MANUAL

ON

TARGET FREE APPROACH

IN

FAMILY WELFARE PROGRAMME

MINISTRY OF HEALTH & FAMILY WELFARE
NEW DELHI

1. INTRODUCTION:

In keeping with the democratic traditions of the country, the Family Welfare Programme seeks to promote responsible and planned parenthood through voluntary and free choice of the following methods of contraception approved under the National Family Welfare Programme.

(i)	Sterilisation (Vasectomy & Tubectomy)
(ii)	IUD Insertions
(iii)	Oral Pill Users
(iv)	Conventional Contraceptives (Condoms)
(v)	Indigenous/Traditional method
(vi)	Natural Method

India's Family Planning Programme (renamed as Family Welfare in late 1970's) has had a single objective for nearly 30 years, to reduce fertility as quickly as possible. The program has sought to achieve this goal through a strategy based on contraceptive targets and cash incentives to acceptors and providers.

The objective of the Family Planning Programme is to reduce the birth rate. Contraception is only an instrument for bringing about reduction in birth rate. The success of the programme with reference to the objective can be judged only on the basis of the reduction in the birth rate. The contraceptive target monitoring now being done has led to a situation where the achievement of contraceptive targets has become an end in itself. According to the National Family Health Survey conducted recently, the extent of contraceptive acceptance is less than indicated by statistics provided by state governments. Although, some state governments receive very good grading for sterilisation under the 20 Point Programme, this has not led to corresponding reduction in the birth rate. It has also been observed that a disproportionately large proportion of the target (40%) is achieved in the last 3 months of the financial year although the service ought to be provided evenly throughout the year.

Since past few years, the Government of India recognized that contraceptive targets and cash incentives have resulted in the inflation of performance statistics and the neglect of quality of services. As a result, cash incentives for IUD insertions were withdrawn. GOI did not fix contraceptive targets for Kerala and Tamil Nadu during 1995-96 and in other States one or two districts were made "target free". Further, State Governments were given freedom to introduce incentives for improving the quality of services.

While there are no two opinions about the need to remove numerical targets for the sake of quality of service, there is a concern that such a move, when taken country-wide, may lead to decline in performance initially. A system of getting estimates of expected levels of acceptance from the State Governments was in vogue for the last three years but now this exercise will be carried out by the grass root workers in consultation with the community to estimate real needs assessment. This will be coupled with the formulation of a PHC level plan covering all activities of family welfare, the materials and supplies required and an operational strategy to achieve the objectives.

Grass root level workers like ANM, Multipurpose Health Workers both male and female, shall be asked to give an estimate of the various family welfare activities required in the area/population covered by them. It is expected that at the PHC level, the local NGO activists,

primary school teachers, pradhans and panchayat members, private practitioners of indigenous systems of medicines would be involved in the formulations of the PHC based Family Welfare Health Care Plan. While in the first year the process of estimation can be tentative but in future years the endeavour should be to start the planning process at village level itself. Aggregation of all such estimates of grass root workers of various subcentres and at the Primary Health Centre shall be prepared at each PHC. District Family Welfare Plan shall be an aggregation of all such plans formulated at each PHC in the district. State Level Family Welfare Plan shall be an aggregation of all such District Family Welfare Plans. All the State level Family Welfare Plans shall be compiled at National level to work out requirement of all materials and supplies.

Although the input requirements for family welfare activities shall be based on the requirement given by the grass root level workers like ANM, the monitoring of the performance of ANM shall not be merely on the basis of achievements in this regard alone, but would be done with the help of indicators relating to improvement and quality of service.

A system of evaluating and introducing corrections in the performance of PHC every month by the district health staff and that of each district by the state level staff every quarter has been worked out. A similar exercise to evaluate the performance of each state would be carried out at the national level. The present manual tries to answer all such issues for the guidance of the field workers, the administrators and other persons responsible for implementing this programme.

There should be minimum change in the records that ANM and other field workers are required to maintain in order that the changed system of working helps them to utilize their time fully to improve the quality of services that they are required to provide to the community. The Eligible Couple (EC) Register will continue to be one of the most important records at ANM level.

2. NEW FOCUS OF FW PROGRAMME - A Target free approach

Family Welfare Programme is to be implemented from the First April 1996 on the basis of Target Free Approach. Besides, the focus of the national Family Welfare Programme is to undergo a change from a segregated approach under Family Planning and Maternal and Child Services to that of integrated approach under Reproductive and Child Health (RCH) Services in future. This means that RCH is equivalent to Family Planning + CSSM + prevention of RTI/STD and AIDS + a client approach to providing FW & Health Care Services.

As the National Family Welfare Programme moves from Target Based Activity to Client Centered Demand Driven Quality Services Programme, there is a need to change various aspects of its operations including increased levels of male participation.

2.1 Illustrative list of services to be provided to general public from PHC & Sub-Centres:

The following services may be provided to general public from Sub-Centres, PHCs and in some cases, with tie-up of referral, from nearest CHCs and district hospitals:

I. Mother Care Services

(A) Ante Natal Care:

(i) **Registration of Ante-natal Care** Cases preferably before 16th week of pregnancy.

(ii) Providing ante natal care to pregnant mothers by **atleast three visits.**

(iii) **Detection and treatment** of anaemic pregnant mothers.

(iv) Timely **detection and referral** of high risk pregnant mothers.

(B) Natal Care:

(i) As far as possible **delivery** should take place in Hospitals, PHCs or subcentres under the supervision of qualified personnel.

(ii) As far as possible, the **domiciliary deliveries** should be assisted by LHV, ANM or by trained birth attendants.

(iii) **Detection and referral** of high risk labour cases.

(iv) **Identification** of existing Dais and organising **dai training.**

(v) Provision of **Dai Kits.**

(C) Post Natal Care

(i) **Growth Monitoring** of new born.

(ii) Detection and referral of **high risk new born babies.**

(iii) **Neo-natal resuscitation** wherever facilities are available and by education of dais & community in other areas.

II. Immunisation:

Immunisation services against following **communicable diseases** to children.

(i) Tuberculosis
(ii) Polio
(iii) Diphtheria
(iv) Whooping Cough
(v) Tetanus
(vi) Measles

III. Prophylactic Services:

Prophylactic Services against **anaemia and Vitamin A deficiency** to

(i) Pregnant Mothers
(ii) Nursing Mothers and IUD Acceptors
(iii) Children below 5 years of age.

IV. Curative Services for

(i) Diarrhoea cases with ORS
(ii) Respiratory infection cases with cotrimoxazole.

V. Contraceptive Services

(i) Male Sterilisation Operation.
(ii) Female Sterilisation Operation.
(iii) Copper T. insertions.
(iv) Oral Pill - distribution.
(v) Nirodh distribution.
(vi) Indigenous/traditional methods
(vii) Natural methods.

VI. MTP

(i) Assessing abortion needs and providing the same by early detection.
(ii) Assessing need for expanding services by increasing trained staff and registered centres.

VII. **Emergency Obstetric Care**

(i) Assessing expected high risk cases.
(ii) Provide for referral in existing Post Partum Centres.
(iii) Provide for referral at identified First Referral Units.

VIII. **Nutrition Counselling** and Supplementary Nutrition

(i) Linkages with ICDS and Anganwadi for provision of supplementary nutrition for pregnant/lactating mothers and for infants.
(ii) Nutritional Counselling through linkages with ICDS/AWW/ANM for anaemic children, adolescents, mothers.
women

2.2 Activities at Sub-centre and PHC

Following activities should be carried out at Subcentre and PHC level for provisions of quality of care to general public.

2.2.1. At sub centre level

Immunization, MCH Information Education and Communication Services are to be provided by Subcentre.

- Activities to be carried out during an **immunisation/MCH session** are:

For children

- immunization of children
- administration of Vitamin A concentrated solution for prophylaxis and therapy
- Diagnosis of anaemia in children and distribution of IFA (small) tablets

For Pregnant Women

- ante-natal check up of pregnant women
- TT immunization
- administration of IFA for prophylaxis and therapy
- deworming of pregnant women who show clinical signs of anaemia (in 2nd/3rd trimester) in areas with high prevalence of Hook Worm infestation.

Communication and counselling

- On infant feeding(exclusive breast-feeding and weaning)
- On home management of diarrhoea and ARI
- On birth spacing as a health promotion measure
- Recognition of danger signs for seeking immediate medical help

Provide

- prepared ORS solution to a child with diarrhoea and give ORS packets for use at home
- tablet Cotrimoxazole to a child with Pneumonia
- oral pills and condoms

Gather Information by talking to mothers

- On new births or pregnancies in the village
- cases of measles, diarrhoea and pneumonia
- counselling on polio and neonatal death
- counselling for reproductive health

Update records

For **holding the sessions** it should be ensured that the health worker:

- Reaches the **FIXED PLACE** on the **FIXED DAY** at the **FIXED TIME** as per subcentre work plan
- carries vaccines in cold chain and has enough syringes and needles so that she can use syringe and one needle for every beneficiary after ensuring proper sterilisation.
- has sufficient quantities of Vitamin A, IFA tablets (both large and small), ORS packets and Cotrimoxazole tablets for giving to children who may need them.
- has the mother and child cards and register with her and updates these during the session
- carries educational aids for interpersonal/group communication

The health workers should contact local influencial persons like Anganwadi worker, TBA, Village Pradhan, Panchayat Members, Other sector workers etc. on arrival and obtain their help for mobilising the beneficiaries. Special efforts should be made with their help to identify and motivate drop outs and those who do not avail services from out reach areas. The opportunity should be utilised by Subcentre Team to inform the mothers and organised groups about the different services and to encourage them to avail these.

2.2.2. At PHC Level

The PHC workplan includes, activities of the Sub-centres and the PHC. The **responsibility** of ensuring proper implementation of the plan however, lies with the PHC. It s necessary that all medical Officers of the PHC are familiar with the plan and the programme components.

