively lower age at marriage, low literacy and poorer out-reach of primary health care infrastructure. The States of Haryana and Punjab, have a comparatively higher age at marriage, higher literacy rate and better outreach of primary health care infrastructure have not succeeded in achieving a parallel decline in fertility rates.

Both Tamil Nadu and Kerala achieved TFR of 2.1 long before the CPR of 60 was reached. In both these states, sterilisation was the major mode of contraception, suggesting that under conditions prevailing in these states, the low utilization of spacing methods was not a hindrance for achievement of replacement level fertility. Health professional believe that availability and access to family welfare services is one of the critical determinant of decline in fertility. In the North-eastern States of Tripura, Manipur, Mizoram and Himachal Pradesh, there is substantial difficulty in access in primary health care facilities; these states have achieved not only low fertility rates but low infant mortality suggesting thereby that a literate and aware population can successfully overcome deficiency in access and availability of primary health care infrastructure.

In spite of infrastructural manpower and financial resource constraints, high illiteracy

and marked diversity between States, the Family Welfare Programme has during the last five decades succeeded in achieving substantial reduction in infant mortality and fertility rates within the framework of democratic set up. In this process, the Family Welfare Programme has shown that factors such as economic status, educational status, access to health services which were thought to be pre-requisite for achieving sustained decline in birth rates are not essential prerequisites for reduction in birth rate in the Indian context. The experience of different States, while implementing FW programmes clearly show, that the programme can succeed despite limitations in several States. The need for identifying local problems and also methods by which these could be overcome from within the resources available is therefore, of paramount importance in rapidly bringing down infant mortality and high fertility. Under the Reproductive and Child Health care, the emphasis on area specific need assessment and micro-planning is expected to provide the policy direction for achieving this.

The fact that perinatal and neonatal mortality have not shown substantial decline over the last two decades is a cause for concern. Improvement in the quality of antenatal, intranatal and neonatal care is urgently needed.

Monitoring of Family Welfare Services

Monitoring and evaluation form an essential component of FW Programme. Indicators used for monitoring and evaluation, include process indicators and impact indicators. Process indicators are used to monitor the progress of implementation of the programme through monthly progress reports as compared to the annual targets. The existing service statistics do provide an inbuilt rapid and ready method for assessment of performance in Family Welfare Programme in terms of process indicators for ANC and for immunisation and FP acceptance. These data are used for mid-course corrections in the States that are not achieving the expected level of performance. However, these indicators do not provide any information on the quality of care or appropriateness of the services. During the Tenth Plan, efforts will be made to collate and analyse Service data collected at the district level and respond rapidly to the evolving situations. Available data will be analysed and utilised at the local level for area-specific micro planning. Efforts will be made to incorporate the district-level information from other sectors and optimally utilise the local resources including human resources in the implementation of the Family Welfare Programme, through inter-sectoral coordination. Efforts will also be made to

generate district- level data on all the related sectors and the Department of Family Welfare has constituted regional evaluation teams which carry out regular regular sample verification of family welfare and RCH Programme and utilise them for programme planning , monitoring and evaluation.

The Office of the Registrar General of India (RGI) works out the annual estimates of crude birth rate (CBR), crude death rate CDR) and infant mortality rate (IMR) through their scheme of Sample Registration System. The system provides an independent evaluation of the impact of the Family Welfare Programme in the country. The vital indices and decennial growth rate estimated by the Office of the Registrar General of India on the basis of the census, also provides indirect evaluation of impact of the Family Welfare programme.

The Department of Family Welfare, in collaboration with RGI, has set a target of 100% registration of births and deaths by the end of the Ninth Plan. Steps to collect, collate and report these data at PHC/District level on a yearly basis have also been initiated.

"However, at the State and District level, IEC efforts have to be multiplied by roping in all departments and securing the services of private ad agencies to improve the quality of the messages. The IEC message today has to cover areas such as Age at marriage, preservation of the child and even the management of infertility."

Monitoring and Evaluation

Monitoring and Evaluation is essential for any ongoing program so that appropriate midcourse corrections can be made. Monitoring is an in-built component of Family Welfare Programme and should be carried out by the existing personnel involved in implementing the programme. Concurrent and periodical evaluation of the programme currently being carried out by a variety of organization under variety of schemes by Governmental, Non-governmental organizations and Research institutions utilizing different study designs and coverage making it difficult to have a comparative assessment of the implementation of the total programme. The evaluations of the programme need be clearly brought under one head, while monitoring of the activities should be through the functionaries of the Dept; if necessary by independent agencies. These should be funded adequately but duplication should be avoided.

To assess the current status and future requirements (short, medium and long term) of basic, clinical, applied and operational research in reproductive health and family welfare.

For purpose of research in contraceptive technology and demography and conducting evaluation studies, grants-in-aid are being provided to Indian Council of Medical Research, National Institute of Health and Family Welfare, Central Drugs Research Institute, Lucknow, Central Council for Research in Ayurvedha and Siddha and Central Council for Research in Unani Medicines under the programme. A net work of 18 Population Research Centres are operational in various Universities and Institutions of national repute to conduct studies on various aspects of the Family Welfare Programme, demographic and other related subjects so as to bring about modification in the ongoing programmes. A small provision has also been kept in the budget for ad-hoc research/ evaluation studies, experimental research projects, and for printing of Eligible Couple Registers (ECRs). In order to ensure that quality services/ equipment are utilised in the programme, a National Centre for Technological Evaluation of IUDs and Tubal Rings has been set up at IIT, New Delhi. The ongoing research activities were reviewed and the Following recommendations were made. Research on eradication of Polio & prevalence of Hepatitis B, including future course of research is an area to be excelled in Tenth Plan.

Basic and Clinical Research

Basic Research studies in the priority areas identified earlier will be continued. These include:

1) Immunological methods for fertility control of B-hCG, FSH, inhibit and riboflavin carrier protein immunization. The projects need to be continued until the logical conclusion is reached.
2) New drug delivery systems for the delivery of contraceptive steroids need to be developed and tested.
3) Trails to test the newer vaso-occlusive methods, efforts to develop spermicides based on plant products such as neem oil and saponins need to be continued. Vaginal contraceptives including those using plantbased substances need to be tested systematically for their safety and efficacy.

4) Testing contraceptives, which are considered to be effective in Indian System of Medicine and among tribals is another rather difficult task that should be continued.

5) In the field of male contraceptives, the concept of injecting a bio-active compound into the lumen of the vas deferens to obtain potentially reversible long term contraceptive effect is a new dimension in the male contraceptive field. The animal model studies and phase I and phase II clinical trials with injectable contraceptive RISUG, a specific copolymer of Styrene with Maleic Anhydride dissolved in 60mg sovent of dimethyl sulphoxide, have indicated that the new technique is safe and efficacious. It is necessary to take steps to bring the technique to a level where it can serve the family welfare needs. A phase III Clinical Trial with this preparation has been initiated to evaluate the safety and efficacy of the drug in a large number of subjects.

6) Emergency contraception is useful in a situation where prevalence of regular contraceptive is low, in couples using barrier methods or oral pills or in couples having infrequent sex. The knowledge and availability of emergency contraception is very limited in India.

7) The study has been initiated to assess the knowledge and demand of these methods. Newer non-surgical methods of MTP are currently under clinical trials in India and elsewhere. These studies need to be supported and the potential role of these in reducing illegal abortion and health hazards associated, if need be, explored.

8) The Central Drug Research Institute has developed once-a-week, non-steroidal contraceptive, Centchroman, which is undergoing post marketing surveillance. These studies need be completed so that information on the safety, efficacy and side effects are available under the Programme conditions in the country.

Operational Research

The group emphasised the need for providing adequate funds for operational and socio-behaviourial research. During the last year of the Eighth Plan, the Dept. of Family Welfare has adopted the target free decentralised PHC based area specific micro planning, implementation and monitoring approach for the implementation of the Family Welfare Services.

This is in line with the recommendations of the NDC Committee on Population. Effective change over to this system would require that all service providers, in the Govt., Voluntary and private sector understand and participate in the process and the population understands and appropriately utilises the available facilities. Reproductive and Child Health Programme under target free approach have been introduced in the last year of the Eighth Plan in the National Family Welfare Programme along with detailed guidelines for operationalising these through existing infrastructure. In order to rapidly translate these written guidelines to actual implementation and smooth out operational problems, it is imperative that operational research studies are set up in different setting in the States. Operational research studies on a massive scale would be required for this. The term operational research has been used to cover a wide variety of formal research studies of varying scale carried out by research workers belonging to different disciplines. In addition to strengthening these types of formal research studies, it might become necessary to encourage local population, health service providers and others who want to try innovative methods to tackle local problems.

Demographic research studies should include testing and validation of relationship between couple protection rate and crude birth rate and relationship between reduction of infant mortality rate and reduction in birth rate in the States in different levels of demographic transition. Focussed studies on continuation rates, use effectiveness under the programme conditions should be undertaken so that these could be used for computing effective couple protection rates.

Research is also required in operationalising integrated delivery of RCH services, nutrition, education, women and child development, rural development and family welfare services at village level utilising available infrastructure under the various programmes.

To review the present status of involvement of organised and unorganized sectors of Industry and trade/labour unions in the Family Welfare Programmes and recommend ways and means for increasing their participation in the Programmes.

Managerial capability of corporate bodies will go a long way in improving efficiency in the field of social marketing of contraceptives. The problem solving approach of corporate sector can be of use in improving operational efficiency of the health care infrastructure.

Possibilities may be explored to deliver health care services in unserved urban area through public, private and/or joint sector as the case may be.

The Steering Committee endorsed the recommendations of the Working Groups on Reproductive & Child Health and Population Stabilisation regarding ways and means for increasing involvement and participation of organised and unorganised sectors of industry, agriculture, trade/labour unions and agriculturists in family welfare programme.

Twelve strategic themes have been identified in the national Population Policy,2000 which must be simultaneously pursued in order to achieve the national socio demographic goals for 2010. Department of Family Welfare will take care of the strategies like Child Health and Survival, Meeting the unmet needs for Family Welfare Services, convergence of service delivery at village levels, underserved population groups, etc.. In addition, the Department of Women and Child Development will also take care for the strategies like empowering women for improved health and nutrition, programs for safe motherhood etc.

CHAPTER -8

Terms of reference -***To project financial implications for implementation of the family welfare programme during the X Plan including the plan and non-plan requirements and the Centre-State participation in the funding.***

The Parliamentary Standing Committee on Human Resource Development in its 20th Report for grants of Deptt. Of Family Welfare recommended that at least 3% of the total plan allocation should be provided for the Family Welfare Programme.

Planning Commission supports the idea that within the available resources more funds should be provided for the programmes under family welfare. At the same time State Governments must be convinced and persuaded to provide funds for the family welfare programme from their own resources and share the expenditure which is of non-plan in nature. The NDC Committee on Population has also recommended that allocations for Family Welfare Programme should be gradually increased to about 3% of the total public sector Plan outlay. The NDC Committee has further recommended that the States should meet at least 10% of their family welfare expenditure which are non-Plan in nature from within their own budget. The expenditure on Health as proportion of GDP has been low to the extent of about 1% only. In USA, public expenditure on health is 4% of GDP. Hence some attention is to be given to increase the proportion of GDP in India.

The activities, which were in operation in the Ninth Plan would be continued in Tenth Plan also. However, in some cases there would be a marginal increase in the outlay wh ich stress on the following points:

(i) Special focus will be given to Districts identified on the basis of child mortality, IMR, CBR & under 5 mortality.

(ii) States which have already achieved the expected level, will be assisted to have other facilities like blood bank and other better facilities like RTI/STI screening.

The allocation for the Family Welfare Programme within the overall public sector Plan outlay has ranged between 1.06 per cent and 1.76 per cent during different Plans. In view of the emphasis given to improvement of these indices during the Tenth Plan period and their implications for rapid population stabilisation, the possibility of enhancing the allocations under this criterion so as to motivate the States to show better performance under Family Welfare Programme may have to be considered. In view of the importance of IEC campaign in improving utilisation of available services for RCH care, Doordarshan and Akashvani will be persuaded to provide specific time slots on a larger scale either free or on concessional rates for IEC efforts.

Over the last 40 years, there has been considerable escalation in the cost of drugs. Supply of adequate quantities of drugs, vaccines and contraceptives is an essential pre-requisite for ensuring adequate coverage. In the Eighth Plan period, there has been adequate supply of vaccines for pregnant women and vaccines to be given to infants. Contraceptive supplies have by and large been adequate. However, there have been a substantial shortfall in the supply of IFA and Vitamin A for achieving 100% coverage of the target groups. It is imperative that the requirement of drugs, vaccines and contraceptives to completely cover all the target groups on the basis of the projected population is provided. Adequate funding for purchase of these items needs to be made available so that coverage will improve. It is essential that the supply of these items are continued free of charge to all segments of population, since even among the population above the poverty line, there is often considerable reluctance to meet the expenses for women and children especially for preventive programmes. The services and supplies under Family Welfare Programme should continue to be provided free of cost so that inability to pay for preventive and promotive services does not become a barrier to the acceptance of Family Welfare Programme and the achievement of the desired family size.

Financing Family Welfare Programme:

Over the last 45 years there had been a progressive increase in Plan outlay for Health and Family Welfare sector. However, considering the population increase over the same period and the fact that primary health care infrastructure in rural and urban areas has undergone substantial

expansion, the investments have been far from adequate. It is noteworthy that Health and Family Welfare outlay as proportion of overall Plan outlay has essentially remained unaltered over the last 45 years.

Realizing the importance of Family Welfare Programme for the overall development of the country, the programme was initiated as a Centrally Sponsored 100% Centrally Funded activity in 1971.

A small provision has also been kept in the budget for ad-hoc research/ evaluation studies, experimental research projects, and for printing of Eligible Couple Registers (ECRs) MCH registers, immunization cards, etc. In order to ensure that quality services/equipments are utilised in the programme, a National Centre for Technological Evaluation of IUDs and Tubal Rings has been set up at IIT, New Delhi. The ongoing research activities were reviewed and the Following recommendations were made.

Basic and clinical Research studies have already been included in the earlier chapter However, the financial implication for their implementation of the projects on the ground is dependent on the financial support.

Basic essential records maintained in respect of eligible couples, maternal and child care should be available with all the Primary level workers. The forms in respect of civil registration which helps in family welfare planning is also in short supply. CNAA forms, which are the basic records of micro-planning are not available. The Tenth Plan needs to provide for the same.

Training of personnel in family welfare including medical & para-medical

Personnel in a continuing manner, is a prerequisite. Necessary infrastructure, including vehicles, computers, etc. is also to be in place for efficient delivery of services.

HP-3-

TFYP WORKING GROUP Sr. No. 26/2001

Dir (DC)

REPORT OF
THE WORKING GROUP ON

Implementation of Population Policy and Achieving Rapid Population Stabilization

FOR
THE TENTH FIVE YEAR PLAN

सत्यमेव जयते

GOVERNMENT OF INDIA
PLANNING COMMISSION
JUNE - 2001

Cr No 1

No.2 (12)/2000-H&FW
Government of India
Planning Commission
(Health, Nutrition & Family Welfare Division)

Yojana Bhavan,
Sansad Marg,
New Delhi-110001
Dated: 4-12-2000

ORDER

Subject: Constitution of Working Group on Implementation of Population Policy and Rapid Population Stabilization

In the context of formulation of the Tenth Five Year Plan (2002-2007) it has been decided to set up a Working Group on Implementation of Population Policy and Rapid Population stabilisation. The composition of the Working Group is as under: -

1. Secretary, Department of Family Welfare, Ministry of Health & Familyt Welfare Nirman Bhavan, New Delhi.	Chairman
2. Member Secretary/Representative, National Commission on Population, Yojana Bhavan, Parliament Street, New Delhi-110011	Member
3.Secretary/ Representative, Deptt. of Health, Ministry of Health & Family Welfare Nirman Bhavan, New Delhi.	-do-
4. Secretary/ Representative, Deptt. of ISM &H, Ministry of Health & Family Welfare Red Cross Building, New Delhi.	-do-
5. Secretary/ Representative, Department of Elementary Education & Literacy, Ministry of Human Resource Development, Shastri Bhavan, New Delhi.	-do-
6. Secretary/ Representative, Ministry of Rural Development, Shastri Bhavan, New Delhi.	-do-

14/12

7. Secretary/ Representative,
Deptt. of Women and Child Development, -do-
Ministry of Human Resource Development,
Shastri Bhavan, New Delhi

8. Director General/ Representative, -do-
Director General Health Services,
Ministry of Health & Family Welfare,
Nirman Bhavan, New Delhi.

9. Director/ Representative -do-
International Institute for Population Sciences,
Govandi Station Road,
Deonar, Mumbai

10. Director, -do-
National Institute of Health & Family Welfare
Munirka,
New Delhi

11. Dr. (Mrs.) Prema Ramachandran, -do-
Adviser (Health),
Planning Commission,
Parliament Street,
New Delhi-110001

12.Registrar General of India/ Representative, -do-
Office of RGI,
2-A, Man Singh Road,
New Delhi

13. Dr. Parveen Visaria, -do-
Director,
Institute of Economic Growth,
Delhi University,
Delhi-7.

14. The President/ Representative, -do-
Federation of Indian Chamber of Commerce
& Industry,
Federation House, Tansen Marg,
New Delhi-110001

15. General Secretary/Representative, -do
Indian National Trade Union Congress,
Sharmik Kendra,
4, Bhai Veer Singh Marg,
New Delhi-110001

the felt needs for health care of women and children and contraception during the Tenth Plan.

4. To project financial implications for implementation of the family welfare programme during the X Plan including the plan and non-plan requirements and the Cenrtre-State participation in the funding.

The Chairman may form sub-groups and co-opt official or non-official members as needed.

The TA/DA of non-official members of the Committee will be paid by the Department of Family Welfare as admissible under Govt. rules. The TA/DA of the official members would be paid by the respective Govt. Departments/Institutions to which they belong.

The Working Group may submit its report by 30th April, 2001.

(T.R.Meena)
Deputy Secretary (Administration)

Copy forwarded to the Chairman and the Members of the Working Group
Copy also forwarded to:

1. PS to Deputy Chairman, Planning Commission
2. PS to Minister of State for Planning & Programmes Implementation
3. PS to Member (Health)
4. PS to Member Secretary
5. PS to Special Secretary
6. Advisors, Planning Commission
7. Pay and Accounts Officer, Planning Commission
8. Under Secretary (Admn.)
9. PA to DS (Admn.)