In addition to the immunization and MCH activities being carried out at the sub-centre level (Immunisation/MCH session, Sub-centre clinic and Village visits), the PHC is responsible for delivery of both **preventive and curative services** in the area. This involves scheduling immunization/MCH sessions and antenatal clinics in addition to the routine inpatient and out-patient services. The activities to be carried out during the immunization/MCH session at the PHC are essentially the same as in a similar session at the Sub-centre level.

Correct Case Management of children with diarrhoea, ARI and sick newborns is an important activity at the PHC level. The PHC is required to provide treatment to children referred to it andshould be able to organise the facilities required for management of these cases as per guidelines.

The PHC should provide services for **safe delivery** of all uncomplicated pregnancies. The labour rooms should be clean and provided with the required supplies for carrying out deliveries and essential care of the newborns. Provision of these services can generally be planned within the existing resources of the PHC.

Management of **complications of pregnancy** like hypertensive disorders, severe anaemia and sepsis should be available at PHC level. **Referral** of severe cases to the first referral units (FRUs) for various childhood and maternal emergencies should be made as per guidelines. The names and location of the FRUs should be known to all doctors and health workers of PHC/Sub-centre area.

It should be ensured that the **PHC is equipped with** relevant supplies like medicine, intravenous fluids and have a regular duty roster providing for round the clock attendance in case of need. Care be taken to indent sufficient stocks of vaccines, needles and syringes from the district stores in time and distribute to the outreach centres according to the plan. MO should monitor the use of individual items in the drug kits supplied to the subcentres and provide for timely replishment out from the PHC stocks, and out of items which are not used in other subcentres. All health workers in PHC area should receive vaccines for conducting imunization sessions/MCH sessions, in vaccine carriers with fully frozen ice packs.

The PHC is the unit for carrying out all **surveillance** related activities. These include case/death analysis, interpretation, action and reporting. Decisions that will have to be taken at PHC level include containment measures for outbreaks, mop-up rounds, investigation of acute flaccid paralysis, neonatal and maternal deaths through line listing and special investigations such as stool test, etc.

Monitoring the implementation of sub-centre work plans, their performance and coverage levels of individual sub-centre areas and identifying problem areas is to be done by the PHC medical officers. Based on the reasons identified for a particular problem, possible solutions should be identified in consultation with the health workers and the community. Care be taken to monitor the establishment and functioning of the village level depots for ORS packets, condoms and in some cases oral pills.

Regular reporting of the achievements and problems to the district/state health department is an important activity of the PHC. Providing feedback to the health functionaries based on discussions at the district level meetings are important.

Problems shared
should include not only grass-roots level ones
but those caused by imposition of top-down
approaches

The meeting is an important activity to review performance, provide feedback and guidance to the workers for improving their performance and coverage levels. The other important meeting at PHC level would be participatory appraisal meeting with the Panchayati Raj leaders at PHC level.

All the activities listed in the workplan of the PHC must be carried out regularly.

2.3 Prerequisites for Target Free Approach :

The following points are needed to be ensured in each state:

(1) Contraceptive targets for the health & non-health staff like ones working in Revenue, Rural Development, Education Departments must be abolished.

(2) The male health workers should be made responsible for motivation for vasectomy and condom.

(3) The motivator certificate and motivator fee, if still in use, should be withdrawn.

(4) Family Planning performance in the district should not be used to rank the Collectors or to assess them for their annual confidential report.

(5) The PHC Plan shall be proposed on the basis of assessment of need of population for FW Services by ANM and others; the performance of the medical officer in charge, PHC and ANM shall be judged on the basis of their quantitative and qualitative achievement with respect to the needs assessed.

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D.O. No. M.11015/15/94-E&I.

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
परिवार कल्याण विभाग
निर्माण भवन, नई दिल्ली-110011

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DEPARTMENT OF FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI-110011

J. C. PANT I.A.S.
Secretary
Phone : 301 84 32
Fax No. : 301 88 87

April 22, 1996

Dear Basu,

Kindly refer to our discussions on the subject of Target Free Approach on 4th April, 1996 in the Conference of State Secretaries of Family Welfare. I am enclosing a copy of the draft of the Manual on Target Free Approach in Family Welfare Programme. We would welcome your suggestions for improvement. We shall be happy to incorporate them while this draft is being sent for printing. You may also like to explore the desirability of this manual being translated into the official language of your State.

With regards

Yours sincerely,

(J.C. PANT)

ADK

Shri Gautam Basu,
Secretary (Family Welfare),
Govt. of Karnataka,
BANGALORE - 560 001.

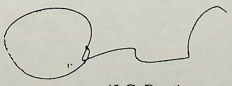
Post Script : It is expected that the preparation of the PHC based family welfare and health care plans must have been taken in hand earnestly in all the districts of your state by now. A difficulty raised by field workers in some states relates to the birth rate (BR) they should take for assessing input needs for MCH activities. This is to clarify that the State Directorate of Family Welfare should be communicating to the districts the birth rate (BR) they should take for calculating their needs for MCH inputs. If this has not been done so far, it should now be ensured on priority.

FOREWORD

From First April 1996 the Family Welfare Programme is to be implemented all over India on the basis of Target Free Approach. From now onwards the centrally determined targets will no longer be the driving force behind the programme. The demand of the community for quality services would be expected to become the driving force behind the programme making it a people's programme.

2. The changeover to a target free approach necessitates decentralised planning in consultation with the community at the grass root level to provide quality services under Family Welfare Programme to the community. Besides, the monitoring and evaluation of the performance also requires a fresh look at the issues of quality of care at different levels of the Primary Health Care System.

3. The Manual on Target Free Approach in Family Welfare Programme has been prepared to provide guidance on decentralised planning at the level of PHC, to improve quality of care and how to monitor the improvements in the quality of care in the services provided to the community by the Primary Health Care System of the country. This manual is a result of intense discussions with State Family Welfare Secretaries and Directors as well as management experts and experts of the Family Welfare Department. Decentralized planning means close association of the community and its leading lights and opinion leaders such as village pradhans, primary school teachers in the formulation of the PHC based family welfare and health care plan. I hope this manual will provide guidance to various functionaries at different levels of the Primary Health Care System to plan for and provide quality care in the services provided to the community as per the requirements of the community under Family Welfare Programme to make it a truly people's programme.



(J.C. Pant)
Secretary to the Govt. of India
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Immunisation services against following communicable diseases to children.

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The meeting is an important activity to review performance, provide feedback and guidance to the workers for improving their performance and coverage levels. The other important meeting at PHC level would be participatory appraisal meeting with the Panchayati Raj leaders at PHC level.

All the activities listed in the workplan of the PHC must be carried out regularly.

2.3 Prerequisites for Target Free Approach :

The following points are needed to be ensured in each state:

(1) Contraceptive targets for the health & non-health staff like ones working in Revenue, Rural Development, Education Departments must be abolished.

(2) The male health workers should be made responsible for motivation for vasectomy and condom.

(3) The motivator certificate and motivator fee, if still in use, should be withdrawn.

(4) Family Planning performance in the district should not be used to rank the Collectors or to assess them for their annual confidential report.

(5) The PHC Plan shall be proposed on the basis of assessment of need of population for FW Services by ANM and others; the performance of the medical officer in charge, PHC and ANM shall be judged on the basis of their quantitative and qualitative achievement with respect to the needs assessed.

3 IMPROVING QUALITY OF CARE

Following are the some of the aspects of quality of care for Family Welfare Services which need to be looked at by the staff at PHC and Sub-centres.

3.1. Service Delivery Aspect:-

3.1.1 Does the package of FW service offered by PHC/Sub-centres meet the needs of general public?

3.1.2 DO PHC/Sub-centres inform the general public about the choice they can have for contraceptive methods?

3.1.3 Is there adequate follow-up for continued use of the services offered by PHC/Sub-centres?

3.1.4 Are there effective referral linkages?

3.2 Informational Aspect:-

3.2.1 Do general public receive comprehensive health education?

3.2.2 Are general public informed about the side effects of contraception and how to address them?

3.3. Technical Aspect:-

3.3.1 Are the service providers (doctors, LHV, ANM) technically competent?

3.3.2 Do they use sound and appropriate technical practices?

3.3.3 Do they take universal precautions for sepsis?

3.3.4 Quality of materials & supplies used by the service providers.

3.4 Interpersonal aspect

3.4.1 Behaviour of the service provider. Is he/she gentle, harsh, indifferent to the clients.

3.4.2 How are general public treated in:-
- time spent
- showing concern for the client
- caring for the privacy & dignity of the Client.

3.4.3 - Listening & counselling general public.

3.5. **Social aspects:-**

3.5.1 Are services gender sensitive?

3.5.2 Is there male participation and responsible sexual behaviour.

3.5.3 Do women have a role in programme.

While all of these aspects to improve quality of care require attention, it may be useful to institute a process of quality improvement by first emphasising counselling, follow up and inter-personal aspects of the services and then adding other aspects.

4. EXPECTED OUTCOME OF TARGET FREE FAMILY WELFARE PROGRAMME :-

4.1. Hundred percent ante natal registration and atleast 3 ante natal check-ups of al pregnant women.

4.2 Hundred percent T.T. vaccination of pregnant women.

4.3. Increase in the proportion of institutional deliveries as compared to the existing level.

4.4 Increase in the proportion of deliveries by trained persons as compared to the existing level.

4.5. Provision of quality obstetric care for complications of pregnancy, abortions ad complications of deliveries at CHC level or FRU level.

4.6. Hundred percent registration of births and neonatal deaths in the area.

4.7. Appropriate measures for underweight babies.

4.8. Promotion of breast feeding.

4.9. Hundred percent immunisation of infants.

4.10. Universal availability of ORS in all villages at all times.

4.11. Provision of facility of treatment of acute respiratory infections including pneumonia at all subcentres.

4.12. Improvement in acceptance of contraceptives by couples with wife less than 30 years of age.

4.13. Improvement in acceptance of contraceptives by couples having 2 or less children with larger spacing between children.

4.14. Improvement in the proportion of spacing methods in the contraceptive method mix.

4.15. Availability of oral pills and condoms in all villages at all times.

4.16. Counselling for RTI & STD at subcentre level.

4.17. Referral of suspected cases of RTI/STD from sub-centre and diagnosis and treatment facilities for RTI & STD at CHC and District level.

4.18. To ensure adequate postnatal care & FP Counselling; all mothers should be visited after 15 days of delivery or EDD.

5. PREPARATION OF SUBCENTRE ACTION PLAN:

Subcentre Action Plan forms the basis of PHC level decentralised planning. It provides us the requirement of various services by the population living in the area of subcentre as their felt need.

5.1 Defining Workload Norms for ANM:-

The activities that are required to be carried out by ANM's at the level of subcentre for the implementation of quality conscious Family Welfare Programme are listed in **FORM-1**. These can be classified into

(a) Specific tasks (e.g. giving TT2).
(b) Quality tasks (e.g. early registration of ANC).
(c) Surveillance task (e.g. number of maternal deaths reported).

Norms are being suggested for the specific tasks and quality tasks. Every State must decide on the norms for quality tasks depending upon the availability of health infrastructure and the needs of the population (for example work load of ANC in a State with 5000 population per subcentre and birth rate of 20/1000 would be 110 per year, as compared to 310 per year for a state having 8000 population per subcentre and birth rate of 35/1000). Hence the State can decide that instead of 60% coverage norm for early ANC Registration only 30% coverage is expected to be registered in first trimester of pregnancy. In the first year of operation these values for norms will have to come from State level data or other studies from similar population. In the subsequent years district level estimates will be available from the monitoring system and hence more realistic norm can be set locally.

Once these norms have been decided, the ANMs will calculate their own workload. It can be argued that this step is mechanical and can be done by computers. But however, if the field worker (ANM) herself estimates her own workload, she will be more involved and motivated in the implementation of programme.

5.2 Consultations:

While doing the exercise of preparing Subcentre Action Plan and Primary Health Centre (PHC) level Family Welfare and Health Care Plan there is a need to associate following categories of personnel:-

1) Personnel of the Primary Health Care System including Medical and Para-medical staff.
2) Private Medical Practitioners available in the area of PHC.
3) Medical Practitioners of the Indigenous Systems of Medicine available in the area of Primary Health Centre.
4) Ex-servicemen residing in the area of the PHC.
5) Grass root level workers of other departments including Primary School Teachers.
6) Pradhans of Gram Panchayats falling in the area of PHC.
7) Anganwadi workers.

While formulating the Sub-centre Action Plan and PHC level Plan, the above mentioned people should be consulted and advice given by them, if any, may be taken into account. It is expected that the moment these people are consulted they also become activists helping us in the process of implementation of PHC level Plan under Target Free Approach.

5.3 Requirement of the Area Vs Felt Need of the Population - Subcentre Action Plan.

The illustrative list of services which are to be offered to the general public from PHC and Sub-centres should be available to all the persons living in the area of jurisdiction of the PHC/Subcentres. One can easily estimate the requirement of services of the entire population of the PHC/Subcentres. Pregnancy related services can be estimated from the population to be covered and the birth rate of that population. Similarly curative services like treatment for diarrhoea can be estimated from the population and the prevalence rate of the illness. Similarly for contraception services, all the eligible couples are needed to be protected. **Requirement of the Area** for a particular service is the demand of the service for hundred percent coverage. But all the people living in that area need not be willing to avail of the services. **Felt Need** of the Population pertains to the number of services for which they are willing to take up from the delivery point. For example not more than 60% of the pregnant women in an area of a subcentre are willing to be registered for ante natal care. Then although the Requirement of the Area for ANC is 100% but yet the Felt Need for ANC shall be only 60%. We must plan for making available the Family Welfare and Health Care Services as per the felt needs of the population.

In the ideal situation the Area Requirement of the service shall be equal to the Felt Need for the same service by the population living in that area. In that event the Family Welfare Programme shall become the people's program.

In the present context, during the implementation of Target Free Family Welfare Programme, it might be noticed in the field that the Felt Need of the Population is less than the Area Requirement for the same service. It is likely to be the trend in the beginning. The gap is likely to be bigger for contraception services than for the MCH services. This should not be a cause for concern. As soon as the quality of care of services through the PHC and subcentres improve, more and more people shall start coming forward to avail the services being provided by the PHC & Subcentres.

Format of Subcentre Action Plan (**FORM-2**) does give the list of services to be provided from Subcentre. It also contains the methodology to calculate the Area Requirement with respect to all the services. ANM should be expected to fill up the Felt Need of the population for service in the area of her subcentre in the Ist column. This shall be a realistic assessment of the need of the population. This should be filled up after she has visited all the households in her area to assess their need.

6. PREPARATION OF PHC FW&HC PLAN

Subcentre Action Plan with respect to all the subcentres of the PHC can give us the felt need of the population of PHC with regard to the services being offered to general public through PHC and subcentres. Medical Officer Incharge of PHC has to calculate the materials, vaccines, medicines etc. required to accomplish the services. Depending upon the existing stock of supplies, the net requirement for serving the felt needs of the population can be worked out. It forms the basis of PHC FW&HC Plan. It shall also identify the resources available within the area as well as support from outside like NGOs, corporate sector, private sector. It shall also take into account the available hospital facilities in the area and health manpower available. The most convenient First Referral Unit (FRU) should also be identified and notified for general awareness.

6.1 Data Base Required for Planning at PHC-level

6.1.1.	GENERAL
6.1.1.1	.General Information about Block - Geographic location/character - No. of Sectors
6.1.1.2.	Persons below poverty line
6.1.1.3.	Religion/literacy
6.1.1.3.	SC/ST population
6.1.2.	DEMOGRAPHIC
6.1.2.1.	Total Population, age, sex structure.
6.1.2.2.	Sex ratio - 1981-1991
6.1.2.3.	Age at marriage
6.1.2.4.	Birth/Death rate
6.1.2.5.	Fertility Rates.
6.1.3.	PROGRAMME PERFORMANCE
6.1.3.1.	Family Welfare Programme Sector-wise performance for the year 1995-96, and every year thereafter.
6.1.3.2.	MCH,ANC,PNC,Deliveries, Sector-wise performance for the year 95-96, and every year thereafter.
6.1.3.3.1.	Line listing of Polio and Neonatal Tetanus.
6.1.3.3.2.	Investigation of cases of neonatal tetanus, polio & measles.
6.1.3.4.	Data on performance of other health programmes.
6.1.3.5.	Epidemic/out-breaks data/investigation report for last three years.
6.1.3.6.	Medical Emergencies at each health institution for last three years.
6.1.3.7.	Information on Eligible Couples.
6.1.3.8.	Sector-wise Demographic Profile of FP acceptors for last three years.
6.1.4.	INFRASTRUCTURE - HEALTH
6.1.4.1.	Private Practitioners - Qualified
6.1.4.2.	Private Hospitals/Nursing Homes with bed strength.
6.1.4.3.	No. of Sub-centres
6.1.4.4.	No. of PHCs
6.1.4.5.	No. of Block PHC/CHC/PP Centre and Referral Hospital

6.1.4.6.	Budget for each institution for the year 1995-96 and subsequent years.
6.1.4.7.	Vehicles with status.
6.1.4.8.	Cold Chain equipment available/status
6.1.4.9.	Supplies of drugs and other equipment
6.1.4.10.	Personnel Section - Staff in position - vacant position
6.1.4.11.	Other Health Facilities
6.1.5.	**INFRASTRUCTURE**
6.1.5.1.	Roads/other means of transport
6.1.5.2.	Population of villages
6.1.5.3.	Electricity Connections at PHC/Subcentre
6.1.5.4.	Drinking water-all villages
6.1.5.5.	Education/Adult Education facilities
6.1.5.6.	Ration shop
6.1.5.7.	Panchayat
6.1.5.8.	Post office
6.1.5.9.	NGOs
6.1.5.10.	Banks
6.1.5.11.	ICDS
6.1.5.12.	Accessibility to Sub-centres
6.1.6.	Sector maps showing important infrastructural facilities.

6.2 **Format** of Model PHC Family Welfare and Health Care Plan is given at **FORM-3**. States are free to enlarge upon this basic format to suit their own needs.

7 PREPARATION OF DISTRICT & STATE FW&HC PLAN

Aggregation of plans of all the PHC's CHC's Rural Hospitals and District Hospital functioning in a district give us the District FW&HC Plan. Similarly aggregation of all the District FW&HC Plans of the State give us the State FW&HC Plan. The plans, prepared at the field level, become the driving force for the programme. However, the plans at each successive higher level are not simply the aggregate of the plans at the lower levels. Each level must also plan for its activities. Thus, while ANMs at Subcentre level would plan for carrying out desired activities, PHC would have to plan for providing support through inputs from the medical officers and supervisors. They would also need to plan for necessary logistics support. The District level may need to plan for improving access, availability and quality of services. The plans at each level would have to use an appropriate mix of coverage, unmet need and quality of care objectives. The District level Plan should provide for an elaborate system of field checking to ensure quality of services at PHC and Sub-centre level. The State level Plan must provide for an elaborate system of field checking in each district of the State. The State Plan must also elaborate the logistic arrangements for supply of essential inputs for Family Welfare Programme down to the PHC, Sub-centre & Panchayat level.

8 MONITORING AND EVALUATION

ANMs and Health Worker (Male) at Subcentre level and Medical Officer at PHC level form the backbone of the Primary Health Care Delivery System. Any attempt at improving the quality of care of family welfare services must take a look at the functioning of these functionaries.