(T.R.Meena)
Deputy Secretary (Administration)

5/9 A

29/12
at 3 pm

16. President/Representative, -do
Bhartiya Mazdoor Sangh,
Ram Naresh Bhavan,
Tilak Gali, Chuna Mandi,
Pahar Ganj,
New Delhi-110055

17. DG/ Representative -do-
Central Statistical Organization,
Sardar Patel Bhavan,
Parliament Street,
New Delhi-110001

18. Secretary (Health & FW)/Representative, -do-
Govt. of Punjab,
Punjab Civil Secretariat,
Chandigarh-160019

19. Secretary (H&FW)/Representative, -do-
Govt. of Madhya Pradesh,
Vallabh Bhavan,
Bhopal-462004

20. Dr. Joseph Abraham, -do-
Joint Adviser (FR),
Planning Commission
New Delhi.

21. Dr. K.V. Rao, Member-Secretary
Chief Director (DRS),
Deptt. of Family Welfare,
Nirman Bhavan, New Delhi.

TERMS OF REFERENCE

1. To review:
   (a) the current demographic projections for the Tenth Plan (2002-2007) and beyond and the time by which the country's population is likely to stabilize;
   (b) goals indicated in the National Population Policy (NPP) 2000.
2. Keeping in view the current Mortality, Fertility and Couple Protection Rate prevailing at present in different states to suggest
   (a) future strategy for achieving population stabilization as early as possible;
   (b) fixation of targets for the Tenth Plan i.e. by the terminal year 2007 and individual years for birth rate and IMR statewise;
   (c) fixation of targets statewise for couple protection rates, immunization/ante natal, intrapartum neonatal and child health services;
3. To assess the current status and future requirement (short, medium and long-term) of demographic, bio-medical, social and behavioural research aimed at meeting

Report of the Working Group on Implementation of Population Policy and achievement of Rapid Population Stabilisation

CHAPTER 1

Introduction

Population pressure is an underlying cause of over-exploitation of natural resources like land, water, forests etc. Spiral linkages amongst excessive population growth, extremes of poverty and prosperity, and environmental degradation have drawn increasing attention of Indian planners, population scientists, ecologists, and environmentalists over the recent past. Stabilizing population has been enshrined as an essential requirement for promoting sustainable development with equitable distribution in the National Population Policy,2000 (NPP-2000) document released by the Department of Family Welfare, Ministry of Health and Family Welfare(MoHFW), Govt. of India at the beginning of New Millenium. The NPP document affirms the commitment of government towards stabilizing population by 2045, as it's long -term objective, which would facilitate economically, environmentally and socially sustainable development.

Working Group's Terms of Reference

In the context of the formulation of the Tenth Five Year Plan 2002 –2007, the Planning Commission has set up a Working Group under the Chairmanship of Secretary (FW) for implementation of Population Policy and achievement of rapid population stabilization.The **Terms of Reference** of the Committee are as under:

1. **To review:**
   (a) the current demographic projections for the Tenth Plan (2002-2007) and beyond and the time by which the country's population is likely to stabilize;
   (b) goals indicated in the National Population Policy (NPP) 2000.

2. Keeping in view the current Mortality, Fertility and Couple Protection Rate prevailing at present in different States to suggest;

(a) future strategy for achieving population stabilization as early as possible;

(b) fixation of targets for the Tenth Plan i.e. by the terminal year 2007 and individual years for birth rate and IMR state wise;

(c) fixation of targets state wise for couple protection rates, immunization/ antenatal, intrapartum neonatal and child health services;

3. To assess the current status and future requirement (short, medium and long term) of demographic, bio-medical, social and behavioural research aimed at meeting the felt needs for health care of women and children and contraception during the Tenth Plan.

4. To project financial implications for implementation of the family welfare programme during the X Plan including the plan and non-plan requirements and the Centre-State participation in the funding.

The group also has the responsibilities, to identify gaps and to examine and suggest alternative strategies, interalia recent developments and innovations, with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy and to consider any other matter related with or incidental to the above terms of reference including aspects of inter-sectoral co-ordination.

The working group intends to review the implementation of Population Policy strategies and achievement of rapid population stabilization objective within the term of reference in the light of the recently released Census-2001 results and other National Level Survey based results from District Level Rapid Household Survey – Reproductive and Child Health in 1998-99 (r\RHSS-RCH), National Family Health Surveys (NFHS) conducted in 1992 and 1997, and other studies sponsored by the MoHFW.

CHAPTER 2

Terms of Reference- ***To review the current demographic projections for the Tenth Plan (2002-2007) and beyond and the time by which the country's population is likely to stabilize:***

Population Growth in India Since Independence:

India's population at the time of Independence in 1947 was estimated to be around 345 million and the eighth decennial census of 1951 counted 357 million people (excluding the State of Jammu and Kashmir, where the Census had not been conducted). India figured out to be the second largest country in the world and which has not changed till date. Since then India's population has become almost three-fold to nearly 1027 million by 2001.

Thee accelerated pace of population growth in each successive decade uptill 1981 had witnessed a marginal decline in the growth or deceleration during 11981-91. The accelerated pace of population growth during 11951-81 is evidenced by increasing decadal growth of population in each successive decade. However, a marginal decline in 1981-91 was witnessed as the decadal growth from 24.66 in 1971-81 to 23.86 during 1981-91. Further deceleration in the population growth process is evidenced by the decadal growth of 21.34 percent during 1991-2001.

The growth of population, as brought out by the population census since Independence is as under:

Year	1951	1961	1971	1981	1991	2001	
Population (in crores)	36.11	43.92	54.82	68.33	84.63	102.7	
Average growth rate	1.24	1.95	2.20	2.22	2.14	1.93	
Crude birth rate	39.9	41.7	41.2	37.2	32.5	26.1	(SRS – 99)

Crude death rate

The evolution of the programme right from the First Plan in 1950's, with emphasis on the family welfare programme has been innovatively changing, the stress of the programme continued to be on population stabilization by providing necessary maternal and child care and other services. The strategies of approach remained to be contraceptive oriented in 1950's, while it was changed to immunization and maternal care later in 1960's and 70's. More interventions were added to the programme over the decade.

The National Health Policy brought out in the year 1983 has also earmarked certain indicators of family welfare programme, to be achieved in a time specified manner. Accordingly the concept of two-child norm in 1985 and a targeted approach has been continued in the family welfare. In order to meet this goal of Health Policy, the Primary Health Care infrastructure was extended during the Seventh Plan by involving PP Centres, enlargening the scope of universal immunizations etc.

Magnitude of the Problem:

India was the first to launch the official Family Welfare Program in 1951. Paradigm shifts in India's population policies from earlier contraceptives-mix-target oriented to target-free approach in April,1996 and thereby client-centred-demand driven community needs assessment (CNAA) approach during 1997 have brought forth focused attention on the reproductive and child health (RCH) services package. The comprehensive definition of RCH was deliberated at length and adopted at ICPD conference at Cairo in September, 1994 and got global acknowledgement since then. India was also a signatory to the UN's resolution at Cairo conference. The Govt. of India's (GOI's) switchover to the community's need assessment (CAN) approach in 1997 necessitates decentralization of planning, monitoring and evaluation of the RCH services at micro and meso levels viz. states, districts, blocks and villages. The paradigm shifts in the Family Welfare Program over the period has brought focused attention towards provision of on quality RCH services to people in general. Program efforts and interventions has been mainly responsible for averting more than 200 million births over the period and has generated health infrastructure comprising Sub-Centres, PHCs, CHCs etc.

As has been brought out in the Sub Group on Ninth Plan, the share of unwanted fertility and high wanted fertility continue to be 20% each, while the momentum of growth of population contribute 60%. While the country has minimum choice regarding the quantum of contribution by the momentum of growth of population, except by a staggering them a little, which could be achieved by reducing early marriages and spacing of births It is seen from the NFHS-2 results that as much as 72% of the couples (including sterilised) having 2 living children do not want to have any more. Similarly, the percentage of couples with parity 3 wanting no more children is 84%. The similar type of ratios as per the NFHS-1 report 1992-93 shows a positive trend of more and more people coming to favour small family norms.

Census count of 1027 million people as of 1st March,2001 has exceeded the population projection figure of 1012 million by the Technical Group on Population Projections constituted by the Planning Commission in 1996. This could be due to inbuilt assumptions of either mortality being improved faster than expected or fertility decline being bit slower than assumed. Another possibility could be that base population assumed in the projections exercise needed a revision (p.65, Census 2001). However, fertility decline in most parts to India are well evidenced through the pace of decline may be little less than the assumed levels in the projections exercises. Nevertheless, India is expected to surpass China, the most populous country in the world in the near future.

The magnitude of the problem of early population stabilization as per the information available through various surveys is quite substantial. The program has made a dent in the family welfare indicators and has been responsible for a TFR of 3.2(1998 SRS). The estimate of TFR stands at 3 as per NFHS-II (1998-1999). However, a TFR of 3 can be taken for 2000 also. *(Table - I)* The population stabilization approach will have to address the issue of higher order births, in different States, with however, high state differentials. The contribution of birth order 3 and above at national level stands at 45% as per SRS-97 and also district surveys 1998 & 1999. The NFHS-2 also brings out the same magnitude of higher order births during 3 years preceding 1998-99. The differentials of States show that the southern States have made a dent in almost accepting a two-child norm, with almost less than 30% contribution to higher order of births out

total births. The contribution of a higher order births is nearly 60% in Bihar and UP. The pattern should be reversed if the population stabilization is to be achieved, especially when the total number of eligible couples are likely to grow continuously for about four decades from now.

The approach of girls getting married and having their first child after 20 is a matter to be given utmost importance. The States of Andhra Pradesh, Uttar Pradesh, Rajasthan, Madhya Pradesh are having more than 50% of the girls married below the legal age at marriage. This causes not only the early pregnancy and hence more prone to maternal deaths and higher mortality with risks of infant mortality. The strategy for increased age at marriage needs the patronage of the community, which requires the backing of the opinion and community leaders. The NFHS –1 & 2 have clearly brought out that the teenage pregnancy is of the order of .535 (the age specific fertility rate between the age of 15 to 19 being 0.107). The NFHS –2 has also shown resul.. of age specific fertility rate of 15 to 19 age group has come down marginally. The mean children ever born in the district survey 1998 & 99 also shows that .55 children are born for teenage mothers. The trend needs to be totally reversed, and this could be achieved only by delaying the age at marriage. A strong component of IEC and social mobilization is required to achieve adherence to the minimum legal age at marriage by all states and communities. *(Table-II)*

As per the Terms of Reference, the Sub Group is to review the current demographic projections for the Tenth Plan 2002-2007 and beyond by which the country's population is likely to stabilize. The official projections available up to the year 2016 as prepared by the Technical Group on population projection gives the population of the country at the end of each Plan period, which are as under: -

Year	1997	2002	2007	2012
Population (In crores)	95.118	102.893	111.286	119.641

Adjusted population as per the 2001 census for the above year is as follows:

96.528	104.418	112.935	121.414

Population Projections by Age clearly indicates that proportionate population would grow faster in the working and reproductive age groups largely because of demographic momentum. Thus an increase of population from 520 million to 800 million in the working age group of 15-59 years, which would generate increased demand for the family planning program. In spite of massive investment in training, the quality of care available to the population specially in remote and rural urban slums are sub-optimal. The monitoring mechanism at district and State level are often inadequate. It is important that a sense of urgency to achieve the goals stated in NPP-2000 is imparted to all the functionaries so that there is a serious attempt made to achieve these goals.

It is very clear and evident from two major surveys that the people in general would like two/three children *(Table-III)*. The results show that the percentage of couples with two children do not want any more is above 75% in the states of A.P., Karnataka, Kerala, Tamilnadu., Delhi, Punjab, Haryana, West Bengal, H.P., Maharashtra, Gujarat, Goa, Sikkim,. In all the states except Bihar, U.P., Arunachal Pradesh, Manipur, Meghalaya & Nagaland, couples with three children want no more is more than 75%. The high wanted fertility is basically for the high infant mortality, which still remains a problem to be tackled fully, with high priority.

(a) Another major factor is increasing the level of contraceptive acceptance both spacing and limiting. The demand of unmet need needs to be viewed from the angle of population stabilization. Considering the fact that the 2-child norm is to be considered by the couples for early population stabilization, contraceptive needs should be targeted in this direction.

(b) If the family welfare programme is to be successful, there is a need to have wider spectrum of services with better quality and also meet the felt needs of MCH and FP Care.

The Technical Group on Projections also estimated the year in which TFR of 2.1 would be achieved for each major State. The country was projected to have a TFR of 2.1 by 2026, while the States of Bihar, Haryana, Madhya Pradesh, Rajasthan and Uttar Pradesh were projected to have this level beyond 2026.

CHAPTER 3

Terms of Reference -*To review the goals indicated in National Population Policy (NPP) 2000:*

The demographic goals, which need to be achieved, by 2010 as per the goals & objectives contained in the Population Policy are as below: -

i) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.

ii) Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.

iii) Reduce infant mortality rate to below 30 per 1000 live births.

iv) Reduce maternal mortality rate to below 100 per 100,000 live births.

v) Achieve universal immunization of children against all vaccine preventable diseases.

vi) Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

vii) Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.

viii) Achieve universal access to information/counseling and services for fertility regulation and contraception with a wide basket of choices.

ix) Achieve 100 per cent registration of births, deaths, marriage and pregnancy.

x) Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infection (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organization.

xi) Prevent and control communicable diseases.

xii) Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.

xiii) Promote vigorously the small family norm to achieve replacement levels of TFR.

xiv) Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centered program.

These are four demographic goals among other goals involving maternal care, child health and related social indicators to be brought about in order to have early population stabilization. The trends in infant mortality for the last decade normally show that the infant mortality at the national level is staggering at 70 *(Table-IV)*. The sample registration system, which is a continuous flow of information on infant mortality, also shows that the major States are not showing a tangible decline after 90's. The infant mortality rate as shown both by NFHS & SRS in 90's are given below:

SRS	1991	1992	1993	1994	1995	1996	1997	1998	1999
IMR	80	79	74	74	74	72	71	72	70
NFHS	1992-93		1998-99						
IMR	78.5		67.8						

This only shows that speaking of infant mortality at state level or national level will not do. The districts/below district levels are to be tackled in order to contain the infant mortality. The basic cause of death for the infants as revealed by the NFHS and SRS are ARI, Diarrohoea and under weight children. The district level survey shows that the percentage of episodes of diarrohea who were administered ORS is only to the tune of 11.2% of cases. Out of all the districts surveyed, the episodes of diarrhea who were administered ORS is less than 25% in about 413 districts of the country (82%). Similarly, the children who were fully immunized in the districts are less than 40% in 152 districts constituting about 30% of the districts in the country. The related problems like underweight that could be controlled by Ante Natal Care (ANC), as well as safe delivery, which do not show a better picture at district level *(Table-V)* Though the provision of three ante natal care check up is made, 265 districts (53%) reported less than 40% pregnant women who had three ANC checkups. Similarly, 142 districts (28.2%) reported less than 30% safe deliveries. These are factors of prevention of infant mortality. The death in infant is more in the first week, followed by first month as compared to the remaining period of the infancy. The newborn care has to be properly undertaken, which requires involvement of local practitioners, etc. since the extent of availability of institutions is on the lower side in most of the States. The maternal mortality ratio, which stands at a level of 400, for the country as a whole is stagnant over the last decade. The NFHS-1 showed the maternal

mortality of 437 (424 as corrected for comparison with NFHS-2 of the order of 540 in NFHS-2). Though statistically the difference is not substantial, the fact that the maternal mortality continuous to be around 400 cannot be undermined. The National Population Policy has targeted to bring down the MMR to less than 100 in a span of 10 years. In order to achieve the goals of infant mortality and maternal mortality, it is obvious that the causes leading to mortalities have to be controlled. In order to have the causes of maternal deaths, a maternal death cause need to be introduced in the Register and identification of each death will lead to plan to prevent recurrence of such deaths. The possible indicators in this direction are anaemia among pregnant women and children as per NFHS, the maternal care (full ante natal care together with IFA & TT), three ante natal care for mothers, safe deliveries, and treatment of diarrohoeal diseases by administering ORS, child immunization, and after delivery care. The number of districts below an unacceptable level is also indicated. In order to bring down infant mortality/child mortality/maternal mortality, we may have to develop a cadre of midwives who could take up ante-natal screening, provide essential obst. care and also provide 24 hours services to those who come to the institutions (CHC/FRU) for delivery. It is important to train more nurse midwives and put them in PHCs/CHCs to improve ante-natal and intra-partum care. It is prefeerral that th midwives are from the local community so that they do not seek transfer outside.

The X Plan has to address the issues in addition to the supplies & resources that are already in place.

The systems to be put in place are:

a) Basic record maintenance in order to ensure full coverage of services;

b) Birth -based approach to provide suitable contraception, counseling & services;

c) Making the Panchayat Raj institutions more involved in Family Welfare Programmes to have community involvement;

d) Ensuing full registration under CRS. This is the only system to monitor all indicators a Panchayat & below.

e) Community involvement & incentives to be continue in a full fledged manner, inv in Panchayat Raj. This ensures participation by smaller villages, with less than a population c 500, which normally are deprived of some facilities, for obvious logistic & infrastructur problems.

It may be seen that the level of acceptance of maternal and child health is quite low, resulting in underweight, malnourished babies. In order to improve the impact indicators of IMR and MMR there is need to improve the status of the indicators mentioned above. A sustained effort to reduce the total fertility rate (TFR) needs to be done.

CHAPTER- 4

Terms of reference - ***Keeping in view the current Mortality, Fertility and Couple Protection Rate prevailing at present in different States to suggest future strategy for achieving population stabilization as early as possible:***

There has been substantial improvement in the availability of utilization to the access to Family Welfare Services and a progressive increase in the acceptance of contraception and couple protection rates. Percentage distribution of birth order in major States shows that in most of the poorly performing States over half of the women have two or more children and are likely to require permanent methods of contraception sooner or later. The number of sterilization per 10,000 unsterilized couples with two or more children is low in Bihar (110), UP(188), Rajasthan(447) and MP (523) as compared to TN(934), Karnataka(1297) and AP(1230). There is an urgent need to improve access to contraceptives care including sterilization in the States like Bihar and Uttar Pradesh. On the other hand in some of the better performing states, increasing number of women may desire to postpone the first or second pregnancy and there may be a progressive increase in the need for spacing methods. Contraceptive need assessment, counseling, improved quality of initial and follow up care would go a long way in meeting the felt needs of contraception in the population and accelerate the decline in fertility. In UP and Bihar, there has been decline in acceptance of sterilization and spacing methods as compared to the past performance. In Madhya Pradesh, the decline is marginal while in Rajasthan, there has been improvement in both permanent and temporary methods used. The poorly performing States thus have to evolve implementing a two pronged strategy for trying to improve acceptance of appropriate contraception in districts.