Monitoring of the quality of care provided by these functionaries is proposed to be done through following instruments.

a. Monthly Activity Report.
b. Technical Assessment Checklist.
   This has following 3 parts.
   i. Observation on skills and practices.
   ii. Facility check list.
   iii. Knowledge and opinion of community.

Monthly Activity Rreport is to be submitted by the functionary him/her self to his/her next supervisory officer. The Supervisory officer shall fill up the Technical Assessment Checklist. The Checklist about observations on skills and practices shall be filled up after the Supervisor actually observes the functionary on the job. The Facility Checklist shall be filled up after actual inspection of the stock and stores provided to the functionary for carrying out his/her duties. The Checklist about knowledge and opinion is to be filled up in following way.

* Select the worker/doctor for review.
* Select one of the villages randomnly in his/her area.
* Start with a household with most recent birth.
* Interview 10 eligible couples with youngest child less than 2 years.
* (Additional target groups are to be interviewed in case of assessment of performance of MO, PHC).

The most important use of this review is to strengthen the supervisors ability to take corrective action. It should be seen as a part of on the job training for skill improvement and enhancement at all the levels.

8.1 Performance of ANM:

There are 23 activities to be carried out by ANM under Family Welfare Programme **(Form-1)**. For evaluation of the ANM for carrying out these activities following instruments are to be used.

8.1.1.Monthly Activity Report by ANM (Form-4)

Monthly activity report of ANM is a two page document listing 27 items to be carried out. The worker should report not only the services she provides but also the services provided by others in the area. For example, if a woman gets ANC services from a private clinic, should the worker include those in her activity report? Yes, she must report all services received by people in her area. She can collect the information from clients during household visits as she s expected to visit all households at least once a quarter.

8.1.2 Technical Assessment of ANM by the Supervisor

It shall be sent by LHV. The report shall have following parts:

i. Assessment of ANM's records (Form 5.1)
ii. Observations on skills & practices (Form 5.2)
iii. Facility checklist (Form 5.3)
iv. Knowledge and Opinion of EC/Community (Form 5.4)

8.2 Performance of Health Worker (Male)

There are only 8 activities to be carried out by male health worker. Following formats are to be used for the evaluation of the performance of Male Health Worker.

8.2.1. Monthly Activity Report by HW(M) in Form-6.

8.2.2. Technical Assessment Report by supervisor shall be sent by the Health Asstt. (Male). It shall have following parts.

i. Observation on skills and practices (Form 7.1)
ii. Knowledge and opinion of the EC/Community (Form 7.2)

8.3. Performance of Medical Officer PHC

Medical officer of PHC plays a crucial role in the primary health care system. There are 25 activities to be carried out by MO, PHC. Following formats are to be used for the evaluation of the performance of medical officer of PHC.

8.3.1.Monthly Activity Report by MO, PHC in Form-8.

8.3.2.Technical Assessment Report by Supervisor.

It shall be sent by Block Medical Officer. It shall have following parts.

i. Observation on skills and practices (Form 9.1).
ii. Facility check list (Form 9.2).
iii. Knowledge and opinion of community (Form 9.3).

8.4 Periodicity of Supervision:

While the monthly activity report is to be submitted by the functionaries once every month to their supervisors, the technical assessment is proposed to be taken up once in a quarter. The supervisors have to check out time table to cover all the workers/doctors working under them at least once every quarter. LHV shall review the work of ANMs once every month.

8.5. Inspection and Supervision

Following system of inspections shall be followed to supervise the qualitative aspects of the reporting. For all supervisory inspection formats of Technical Assessment Check lists be used.

8.5.1. District Health Officer shall ensure inspection and supervision of the work of atleast two

ANMs, two HW(M) and one MO (PHC) per PHC for all the PHCs in the district once every quarter.

8.5.2. **State Directorate of Health & Family Welfare** shall ensure inspection and supervision of work of atleast two ANMs, two HW(M) and one MO (PHC) per PHC for 10 percent of the randomly selected PHCs in a district with respect to all the districts once in a year.

8.5.3. **Evaluation and Intelligence Division** of the Department of Family Welfare, Ministry of Health and Family Welfare has 8 **Regional Evaluation Teams.** Their area of jurisdiction is as follows. Each team shall be carrying out inspection in two districts of one of the States allocated to them every month. They shall inspect work of atleast two ANMs, two HW(M) and one MO (PHC) in 10 percent of the randomly selected PHCs of each district. Each State Government shall provide necessary technical assistance to the Regional Evaluation Team to carry out the inspection.

Sl. No.	HQ. of the Regional Evaluation Team	States of jurisdiction
1.	DELHI	J&K, HIMACHAL PRADESH, PUNJAB, DELHI, HARYANA, RAJASTHAN, CHANDIGARH
2.	LUCKNOW	UTTAR PRADESH
3.	PATNA	BIHAR
4.	CALCUTTA	WEST BENGAL, SIKKIM, ASSAM, TRIPURA MEGHALAYA, ARUNACHAL PRADESH, NAGALAND, MIZORAM, MANIPUR
5.	PUNE	MAHARASHTRA, GUJARAT, DAMAN & DIU, GOA, DADRA & NAGAR HAVELI
6.	BHOPAL	MADHYA PRADESH, ORISSA
7.	BANGALORE	KARNATAKA, ANDHRA PRADESH
8.	MADRAS	TAMIL NADU, KERALA, LAKSHADWEEP, PONDICHERRY, A&N ISLANDS

8.6 Client Based Records:

Another step suggested for improving the quality of services is to introduce client centred approach in record keeping. The system of recording different services in different registers, has been found to hinder this approach. This is so because the ANM does not have in front of her, a full record of the client's health needs when she meets her at home or in the clinic. If the ANM could have such a record, presumably she will be able to provide services in a comprehensive manner. Incidentally, if the clients can read their records, they themselves will know what services they are entitled to get.

This assumption was tested in Maharashtra and found to hold good. This was done by introducing a "Family Health Card" which replaced all registers. Use of the Family Health Card

led to improvement in coverage of services and in quality of supervision. It also reduced the burden of record keeping. Some states like Tamil Nadu and UP have developed comprehensive Mother and Child registers, which are similar in concept, to the Family Health Card. In case of Tamil Nadu, services are recorded in three registers (EC, Mother Care, Child Care). In UP, services are recorded in 2 registers (EC and CSSM). These registers are easy to use, and contain all services given to a client (i.e. a pregnant woman, EC or a child), in one place. Family Health Card of course goes much further in that direction. Simplifying the concept of Family Health Card, a format for Client-Based RCH related services provided to mother and her children is suggested.

It is recommended to change over to Client-Based records on a pilot basis at this stage It is suggested that this format is used as an instrument to be used in the rapid surveys meant to assess the coverage and quality of services. This instrument will help in assessing the extent to which the ANMs maintain client-centred information, and also the comprehensiveness and quality of services. If the ANMs find this format useful as a basic record, then these may be introduced at a later stage. Some states may consider trying these records in one block, to assess their efficiency and costs (FORM-12).

8.6.1.Registers and Record at Subcentre level

Manuals for Health Worker (Female)/ANM and Health Worker (Male) and instructions of the state governments have defined a number of registers and records to be maintained at sub centre level. There is no intention to change the existing records being maintained by Health worker (Female)/ANM and Health Worker (Male) at sub centre level.

8.6.2.Eligible Couple Register

Eligible Couple Register should be updated every year in the month of April every year after a fresh door to door survey by the ANM.

8.7 Procedures for the Rapid Survey by PRC or other Agencies

For assessing the coverage, quality and client satisfaction with the FW services, client surveys will be conducted, by independent agencies in each district, once a year. These surveys will be designed to be economical and rapid so that the results will be available within a month of starting the surveys. Survey instruments will be kept short and simple, keeping these requirements in mind.

The suggested sampling method for the rapid survey is;

- Select 25 PHCs randomly per district.
- Select 2 ANMs randomnly per PHC.
- Select one village from the ANM's area.
- Using cluster sampling method select 20 ECs in each village.

For each selected households, information included in the Client-Based FW Record will be obtained by first extracting that information from worker's register, and then confirming it with the clients. In case the family is not recorded with the worker, the information will be collected only from the mother. This process of extracting information from worker's registers is meant for improving the quality of their recorded data, over time.

In addition to the services, information will be collected on EC's knowledge, attitude and

from 1000 ECs per district, will be adequate to provide very useful measures of quality, and coverage of various services. The survey design can be modified in terms of sample size and frequency of survey, by taking into account the cost aspects.

Along with the Rapid Survey, a Facility Survey will also be carried out, using a format somewhat similar to the supervisors check-list. This Facility Survey carried out by independent agency will corroborate the assessment of the supervisors and also provide an independent assessment of the skills, knowledge and facilities available with the ANMs and others once a year

8.8 Monitoring System of CHC/FRUs and PP Centres for quality of Services:-

The system outlined above mainly deals with the services provided at the Subcentres and PHCs levels. A similar system of monitoring will be needed at the FRU level. In that system, in place of Client-Based record, there will be a Case Sheet. There will be a Monthly Activity Report from FRUs (**FORM-10**). In place of client survey, an in-depth analysis of a sample of case-sheets(**FORM-11.1**), and a facility survey at the FRUs(**11.2**) will be carried out once a year. These three components of the monitoring system together, will provide adequate information to assess quality of care provided at the FRUs, as well as their status in terms of specialists, staff, equipments, and supplies.

8.9 Monitoring indicators

Following is the illustrative list of three types of indicators which shall be used to assess the effectiveness and impact of the Target Free Family Welfare Programme. These are the indicators to assess the Accessibility, Quality and Impact of the Programme. The data required for calculation of these indicators shall be available from the monthly activity reports and from the technical assessment check lists.