The census results of southern and western states have shown that the birth based approach and also acceptance of sterilization have yielded results showing a much lower growth rate as compared to some of the northern states. The target of a crude death rate of 9 has already been achieved as may be seen from the information available from SRS as well as from the National Family Health Survey (NFHS). The matter of concern is only the infant and

of IMR and MMR there is a need to improve the status of the indicators mentioned above. A sustained effort to reduce the total fertility rate (TFR) needs to be done.

The strategy to be adopted in controlling the related issues are discussed below:

Anaemia prophylaxis programme

India is one of the countries with highest prevalence of anaemia in the general population. Prevalence of anaemia in pregnant women ranges between 50-90%. This is mainly due to low intake and poor bioavailability of iron from the diets consumed in India; poor intake of folic acid and coexisting foliate deficiency also contributes to the problem. Anaemia present from childhood through adolescence antedates pregnancy; it gets aggravated during pregnancy and perpetuated by blood loss during labour. Anaemia continues to be responsible for substantial proportion of the perinatal and maternal morbidity and maternal mortality.

Child Survival Programme

The fact that perinatal and neonatal mortality have not shown substantial decline over the last two decades is a cause for concern. Improvement in the quality and coverage of antenatal, intranatal and neonatal care is urgently needed. Initiatives for detection and management of low birth weight babies; detection and management of birth asphyxia and essential newborn care have to be added in a phased manner to the existing package of services. Improving utilization of nutritional supplementation programmes under the ICDS, massive dose of Vitamin A prophylaxis programme and anaemia prophylaxis programme need priority.

The ongoing programme aims at reduction of infant and child morbidity and mortality through:

i) sustaining and strengthening of ongoing programmes of universal immunization, ORT, massive dose of Vitamin A, Iron & Folic Acid supplementation programmes.

ii) expanding the coverage of ARI control programme.

iii) Coverage under the anaemia and Vit A prophylaxis programme showed substantial improvement but is still way below the target of 100%.

Immunisation

During the Eighth and Ninth Plan period, the coverage under the immunisation programme was maintained *(Table-VI)*. However, the target of 100% coverage by 2002 is unlikely to be achieved for all the six Vaccine Preventable Diseases (VPD). There has been substantial improvement in the quality of the programme but even now, there are slippages in the

maternal mortality, where about 7 % of the infants do not see their first birthday, while more than a lakh of maternal deaths takes place every year.

The key component for the success of the population program is to have an integrated approach and address the whole gamut of related issues, instead of tackling the single problem of population growth. There is a need to focus on causes responsible for adult mortality and initiate interventions. There is an urgent need to improve availability of transport to take patients who are having emergency obst. problems to first referral units. In areas where NGO hospitals are available to provide emergency obstetric care they should be included in the network of FRUs providing emergency care. India is in the midst of demographic transition and there is a need to pay attention to old women and their health problems. Urban slum areas represent a high risk area where health indices are poorer than rural population. The key elements to have early population stabilization are, provision of health care to women and children, together with the provision of contraceptive services. In India, the contribution to health services is done both by the public and private sectors, especially in rural areas e access to health services have been hitherto provided by the private providers in various kinds of health systems existing in the country over ages, along with organized public health system. The contribution by the practitioners of Indian System of Medicines to the far-flung villages, numbering 6 lakhs in the country cannot be undermined.

The main recommendations of the NDC on population as well as the ICPD is to have decentralized area specific approach, based on the needs assessment and provision of qualitative services to be given to women and children and the accelerated pace of implementation of family welfare programme, which is in vogue. The acceptance of the family welfare programme is a factor of many extraneous variables like education, community intervention & involvement, and policy support by opinion & political leaders and commitment of the implementing agencies of the programme in a given area.

The current high population growth is due to three factors

a) the large size of the population in the reproductive age group (estimated contribution 60%)

b) higher fertility due to unmet need for contraception (estimated contribution 20%)

c) high wanted fertility due to prevailing high IMR (estimated contribution about 20%)

programme resulting in occasional morbidity and rare mortality. It is a matter of serious concern that coverage was lower in high-risk group of children from poorer communities in rural areas, urban slums and in poorly performing districts.

MTP Services

Efforts to improve access to family planning services to reduce number of unwanted pregnancies and abortion will continue to receive attention as a part of RCH services. In addition, there is a need to provide improved access to safe abortion services. There is also a need to train and recognise practitioners and institutions that are capable of providing safe abortion services during the first trimester. Provision of first trimester abortion should be coupled with appropriate contraceptive care so that these women do not incur the risk of yet another unwanted pregnancy and induced abortion. The role of private sector needs to be defined and utilized. It is important to modernize regulatory system in health care so that individuals and institutions who are performing their assigned roles efficiently can prosper. There is a need for area specific programs not only between states but also in different districts.

RTI AND STI

Sexually transmitted infections had been and continue to be major public health problems in developing countries such as India. HIV is the most recent addition to the already long list of RTI/STI. So far there had been no major initiative for detection and management of STI/RTI in women. The major constraint in effective STI/RTI control is the absence of simple, inexpensive, accurate methods of detecting the infecting organism so that appropriate treatment could be provided.

Adolescent Health

In India early age at marriage is still the rule in many parts of the country and adolescent pregnancies are very common. However, till such time as adolescent marriages decrease, one of the major problems to be tackled is care of adolescent girls during pregnancy. Adolescent girls are at high risk of anemia, toxemia and infections. They require appropriate care throughout

pregnancy and institutional delivery to ensure safety of both the mother and the baby, in order to reduce maternal mortality.

Male participation in Planned Parenthood Movement

Vasectomy which is safer and simpler than tubectomy was widely accepted in the sixties, However, after 1977 there had been a steep and continuous decline in vasectomies; in the nineties vasectomy forms less than 2.5% of all sterilisations. There is a need to find out and address the needs and conveniences of men seeking vasectomy and provide ready access to vasectomy services both in urban and rural areas. In Institutions with adequate trained expert surgeons, No-scalpel vasectomy might provide a useful technique for popularisation of vasectomy among some segments of the population.

The village level functionaries - namely Anganwadi workers, Mahila Swasth Sangh (MSS), Traditional Birth Attendant (TBA), Krishi Vigyan Kendra (KVK) Volunteers, Schoo teachers need to work together and achieve optimal utilisation of available services.

The Opinion leaders at the National, State and local levels will participate in community education efforts regarding the Family Welfare Programme so that community awareness and involvement vital to the success of this programme is improved. Simultaneously, the Dept wil launch an intensive drive to promote health education so that India builds a sound foundation fo a successful health programme. IEC on basic principles of hygiene, sanitation, nutrition, and prevention of illnesses and disease will be promoted through not only the educational institution and the adult education programme but also through the ICDS programme, the counselin offered by the health workers at all levels, and the mass media.

To establish male welfare centers to address health problems and special needs of men.

- The present Family Welfare Program is mostly geared to the needs of women's heal care. There are no Centres at present where men could go to address the Reproductive Health Problems.
- Establishment of comprehensive Male Family Welfare Centres to address the Reproductive Health problems like RTI/STI/HIV/AIDS, impotency, infertiliy ar other sexual disorders.

- This will help men's involvement in the FW program.

Components of male Reproductive Health care needs including that of adolescent boys are:

i) Male involvement in maternal care and care of the child

ii) Adolescent reproductive health and premarital counseling

iii) Education on gender discrimination and gender based violence

iv) Prevention and control of reproductive tract infections, including HIV and AIDS.

v) Treatment of infertility, impotency and other sexual disorders.

vi) Responsible parenthood and male involvement in acceptance of FP methods – NSV etc.

vii) Treatment of Reproductive tract malignancies

viii) Treatment of Reproductive health cares for elderly males

Private Sector participation

Involvement of Non-Government Voluntary Organisations for Promotion of Family Welfare would bring the programme nearer to the people in remote/inaccessible areas. It is estimated that the private sector accounts for more than three quarters of all health care expenditure in India. It is increasingly recognised that the private sector represents an untapped potential for increasing coverage and improving the quality of reproductive and child health services in the country.

(a) Measurement of Indicators

Monitoring and evaluation form an essential component for any on going programme. Monitoring of on going programme process is important so that it becomes possible to quickly identify the problems at implementation level in order to effect mid course corrections for achieving the pre-defined goals.

Process indicators are used to monitor the progress of implementation of the programme and a sound data-collecting base is essential for scientific planning, monitoring and evaluation of the programme. Service Statistics are useful for monitoring of the programme against the assessed needs.The impact evaluation parameters currently used by the Deptt. of Family Welfare

Urban Health and Family Welfare Services

Nearly 30% of India's population lives in urban areas. Urban migration over the last decade has resulted in rapid growth of people living in urban slums. The massive inflow of the population has also resulted in the deterioration of living conditions in the cities. In many towns and cities the health status of urban slum dwellers is worse than that of the rural population The available urban health care infrastructure is insufficient to meet the health care needs of the growing urban population.

Involvement of Panchayati Raj Institutions/ Local Self-Government Institutions

With the 73rd and 74th Constitutional amendments the Nagar Palikas and Panchayati Raj Institutions, are becoming operational in many States. These institutions will play increasing role in ensuring planning, implementation and monitoring of health and family welfare services at local level. Involvement of voluntary organizations and improved Information Education and Communication (IEC) activities are essential to ensure adequate community participation and improved utilization of the available health facilities.

At the current level, the demand of 20% of eligible couples are to be met by spacing or permanent methods. Assuming the similar ratio of acceptance, 4% of the couples needs to be provided review of spacing method and 16% of permanent methods, in addition to the acceptance prevailing. Hence the total couples currently protected need to be 13% (modern methods) by spacing methods and 51% by permanent method. This ratio is used to obtain the couples effectively protected. Sterilization is the most appropriate method for reducing higher order of births.

The RCH approach will address the reproductive needs of the population. Ample a exist to clearly indicate that there is a substantial un-met need for family planning estimated to be around 20%. Efforts to reduce IMR can create more acceptors for F.P.in districts having high fertility The family welfare programme during the Tenth Plan is to be geared up to meet the un-met need for contraception and achieve rapid reduction in IMR, maternal mortality and under5 mortality. If these programmes are fully implemented in the States/ Districts which

currently have high IMR and high fertility, there may be substantial reduction in IMR, CBR, TFR and population growth rate.

Strengthening and operationalisation of the FW infrastructure

The focus of the 8th Plan was on strengthening and operationalising existing infrastructure for delivering of primary health care through improvement in physical facility, filling up of vacant posts, ensuring supply of essential drugs and improving referral services. To some extent this has been possible; however, there are still some key posts like specialists at CHC, lab technicians at PHC/CHC and male multipurpose worker at the sub centre which are either not sanctioned or continue to remain vacant, resulting in suboptimal performance.

Assistance to poorly performing states/ districts

In view of the substantial difference in performance not only between States but also between districts in the same state and the fact that lack of infrastructure and manpower was one of the factors responsible for poor performance, the NDC Sub- committee recommended that the focus should be on providing special assistance to poorly performing districts. Data available from the Districts surveys may be used to identify districts for specific programmes.

Legislation pertaining to population stabilisation:

In order to ensure stronger political commitment to the small family norm, the 79th Constitution Amendment Bill has been introduced in 1992 in the Rajya Sabha. The Bill seeks to incorporate promotion of population control and small family norm in Art. 47 dealing with Directive Principles of State Policy and annexing it in the list of fundamental duties (Article 51 (A)) a clause of enjoining citizens of India to promote and adopt a small family norm. The Bill proposes to add an additional schedule under which a person shall be disqualified prospectively from being elected or holding office as Member of either House of Parliament or Legislature of the State if he/she has more than two children. The Parliamentary Standing Committee on Human Resource Development has recommended the bill for passage in the Parliament.

Rajasthan, Orissa, Delhi, Haryana and Andhra Pradesh have passed this Bill to c elected representatives to Panchayats and Nagar Palikas.

The programmes needs to be directed towards bridging the gaps in essential infrastructu and manpower through a flexible approach and improving operational efficiency.

a) providing additional implementational assistance to poorly performing districts identifi in order to have a full coverage services for the target population.

b) ensuring uninterrupted supply of essential drugs, vaccines, contraceptives of appropri quality and quantity to the nearest point.

d) participation of general medical practitioners working in voluntary, private, joint secto and the active cooperation of practitioners of ISM&H,

e) involvement of the Panchayati raj institutions for ensuring intersectoral coordinatic community participation, in the planning, monitoring and management,

f) involvement of the industries, organised and unorganised sectors, agriculture workers a labour representatives, through local specific interventions.

To sum up:

Family Welfare programme has made considerable progress during the last four decad Major lessons learnt while providing family planning services during these four decades are:

a) adequate financial inputs and health infrastructure are essential pre-requisites f success of the programme.

b) providing integrated Reproductive and child care through CNAA ensures not or efficient and effective delivery of services but also helps in building up rapport with t community, so essential to sustain the FW programme, which include:

i) Safe Motherhood interventions e.g. ante-natal check up, immunisation for Tetanus, s delivery, anaemia control programme.

ii) Counseling and education are powerful tools to overcome the barriers of pover illiteracy and conservative social norms for achieving the small family norm.

iii) The population is conservative but responsible, responsive and mature; their respor to rapidly changing attitude positively towards population stabilization is to be encash by providing necessary services, which is rational and sustained.

The 9th Five Year Plan had identified the need to increase the strength of nurses and paramedical. In addition, women from a particular village may be trained to render health education, talk about small family and guide women for CNAA etc. This strategy adopted in the IPP8 at Calcutta, Hyderabad and Bangalore seems to be effective and we can try to replicate.

Health Manpower Development

- The training of doctors and the paramedicals continues to be grossly unsatisfactory, both initially during the professional course and during the reorientation program. The focus is on theory and there is hardly an attempt to provide 'hands on' training. As suggested in both the 9th and the 10th Five year Plans, SKILLS TRAINING is of tremendous importance, in order to render proper RCH care.
- The training in skills requires special knowledge, planning and appropriate operationalisation of the training programs. Therefore, it is suggested that TOT programs should be organized for all the training of RCH.
- The TOT programs should focus on list of essential skills, development of standard management protocols for common problems, development of checklists for the identified skills.

Population Stabilization

- In order to provide QUALITY services in FW program, we need to train health care providers in COUNSELLING and spacing methods.
- The male paramedical worker must be given the task of counseling the men. Currently, the whole burden of family welfare program is on the female worker.

CHAPTER- 5

Terms of Reference -*Keeping in view the current Mortality, Fertility and Cou Protection Rate prevailing at present in different states, and to suggest fixati of targets for the Tenth Plan i.e. by the terminal year 2007 and individual ye for birth rate and IMR state wise.*

The Ninth Plan had two level targets for the demographic indicators like birth rate, D and other family welfare services. The two areas have been specifically given with the idea achieving the enhanced targets as the additional inputs in the family welfare programme. RCH is one of such inputs covering the whole aspects of family welfare services as envisaged ICPD Cairo Conference in 1994.

Registration of Birth and Death

The use of civil registration data has been limited because of the substantial amount under-registration. In states, where 90% of registeration of all births & deaths have b achieved, data may be used at district level for PHC based planning. In districts where c registration is over 70%, efforts may be stepped up to ensure that over 90% of birth and death reported so that independent data base is available for planning.

Expected levels of achievement (ELA) for the Ninth Plan

The performance under the Family Welfare Programme will depend upon:

1. programme initiatives during the Ninth Plan;
2. financial resources available;
3. capability and effectiveness of the infrastructure and manpower to carry out the programm
4. literacy and economic status of the families particularly of the women;
5. policy support by opinion leaders and the society.

Health indices and demographic targets for the Ninth Plan

Table		
Indicator	**If current trend continues**	**If acceleration envisaged in Approach Paper to the Ninth Five Year Plan is achieved**
C B R	24/1000	23/1000
I M R	56/1000	50/1000
TFR	2.9	2.6
CPR	51%	60%
NNMR	35/1000	-
MMR	3/1000	-

Even though method specific family planning targets have been abolished since 1.4.96, it is essential that at the central level some figures indicating the expected achievement is available for procurement of contraceptive and making necessary budget provisions.

The impact evaluation parameters currently being used, by the Deptt. of Family Welfare and O/o Registrar General, India should continue. In addition, a target of 100% registration of births and deaths by the end of 9th Plan has been set. These data will be collected, collated and reported at district level to assist the district based planning as well as monitoring of the program.

The current birth rates and infant mortality rate available and expected level by 2007 are at **Table-VII & VIII.**

The targets for the Tenth Plan have to be considered. The latest status of the indicator are as under at all India level:

Indicator	Latest information available	Expected level by 2002	Expected level by 2007
Birth Rate	26.1 (1999 SRS)	23/24	21/20
IMR	70 (1999 SRS))	50/56	45/40

Immunization program was initiated in 1978with the objective of reducing morbidity and mortality associated with Vaccine Preventable Diseases. Coverage evaluation surveys (NFI--, UNICEF 1998, RCH 1998-99) indicate that only about 50% of infants get immunized against 6 VPD in the first year.

A: Contribution of higher order of birth to be reduced, contraceptive acceptance (Terminal/Spacing) to go up.

B: Maternal Care/Child Health, ORS/AARI

Immunization to improve.

Statewise estimates of Birth Rate and IMR is given for the terminal year of Tenth Plan period.

"C: Infertility is to be given due consideration since it is a very serious social problem for about 10% of all couples. A provision for management of infertility atleast at District Centres essential and a beginning should be made in the Tenth Plan. "

CHAPTER -6

Terms of reference- ***Keeping in view the current Mortality, Fertility and Couple Protection Rate prevailing at present in different States to suggest fixation of targets state wise for couple protection rates, immunization/ antenatal, intrapartum neonatal and child health services:***

The Ninth Plan initiatives have been in the direction of providing Reproductive and Child Health services at peripheral level and to undertake micro planning with the provision of demand driven for high quality maternal and child care services. This Plan was specifically diverted to bridge the gap in essential infrastructure, manpower, through a flexible approach to improve the operational efficiency. The Reproductive and Child Health Project, which coincides with the Ninth Plan period, have also taken up the strategies to fill in the gaps in the infrastructure, involvement of the Panchayat Raj institutions and voluntary private and un-organised sectors in the family welfare services.

Couple Protection Rate

Couples currently protected under the various methods of the Family Welfare Programme include, all those who accepted the programme thus for, leaving out those who have dropped out because of mortality or widowhood and attribution due to aging or discontinuation of the method in case of IUD and Conventional Contraceptives. In the case of sterilisation, attrition takes place due to death of either spouse or the wife attaining the age of 45 years. (Table-IX & Table-X)

The Ninth Plan initiatives have been in the direction of providing Reproductive and Child Health services at peripheral level and to undertake micro planning with the provision of demand driven high quality, maternal and child care services. This Plan was specifically diverted to bridge the gap in essential infrastructure, manpower, through a flexible approach to improve the operational efficiency. The Reproductive and Child Health Project, which coincides with the Ninth Plan period, have also taken up the strategies to fill in the gaps in the infrastructure,

involvement of the Panchayat Raj institutions and voluntary private and un-organised sectors in the family welfare services.

The ratio of spacing and permanent method as per the current use by NFHS 1998-99, and the CPR as reported by the Department of Family Welfare (**Table-X to XII**) are as follows:

NFHS 98-99	(9 : 36)
CPR March 2000	(17 :29)

Realism of targets

To a large extent the performance of the family welfare program depends upon the effective functioning of the primary health care facilities. Though the infrastructure for the provision of primary health care exists in all States, it is not functioning optimally. By ensuring that they function affectively and efficiently, and holding them accountable for performance against set goals, it will be possible to achieve the goals set in the NPP 2000 including birth rate of 21 and total fertility rate of 2.1 by 2010.

Over the last four decades, there has been substantial improvement in the availability and utilization of and access to FW services and a progressive increase in the acceptance of contraception and couple protection rates. In the last decades, the rise in CPR is less steep but for the fall in CBR has been steeper and sustained than in the earlier decades. The trend in CPR and CBR over the last 30 years suggest that over the years, there has been an improvement in the acceptance of appropriate contraception at appropriate time. By the end of March,2000, we had 46% of couple protection rate.

At the current level, the demand of 20% of eligible couples are to be met by spacing or permanent methods. Assuming the similar ratio of acceptance, 4% of the couples needs to be provided review of spacing method and 16% of permanent methods, in addition to the acceptance prevailing. Hence the total couples currently protected need to be 13% (modern methods) by spacing methods and 51% by permanent method. This ratio is used to obtain the couples effectively protected. Sterilization is the most appropriate method for reducing higher order of births.

While projecting a minimum level of 30% contributing Terminal methods has been specified and a minimum level of 10% spacing have been specified. In order to have the

HP-3.

http://www.maharashtra.gov.in/english/gment/policyfr.htm

MAHARASHTRA STATE POPULATION POLICY

An Extract

Maharashtra is one of the Progressive States in the country. The State however, has not been able to control its population as per expectations. The first doubling of the population occurred in 60 years between 1901-1961. The next doubling occurred only in 30 years. The present birth rate of the State is 22.3 and we rank 5th in the country. The State is declaring its population policy with an intention to bring down the rate of population growth.

The objectives of this policy are:

(1) Reducing Total Fertility Rate to 2.1 by year 2004;
(2) Reducing Birth Rate to 18 by year 2004;
(3) Reducing the Infant Mortality Rate to 25 by year 2004;
(4) Reducing the Neonatal Mortality Rate to 2- by year 2004.

Following schemes will be introduced under this population policy: -

1.. Accepting concept of two child norm as "Small Family Norm";
2.. For obtaining subsidies under various Government schemes acceptance of "Small Family Norm" would be considered essential.
3.. In order to propagate the concept of Small Family Norm amongst the Government and semi-Government employees this condition will be included in the service rule. Schemes such as House Building Advance, Vehicle Advance and Medical Reimbursement will be admissible those who limit their family to two children;
4.. Performance in Family Welfare to be part of assessment of officers at various levels;
5.. Strict implementation of existing acts and policies such as Child Marriage Act, Prenatal Sex Determination Act, Birth and Death Registration Act etc.;
6.. Organisation of Family Welfare Camps with the financial assistance from Cooperative Societies, Sugar factories and other industrial establishments;
7.. Acceptance of small policy norm as a condition for qualifying for elections to various bodies such as Zilla Parishad, Panchayat Samiti, Corporation, Co-operative Societies etc.;
8.. Constitution of Mahila Vikas Group under the Chairmanship of Hon. Chief Minister's wife at State level and under the Chairmanship of Minister or Guardian Minister's wife at District level;
9.. Enhancing involvement of Panchayat Raj Institutions in implementation and monitoring;
10.. Village Level Scheme based on achievements in various Family Welfare Indicators;
11.. Schemes for motivating the health infrastructure for improving quality of care;
12.. Training of Dais to ensure self delivery practices;
13.. A population council under the Chairmanship of Chief Minister and a Coordination Committee under the Chairmanship of Chief Secretary to monitor the implementation of policy; and,
14.. An incentive of Rs. 10,000/- in the form of fixed deposit for 18 years to Below Poverty Line couples accepting terminal method after one or two daughters (with no male child) (If two daughters an amount of Rs.5000/- for each daughter). This daughter(s) will be given an additional incentive of Rs.5000/- each as fixed deposit for 5 years when she completes her schooling unto 10th standard and does not get married before completing the 20 years of the age.

~~HP-5.~~
HP-3.

THE NATIONAL POPULATION POLICY: PROBLEMS AND POSSIBILITIES

By Imrana Qadeer

The National Population Policy (NPP) announced by the government indicates that, at least on paper, the oscillation between a coercive and a voluntary approach has been settled in favour of the latter. The document unambiguously states that it strives for a welfare strategy that is voluntary, target-free, and integrated with key components of the welfare sector. It also states that the "overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society".

Looking at past population policy guidelines, the present policy appears to be a step forward. The policy makers have arrived at this public position only after repeated failures of earlier strategies, and not necessarily because of their enlightened collective assertion. It is therefore problematic as it comes at a point of time when the very components with which the strategy is to be integrated are being dismantled by rapidly receding State initiatives.

The population policy fixes a goal of population stabilisation by 2045. It envisages that population replacement levels will be achieved by 2010. To achieve these goals a range of objectives have been set up. These include:

- effective coverage with reproductive and child care services to reduce infant mortality rates, maternal mortality rates, and total fertility rates;
- education up to secondary level;
- delay in age of marriage;
- registration of vital statistics;
- control of communicable diseases, with a special focus on AIDS; and
- a commitment to convergence of social sector programmes.

To achieve these objectives a set of twelve strategies is spelt out. Many of these are a continuation of previously accepted strategies. Such as decentralised planning for reproductive and child health (RCH), education up to 14 years of age, convergence of welfare services, empowerment of women, insuring child health, providing for the unmet need for family welfare and for the basic needs of the under-served. Special needs of adolescents and men, use of diverse health care providers (NGOs and private sector), mainstreaming Indian system of medicine, strengthening contraceptive research, effective information education and communication strategies, and providing for the older population are also not new. Notable among the new steps is the proposal to revive the system of licensed medical practitioners to fill in the gaps in clinical care and to converge

services at the village level. While these are welcome strategies, their content leaves much to be desired.

The policy document raises two sets of questions. Firstly, how consistent is the content of the policy document with its overall perspective? Secondly, how will the challenge of convergence (of the welfare sectors) be interpreted by the States, which will actually be implementing the policy? This paper attempts to explore these questions. It is our belief that if the inherent contradictions within the NPP and the potential of coercion in the implementation of this policy are not corrected right at the beginning, and strict guidelines not provided, the policy will fail to realise its potential.

INTERNAL IN CONSISTENCY OF THE POPULATION POLICY

There are some very obvious inconsistencies in the NPP, which need to be addressed if the policy has to acquire a positive edge. Some key areas for consideration lie in the dissonance between the NPP's welfarist approach and the reality of the government's disinvestment plans, between primary health and reproductive health, between convergence of welfare services and the available structures, and between voluntarism and coercion.

Conflicting Population and Development Policies:

If the population policy's expressed concern for quality of life and well being is genuine, then structural issues cannot be under-emphasised, even when it is accepted that population number is an important factor in development. The NPP document, however, neither talks of land reforms or strategies for employment generation and food security systems, nor of ensuring the celebrated 'safety net'. But it does reiterate that, "stable population is an essential requirement for promoting sustainable development with more equitable distribution", thus making it a one-way process. It warns, "if current trends continue" India's population may overtake China's by 2045! And it adds that, "at the current growth rate, the additions 'neutralise' efforts to conserve resources and environment!"

These demographic fears are not new. They reflect a mind-set rather than a real new threat - a mind set that is unable to accept the complexity of the problem and that must hide behind these linear projections. In India, for example, despite the perpetual failure of the family planning programme for population control, birth rates have steadily fallen over the 20th century (1). Interestingly enough, in 50 years of planning, the programme targets have never been achieved at the end of a Plan period (except during the Emergency!). As things stand, there is nothing different as far as the present projections go. But over the later half of the 90s, the rate of decline of infant mortality rate (IMR) has slowed down and, over 1996-98, the Sample Registration Scheme shows its reversal in at least eight major States (2). Thus, the not-so-improbable danger that population growth rate may come down, but because of the added factor of rising mortality rather than declining fertility rates, has not been taken note of by the NPP.

The above trends, along with the increasing pressure on land, ensuing migration, and the unmet need for contraception, indicate that, instead of using hypothetical situations to justify the so called 'dangers' inherent in India's demographic status, there is an urgent need to look at the processes behind demographic shifts. By blaming future population growth for the "neutralisation of efforts to conserve the resource endowment and environment", the policy, at best, protects processes such as liberalisation and Structural Adjustment that ensure a kind of development which sustains only certain sections at the cost of others. The NPP yet again refuses to accept that population stabilisation requires efforts to create well-being, which is a necessary prerequisite of, or an instrument for, population stabilisation, rather than the exercise of demographic goal fixing!

Just the issue of utilisation of natural resources shows that it is the international market-oriented model of development and its strategies that cause mindless destruction and waste and certainly not population numbers, even when they are increasing. For example, the pattern of industrial growth is characterised by large-scale closure, privatisation, and displacement of workers, in a way that the worsening employment situation affects their well-being (3). Despite adequate growth rates, poverty levels have not changed much. Rural poverty, in particular, shows stagnation over the 90s (4). There is also evidence of severe destruction of life and livelihood. In Andhra, 300 cotton growers committed suicide, as they could not sustain their livelihood within the shifting policies that generated a systemic crisis (5). At the Narmada Dam site, the so-called development created death traps of malaria and human displacement (6), which have become key contributions of development projects in independent India (7). These projects are meant to "adjust" Third World economies to suit the hi-tech markets and for the promotion of distorted development.

Even when we look at those above the poverty, there is sufficient evidence to show that majority of them are negatively affected by the ongoing social and economic processes. For examples in late 90s, total employment has declined - especially among the literate and the educated - who seek employment other than manual (8). Similarly, the contraction of the unorganised sector in the late 90s has pushed a large number of rural people into relatively low productivity areas. Added to this is the shrinking social sector that reduces employment opportunities (9), and makes services inaccessible as private sector hikes prices of health, education and other necessities.

These examples illustrate that the conflict is not simply between the "population added" across classes and the resources generated by those classes, but between sections of population with respect to control over resources, irrespective of the population added. The issue is more of livelihoods for the poor, and their basic rights to survival with dignity, against the rights of other classes to further enrich themselves. The inability of the NPP to focus on the broader linkages is also reflected in its narrow approach to under- nutrition. It clings to Integrated Child Development Services (ICDS) alone and to distribution of micro-nutrients when studies in the past have shown the inadequate coverage and the

inability of the feeding programmes to impact nutritional status of the population (10). These programmes were actually short-term strategies, initiated in the 60s and 70s to tackle a crisis situation. The assumption was that with long term planning, these would become redundant.

As it is now, the NPP does not mention any concern either about the failures of the Public Distribution System (PDS), nor of the process of commercialisation of agriculture that is undermining the food security system (11). Employment opportunities for the unemployed, ensuring minimum wages, public distribution system for food grains and electrification are not important issues for the NPP. By avoiding a review of the nature of the developmental process that burdens the weak and forces them to wait for relief, and not defining concrete shifts in structure for the benefit of the marginalised, the NPP creates a myth of perfect choices and opportunities. This fits the demographic requirements of the globalisation process that demands the profitable use of hi-tech, but not of human labour.

Conflicting RCH and Primary Health Care Policies

While the NPP proposes an integrated approach to basic health care, it in fact reduces basic health to RCH. This is at the cost of general health care, especially for women. In the absence of an explicit health policy, the NPP sends a clear message about the priority being placed on population control as against Primary Health Care (PHC). The previous health policy, that had committed itself to achieving PHC by 2000 AD, has not merited even a reference in the NPP document. It talks only of "primary level care". The supportive secondary and tertiary care essential for PHC is ignored, as is the notion of comprehensive development of communities. The result is that Primary Health Centres and Sub-Centres have been totally identified with the Family Welfare Programme in the NPP. This will only further alienate people from the peripheral institutions.

The NPP, instead of strengthening PHC, appears to initiate a quiet process of appropriation of the basic infrastructure for RCH, while simultaneously condemning the existing infrastructure for lacking 'supervision' and 'motivation' and for being limited and over burdened! The policy, in fact, goes out of its way to declare that the last 50 years have demonstrated "the unsuitability of these yardsticks" for assessing health care infrastructure, particularly for remote, inaccessible, or sparsely populated regions. According to the NPP we need to promote, "a more flexible approach, by extending basic RCH care through mobile clinics and counselling services". In other words, experiments such as mobile clinics that were proven to be costly and a failure in the 70s (12) are being revived at the cost of that very infrastructure that needs resources for its rejuvenation. There is not a word to explain why RCH cannot remain a component of PHC and why the available infrastructure (among the best in South Asia) cannot provide comprehensive PHC (i.e. including RCH), fully supported by secondary and tertiary level care.

There is much talk of "partnerships" and mobilising a variety of service providers to overcome the need for infrastructure. However, what would be the State's share of

responsibility in the areas identified and how much would the partners contribute, remain any one's guess. The "partners" seem to be free to bargain with the government on this issue. At the same time, with cuts in subsidies and plans to privatise welfare sector services, the access of those who need the services most will necessarily be marginalised further.

While the NPP emphasises quality of RCH care, it also proposes, "elimination of the current cumbersome procedures for registration of abortion clinics"! This is counter to all notions of strengthening and enforcing mechanisms for standardised services. Registration is a means to assess the adequacy of the institutional infrastructure and its quality. Any dilution of conditions for registration will have a direct effect on the quality of services provided by institutions. Laxity in registration will ensure only profiteering by unscrupulous providers and not add to expansion of effective services in the real sense.

As a part of its integrated strategy, NPP does mention control of communicable diseases but does not comment on their vertical structures, their inefficiency and inappropriateness (13). With their exclusive single purpose workers, who travel to the same places and multiply travel costs as well as waste people's time by increasing the number of visits per family, the present vertical programmes enhance inefficiency. This was recognised by the government itself in early 1970s when the Ministry of Health and Family Welfare introduced the concept of multipurpose workers (14).

The NPP's exclusive focus on AIDS control programme is due to the perception of a shared interest in promoting condoms and treating reproductive tract infections and sexually transmitted diseases. The policy does not recognise the dangers of poor infrastructure for PHC that makes the population vulnerable to contacting AIDS through the use of inadequate facilities such as unsterilised syringes. The programme records 24% of the AIDS cases come from among professional blood donors, drug users, recipients of blood transfusion and others (15), which are indicative of laxity of services. Yet, there is no accurate assessment of the implications of the inadequacy of the PHC services for AIDS. It is evident that improving the quality of PHC (including blood banks) will contribute to AIDS control. An aid amount of Rs. 1425 crores from the international funders for the second phase of the programme seems only to enhance its vertical nature (16). The NPP ignores the social situation that was conducive to the spread of AIDS. As a result people remain victims of their conditions, as well as of the very system of health care that was to protect them.

This deliberate undermining of PHC services and the NPP's linear approach to RCH is damaging to the cause of reproductive health itself. The problems of maternity and infant health are the outcome of a continuum of ill health for women. Over 40% of deaths among girls under 14 years of age are caused by communicable disease (17), and anaemia and malnutrition are prevalent in about 60-70% of the women (18). Therefore, no amount of reproductive health services alone can be effective. The reproductive system is a part of the body and a sick woman can hardly sustain a healthy reproductive system. It is well known that a significant part of maternal mortality is due to sickness. Any isolated

approach to RCH can, therefore, only be self-defeating. Thus, it is very significant that the NPP rejects the positive ideas evolved by an earlier draft that had called for "a restructuring of the ministry", in a manner that its two departments are actually merged, and vertical programmes are integrated into the general health services (19).

Conflicts Between Conceptual and Structural Needs of Convergence

Just like the professed policy for integration of RCH, the stated strategies for converging welfare services to strengthen RCH are vague, weak, and ill defined. It is also not clear that, if the prescribed services (such as primary and secondary education, housing, drinking water etc.) are to be provided to the needy, then how are the respective departments going to define their tasks and restructure themselves so as to be able to deliver these services. A policy of inter-sectoral convergence can be successful only when the ministries have clear guidelines and mechanisms for delivery of the required services. These guidelines are missing in the NPP. In which case simply putting bureaucrats from the concerned ministries on to the Population Commission may not help. These services can be supportive of RCH only when they are operative in the field and cover both the rural and urban poor. For this the respective departments need to undertake very clear-cut financial and structural reforms.

By adding a hundred member National Population Commission to oversee the implementation, the policy does not actually set up an efficient mechanism for implementation of policies. The Commission's members are from different walks of life. They may be imbued with excellence in their own area of expertise but they are bound to have varying competencies in assessing issues of implementation of the NPP. These issues range from technological, administrative, financial, organisational, to social and ethical ones. At best the Commission can work towards evolving a consensus on issues. To oversee implementation a more cohesive group will be required, with clearly set evaluation mechanisms and working on a continuous basis. The policy does not visualise any such rigorous mechanism. It neither sets up an internal assessment mechanism within the Ministry, nor an independent external monitoring mechanism through the Planning Commission. In the past the Planning Commission has provided excellent monitoring services for the family welfare programme (20). But the NPP only proposes to use the Planning Commission as a co-ordinating unit.

The reasons for the absence of rigorous mechanisms are not difficult to identify. The health sector has to function as a sop to get soft loans and international aid to keep up the trickle of foreign currency to correct the balance of payments! As a result, the tags attached to developmental programmes have to be accepted. Consequently, the distortions in the welfare sector have to be ignored rather than remedied. It is not surprising then that, despite so much emphasis on Panchayati Raj, both the devolution of power and disbursement of funds remain inadequate.