Indicators for Evaluation of Subcentres

Item	Accessibility Indicators	Quality Indicators	Impact Indicators
01. Ante-natal Care	No. of ECs/ANM	% ANC registered before 12 weeks	% deaths from maternal c causes among Ecs.
	% ANC sessions held as planned	% with 5 ANC visits	Maternal Mortality Ratio
	% SCs with no ANM	% ANC receiving all Services	Prevalence of maternal morbidity
	% ANMs without requisite skills		
	% SCs with working equipment for ANC	% High Risk referred	Mean Birth Weight
	% SCs with IFA, TT	% HR followed up	% Low Birth Weight
02. Intra-natal Care	% SCs with no ANM, TBA	% Deliveries at SCs	Obstetric mortality
	% ANM/TBA without requisite skills		
	% SCs with DDKs	% Deliveries by ANMs/TBAs	Prevalence of obstetric morbidity
	% SCs with infant weighing machines	% Birth weight recorded	Neonatal Mortality Rate
		% HR referred	
		% HR followed up	
Item	Accessibility Indicators	Quality Indicators	Impact Indicators

03. Post-natal Care	% SCs with no ANM, TBA	% PNC with 3 PNC visits	Prevalence of Post-natal maternal morbidity
	% ANM/TBA without requisite skills	% PNC receiving all counselling	Prevalence of Neo-natal morbidity
		% PNC complications referred	% Children breast fed within 6 hours of delivery
		% Complicated cases followed up	
04. Immunisation	No. of Infants/ANM	% Children 12-23 months fully immunised	% Deaths because of VPDs.
	% Immunisation sessions held as planned	% Drop outs from immunisation	
	% SCs with no ANM		
	% SCs with working equipment necessary for immunisation		
	% SCs with vaccine supplies		
05. Family Planning	No. of ECs/ANM	% Ecs offered choice	Couple Protection Rate
	% SCs with no ANM	% Acceptors screened for contra-indications	Prevalence of terminal methods
	% ANMs without requisite skills	% Acceptors followed up	Prevalence of spacing methods
	% SCs with equipment for FP	% Acceptors with complications	
	% SCs with FP supplies	% complicated cases referred	% Abortions related morbidity
		% Referred cases followed up	
06 Surveillance for Diseases	% ANMs with requisite skills	% ECs screened for RTIs/STDs	Prevalence of RTIs/STDs
		% ECs counselled for prevention of RTI/STDs	
	% SCs with ORS packets	% ADD given ORS	Prevalence of ADD
	% SCs with medicines	% ARI treated	Prevalence of ARI
		% Children 12-23 months fully immunised	Prevalence of VPDs
		% Cases referred	% ADD related mortality
		% Referred cases followed up	% ARI related mortality

8.10.Reporting System

The detailed format of preparing monthly reports from PHC/CHC/District Hospital/Private Hospitals is given in **FORM-14**. On this format information shall be collected by the Chief Medical Officer of the district before 5th of the following month and shall be sent by him to Director Health and Family Welfare of theState before 10th of the following month. The DH&FW of the state in turn shall forward this information with respect to the entire State to the :

Chief Director(E&I)
Department of Family Welfare
Ministry of Health & Family Welfare
Govt. of India
Nirman Bhavan
New Delhi-110 011.

by 20th date of the following month through speed post or Fax No. (011)-3019066, (011)-3017740. Format of monthly report is given at (**FORM-14**).

8.11.Summary Reporting

The summary report of the progress is also required to be given to Chief Director (E&I), Department of Family Welfare, Ministry of Health & Family Welfare, Nirman Bhavan, New Delhi by telegram or Fax No. (011)-3019066, (011)-3017740 by 7th of the following month by the Director Health & Family Welfare of the State.

Monthly Report to Govt. of India through FAX

Items to be reported	Progress of the month	Cumulative total
Vasectomy done		
Tubectomy done		
Total sterilisation done		
Condom pieces distributed		
Oral Pill Cycles distributed		
T.T.(PW) doses given		
DPT doses given		
OPV doses given		
BCG doses given		
Measles vaccine does given		
MTP performed		
Vit. A doses given		
ORS packets distributed		

9.3.3 While top most priority has been given for knowledge and skill development of the health providers, it is also considered necessary that the functionaries of other departments working at the grass root level who are already of great help in furtherance of maternal and child health care programmes should be coopted fully into the programme. It is thus recommended that a "team approach" should be built up at the grass root level. To further the efficacy of functioning of the "village team" of ANM/AWW/TBA, it is recommended that joint orientation/ training of these functionaries should take place in all districts. Any experiments in joint training in any State should be studied and followed with modifications if necessary. The district planning should incorporate this joint orientation/training as well.

9.3.4 NGOs/voluntary organisations/private hospitals, universities, autonomous institutions may be utilised for training purposes.

9.3.5 The initial training at the district may not be sufficient for required skill development e.g. I.U.D. insertions, sterilisation operations, and delivery cases. This may require placement of the trainees to different health facilities at a later date. To ensure quality, a minimum prescribed number of procedures will have to be carried out by each trainee before she is certified as having been trained. District training has to be flexible enough to allow this.

9.3.6 District Training Coordinators and the Trainer must certify the trainee as having acquired requisite skills. This is necessary to ensure accountability of the system.

9.3.7 While this model plan has not specifically mentioned urban areas, the training planning for urban areas should be on similar lines.

10 I.E.C. PROGRAMMES

Communication Programmes aim at generating demand and better utilization of health and family welfare services in the community and empowers people to take care of their health The Government of India provides guidelines for IEC programmes in each State and allocates the budget planned at STate level and distributed to the District and below:

Now, it is being realized that the IECI programmes have to be area specific and addressed to the problems of the area. This warrants decentralized planning approach in designing IEC programmes.

The community receives different messages from peripheral functionaries of different departments of Health, Nutrition and Family Welfare. It necessitates uniform approach to the target audience by different personnel. The another important dimension of IEC programme must be based on needs of the area.

It is observed that there is a need for improving interpersonal communication skills among the health providers at grassroots level. The existing communication resources are not fully utilized.

10.1 Available Media Equipments and Materials:

Media equipments and materials available in PHC.

i. Film Projector
ii. Cassette player
iii. 8 mm Projector
iv. Tape Recorder
v. Slide projector
vi. Communication materials given by ICDS
vii. Communication materials given by UNICEF and AIDS cells.

10.2 Communication Needs.

The situation Analysis of PHC reveals the following thrust areas for designing IEC programmes:

- Reproductive Health of Adolescent Girls
- Counselling of adolescents entering the reproductive age group for family life education
- Women's education
- Higher age at marriage
- Early Ante-natal registration and Care
- Nutrition during pregnancy and lactation
- Institutional delivery
- Vaccine preventable diseases
- Protected water supply
- Diarrhoea and ARI Management
- Low Birth weight
- Birth Interval, Birth Spacing
- Medical Termination of Pregnancy

* Child labour
* Childhood disability
* Rational drug use
* Breast feeding

10.3 IEC Methodology

The proposed IEC activities in the PHC will have the following objectives:

i. Identify the communication needs in their areas.
ii. Identify and utilise the communication channels effectively in the community
iii. Utilise the available Audio Visual materials effectively.
iv. Improve interpersonal communication skills among peripheral workers.

10.4 IEC strategy

Even though the awareness about Health and family welfare programme, is more but the acceptance and the utilisation are not upto the expected level. There is a wide gap between the awareness and the acceptance of healthy way of life. It is observed that many of our Health personnel are lacking interpersonal communication skills. It is also observed that there is no proper functional co-ordination on IEC activities among inter and intra-departmental personnel working at various levels. So, the proposed IEC strategies are as follows:-

i. Identifying the communication needs to plan IEC activities.
ii. Involve community and NGOs through unified messages.
iii. Effective use of mass media for back up (Ex.Cable T.V. folk media).
iv. Strengthening Interpersonnel communication.

10.5 Existing IEC Schemes

10.5.1 CENTRAL SECTOR IEC SCHEMES

(i) **Sensitization of Opinion Leaders:**

With the support of UNFPA this scheme is being implemented in 135 weak districts to sensitize various Opinion Leaders such as religious, social, political, official and other leaders of the society.

(ii) **Hiring of TV/VCP Scheme:**

This scheme is being implemented from 1994-95 to organise video shows by hiring TV/VCP in demographically weak districts to create awareness for small family norm.

(iii) **Scheme of health awareness through Nehru Yuva Kendra Sangathan:**

(iv) Population Clocks:

Population Clocks have been installed at ISBT, AIIMS, Pragati Maidan and Nirman Bhavan, Delhi, Tribune Office, Chandigarh and Bus Stand of Bangalore. The Population Clock at Lucknow has been installed. It is shown on the T.V. also.

(v) Counselling of Health Workers:

This scheme is to be implemented with UNFPA assistance in the States for success of the Family Welfare Programme by using counselling approach. An amount of Rs. 1261.4 lakhs will be available for the year 1995-96 to 1997-98 for this activity.

(vi) Swasthya Mela

The main intention is to make family welfare synonymous with family health care in order to improve the credibility of the health care delivery system and promote the small family norm. Swasthya Melas are being organised in the States, at the PHC level which are ill served.

(vii) Pulse Polio Immunisation (PPI):

For eradication of Polio from the country unprecedent social mobilization of PPI is being done through multi-media approach.

(viii) IEC for School Health check up:

For social mobilisation and for Primary School Health Check-up, campaign approach is being followed to create awareness of its importance among the people of India.

(ix) PHC Sensitisation:

Since this Ministry gave up the target approach, all kinds of opinion Leaders are being sensitised for making suitable Family Welfare Plan for themselves. This is a beginning for bottom up approach.

(x) Social Safety Net Schemes:

The scheme is being implemented with World Bank assistance in 90 demographically weak districts of the country. The scheme envisage infrastructural facilities at PHCs.

(xi) Population Education through NGOs:

NGOs who wish to work on Population Education are being provided with funds for running Population Education activities.