It is apparent that plans evolved by international funding agencies like the World Bank cannot be over-ruled, despite all the wisdom buried in the shelves of the Ministry of

Health and Family Welfare and government institutions. The forgotten report of the Planning Commission's Working Group on Population (21), and the ICMR-ICSSR Report on PHC (22), reflected the official understanding of population stabilisation as a function of well-being. PHC for the underprivileged was seen as much more than simple mid-way correctives in the delivery system. And, for all this, major restructuring was envisaged. Today, all that has become a thing of the past. The NPP, on the face of it, appears to be striving for a broad comprehensive approach, but is actually trapped in the demographic compulsions of the prevailing economic policy. A policy that reduces, rather than increases, investments in the welfare sector (except for population control) and forces restructuring to promote markets for the planned benefit of a handful.

The lack of legal structures to support the policy is yet another aspect of the conflict between strategies and structures. The NPP's treatment of women's empowerment reveals not only a lack of sensitivity towards the issue but also a poor understanding of it. For example, empowerment is to improve "nutrition related capabilities that become crucial to a woman's well being, and through her, to the well-being of children". How this empowerment will happen is not clear except that Panchayats are expected to provide them employment. In the absence of resources within the Panchayats, this remains a hypothetical proposition. Only one thing is clear: according to NPP, women's health and nutrition problems can be largely prevented or mitigated through "low cost interventions designed for low income settings". Thus, while one is not sure of their empowerment, women's destiny to stay in "low income groups" is assured.

Except for extending the legal freeze on the 42nd Amendment to 2026 AD, so that the states may "fearlessly and effectively pursue the agenda of population stabilisation", no other legal provision is offered that might be supportive of women. The legislative requirements for ensuring women's right to information, property rights, political participation, and safety etc. all are missing. Women's empowerment is thus seen as a programmatic intervention from above that promotes fertility control rather than creates enabling conditions for them.

Conflict of Voluntary Acceptance and Coercion

The NPP courageously rejects force and coercion. It is therefore critical that the same does not re-enter the programme through the back door of motivational strategies. This is imminent in three steps being included in the policy proposals. There is a proposal to start national health insurance coverage for hospitalisation costs for children below 5 years of age. It is however linked to acceptance of terminal methods of contraception and small family norm by the family. The policy thus proposes to deny help to a child for the acts of its parents! Should a NPP working towards well being do so, when that child invariably will be a little girl who is dispensable in families waiting for the arrival of a son?

The second proposal is for those below the poverty line. A health insurance scheme, again for hospitalisation not exceeding Rs. 5000, and again linked to acceptance of the two-child norm. The spouse accepting sterilisation is also given a personal accident

insurance cover. Shouldn't those below the poverty line be given assured services and better coverage without arm-twisting, so that well being induces acceptance of a small family and population stability, rather than denying basic amenities? The third proposal is to honour and award the Panchayats and Zila Parishad for successful performance on the basis of services provided, excluding sterilisation and harmful contraceptives. However, such incentives may induce pressure for achievement and we have the experience to foresee which section will bear the brunt of this pressure.

The NPP lacks trust in the people. It assumes that they do not think of their welfare and hence a certain amount of pressure and conditional incentive are required. This is dangerous because the limits of these pressures are very ill defined. Perhaps this attitude is born out of the knowledge that, in the present policy for overall development, there is no scope for well being of the poor. They have to bear the burden of the Structural Adjustment Policies and hence must be coerced, coaxed and pushed; not through well-being and expanding opportunities, but through pressure and coercion.

Interestingly, the lack of trust in people is not limited to the common people alone - it extends beyond. The NPP proposes to set up two technology missions outside the purview of the existing national research institutions. One of these is for neonatal care and the other for the assessment of new contraceptives. While the first is to be composed of Indian obstetricians and paediatricians, and is called the National Technical Committee, the second is called the Technology Mission and will have international experts on it! Thus, in the name of high-powered commissions the NPP brings in international interest groups on national planning commissions. This Technology Mission will be within the department of Family Welfare itself and will work towards the incorporation of "advances in contraceptive technologies". This is an extremely retrogressive step. It undermines our own scientific community that has worked with diligence within research institutions like ICMR, and saved the programme from incorporating harmful contraceptives such as Depo-Provera and Quinacrine pellets. All of these were proven to be damaging to women in India and elsewhere (23,24,25), but were being pushed by corporate experts. It also unnecessarily duplicates institutions while there is resource scarcity.

The case of Quinacrine is particularly alarming, where ethical concerns have collapsed altogether. Despite WHO's advice to stop all trials, unscrupulous doctors have - taking advantage of weak control systems and free market mechanisms - promoted the use of this unapproved contraceptive among unsuspecting women. This drug has not even cleared the required stages of testing necessary before a human trial and yet First World academic journals have chosen to publish the unethical human trials on Third World women as scientific research (26).

We therefore need to ask, why do we need foreign experts in our National Technology Missions? What role did the foreign experts play in the past; be it the Family Welfare Programme, the National Malaria Programme, the Tuberculosis Control Programme or the AIDS Control Programme? In the Family Welfare Programme they advised to keep maternity and child health services out of the scope of the programme, as

the poor state of health of women and children would exhaust all resources (27). India was pushed into accepting a National Malaria Eradication Programme without any preparatory phase, a necessary component of the programme design (28), and paid a heavy price for it when hit by resurgence of the disease. Similarly, Directly Observed Treatment Schedule (DOTS) has been thrust on the Tuberculosis Control Programme against the advice of national experts who had clearly outlined a more economic and context specific alternative strategy (29). "Experts" have also made projections of AIDS for India that promoted panic and ignored the specificity of the Indian population. They ARE also shifting attention towards treatment OF AIDS without at all considering the problem of its control (30). Without a rational strategy for control, AIDS becomes yet another means for expansion of foreign markets in technology and dependence of the Third World. What role are the technical experts in the mission going to play now and whose interest will they represent?

Hints of vested interests are visible in the pressure on the Third World to do away with stringent safety guidelines in research and take up more of the so-called "essential research". This research will be funded by international agencies but will be conducted in the Third World for the benefit of humanity (31). There is a view that life is cheap in the Third World, hence it can be used as a dumping ground (32). The increasing use of Third World populations as cheap human material for experimenting with new technologies (33) are indications of a trend. It is, therefore, extremely critical to understand who provides the technical expertise and for whose benefit.

PROBLEMS OF IMPLEMENTATION

The implications of these contradictions are evident in the State Population Policy documents circulated by Uttar Pradesh and Madhya Pradesh. Both these states join Maharashtra, Haryana and Rajasthan in enacting laws that debar people from elections to the local bodies (but not to Parliament!). The thrust of their Population Policy is fertility control through the RCH approach. The two policies barely articulate their broader developmental strategies. Also, little is said about enhancing opportunities, capabilities, or convergence of inter-sectoral development.

Uttar Pradesh (34) for example, proposes to:

(i) Refuse government services to those who marry before the legal age of marriage.

(ii) Sterilisation will continue to play a critical role in its strategy.

(iii) Hold sterilisation and RCH camps! It does mention "periodic reviews" and "follow ups" to diffuse the damaging image the word "camps" elicits (35). At the same time, it confesses that camps are not the best way to provide high quality services on a regular basis. Yet it hopes to "improve access to and quality of services".

(iv) Performance appraisal of medical officers will be based on their "contribution to meeting RCH needs"! This means that if they do not perform other duties it does not matter!

(v) People will be "encouraged to utilise services of the private institutions" at all levels of the district. These will be identified by the State and given support both in terms of equipment and resources. This not only means that the tax payer's money is diverted into the private sector, but also that those 36% people who are below the poverty line (36) may not get any secondary or tertiary level care even for RCH.

(vi) Train its workers & upgrade their skills and knowledge in modem research with newer technologies. However, there is not a word of caution about the use of contraceptives that are not suitable for Indian conditions. In fact, the State proposes to incorporate material on injectable contraceptives in its training and hopes to conduct operations research to assess the possibility of introducing injectables and other new technologies in family planning services. It needs to be pointed out that operations research helps optimise a system. The choice of technology should depend upon epidemiological studies. The fact that the Ministry has not included injectable contraceptives in the National Family Welfare Programme, and epidemiological studies have shown that they are inappropriate, is totally ignored (37).

(vii) Despite the fact that the Centre has created a special fund for population stabilisation and the NPP considers RCH a basic service, Uttar Pradesh proposes to introduce user fee even for RCH. This is proposed despite the evidence that user fee excludes the poorest from services (38).

The State of Madhya Pradesh (39), chooses education and Panchayati Raj as its main social sector programmes that will support its population stabilisation strategy. The rest of the welfare sector does not enter the debate nor does the document state the share of resources to be provided for the Panchayats for the social sector programmes. Along with these, the policy proposes that:

(i) Persons having more than two children after January 26th, 2001 would not be eligible for contesting elections to Panchayats, local bodies, or co-operatives in the State.

(ii) Legal age of marriage will be made a criterion for employment.

Thus, on the one hand there is talk of empowering women, and on the other hand policies like the above negatively affect women. The majority of women are hardly in a position to either decide the age at which they are married or the number of children they bear. If these State policies are any indication of future possibilities, then it is clear that coercion is there to stay. Child marriage, for which the social and economic conditions of parents are responsible, will further deprive an already hopeless youth (especially girls) from seeking opportunities.

In addition to these two States, the Maharashtra government is reported to have put up a most draconian bill for the approval of the Governor. It not only refuses families with more than two children all welfare facilities (housing, land for housing or agriculture,

free studentship, loans etc.), but also denies the third child rationed food grains and even health care for the mother and the infant! Even the poorest are not spared the wrath of this policy (40) and the Minister of Food and Civil Supplies is reported to have justified the decision as being "in the national interest" (41).

Thus we see that, in the interpretation of the national policy, the States reflect a single-minded pursuit of the demographic goal. Whatever was left of the public sector health services is going to be fully appropriated and peripheral health institutions will be transformed into RCH service outlets. As a result, the workers may not have time for the rest of the services for which they were earlier responsible. The poor will be further marginalised and sucked into the vortex of a free market for health care being formally promoted by the States by providing space and formal financial assistance to the private sector. What then, is different about this NPP except its liberal camouflage?

It is evident that the NPP yet again falls short of striking a balance between well being, through increased human productivity, and population numbers. The latter by itself makes little sense unless seen in terms of integration into or alienation from the economic and social processes. The NPP, unfortunately, is too preoccupied with demographic targets to provide that balance. The States have taken their cue and are going to alienate a big chunk of the population from the mainstream socio-economic process, labeling them as undesirable and an obstruction to development. We seem to be losing sight of the fact that the level of poverty in the country is stagnating. Even those who are above the poverty line are increasingly facing greater insecurities due to shrinking employment opportunities, under employment and a failing service sector. The IMR is not only stagnating but also giving hints of a rise in some of the major States (42). In such a situation, should demographic achievements of fertility control alone be considered the need of the hour?

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HP-3.

The role of the Language of Rights in population, health and development : An exploratory paper .

Devaki Jain

Summary

The language of rights has always been a problem in poor unequal countries where instruments to enforce legal safeguards are muted or blunted by the very poverty and inequality of the situation. (ref)

But as globalisation strides along - and inequality hurts harder - almost as hard if not harder than poverty and deprivation - people are mobilising around rights even in developing countries.

A recent example of this mobilisation is the newly formed National Alliance of People's Movement (NAPM) which is an alliance of 9 struggle based organisations such as the Azadi Bachaon Andolan, Himalaya Bachaon Andolan, National Fishworkers Forum, Bhopal Gad Peedit Mahila Udyog Sangathan, Samajwadi Jan Parishad, Manav Vahini, Ganga Mukti Andolan, Chilika Bachaon Andolan and Narmada Bachaon Andolan and number of other movements are part of this process.

The alliance has drafted a declaration from which I quote only their slogan:

" HAMARA BEEJ, HAMARI BHOOMI
HAMARA KHAD, HAMARA PANI"

If I could summarise in a few sentences the position of the members of this alliance, it is "Bachao us from Badlao", to quote Medha Patkar who argued at the Jaipur Conference on Women Studies that everything is being advocated in the name of Badlao - transformation, change. But all these changes are damaging lives and livelihoods and an increasing number of groups, formations are asking for Bachao, save us, from this transformation. She went further to say that it has become so bad, the pressure of this new type of transformation that "we just want to be left where we are left alone even in the misery of the current situation . The spirit is to say: enough is enough, stop. Say no to development. Object, obstruct it, pull down the existing structures that are encroaching. Very similar to feminist responses to global pressures: - 50 years of Bretton woods is enough and so on.

These responses can be traced to the gradual reduction of people's rights to what was earlier a free public utility - namely rivers, oceans, forests, gracing land etc. These natural resources are beginning to be contracted for production, for trade by agencies which are once removed if not many times removed from the people in these areas, who used to access them.

This crunch or squeeze to use the language of today is beginning to hurt deeply enough to be responded to with a movement for affirming people's rights to natural resources. Thus the NAPM itself has moved from a call to support the right to work, to a call for the right to resources as even prior to the right to work.

Groups like the NAPM have no hesitation in pointing their finger to the globalisation, liberalisation process as being responsible for the devastation and taking a unqualified stand against it. They propose to have a march through India starting from January 25 and ending on March 15, awakening people's consciousness to their total objection, resistance, dissociation from the macro policy. They propose this as a way of voter education prior to the elections. (Annex.)

In another area namely the area of violence against women, which is now at the top of all the agendas, rights and their protection has come to be accepted as a necessary condition for beginning to turn around the terrible situation of women in India and South Asia. The situation of women in India and South Asia where the house-hold authority and conventional models of women's roles and behaviour is so deeply embedded that recourse to the Language and instrument of right, it is believed, might provide at least one enabling mechanism for fighting this millions of battles in millions of homes.

Another extension of the use of rights initiated through 73rd and 74th Amendment is the right to participate in political structures. While it is nobody's claim that this participation is as wholesome in either its feminist expression or its consequence of improved gender relations, agency or sex ratio, the sheer numbers in terms of female visibility in governance is beginning to be felt in local areas. According to those working at the Panchayat Raj level, translating women's political presence into a larger right namely the right to actually have the information, the skill, the autonomy to take decision on local development has become a challenge for those feminist who ar working with these institutions. Again awareness of laws and how to access them using the language of rights is a part of the orientation.

Many of the women in local politics talk of their rights, "haq" to be in larger and larger aces of politics. A taste of honey. But even though to many including people like Medha Patkar - entering political parties as they are shaped, as they are ideologically bound are not palatable nor desirable; the quest and aspiration is to transform these structure and their ideology both through flooding them with women - as well as through greater attention to enhancing the feminist aspects of leadership.

And so we come to reproductive rights: The effective expression of reproductive rights is dependent on a broader acceptance of the language of rights, in a broader set of areas such as mentioned above - the right to natural resources, the right to protest, the right to leadership and to information. Expanding the concept of reproductive health to include the concept of social and economical security for women would bring us directly to notions of development rights to the rights of the poor to livelihoods, food and so on.

Again ground swell movements in India including - parts of the women's movements, are adopting this language as it links them to constitutional and judicial mechanisms which seem to have more potential to provide justice than the government or even civic society - apart from the market of course.

Some of the older institutions such as trade unions and cooperatives have always used the language of rights. Being representative bodies most of their "procedures" and rules are based on elections, on voting and therefore on rights of the members. The reasons these institutions like cooperatives and trade unions need to be seen with greater interest in the landscape of globalisation and liberalisation is not only because of their representative nature which engages itself in rights (even if women are not yet visibly present in the current scenario of these institutions) but because in the context of large corporations, large scale financial institutions coming into to play in the fields of India, the only possible source of countervailing power is to build alternative economic organisations, federate them.

One such new coalition is the National Centre for Labour that has emerged in India as a confederation of the various unions of unorganised workers. A similar move is taking place in the cooperative sector where the cooperative act is being re-designed to free itself from government control, thereby bringing greater place for membership rights, and through that process of liberation from government control and bringing more representative self-managed process develop into a cooperative movement which can challenge with corporate movement.

In making this presentation and drawing attention to this phenomenon of economic institutions, and modes of resistance, the purpose is to argue that if ideas and actions in the field of population and health and development have to be shaken out of their current cruelty, discrimination and assault on women, the language of rights and the building up of representative institutions are key instruments, perhaps more key or more valuable than more research, or more advocacy on policy or more programmes by government.

Whether it is a notion of research or the notion of activism what emerges as one strong phenomenon in South Asia is the intense oppression of women and unqualified discrimination apart from lack of escape routes. It appears like a "no exit" situation except for some categories who are still a small proportion. Re-valuing women is critical and would require very deep disruption of perceptions and a replacement of 'new'. Such a transformation may be beyond development and may be only possible through cultural revolutions as well as psychological

deschooling of men and society. That job certainly needs to be done.

Further, in the frame of the theme of this conference, it is necessary to draw out the current preoccupations of the women's movement which is in political consciousness, in control over resources and social arenas through an entry into the structures of power, an interest in the process of social and economic transformation and an interest in poverty. The language of rights has been found to be ideal in dealing with these concerns.

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Dear Dr. Devaki Jain

Thanks for inviting me for the colloquium on Population Policy. It was very informative to listen to the presentations. I am attaching the draft note I prepared along with this.

Regards and in solidarity

Unni

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Rough notes/ draft. PLEASE EDIT.

Colloquium on population policy
19-20 October 2000, Bangalore.

Dr. Mohan Rao:

Good to see people from various background and we have a very flexible agenda. Our key concerns are on gender, health and rights issues. The inter-linkages between them are important and the social context in which the new policy document has to be located has to be looked at.

When I met Dr. Devaki Jain several months ago, we were looking at the policy related issues. The new policy document has to be placed in the context of recent developments like panchayati raj and other local self-governance initiatives.

My concerns : To re-emphasise on the need to have a holistic view and approach.

Two basic questions: Is this a population policy or a family planning policy? If it is a population policy, what should be the elements ?

We need to place reproductive health in the context of larger public health issues.

There is a need to look at epidemiological and mortality data as it often gives a different picture/ signal. Reproductive morbidity is high. But it is not epidemiologically correct to delink mortality with morbidity. There is a need to link mortality and morbidity.

Most of the studies have focussed on ill designed strategies and symptomatic variables. White discharge is a case. This need NOT be related to reproductive issues. We must look at the larger context.

On the absence of reliable data : We don't have death data since 1990. (.....please explain the OH sheet on female deaths in India (1992-93).

Death related to childbirth and pregnancy is only 2.4. This proportion has increased between 1982 and 1993, despite all commitments.

Age specific deaths: Communicable diseases double or even triple amongst all women irresptive of age groups. Deaths due to reproductive reasons are comparatively minimum.

There has NOT been a drop in .....in India and Indonesia despite the over use of contraceptives.

We are not concerned about maternal mortality, but family planning. Maternal mortality has been increasing from....to..... But the death due to communicable diseases has changed and is showing a reverse trend.

Level of hunger is increasing / high in the country. Anaemia is an indicator. But we get concerned only when women are pregnant and lactating. But half the deaths is anaemia induced.

Reproductive health care is being discussed as a vertical programme despite all experience. **IMR data is extremely worrying. Still, we have misplaced priorities.** In a recent WS, there was one paper on malaria, one on IMR but 40 on sexuality.

10 states have shown an increase in the IMR rates. MOHFW has made a statement to the supreme court that they are planning to introduce Neten.

Dr. Devaki Jain:

This is the best time for me to off load my burden on NPP.

The policy is already out, but we need to look at the strategic avenues and opportunities available to influence its implementation. Any opportunity to link policy with practice and influence policy its implementation is a moral responsibility. **The initiatives and the ground level realities should be listed.**

Some of the key concerns:

1) **Many of us are in different working groups. We need to co-ordinate between ourselves.**
2) **Our role in state level commissions may be defined and strengthened.** Thelma and me managed to name it as a policy for population..... and social development. I, Thelma and Geetha sen are members (edit)
3) Thelma and Dr. Sudershan are part of the National commission/ Working group (?) So they could bring in their experience to the state.
4) **Investement in social sector is low and it is not ok.**

- **5 things that bother me:**
  a. To meet the assault on rights – **rights perspective is missing in the NPP.**
  b. Conditionalities of the 2 child -norms should be resisted and rejected. **Lobbying and advocacy is needed to block the private member bill that aims for restrictive practices.**
  c. Delivery and availability of health services. 4 stake holders in Karnataka- the govt, academicians, demographers and .....Can we wrok on the details that will help.
  d. We had documents in the past. **How do we build public opinion is the challenge. We need to work on a policy.**
  e. Narmada – The need to make alliances and the need to extent solidarity on the rights issues.
  f. **Private member bill: If this group can come up with guidelines and strategies, we may be able to block the bill.**

Interest generated within NHRC, RBI, MOHFW: My meeting with Justice Verma of NHRC....This is a rights issue. **NHRC may join hands with us for the delhi meeting.Health ministry will fund.** Bimal Jalan of **RBI** may fund the Delhi meet.

I thank all of my people at the foundation, ...from UNFPA, etc. etc.

We want to make this as your colloquium.

Let me brief you about the conflict between NPP and MO Health. **The representatives from Health Ministry are coming because they would like to listen and equip themselves to lobby for a pro-people and humane policy. This is a good occasion to influence their thinking and understanding.**

Explained programme for today and tomorrow.

I am NOT a great believer that the government will be the only service delivery people. The crux is that **this should transform into a peoples' movement**, like the Narmada struggle.

Mechanics: I thank the Govt. of Karnataka and ....for the hall.

We have invited media tomorrow. But if you don't want, we skip that.

Comparison between the state and central population policies are required to develop linkages and even develop a monitoring matrix. TOR for the WG to be redrafted as it is not uniform and inappropriate.

Padmini:

How do we read the document, where do we go from there? What actions evolve from this?

Sheela Prasad: Sec of

I got the document just now. But I will **focus on the AP state policy**, the first state to come up with a state population policy in 1997. Shared the lessons learnt.

AP has been aggressive and has come out with reforms of aggressive nature. The 1997 document was based on the recent results in TN. The political commitment in TN, facilitated the AP policy.

Women's health is talked in a big way. **The girl child is the main focus and not adults. Women and children are the key factors .....The other pressures used as justification was pressure on land, agriculture etc. But the there is no reference about how this will be dealt with this.**

In last March, there was a target of 20,000 sterilisation. **Groups Against Targeted Sterilisation** stepped up a campaign. But even the media didn't interpret the way in which we wanted it to do. Then the WB asked the question how could the govt. pressurise and ..... incentive and target oriented sterilisation in the post Cairo situation. **WB was forced to back track.** WB made clear that they were NOT keen on targeted oriented camps. The CM said that the women were coming on their own. But this year nothing of that sort has happened, by design or by default.

Donna: I work on domestic issues.

Ravi:

CEHAT Co-ordinator, into research on health issues of women, finance etc.
We have a perspective on population policy.

Demographic targets are a concern. It is good to reduce IMR, but it is done in the context of demographic issues. This needs to be confronted. **National policy is more progressive, compared with the Maharashtra state policy.** There was lot of involvement of NGOs, grassroots etc. in the national policy formulation. But **the state policies are more blunt- UP , AP and Rajasthan is a good indication.** In all these

3 states, an American consultancy group, FUTURES has bagged the contract. The group is an US based consultancy group.

We are worried about the common elements, mostly on the nature of incentive elements this consultancy group has been able to place as a policy. The element of cohersion is coming back. After emergency, cohersion have moved away. But it is coming back, in a more subtle way. So the rights perspective becomes more important.
We need to look at why we have separate family planning and population policies and why it is not based in the larger context of primary health care.

Padma Prakash:

This document is a beautiful patchwork. It is frustrating because it is an extreme note. **Impoverishment is central issue, but this document doesn't deal with it.** We must be concerned why there is no mention about the nutritional programmes . On the one hand, impoverish people through big dams and impoverish through other means and then talk about a population policy that misses the realities.

Why there is a women oriented pop policies. This would target women and it puts the burden and responsibility on women. If it is health or nutrition policy we can understand. But not this.

Fathima Ali Khan from Osmania University:

This doesn't look like a pop but family planning policy. **The language is right, but never gets translated.**

Targetting women again are the model. Story of the women that sums up the need to empower women and give choices. The case of the fight for the abortion rights. **Rights issues should be our focus.**

Eliamma Vijayan:

I am not an expert on policies. Sighted a section that mentions about sustainable development : **In the absence of a sustainable development policies, how would we achieve long term results by 2045.**

Even in Kerala is not an exception. Privatisation and cost is going up for medical care. Self help groups are formed and this is not sustainable. The self help groups are asked to takecare of the health needs as well. This is dangerous.

Lija Shibhu, elected member of Panchayat :

I am an advocate, a very new member. I will speak tomorrow.

.....from Achutha Menon Centre for health.....

We don't see it as a complete policy. I am a demographer. This policy is biased.

Feasibility of the stabilisation is questionable. Stabilisation is never stable. Stabilisation process can never be a reality. This could be a statistical wonder. **It may be noted here that if we look at only statistical indicators , Kerala may NOT need a policy because the it is already below the stability level.**

But if we focus on the rights issues, the **population policy doesn't reflect the individual rights**. This doesn't mention anything about the individual needs. We should go back to the rights perspective. This is a wish list and not a policy in total.

Sangamitra acharya from JNU:

Stabilisation is a questionable concept. The policy has been successful in giving a cosmetic touch to numbers that is away from realities. It is not possible to have death rates and fertility rates falling in the same pace. **The inter linkages between pop and health and other holistic issues related to redistribution is not addressed.** Case of AP, Bihar and .....,with all the natural resources but the least development indicators.

Rather than making it as a clinic oriented (case of surgeons), can we involve other needs including psycho social issues.

Thelma Narayan:

(1) We need to look at **assumptions like why we need a pop policy** ? The assumption that if we cut the numbers, we make the world better is wrong.

(2) Can we look at the policy as a process that evolved over a period of time and its dynamics..

(3) The context in which this doc has been developed. **The influence of agencies (external and internal) on this process and the final doc. The lobbying has not been adequate.**

The pressure of the WB and others to stress on family planning. But the cost of the "women's rights and choices " needs to be questioned.

Some of the practices in the form of camps must be resisted. **We have stopped many basic/ survival programmes like ANM training and distribution of folic acid etc.** It is in this context we need to look at the aggressive way in which the pop policy is pushed.

Gender equity:

In the absence of birth registration, we rely on unreliable data and thus improper policies. **We must insist on data collection.**

Sudershan:

I share the same concerns as Thelma. The positive thing was that PM was there from 10 to 5.

My main concern is whether we will be able to implement at least 10 % of the doc.
Karnataka Task force has the responsibility to make concrete recommendations and monitor the implementation. The system is bad, but some improvement is in the pipeline. Decentralised demographic calculation is what is happening. **Non availability of iron folic acids for ordinary anaemic patients is worrisome.** It is available only for pregnant women.

I am against the pop policy if it is away from the health policy. I think that implementation is the key issues. The issue issue and policy needs better inter sectoral co-ordination.

Prakash Rao: DAF

Role of drugs in national pop policy. It is a distorted view to think that contraceptives will help to bring down the numbers. We have taken it for granted that drugs will help. Use of drugs is in a sorry state. Western drugs, sold over the counter, can create problems. **There is a very ambiguous statement on use of drugs.** With the issue of patents in place, the situation becomes more complicated as it may allow a free entry.

Ina Sen , UNFPA:

The historical context is important. Birth control is missing and this is a positive element. The gender is not taken as such, but is integrated. **There is a progress here, even on decentralisation. It has NOT come out loudly on the issue of cohersion.** It should have been more vocal. If there was more dialogue, some of the controversial things in the draft would NOT have found its way.

Out side (and govt level) action is required in state level policy formulation. It is good that people from different backgrounds and ideologies are there in the working groups.

State actions are not consistent with policies. **Some of the state policy documents are good, but not when it gets implemented when they close political participation.** CMs may have to listen to grassroots. **A strategy to amplify the voices of the grass roots is required.**

Documentation has to come in about the field experience. Earlier the cohersion was based on family planning. Now it is based on fertility. We move from pressures on contraceptives to the fertility issue itself.

Role of donors- USAID has said that they don't like what Maharashtra does. No agency is a monolith. They have said that the trend is worrying.

We must try to use the existing windows of opportunities and develop indicators and monitoring systems. I am a believer in indicators and monitoring systems.

It may be a good idea to suggest to the working group what could be the indicators and monitoring systems/ indicators.

Looking at a transition from where we were 10 years ago, this a good step.

Dr. KR Nair:

I will focus on decentralisation. What is happening in the name of decentralisation ? **What is happening is deconcentration and not really decentralisation. We need to focus on what is happening to places like PHCs and sub centres who has to bear the brunt.**

In Rajasthan, they are not filling the vacancies and even abolishing male multi purpose workers. They are not filling the vacancies. This is worrisome.

The second area is research. Research is required. **Historically social research is done when the programme fails, as a post mortem. What we need is a process oriented research.** Social differences are important. I am shocked at the recent observations in the health research sector. **It is mostly donor driven.** The results are evident in the language they use.

Ashish Sen , VOICES

Media for social change

Does this document touch the rights issues ? **Does rights link with representation.** It is good to talk about women, but if we don't touch the issues related to survival and livelihood, we miss the point.

Shyama Narayan :

Jaya :

I am here to react on the pop policy. We don't need a pop policy. **Constant reassurances at Cairo and other forums didn't work.** They said doors are opening. But after 6 years, we are convinced that all the fear is coming back with full force. I differ with Ina. Targets are there. It is there in print. They talk about women's health, empowerment etc. But **if you look at the Maharashtra pop policy, it says that no ration for the third child. It is cohersion. If so, how will the third child will live.**

This is anti poor and not anti poverty. Maharashtra government is planning to focus on child marriage, but not from their rights but the number issue. **There is nothing on male responsibility.** We must stop camp approach as it is violation of rights. **Denying the right to context in elections (in the context of more than 2 children).**

In Maharashtra the number one reason for women's death is accident. Stoves burst only when young brides turn it on. The Maharashtra govt is moving away from MMR to IMR. Without bringing down MMR, you can't bring IMR.

Botn National and Maharashtra state policy stresses the role and responsibility of panchayats. **It is worrying to note that the funding pattern will be based on the performance of the panchayats on pop control programmes.**

The most disturbing factors of these documents are the **underlying philosophy and language is disturbing. If the state can't assure the survival, it can't limit the number.** The national document says "states are persuaded to fearlessly pursue...". We can demand consumption policy.

Mira , IISt.

Rights perspective missing. Approach of having **Non- negotiables to implement a policy is questionable.** Women have no assurance for survival medicines like for snake bites or ...etc.

Eg: During a field visit to Raichur, a lady asked me to write a note to so that he could go for a surgical sterilisation. After the surgery she had to do everything.

Years later, it was found that she had serious reproductive health problems. There are linkages

Recent initiative of the ISST on conducting panchayats.

Capacity building needs to be looked at.....has come down to equipping them NOT to write the numbers.

Janaki nair:

Arya Bhat :

Sample registration system doesn't work. **Population policy needs a holistic approach.**

Sabu George:

(Sabu will fill....)
stressed on female infanticide

3 Panchayat members spoke in Kannada, please fill.....

Last speaker spoke about the initiative to federate elected members. Didn't get into the details.

Padmini Swaminathan, MIDS:

My analysis found that increased participation alone .....

TN govt's explanations about 4 (symbolic) indicators are in place and so we are in good shape. Explanations were not conclusive and final.

How do we go about sustainable development. **Linkage between poverty and population policy is important. It is more important in the context of increasing inequality levels.** The argument that we are over populated to deal with development. **We are loosing track of the lessons learnt by developed countries. The nature of economic development has made is extremely difficult to bring up a child in the west.** The working hours have made it extremely difficult to share the responsibility between parents. Sweden gives three years of leave to bring up a new born child. **We need to look what we can learn and what we need to be careful from the experiences of these developed countries.**

The recent move to develop social development indicators in TN: Concerns raised in the concept note are:

Exceptionally high MMR
Existence of anaemia, malnutrition
Omissions of men's role in contraception.
Excess female child malnutrition is appalling.

Structures of governance are not explained and understood. To locate the implementing and monitoring aspect.

Post-lunch:

Ravi

Thelma

Sanjay Kaul: (please pick up the notes from Sabu. I am sorry , I missed this)

No more incentives for sterilisation in Kranataka.

Targets for sterilisation has been given up but not the target for immunisation.

Case of Bijapur

GOI is promoting male responsibility. We need to tap the potential strengths of TSMs.
We need to involve NGOs as well. If it was not for the financial strengths of these NGOs, the system would have collapsed.

Lot of money is available for AIDS and TB.

IEC needs revamping.

In the health system, there is lot of resistance to look at things differently. One is scepticism that if we don't keep targets , number will go up.

Challenge is to develop documentation that will prove that targets alone don't help.

Ravi: Small family Vs healthy family.

Suman:

Shyama:

I work with IVF clinics.

No govt. clinic gives services. So ordinary people are left out. There is no work being done to tackle infertility.

The **Maharashtra policy will enable structural discrimination against female embryos.**

The negative side of the technology was stressed.

Ravi: On amniocentesis

Sabu:

The recent moves of the task force , let us hope they come with something new.

Mala:

Complications related to sterilisation and not just the loss of child is why women move away from sterilisation.

We must be careful when we quote Kerala and TN. In fact, Punjab and Haryana has better male responsibility in contraception.

Devaki Jain:

Population policy is more to
No stress on individual and social well being.
Use birth control term instead of family planning.

Panchayati Raj and decentralisation is to be looked at.

Critique of Sanjay's presentation and critique of macro economic policies.

Ina :

3 suggestions

Possibility of recommending one more working group to safe guard cohersion.
If not central, why not in states

For strategic reasons, I oppose the NHRC angle. No decision maker wants a right's angle.

On vertical programmes: In Orissa, local level Swasthya committees.

Central-State fund flow patterns.

Target free approach and its impact.
It may be important to move away from the contraceptive targets.

Mohan:

No country has been able to achieve health care without state responsibilities.
Groups like ours we could remind the govt. of its duties.

Lady speaker: Stress on birth data and other statistics. The comment that Govt. can't be blamed for the notion that number is the problem, who else is strengthening this notion.

Observation: By default or by design, there was a single ideology / tone throughout discussions barring two exceptions.
The conceptual clarity exists. It may become easier for the group to move forward tomorrow.

Ravi:

India has the largest unregulated private sector. In India less than 20 percent comes from govt. where as in US it is 40 %. I would like to look at this in the context of primary health care.

To train a doctor, India spends one million rupees. Despite expansions, 75 % of the students are coming out from the private sector.

State provided the channel for the introduction of modern medicine and then the private sector enters. Even in the case of CT scan, this is happening. Our pharmaceuticals are strong. 40 % of our products go as exports. We are NOT sure what will happen after 3 years when the patent regime comes to an end.

Medical insurance is still small. Private medical insurance companies are going to come in a big way

Groups:

Please add who is in which groups

NATIONALPOPULATION POLICY

2000

FACT SHEET ON NATIONAL POPULATION POLICY-2000

➢ DEMOGRAPHIC PROFILE OF INDIA

a. **Adverse sex ratio**- The sex ratio has decreased from 972 in 1901 to 927 females to 1000 males, in 1991.

b. **Inter state disparities**- Despite uniform norms for health care, infra structure and funding substantial differences have emerged between states in the achievement of basic socio-demographic indices.

c. **Demographic projections in 5 States if present trends continue**- From 1991-2016, the increase in numbers is projected to be 410 million. 55% of this increase is taking place in 5 States : Bihar, Rajasthan, Madhya Pradesh, Uttar Pradesh, and Orissa..

d. IMR of India is 72
e. MMR of India is 437

➢ INTERSECTORAL AGENDA FOR STABILISING POPULATION

1. Making reproductive health accessible and affordable.
2. Increasing the coverage and outreach of primary and secondary education.
3. Extending basic amenities like sanitation, safe drinking water and housing.
4. Empowering women with enhanced access to education and emplayment
5. Providing roads, transportation and communication.