(xii) IEC Fellowship:

IEC short term training cum observation study tours are being organised with the support of WHO-funding for updating the knowledge of IEC Officers working for Family Welfare Programme.

10.5.2 IEC SCHEMES IN STATES/UTs.:

(i) **Mahila Swasthya Sangh:**

74,177 Mahila Swasthya Sanghs are working in States/UTs. at grass root levels for creation of awareness about Health and Family Welfare Programmes through inter-personal communication.

(ii) **Joint Training:**

The Joint Training Scheme is being implemented to train the grass root level workers and bringing about convergence with ANM & Anganwadi Workers.

(iii) **Training of Block Extention Educators (BEE)**

Block level Extension Educators are being oriented for 14 days training in IEC activities.

(iv) **Local Specific IEC Activities:**

The folk activities are being organised in regional languages and local specific printed materials are being printed and distributed in demographically weak districts.

(v) **Mass Education and Media (MEM) Activities:**

OTC, Exhibition, Films shows, printed publicity, advertisement in newspapers, Bus panels, population education in schools, celebration of national and international days, workshops, seminars and social mobilization etc. are being organised under this scheme.

(vi) **IEC Bureau:**

For better functioning of IEC set-up in the States/UTs Bureaus are being set up.

10.5.3 Population Education Projects of IEC

(i) **National Council of Education Research and Training.**

Project aims integrating population related messages in the curricula and text books, training of teachers and allied functionaries and popularising the message of small family norm among the younger generation through co-curricular activities. it is being implemented all over the country through NCERT in schools and non-formal education centres.

(ii) **University Grants Commission (UGC)**

Through youths of universities and colleges the issues concerning family size, quality of life and the impact of population growth are publicised for creating awareness and generate demand for small family norm. The programme is being implemented through Population Education Resource Centre (PERCs), established in the Department of Adult, Continuing Education and Extension in 12 Universities.

(iii) Deptt. of Adult Education (DAE)

Under this project steps are being taken to integrate population education components with total literacy campaign. it is expected that about 70% of illiterate girls and women will receive population education messages through this effort.

(iv) Directorate General of Employment and Training (DGET)

The project would seek to include education and counselling of students of ITIs in the areas of gender relations,and equality, responsible sexual behaviour and family planning practice, family life, reproductive health, sexually transmitted disease, HIV infection and AIDS prevention.

11 ALTERNATE STRATEGIC INITIATIVES AT DISTRICT LEVEL:-

Targets in the Family Welfare Programme, for long, have been the driving force and have guided its operations. A major strategic issue is - what alternate driving force should be used in the absence of targets. Several possibilities need to be considered.

11.1 Increasing coverage : The targets for service provision are substituted by those for coverage of different programme services as the major force. Targeted coverage levels may differ for different population segments. Many states have revised (or are considering revising) MIS to reflect this focus. For instance, in Maharashtra, the focus is on coverage within a sub-centre area by different services rather than services provided by a specific ANM. The main instrument for organising work becomes the family register or card. The record of specific services provided could emanate from specific service delivery sites (immunization sessions, camps, clinics etc.) or from service delivery records. The coverage-based focus is closest to the current target system. Its advantage is that it removes method-specific targets in family planning and minimizes conflict for 'credit' for services. While this focus leads to improving accessibility and availability of services, it does not directly emphasize improvements in quality of care.

11.2 Reducing Unmet Need : Here the targets are substituted by the unmet need for services. For family planning, this means focus is on couples who do not desire additional child or wish to space their next child but are not practicing contraception. For most other MCH/RH services (such as ANC), the goal of providing services to all those who need it remains. The advantage of using unmet need as a focus is that it separates out the responsibility of providing services to that of institutionalizing small family norms. It also may lead to focus on those geographic areas where the unmet needs may be the highest, and appropriately emphasise demand creation and service delivery interventions.

11.3 Ensuring Quality of Care : Here the major driving force is making quality services, defined according to specific standards, accessible and available. The onus of use of these services is on clients. Generally accessible quality services are utilized better and thus both coverage would increase over time and unmet need would reduce. But this may not happen for services whose need is not perceived. For instance, many women have silently suffered RTIs and have not been able to seek or have not sought such services. So IEC coverage may have to accompany improved quality if the utilization of such services is to increase rapidly.

Activity	Type	Norm
1. ANCs Registered(total)	Task	Pop * BR* 1.1
2. Early Registration(less than 16 weeks)	Qual	60% of ANC Reg
3. ANCs received TT 2 doses	Task	100% of ANC Reg
4. ANCs received IFA Therapy	Qual	50% of ANC Reg
5. ANCs completed 3 visits	Qual	90% of ANC Reg
6. ANCs Clinics conducted	Task	1/1000 pop/month
7. ANCs examined	Task	3* ANCs registered
8. ANCs referred	Qual	15% of ANC Reg
9a. Institutional Deliveries	Qual	25% of Exp. Delivery
9b. Deliveries by trained person	Qual	95% of Exp. Delivery
10. PNCs completed 3 visits	Task	100% Exp. Delivery
11. MTPs referred	Task	**********
12. Birth Weight recorded	Task	95% of Ecp Births
13. BW below 2.5 kg	Qual	**********
14. High risk newborns referred	Task	10% of live births
15. No. Imm sessions conducted	Task	1/1000 pop/month
16. Immunizations:		
a. BCG	Task	
b. DPT(3)	Task	
c. Polio(3)	Task	100% of live births
d. Measles	Task	100% of live births
17. Children fully immunized	Qual	100% of live births
18. Children given Vit A (5 doses)	Task	100% of live births
19. Adverse imm. events referred	Task	No. of live births
20a. Joint sessions with AWW	Task	33% *(ch under 3)
20b. Joint sessions with Dai		**********
20c. Joint sessions with women's groups		100% of AWW/pm
21a. Total Eligible Couples listed	Task	
b. Current Users of Pmt. methods	Task	
c. Current Users of Spacing methods	Task	
d. Potential Accpt. of Pmt methods	Task	
e. Potential Accpt. of spacing methods	Task	
f. Non Users	Task	
22a. Cases reported	Survey	
i. Polio		
ii. Measles		
iii. NN Tetanus		
iv. ARI U5 treated		
v. ARI U5 referred		
vi. Diarr. U5 treated		
vii. Diarr. U5 referred		
22b. RTI/STD referred		
22c. Gyn Prob referred		
22d. Infertility cases referred		
23. Vital events recorded	Survey	
a. Live births		
b. Neonatal deaths (U28d)		
c. Infant deaths (under 1y)		
d. Child (1-5) deaths		
e. Maternal deaths		
f. Marriages		
g. Marriages of girls below 18 years		

A. GENERAL

PHC _____ Sub-centre _____

Population of Sub-centre _____ Name of ANM/_____
(rounded to nearest thousand) Female Health Worker

B. SERVICES

Sl. No.	Services	Method of assessing demand of the area of sub-centre		Felt need of the population of the sub-centre	
		Coverage norm 1996-97	Methodology (Example of a state with birth rate of 20 & 5000 population per sub-centre)	Annual	Monthly
(1)	(2)	(3)	(4)	(5)	(6)
1.	A.N. Registration MCH, Nutritional Counselling, & Prophylaxis for Nutritional Anaemia	100%	Population X BR = 5000 X 20/1000 = 100 Add 10% pregnancy wastage = 10 110		
2.	Early A.N. Registration (i.e. within 16 weeks)	60% of the AN Mother	110 X 60/100 = 66		
3.	Detection and referral of high risk pregnancies (15% of AN Mothers will be high risk Mothers)	100% of the High Risk Mothers	110 X 15/100 = 16.7 = 17		
4.	Detection and Treatment of Anaemic Mothers	50% of the AN Mothers	110 X 50/100 = 55		
5.	T.T. AN Mothers	100% of AN Registered	110		
6.	3 visits completed AN Mothers	Minimum 3 visits to be given.	CSSM Schedule of AN visits to be followed 110 mothers to be completed with minimum of 3 visits		
7.	Institutional Delivery (GH + PHC + HSC + PNH)	25% of the expected delivery	100 X 25/100 = 25		
8.	Skilled attention at delivery (Institution + Health Worker + Trained Dai)	95% of the expected delivery	100 X 95/100 = 95		
9.	Growth Monitoring of the New Born Live Births	95% of birth weight recording	100 X 95/100 = 95		

(1)	(2)	(3)	(4)	(5)	(6)
10.	Detection and referral of high risk new born	10% of the live births	10		
11.	Infant Immunisation (BCG, DPT, OPV, Measles) (DPT/OPV Boosters) (DT at 5 years)	100% of the infants	100		
12.	Vit 'A' Solution for the children upto 5 years to be given in campaign twice a year	100% of the children upto 3 years	$20 \times \frac{5000}{1000} \times 3 = 300$		
13.	Diarrhoea cases treated with ORS each child in 0-5 years age group is likely to get 2 episodes of diarrhoea in a year	100% of Episodes	$20 \cdot \times \frac{5000}{1000} \times 5 \times 2 = 1000$		
14.	ARI Pneumonia cases (upto 5 years)	100%	Each child in 0-5 years is likely to get 2 episodes of ARI in a year. 10% of ARI cases are likely to be pneumonia cases		
15.	F.P. Acceptance	Acceptance of contraception by all eligible couples in the area	(a) number of couples with 3 or more children (i) number already accepted a permanent method (ii) number expected to accept a permanent method during the year (b) number of couples with 2 children (i) number already accepted a permanent method (ii) number expected to accept a permanent method (iii)number expected to continue with/ accept a spacing method IUD OP Condom (c) number of couples with less than 2 children (i) number expected to continue with/ accept a spacing method IUD OP Condom		