➢ OBJECTIVE

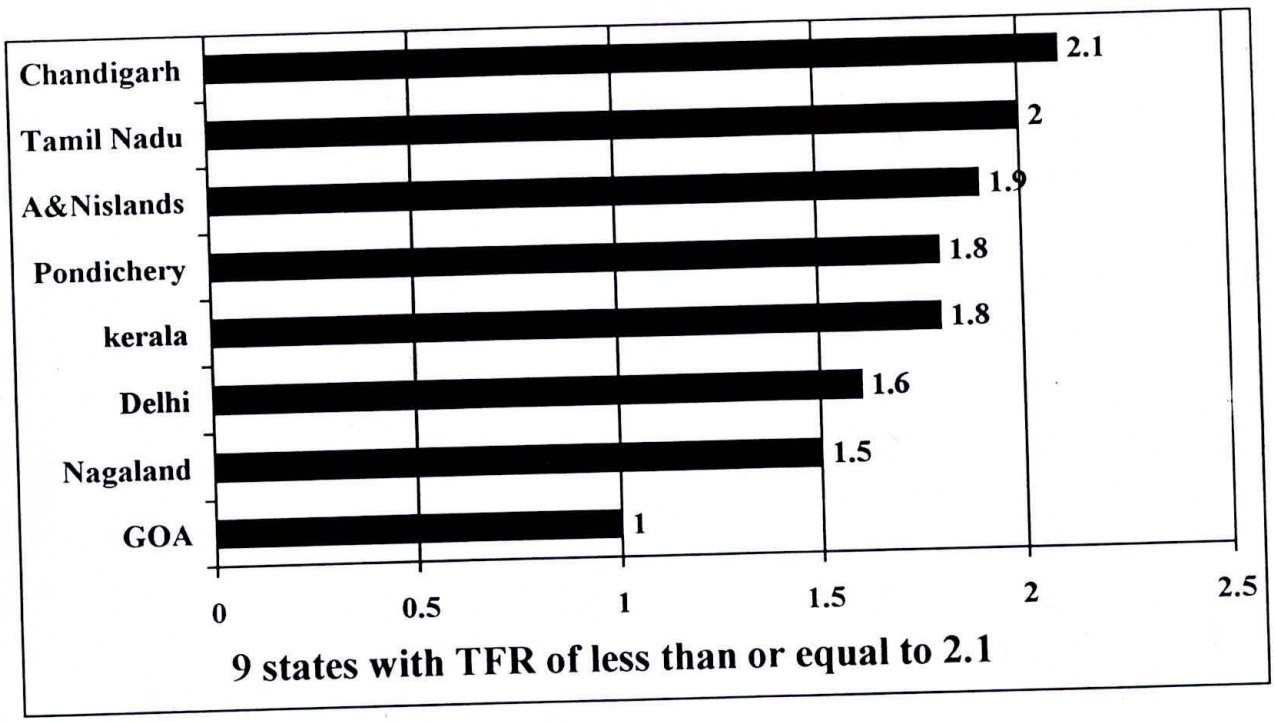
& gender equity

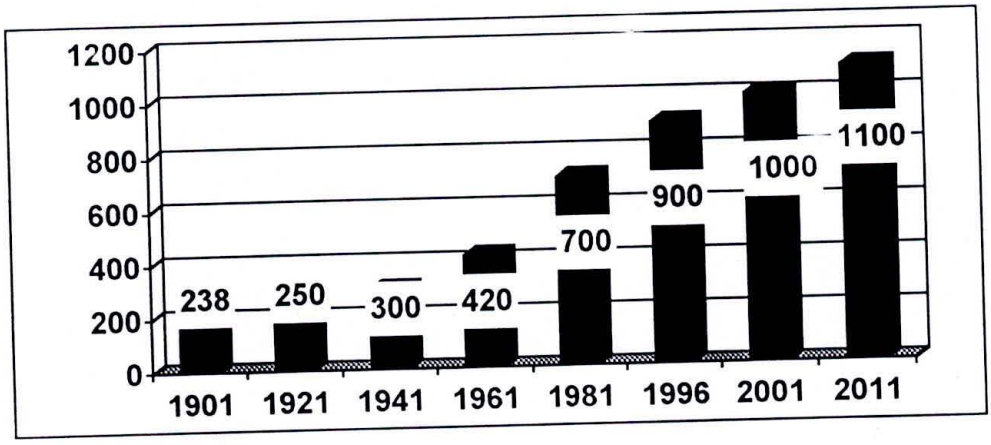
a) LONG TERM OBJECTIVE

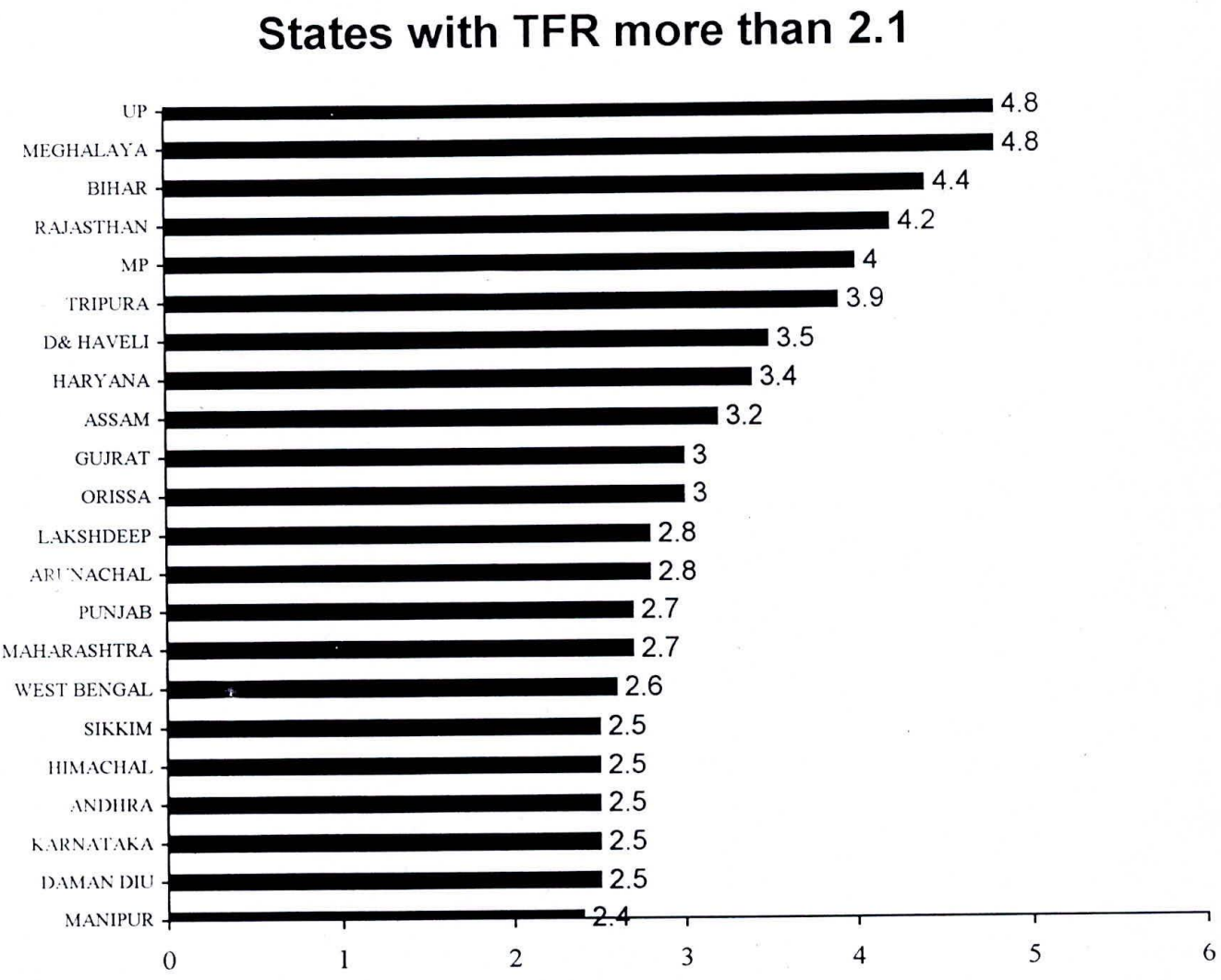
1. To bring about population stabilization by 2045 consistent with the requirements of sustainable economic growth, social development and environmental protection.

b) MEDIUM TERM OBJECTIVES

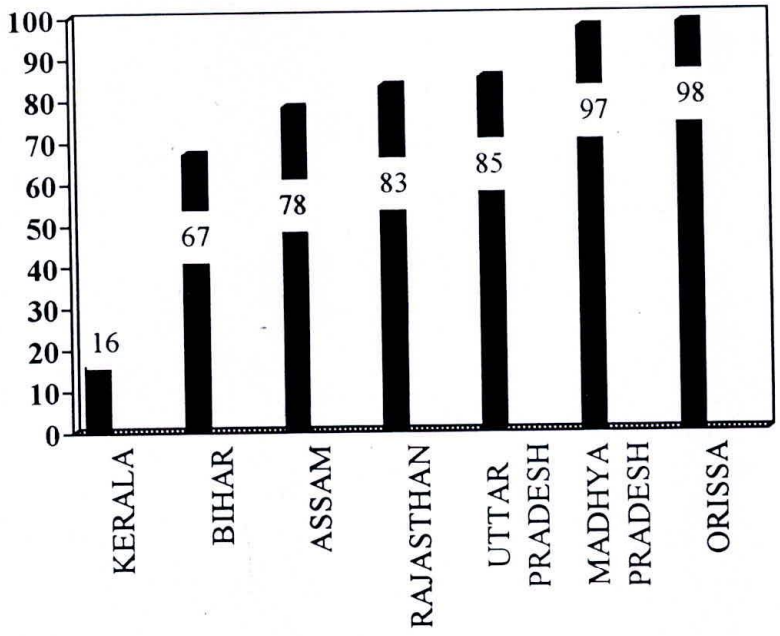
1. To bring the total fertility rates to replacement levels country –wide by 2010.
2. To implement multi-sectoral operational strategies.


Chandigarh
Tamil Nadu
A&Nislands
Pondichery
kerala
Delhi
Nagaland
GOA
2.1
2
1.9
1.8
1.8
1.6
1.5
1
0
0.5
1
1.5
2
2.5
9 states with TFR of less than or equal to 2.1

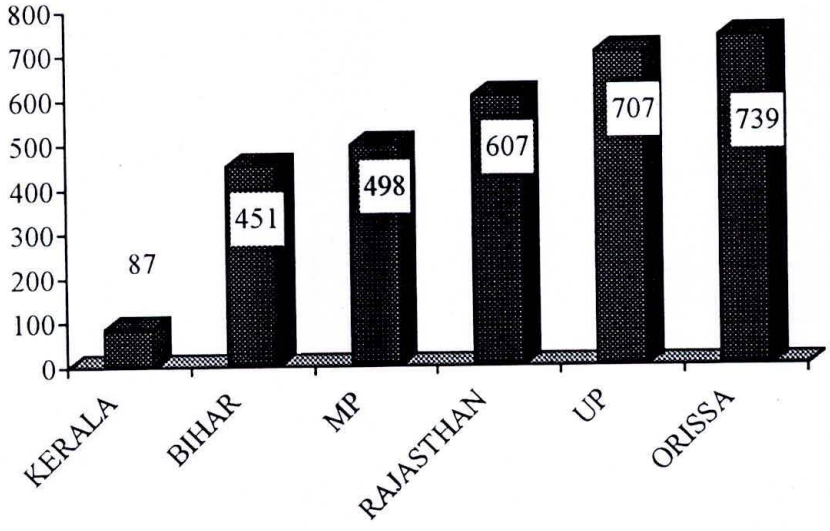

Growth in population(millions)
1200
1000
800
600
400
200
0
238
250
300
420
700
900
1000
1100
1901
1921
1941
1961
1981
1996
2001
2011

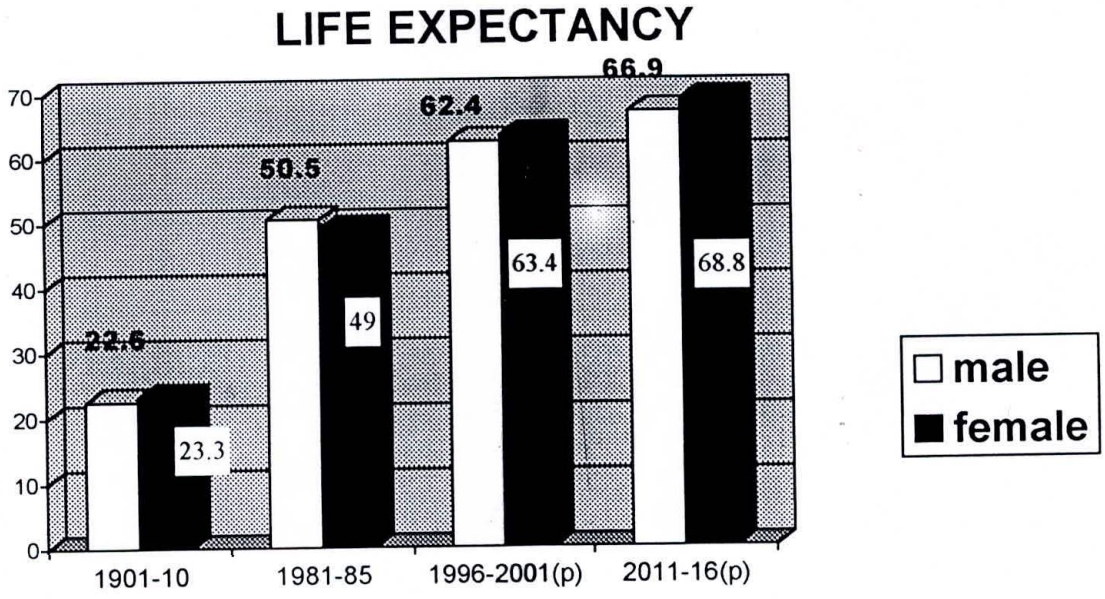

States with TFR more than 2.1
UP
MEGHALAYA
BIHAR
RAJASTHAN
MP
TRIPURA
D& HAVELI
HARYANA
ASSAM
GUJRAT
ORISSA
LAKSHDEEP
ARUNACHAL
PUNJAB
MAHARASHTRA
WEST BENGAL
SIKKIM
HIMACHAL
ANDHRA
KARNATAKA
DAMAN DIU
MANIPUR
4.8
4.8
4.4
4.2
4
3.9
3.5
3.4
3.2
3
3
2.8
2.8
2.7
2.7
2.6
2.5
2.5
2.5
2.5
2.5
2.4
0
1
2
3
4
5
6

INTERSTATE DISPARITIES IN INFANT MORTALITY



INTER STATE DIFFERENCES IN MATERNAL MORTALITY RATIOS




LIFE EXPECTANCY
70
60
50
40
30
20
10
0
22.6
23.3
50.5
49
62.4
63.4
66.9
68.8
1901-10
1981-85
1996-2001(p)
2011-16(p)
male
female

c) **IMMEDIATE OBJECTIVES**

1. To address the unmet needs of contraception, health infrastructure and trained health care personnel.
2. To provide integrated service delivery for basic reproductive and child health care.

➢ **STRATEGIC THEMES-**

1. Decentralised planning and program implementation.
2. Convergence of service delivery at village levels
3. Empower women for health and nutrition.
4. Mainstream Indian systems of medicine.
5. Upscale information education and communication.
6. Provide for the older population
7. Meet the unmet needs for contraception and trained health care providers.
8. Facilitate diverse health care providers.
9. Target under-served population groups.
10. Include specific good management practices from South East Asia- Malaysia, Indonesia and Sri Lanka.

➢ **ACTION PLAN FOR DIFFERENT GROUPS**

(a) **WOMEN'S HEALTH AND NUTRITION**

" The complex socio-cultural determinants of womens health and nutrition have cumulative effects over a life time. Impaired health and nutrition is compounded by earlly or frequent child bearing, serious complications, unsafe abortions, RTI and STI premature death or disability

1. Cluster services for women and children at the same place and time.
2. Lower service delivery costs and positive interactions in health benefits.
3. Expand the availability of safe abortion care and post abortion counselling.
4. Maternity hut in every village
5. More child care centres in rural areas and urban slums to facilitate participation in the labor force.

(b) CHILD HEALTH SURVIVAL

"Infant mortality is the most sensitive indicator of human development"

1. A National Technical Committee to review programs and interventions for reducing infant mortality.
2. Align program implementation with current advances in perinatology and neonatology.
3. Improve capacities at health centres for essential neonatal care, including the management of childhood illness.
4. A national health insurance : hospitalisation costs for children below 5 years.
5. Expand the ICDS program to include children up to age 9, in order to promote 100% retention up-to primary school.
6. Sub-groups like street children and chld labourers should get focussed attention.

(c) URBAN SLUMS

1. A comprehensive urban health carestrategy and inter-sectoral coordination with municipal bodies, water, sanitation and housing, education and nutrition.
2. A network of health care providers in the urban slums, incusive of para-medical personnel, retired doctors, NGOs.

(d) TRIBAL COMMUNITIES/ HILL AREA / MIGRANT POPULATIONS

1. A system of preventive and curative health cares, responding to seasonal variations in work and income.
2. Mobile clinics to widen and expand regular coverage/outreach with a burden of disease approach to provide for their special needs.

(e) ADOLESCENTS

> ***" Improvement in the health status of adolescents has an intergenrational impact. It reduces the risk of low birth weight amd minimizes neo-natal mortality."***

1. Provide the package of nutritional services available under ICDS program.
2. Ensure access to information, counselling and affordable reproductive health services.

(f) MALE PARTICIPATION

1. Inform, educate and counsel men to plan smal families, support contraceptives use, arrange skilled care during deliveries, be responsible fathers and educate the girl child.

(g) HEALTH CARE PROVIDERS

1. Revive the earlier system of licensed medical practioners who could become eligible for providing clinical services.
2. Involve non-medical fraternity in Counselling and advocacy, in order to demystify the national family planing effort.
3. Create a national network of voluntary, public, private and non-government health centres identified by a common logo delivering RCH services free to any client.

(h) NON-GOVERNEMNT ORGANISATIONS

> ***"Where government interventions or capacities are insufficient: private sector participation unviable; focussed service dellivery by NGOs effectively complements governments efforts."***

1. NGOs should augment information, education, communication, motivation, training, Counselling, advocacy, clinical services and innovative social marketing schemes.
2. NGOs should facilitate efficient service delivery to viollage levels, increased clinical; outlets and mobile clinics.
3. NGOs should provide efficient service delivery to village levels, increased clinical outlets and mobile clinics.
4. NGO should pursue and strengthen activities where there are acute deficiencies in supplies and services.
5. Commence activities in States and pockets with under-served segments of population.
6. There should be a genuine long-term collaboration between the government sectors.

FACT SHEET ON RECOMMENDATIONS OF NATIONAL WORKSHOP OF NGOs HELD ON 28TH June '2000 ON NATIONAL POPULATION POLICY'2000

Participants of the Workshop - 140 NGOs from different parts of the Country

Chairperson - Dr C.P.Thakur

Co-Chairperson - Prof Rita Verma

Presentations made by

- Tagore Society for Rural Development, Calcutta
- Chetna, Ahmedabad
- SOSVA, Delhi, Punjab, Haryana and Chandigarh
- Adithi, Bihar
- Health WatchTrustee, IIM, Ahmedabad

1. The budget allocation to the MNGOs need to be made flexible so as to accommodate the difficulties of local terrain and sometimes the widely differing capabilities of the FNGOs funded by the MNGOs.
2. The financial allocations to the NGO sector must increase and the range of activities entrusted by the NGO sector must expand beyond the current limited set of activities.
3. The department of Family Welfare should examine whether MNGOs can maintain a common bank account for the grants received from different departments of the same Ministry.
4. The limitation of 2 days imposed upon the MNGOs for evaluating 2 FNGOs should be modified.
5. Mobile clinics should be sanctioned at least to those MNGOs who monitor NGOs in hilly remote and inaccessible areas.
6. The MNGOs should be allowed to operationalise in direct manner in certain in certain areas.
7. Districts should be reallocated between MNGOs for better monitoring.
8. Terminal family planning methods should be implemented additionally through MNGOs that have clinical facilities.
9. MNGOs must observe transparency in financial dealings with the FNGOs.
10. The Ministry must provide copies of the entire schemes and projects run by them that directly impact the empowerment of women.
11. Wherever reaching the household level is essential, self help groups must be formed in villages and should be trained in health related activities.
12. Department of family welfare should reconsider the 6 bedded hospital scheme.
13. The services of the already existing health sub-centres, PHC and CHC should be improved before constructing the new ones.
14. Public sector organizations should be involved in operationalizing the agenda for population and development.

FACT SHEET ON RECOMMENDATIONS OF NATIONAL WORKSHOP OF PROFESSIONAL ASSOCIATIONS AND EXPERTS HELD ON 27TH June '2000 ON NATIONAL POPULATION POLICY'2000

Participants of the Workshop –

- **Experts from the Indian Systems of Medicine.**
- **Presidents and delegates from the following all India level professional organizations**

➢ Federation of Obstetrical and Gynecological Societies of India(FOGSI)
➢ Indian Academy of Padiatrics(IAP)
➢ National Neonatology Forum(NNF)
➢ Indian Association of Preventive and Social Medicine(IAPSM)
➢ Indian Medical Association(IMA)
➢ Indian Society of Anesthesiologists(ISA)
➢ Indian Ayurvedic Conference(IAC)

Chairperson - Dr C.P.Thakur
Co-Chairperson - Prof Rita Verma

1. The current level of government's direct expenditure on health is too small to permit a significant improvement in the health status of the Indian people.
2. The gaps and deficiencies in primary and secondary level health care infrastructure and the delivery systems are the major cause of high IMR and high MMR. Bridging this gap is essential to fulfill the unmet needs of contraceptive services and basic health care.
3. Quality and the coverage of routine public health activities should be improved by providing equipped and trained manpower in hospitals.
4. The staff and official in charge of the operation of health facilities have to be made accountable.
5. ISM Practitioners, after suitable orientation, should be involved in the basic health care delivery.
6. Nutritional Support should be provided not only to mothers during pregnancy but also to adolescent girls and children of the age group of6mths-2yrs. Awareness generation in this area is also recommended.
7. Crash courses in disciplines like Anesthesia should be introduced so that emergency obstetric care services become available in referral hospitals and rural hospitals.
8. Supervisory powers with respect to the MTP Act, 1972 should be transferred from the State to the district.
9. The anganwadi workers in the ICDS program should be trained in the techniques and management of ARI. They should be allowed to distribute Cotrimoxazole tablets.
10. The members of different Associations should be motivated to provide consultancy services at the PHC or CHC level in the RCH program.
11. At the block level blood storage facilities have to be made available.
12. Those contraceptives, which have already been tested and found safe and used elsewhere with considerable success, should be introduced in the country.
13. In States with high Birth Rate and total fertility rate, Centchroman (once in a week pill) should be introduced for the uneducated women, who cannot have the oral pill daily.

HP-3

Drafts + Nadgir
National Pop Commn

भारत सरकार
राष्ट्रीय जनसंख्या आयोग
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फोन : 3710051, फैक्स : 3717681
Government of India
National Commission on Population
Yojana Bhavan, Parliament Street
New Delhi-110001
Tel. : 3710051, Fax : 3717681

I SHNA SINGH
Member Secretary

D.O.No. N-11011/25/2000-NCP

October 4, 2000

Dear Ms. Jain,

In pursuance of the decision taken in the first meeting of the National Commission on Population held on 22nd July, 2000, Working Groups as described in the Order enclosed have been constituted. While constituting these Groups, we have tried to take into consideration options / preferences given by the Members and their area of specialisation. I am glad to inform you that you have been nominated to the Working Group(s) detailed in the Order enclosed.

The first meeting of your Working Group(s) is likely to be convened shortly.

With regards,

Yours sincerely,

Krishna Singh

(Krishna Singh)

Ms. Devaki Jain
Singamma Sreenivasan Foundation
"Tharanga" 10th Cross,
Rajmahal Vilas Extension
Bangalore.

No. N-11011/25/2000-NCP
Government of India
National Commission on Population

Room No.243, Yojana Bhavan,
Sansad Marg, New Delhi – 1.

Dated 4th October, 2000.

ORDER

Subject: Working Groups of the National Commission on Population.

(1) In pursuance of the decision taken in the first Meeting of the National Commission on Population held on 22nd July, 2000, the following Working Groups are constituted:

I) WORKING GROUP ON STRATEGIES TO ADDRESS UNMET NEEDS :

a) Sub-group on strategies to address unmet needs for contraception
b) Sub-group on strategies to address unmet needs for maternal and child health
c) Sub-group on strategies to address unmet needs for public health, drinking water, sanitation and nutrition
d) Sub-group on strategies to address unmet needs for empowerment of women and development of children

a) Sub-group on strategies to address unmet needs for contraception

i) Mr. K. Srinivasan, Ex. Health Secretary - Chairman
Members:
ii) Dr. Nina Puri , President, FPIA
iii) Dr. Saroj Pachauri, Regional Director, South and South East Asia Population Council
iv) Prof. Sunder Lal, Rohtak Medical College, Indian Association of Preventive and Social Medicine
v) Shri K. Gopalakrishna, President, JANANI
vi) Shri Alokendu Chatterjee, President, Federation of Obst. & Gyna. Society of India, (FOGSI)
vii) Prof. Ranjeet Rai Choudhary, Scientist, National Institute of Immunology
viii) Dr. D. Takkar, Head of Department, Deptt. Of Gynaecology, AIIMS,
ix) Representative of Birla Management Corporation Ltd's Community Initiatives and Rural Development, Mumbai.

x) Representative from Hindustan Latex.
xi) Representative of National Commission on Population
xii) Secretary, Family Welfare, Government of Bihar
xiii) Secretary, Family Welfare, Government of Rajasthan
xiv) Representative of Department of Family Welfare - Convenor.

Special Invitees

i) Dr.(Ms.) Banu Coyaji, Director, KEM Hospital, Rastapet
ii) Dr. Sharud Iyengar, ARTH, Udaipur
iii) Representative of Department of Indian Systems of Medicine & Homeopathy
iv) Sudha Tiwari, Pariwar Seva Sanstha.

Terms of Reference

i) To identify gaps and
ii) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
iii) To consider any other matter related with or incidental to the above terms of reference.

ii) Sub-group on strategies to address unmet needs for maternal and child health

i) Secretary, Health, Government of India, Chairman

Members

i) Shri Dileep Kumar, Indian Nursing Council
ii) Shri Abhay Bang, SEARCH, Gadchiroli
iv) Dr. T.N. Mehrotra , President, IMA
v) Dr. (Ms.) Manorma Singh, Ram Manohar Lohia Hospital
vi) Shri Alok Mukhopadhyay ,Chairman, VHAI
vii) Mrs. Neidonud Angami, President, Naga Mothers' Association
viii) Dr. Badri N. Saxena, Centre for Policy Research
ix) Representative of Department of Family Welfare
x) Representative of Department of Women & Child
xi) Representative of Department of Social Justice
xii) Representative of National Commission on Population
xiii) Secretary, Family Welfare, Government of Madhya Pradesh
xiv) Secretary, Family Welfare, Government of Uttar Pradesh
v) Adviser Health, Planning Commission
vi) JS (FW/RCH).
vii) Department of Health - Convenor

Terms of Reference

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c) To consider any other matter related with or incidental to the above terms of reference.

c) Sub-group on Sub-group on strategies to address unmet needs for public health, drinking water, sanitation and nutrition

i) Dr. H. Sunderasan, Ex-Vice Chancellor (Madras University) - Chairman
Members:
ii) Ms. Imrana Qadir, Professor, Population Studies, JNU
iii) Dr. B.K. Tiwari, Nutrition Adviser, DGHS
iv) Prof. K.J. Nath, All India Institute of of Hygiene & Public Health, Calcutta
v) Mr. Bindeshwar Pathak, Sulabh International
vi) Representative of Department of Rural Drinking Water
vii) Representative of Department of Urban Drinking water
viii) Representative of Department of Women & Child development
ix) Representative of Department of Environment
x) Representative of Department of Health
xi) Representative of National Commission on Population
xii) Dr. Prema Ramachandran, Adviser (Health), Planning Commission
xiii) Adviser or Representative, Drinking Water/Sanitation/Planning Commission - Convenor.

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

d) Sub-group on strategies for empowerment of women, development of children and issues relating to adolescents

i) Mrs. Margaret Alva, Member of Parliament - Chairperson
Members:
ii) Ela Bhatt, SEWA, Ahmedabad
iii) Dr. Swapna Mukhopadhyay, IEG, Institute of Social Studies Trust

iv) Ms. Deviki Jain, Sangamma Foundation
v) Ms. Aaditti Mehtta, Rashtriya Mahila Kosh
vi) Dr. Suroj Pachauri, Regional Director, Population Council
vii) Dr. Tyagi, Indian Academy of Paediatrics, Department of Tele Medicine, AIIMS
viii) Dr. Sunil Mehra, MAMTA
ix) Representative of Department of Women and Child development
x) Representative of Department of Youth Affairs
xi) Representative of National Commission on Population
xii) Representative from IGNOU
xiii) Adviser or Representative, Social Welfare, Planning Commission - Convenor.

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

II) WORKING GROUP ON PRIMARY AND SECONDARY EDUCATION IN RELATION TO POPULATION STABILIZATION.

i) Dr. K. Venkatasubramanian, Member (Education), Planning Commission - Chairman.

Members :

ii) Dr. (Mrs.) Usha Nayyar, NCERT
iii) Prof. Mohd. Amin, Ex- Vice Chancellor, Jamia Hamdard
iv) Dr. Ketan Desai, President (MCI)
v) Dr. Digvijay Singh, Ex-M.P.
vi) Ms. Jaya Jaitley, President, Samata Party
vii) Mr. B.G. Deshmukh, Ex-Cabinet Secretary/Pr. Secretary to PM
viii) Principal Adviser (Education), Planning Commission
ix) Representative of Department of Family Welfare
x) Representative of National Commission on Population
xi) Representative of Department of Education - Convenor

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.

III. WORKING GROUP ON REGISTRATION OF BIRTHS, DEATHS AND MARRIAGES

i) Registrar General of India - Chairman

Members:

ii) Dr. Pai Panandiker, Centre for Policy Research
iii) Shri K.Srinivasan, President, Indian Association for Study of Population
iv) Shri Ashish Bose,
iv) Representative of Department of Statistics
v) Representative of Department of Family Welfare
vi) Representative of National Commission on Population
vii) Adviser, Health/Planning Commission - Convenor.

Terms of Reference

a) To identify gaps and
b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.
c) To consider any other matter related with or incidental to the above terms of reference.
d) Both legislative and implementational issues should be addressed.

IV. WORKING GROUP ON MEDIA FOR INFORMATION, EDUCATION & COMMUNICATION (IEC) AND MOTIVATION :

i) Shri H. K. Dua, Press Adviser to PM - Chairman

Members:

ii) Shri Alyque Padamsee, President, AP Associates,
ii) Shri Rajiv Shukla - M.P. (Rajya Sabha)
iii) Dr. J.K. Jain, Jain TV
iv) Ms. Sharmila Tagore, MP
v) Shri Ajit Bhattacharya, Press Institute of India
vi) Ms. Rami Chhabra, Member NCP
vii) Dr. Mahip Singh Member NCP
viii) Dr. K. Jaipal, Principal, Siddha Medical College, Chennai, Tamil Nadu
ix) Shri Narendra Mohan, MP
x) Ms. Usha Rai, Editors Guild of India
xi) Shri Qari M. M. Majari, Urdu Secular Qayadat
xii) Representative of Department of Family Welfare
xiii) Representative of Department of Ministry of IB
xiv) National Commission on Population - Convenor.

Terms of Reference

a) To identify gaps and

b) To examine and suggest alternative strategies, inter alia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.

c) To consider any other matter related with or incidental to the above terms of reference.

d) Aspects of inter-sectoral co-ordination should be given special attention.

2. The Working Groups may co-opt any official or non-official as a special invitee to one or more sittings of the Group.

3. The expenditure on TA/DA of the non- official members, in connection with the meeting of the Working Group will be borne by the National Commission on Population, as per rules and regulations of TA/DA applicable to Grade I officers of Government of India or as otherwise decided by the Vice Chairman NCP. The expenditure on TA/DA of the official members, in connection with the meeting of the Working Group will be borne by their respective Departments/Ministries.

4. All the Working Groups will submit their final reports to the National Commission on Population within six months from the date of issue of this order.

R.K. Parmar

(R.K. Parmar)

Under Secretary,

National Commission on Population

To

1. All Members of the National Commission on Population
2. All Members of the Working Groups.

Copy to :

1. JS, Prime Minister's Office,
2. PS to Deputy Chairman (Planning Commission)
3. PS to Member Secretary (National Commission on Population)
4. PS to Joint Secretary (National Commission on Population)

HP-3.

NATIONAL COMMISSION ON POPULATION : LIST OF THE MEMBERS

Chairman:

Prime Minister of India

Vice Chairman:

Deputy Chairman, Planning Commission.

Members:

Union Minister incharge of Education

Union Minister incharge of Environment and Forests

Union Minister incharge of Finance

Union Minister incharge of Health and Family Welfare

Union Minister incharge of Information and Broadcasting

Union Minister incharge of Rural Development

Union Minister incharge of Social Justice and Empowerment

Union Minister incharge of Urban Development

Union Minister incharge of Women and Child Development

Leader of the Opposition in the Lok Sabha

Leader of the Opposition in the Rajya Sabha

Chief Ministers of All States/Union Territories

Dr.(Smt-) Najma Heptulla, Deputy Chairman, Rajya Sabha

Leader of Bharatiya Janata Party (Shri Kusha Bhau Thakre)

Leader of Communist Party of India (Shri A.B. Bardhan)

Leader of Indian National Congress (Smt. Sonia Gandhi, M.P.)

Leader of Nationalist Congress Party (Shri Sharad Pawar, M.P.)

Leader of Janata Dal (United) (Shri Sharad Yadav, M.P.)

Mrs. Margaret Alva, Member of Parliament

Shri Pumo Sangma, Member of Parliament

Smt. Shabana Azmi, Member of Parliament

Shri Vinod Khanna, Member of Parliament

President, Associated Chamber of Commerce and Industry of India

President, Confederation of Indian Industries

President, Editors Guild of India

President, Federation of Indian Chambers of Commerce and Industry

President, Federation ofObst. & Gyna. Society of India, FOGSI

President, Indian Medical Association

President, Indian Newspapers Society

President, Indian Nursing Council

Representative, Jain T.V. (Dr. J.K. Jain)

President, Medical Council of India

Representative, STAR T.V. (Shri Prannoy Roy)

Representative, SUN T.V.

Representative, ZEE T.V. (Shri Subhash Chandra)

Professor Abad Ahmed

Mr. Abhay Bang, SEARCH, Gadchiroli

Shri A.C. Muthiah

Shri Alok Mukhopadhyay, Chairman, VHAI

Shri Alyque Padamsee

Dr. A. Vaidyanathan, Madras Institute of Development Studies

Shri Aveek Sarkar, Telegraph

Dr. Banoo Coyaji, Director, KEM Hospital, Rastapet

Shri Barun Sengupta, Bartman

Dr. Darshan Shankar (ISM), President, Foundation for Revitalisation of Local Health Traditions.

Dr. E.K. Iqbal, KSSP

Smt. Ela Bhatt, SEWA, Ahmedabad

Smt. Imrana Qadir, Professor, Population Studies, JNU, New Delhi

Ms. Jay a Jaitley

Ms. Jayanti Natarajan

Shri K. Gopalakrishna, President, JANANI

Dr. K. Srinivasan, President, Indian Association for Study of Population

Dr. Mahip Singh

Shri Mammen Mathew, Malayalam Manorama

Professor Mohd. Amin, Ex. V.C., Jamia Hamdard

Ms. Mohsina Kidwai

Shri Narayana Murthy

Shri Narendra Mohan, Dainik Jagaran

Dr. Neena Puri, President, FPIA

Mrs. Neidonud Angami, President, Naga Mothers' Association

Shri N. Ravi, The Hindu

Dr. N.S. Deodhar, Pune

Ms. Padma Sachdeva

Shri Prabhash Joshi, Jansatta

Dr. Pravin Visaria, Director, IEG, Delhi

Shri P.N. Tripathi, AVARD

Shri Qari M.M. Majari, Urdu, Secular Qayadat

Ms. Quatarlain Haider

Ms. Ragni Ben Banwari, Seva Ashram, UP

Dr. Rajnikant Arole, Jamkhed Project, Ahmednagar

Ms. Rami Chhabra

Shri Ramoji Rao, ENNADU

Ms. Rani Bang, SEARCH, Gadchiroli.

Shri Ratan Tata

Shri R. Srinivasan, Ex. Health Secretary

Dr. Saroj Pachauri, Regional Dir., South and South East Asia Population Council

Ms. Sharmila Tagore

Ms. Sheema Rizvi, MLC, UP

Dr. Sudarshan (Right Livelihood Awardee), Mysore

Prof. Sundar Lal, Rohtak Medical College, Indian Association of Preventive and Social Medicine

Dr. Susheela Nayyar, Gandhi Medical College, Wardha Prof. Swapna Mukhopadhyay, IEG, Institute of Social Studies Trust Smt. Thelma Narayan, International Health Network of WHO Dr. Trilochan Singh

Dr. V.H. Pai Panandhikar, Centre for Policy Research

Member –Secretary:

Smt. Krishna Singh, Planning Commission

In addition to the above composition, the following shall be Permanent Invitees to the Commission:-

Principal Secretary to the Prime Minister

Cabinet Secretary

Secretary to the Prime Minister

Secretary, Department of Elementary Education

Secretary, Department of Family Welfare

Secretary, Finance

Secretary, Department of Health

Secretary, Department of Higher and Technical Education

Secretary/ Member-Secretary, Planning Commission

Secretary, Department of Social Justice and Empowerment

Secretary, Department of Women and Child Development

Joint Secretary to the Prime Minister (Incharge of Health and Family Welfare)