C. EQUIPMENTS

1.	IUD Kit	Available / Not Available
2.	Examination Table	Available / Not Available
3.	Weighing Machine	Available / Not Available
4.	BP Instrument	Available / Not Available
5.	Delivery Kits	Available / Not Available
6.	Steam Sterilisers	Available / Not Available
7.	Syringes & Needles	Available / Not Available
8.	Immunisation Cards	Available / Not Available

D. FACILITIES & HELP AVAILABLE TO SUB-CENTRE

1.	Number of Trained Dais available	_____
2.	Number of Anganwadis working	_____
3.	Number of Voluntary ORS Depot functioning	_____
4.	Number of Private Medical Practitioners (MCH, ISM&H)	_____
5.	Number of Primary School Teacher	Male_____Female_____
6.	Number of Panchayat Members	Male_____Female_____

PHC FAMILY WELFARE & HEALTH CARE PLAN

1. GENERAL

1.1 State _____ 1.4 Year _____

1.2 District _____ 1.5 Population of PHC_____

1.3 PHC _____ 1.6 Eligible couples on 1st April _____

2. PERFORMANCE & EXPECTED DEMAND

	SERVICE	PERFORMANCE LEVEL IN LAST YEAR 1.4.95-31.3.96	EXPECTED NEED IN NEXT YEAR AS COMPILED FROM SUB-CENTRE ACTION PLAN
	(1)	(2)	(3)
2.1	FAMILY WELFARE		
2.1.1	Male Sterilisation		
2.1.2	Female Sterilisation		
2.1.3	IUD Insertion		
2.1.4	Oral Pill Users		
2.1.5	Nirodh Users		
2.1.6	Follow-up Sessions		

	(1)	(2)	(3)
2.2	MOTHER CARE		
2.2.1	Ante-Natal Care		
2.2.1.1	ANC cases registered		
2.2.1.2	ANC cases with three contacts		
2.2.1.3	Detection & treatment of anaemic mothers		
2.2.1.4	TT to AN mothers (Total)		
2.2.1.4.1	TT(1)		
2.2.1.4.2	TT(2) / Booster		
2.2.1.5	Detection & referral of high risk mothers		
2.2.2	Natal Care		
2.2.2.1	Deliveries in PHC & Sub-centres		
2.2.2.2	Domiciliary deliveries conducted		
2.2.2.2.1	by LHV/ANM		
2.2.2.2.2	by Trained dai		
2.2.2.2.3	by Untrained dai		
2.2.2.2.4	by others		
2.2.2.3	High risk cases referred		
2.2.3	Post-Natal Care		
2.2.3.1	Birth weight recording of new born live birth		
2.2.3.2	Detection and referral of high risk new born		

	(1)	(2)	(3)
2.3	IMMUNISATION		
2.3.1	B.C.G		
2.3.2	O.P.V		
2.3.2.1	OPV routine		
2.3.2.2	OPV for PPI		
2.3.3	D.P.T. (1,2,3)		
2.3.4	Measles (after 9 months)		
2.3.5	DPT (18 months)		
2.3.6	OPV (18 months)		
2.3.7	D.T. (5 years)		
2.3.8	T.T. (10 years)		
2.3.9	TT (16 years)		
2.4	ANAEMIA & VIT.'A'		
2.4.1	Anaemia treatment given to :-		
2.4.1.1	Pregnant women		
2.4.1.2	Nursing mothers & IUD acceptors		
2.4.1.3	Children below 3 years of age		
2.4.2	Vitamin A solution given to children 9 months to 3 years age		
2.5	DIARRHOEAL DISEASES		
2.5.1	Acute cases recorded		
2.5.2	Cases treated with ORS		
2.6	RESPIRATORY INFECTIONS		
2.6.1	Pneumonia cases recorded		
2.6.2	Cases treated with Cotrimoxzole		
2.6.3	Pneumonia cases referred		

3. MATERIALS AND SUPPLIES

	Items	Stock Position on Ist April	Additional quantity required in				
			1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
3.1	Contraceptives						
3.1.1	Nirodh (pieces)						
3.1.2	Oral Pill (cycles)						
3.1.3	IUD's						
3.1.4	Tubal Rings						
3.2	Dai Kits						
3.3	Vaccines (doses)						
3.3.1	DPT						
3.3.2	OPV						
3.3.3	TT						
3.3.4	BCG						
3.3.5	Measles						
3.3.6	DT						
3.4	Prophylactics						
3.4.1.	IFA Tablets (large)						
3.4.2	IFA Tablets (small)						
3.4.3	Vit. 'A' Sol. (100 ml)						
3.5	ORS Packets						
3.6	Cotrimoxzole						
3.6.1	Tablets (paediatric)						

4. EQUIPMENT & FACILITIES

		TOTAL AVAILABLE	IN WORKING ORDER	ADDITIONAL REQUIREMENT
4.1	Vehicle			
4.2	Refrigerator			
4.2.1	I L R			
4.2.2	Cold Box			
4.2.3	Deep Freezer			
4.2.4	Vaccine Carrier			
4.3	Xray Machine			
4.4	IUD Kits			
4.5	Examination Table			
4.6	Weighing Machine			
4.6.1	Adult			
4.6.2	Infant			
4.7	BP Instrument			
4.8	Needles			
4.9	Syringes			
4.10	Autoclare			
4.11	Steam Steriliser Drums			
4.12	O.T. Table			
4.13	MTP Suction Apparatus			
4.14	Equipment for Infant Resuscitation			

5. INFORMATION, EDUCATION AND COMMUNICATION

5.1	Action taken to mobilise (a) The medical fraternity Allopathic, Ayurvedic, Unani & Homeopaths (b) The para medicals including Dais (c) Primary School Teachers (d) Panchayat Members (e) Ex-servicemen (army & civil) (f) N.G.O. activities (g) Anganwari worker	
5.2	Counselling facilities at PHC & Subcentre	
5.3	Action taken to mobilise (a) Village folk dances & singers (b) Street plays (c) Puppettiers (d) Video films (e) Radio (f) Film shows	
5.4	Urging Panchayat Members to prepare village level family welfare & health care plans	

6.0 VACANCY POSITION

	Category	Sanctioned		Vacant	
5.1	MO (Including Specialist)				
5.2	Dental Surgeon				
5.3	Staff Nurses				
5.4	Pharmacist/Compounder				
5.5	Lab. Technician/Lab. Asstt.				
5.6	Radiographer				
5.7	Driver				
5.8	Driver				
5.9	Para-medical supervisosrs (Malaria Inspector, BEE,PHN,LHV)				
5.10	Multi-purpose worker	Male	Female	Male	Female

ANM's Activity Reports for Month_____

SC_____ PHC_____ Subcentre Population_____
No. of ECs_____ Current Users of FP_____

Activity	Service Need		Performance		
	Annually (1)	Monthly (2)	Monthly (3)	Cumulative (4)	% Ach (4/1)
1. ANC Registration(total)					
2. Early Registration(less than 16weeks)					
3. ANCs received TT 2 doses					
4. ANCs received complete IFATherapy					
4a.ANCs received treatment for Anemia					
5. ANCs completed 3 visits					
6. ANC clinics conducted					
7. ANCs examined					
8. High risk ANCs referred					
9a.Institutional Delivery					
9b.Delivery by trained person					
10.Birth Weight Recorded					
11.BW below 2.5 Kg.					
12.High risk newborns referred					
13.No. of PNCs completed 3 visits					
14.MTPs referred					
15.No. Imm sessions conducted					
16.No. children Immunized					
BCG					
DPT3					
Polio3					
Measles					
17.Children fully immunized					
18.Children given Vit A(5 doses)					

***indicated "no norms s to be used

Activity	Service Need		Performance		
	Annually (1)	Monthly (2)	Monthly (3)	Cumulative (4)	% Ach (4/1)
19. Adverse events foll.Imm.					
20a. Joint Sessions with AWW					
20b. Joint sessions with Dai					
20c. Joint sessions with women's groups					
21a. Current users of pmt.methods					
(i) Vasectomy					
(ii) Tubectomy					
21b. Current acceptors of spacing methods					
(i) IUD					
(ii) OP Users					
(iii)Condom Users					
(iv)Traditional/Indigenous method					
(v) Natural methods					
21c. Potential acceptors of pmt. methods :					
(i) Vasectomy					
(ii) Tubectomy					
21d. Potential users of spacing methods :					
21e. Non users					
22. No. IUDs discontinued	****				
23. No. FP users followed-up					
24. Complications due to contraception					
25. Sterilization Failures	***				
26a. No. of cases of:					
Polio	***				
Measles	***				
NN Tetanus	***				
ARI U5 treated	***				
ARI U5 referred	***				
Diarr. U5 treated	***				
Diarr. U5 referred	***				
26b.No.of cases of Reproductive problems					
RTI/STD referred	***				
Other Gyn Prob. referred	***				
Infertility cases referred					
27. Vital Events Recorded:					
Live Births	***				
Neonatal deaths (28d)	***				
Infant deaths (under 1)	***				
Child (1-5) deaths	***				
Maternal deaths	***				
Marriages					
Marriages of girls below 18 years					

FORM 5.1

Technical Assessment check-list
Assessment of ANMs records Month _____

PHC_____ Village_____

Sub-centre_____ ANM_____

HH	Name	Item1	Item2	Item3	Item4	Item5	Item6
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
Score							

Total score

Items: (1) No. of living children,
(2) Contraceptive status of EC,
(3) Immunization status of the youngest child,
(4) Did she receive TT/IFA during pregnancy
(5) Whether the child was weighed at birth
(6) Who did the delivery

Scoring system : ANM recorded the item correctly +1
ANM recorded the item wrongly / not recorded 0

Technical Assessment Check-list for ANM
Observations on skills, Practices and Facilities

PHC _____ Month _____

Sub-centre_____ Name of ANM_____

	Yes/No	Comment
Overal Quality Aspects		
1. Washes hands before and after examination/treatment		
2. Uses principles of sterilization		
3. Respects the client seeking services		
for New ANC:		
1. Outcome of Previous preg recorded		
2. Asked about BOH/associate diseases		
3. Recorded LMP and EDD		
For any ANC:		
4. Did abdominal palpation		
5. Recorded BP correctly		
6. Recorded Hb Correctly		
7. Height and weight checked and informed the client		
8. Foetal heart sound heard		
9. Iron and folic acid tablets given		
10. TT given		
11. MCH card issued		
12. Did breast examination		
13. Advised on nutrition and rest		
14. Advised on place of delivery and preparation		
15. Reminded about next visit		
16. Checked for high risk and informed / referred		

	Yes/No	Comments
For Child Immunization:		
17. Uses single needle, single syringe		
18. Throws away opened measles vial		
19. Imm card filled		
20. Advised mother about next visit		
21. Cold chain maintained		
Postnatal Visit:		
22. Asked mother about:		
Fever		
Foul smelling discharge		
Bleeding		
23. Checked for		
Involution of uterus		
Cord healing		
Recorded baby weight		
24. Mother advised about:		
Proper breast feeding		
Keeping baby warm		
Contraception		
25. Counsels on contraception		
Contraception (for any method) :		
26. Uses screening criteria and rules out contra indications		
27. Informs woman about side effects and action		
Treatment of ARI / Diarrhoea		
28. Can count respiratory rate		
29. Advise about feeding and fluid		
30. Advises about danger signs		

FACILITY CHECKLIST FOR SUB-CENTRE

PHC _____ Month_____

Sub-Centre_____

Selected Equipments and Supplies	Available		Quantity/Quality
	Y	N	
A. Facilities			
Accommodation			
Water			
Electricity			
B. Furniture and Equipment			
Examination Table			
Benches for clients			
Cupboard for drugs			
Foot stool			
Vessels for water storage			
Waste disposal containers			
Brooms and Mops for cleaning			
Steam sterilizer			
Delivery Kit			
Torch light			
Stove			
Weighing scale			
BP apparatus			
Vaccine carrier			
C. Supplies and Drugs			
Thermometer			
Gloves			
Syringes and Needles			
Slides for blood test			
ORS Packets			
DDKs			
Uristix			
Kerosene			
Co-trimoxazole			
Vit A solution			
IFA tablets (big and small) and syrup			
IUDs			
OPs			
Condoms			
Antiseptic solution			
Chloroquine tablets			
Paracetomol tablets			
Metronidazole tablets			
D. IEC material			
Posters			
Models			

Technical Assessment Checklist for ANM
Knowledge and Opinion of EC/Community

PHC _____ Month _____

Sub-centre_____ Village_____

ANM _____

	Households									
	1	2	3	4	5	6	7	8	9	10
Were you visited by the ANM during the last month										
Is the ANM available when needed										
Does she treat you with respect when you go to her										
Did you have any problem in the last pregnancy										
If yes, were you given timely advise										
Was your delivery conducted by a trained person										
Was your baby weighed after birth										
Were you visited at home after delivery										
Did you get information about proper breast feeding practices										
Do you know the danger signs of ARI										
Do you know what fluids are to be given to your child during diarrhoea										
Do you know against what diseases immunization is given dto your child										
Do you know at what age Measles vaccine is given										
What is your desired family size How many children do you have										
Are you aware of contraceptive methods										
Are you aware of side effects of contraceptive methods										
Are you aware of the ideal gap between two children										
Have you had an abortion										
If yes, were you given advise and treatment										
Did you have RTI/Gynaea problem										
If yes, did you seek the services of ANM										

Monthly Reporting Format for the Health Worker Male

Name of the Sub-centre :

Name of the Worker :

Month :

Year:

Activity	*Annual Service need*	*Monthly Service need*	*Achievement*		
			Monthly	*Cumulative*	*Percentage*
	1	*2*	*3*	*4*	*4/1*
1. Health clinics					
i. No. of Health clinics attended with ANM					
2. Family planning methods					
i. No. persons motivated for vasectomy					
ii. No. persons using CCs					
iii. No. vasectomy cases followed up					
3. Communicable diseases					
A. Malaria					
i. No. of fever cases identified					
ii. No. of blood smear slides sent to PHC					
iii.No. of cases given presumptive treatment					
iv. No. of positive cases given radical treatment					
v. No. of high risk villages identified					
vi. No. of anti-mosquito activities co-ordinated					
B. Tuberculosis					
i. No. of suspected cases identified and referred					
ii. No of TB cases followed up					
C. Leprosy					
i. No of suspected cases identified and referred					
ii. No. of suspected cases followed up					
D. Epidemics					
i. No. of GE cases identified and reported					
ii. No. of cases of preliminary treatment given					
iii. No. of cases referred					
iv. No. of cases other epidemic diseases referred (Filariasis, Malaria etc)					

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage
	1	2	3	4	4/1
4.Environmental sanitation					
i. Number of drinking water sources chlorinated					
5. School health					
i. No. of school health programmes participated					
ii. No. of school children examined and treated	-				
iii. No. of school children referred	-				
iv. No. ofschool children immunized	-				
v. No. of school health cards filled	-				
6.Interaction with community					
No. of meetings with village health committees	-				
ii. No. of meeting with youth committees	-				
iii. No. of meetings with village leaders	-				
iv. No. of meetings with PMPs	-				
7.IEC					
i. No. of Health Education programmes on environmental sanitation conducted	-				
ii. No. of group talks to males on contraceptive methods	-				
ii. No. of health talks to males on reproductive health (STD/RTIs/ Infertility)	-				
8. Reporting and recording					
i. Malaria reports					
ii. Other communicable diseases reports					
iii. School health reports					

Technical Assessment Check-list for HW(M)

Male Health Worker_____ __ PHC _____ Month _____

Observation of Skills and Practices

Activities	Yes / No	Grading *			
		E	G	A	P
1. Family planning methods					
A) Motivating for vasectomy					
i) explained the method					
ii) listed the benefits					
iii) spoke about use of CCs after Vasectomy					
iv) discussed the misconceptions if any					
B) Motivated for use of condoms					
i)explained the benefits					
ii) demonstrated use and disposal					
2. Communicable Diseases (Malaria)					
i) Took aspetic precautions before taking smear					
ii) Selected the correct site for skin prick					
iii) Allowed time for forming a blood drop					
iv) Kept a clean slide ready					
v) Prepared both thick and thin smear					
vi) Identified the slide correctly					
vii) Provided presumptive treatment according to age					
viii) Transferred the blood smears to the PHC					
ix) Made correct entry into the records					
x) Provided radical treatment to the smear positive cases					
3. Environmental sanitation					
i) Estimated the volume of water in the source					
ii) Estimated the free and combined chlorine demand					
iii) Calculated the correct requirement of bleaching powder					
iv) Contact period of chlorination correctly followed.					

** E = Excellent; G = Good; A = Average and P = Poor.*

FORM - 7.2

Technical Assessment Checklist for HW (FW)

Knowledge and Opinion of EC/ *Community*

Name of HW(M) Month

PHC Sub-Centre

Item	*Households*										*Yes / No*
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	
1. Were you visited by the Male worker during the last month?											
2. Did he collect blood smear during the last episode of fever in your family?											
3. Did he give you presumptive treatment?											
4. Did he inform you about the blood smear report ?											
5. Did he give you radical treatment (in Positive cases only)?											
6. Did he ever advise you to consult the PHC MO for any ailment?											
7. Did he advice you about the correct use of condoms?											
8. Did he supply you condoms regularly? (Ask user only)											
9. Did he explain how to dispose off the condoms?											
10. Does periodically seek your assistance in the implementation of the health programmes? (Ask a village leader)											
11. Does he visit your village atleast once a month? (Ask a village leader/elder)											
12. Did he help you in chlorination of water sources? (To be asked to a village leader)											
13. Did he seek your assistance and help in environmental sanitation? (Asked a member of youth club or village leader)											
14. Did he refer you to the PHC MO for further mangement of your ailment (Ask a TB patient)											
15. Did he visit you for followup care ?											
16. Did he refer you to the PHC MO for further mangement of your ailment ? (Ask a Leprosy patient)											
17. Did he visit you for followup care?											
18. Does he periodically visit your school? (Ask a school teacher)											

Name of the Supervisor :

Date : *Signature*

Name of the MO :

Name of the PHC :

Month :

District :

Year :

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage
1) O.P. Clinics conducted					
a) No.of cases examined					
b) No.referred from SCs					
c) No. treated					
d) No. referred to FRU/hospital					
2) ANC clinics conducted					
a) No.of cases examined					
b) No.referred from SCs					
c) No. of high Risk cases identified					
d) No. referred to FRU/hospital					
3) Immunisations performed					
i) a) DPT (3)					
b) OPV (3)					
c) BCG					
d) Measles					
ii) a) No. fully immunised					
b) No. partially immunised					
c) No. not at all immunized					
iii) Cases of adverse effects of immunization managed					
iv) No. of Immunisation sessions attended at periphery					
4) ARI					
a) No. of cases treated					
b) No. of cases referred from SCs					
c) No. referred to FRU/hospital					
d) No. of deaths due to ARI					
5) Diarrhoea					
a) No.of diarrhoeal cases treated					
b) No.of cases referred from SCs					
c) No. referred to FRU/hospital					
d) No. of deaths due to diarrhoea					
6) Deliveries conducted at PHC					
a) No. of Institutional deliveries conducted					
i) Conducted by MO					
ii) Conducted by other trained personnel					
iii) Complicated deliveries referred to FRU/hospital					
iv) Recording of Birth Weight					

Activity	ANNUAL Service need	MONTHLY Service need	ACHIEVEMENTS Monthly	Cumulative	Percentage
7) MTP performance at PHC					
a) No.of MTPs performed at PHC					
b) No.referred from Scs					
c) No.referred to FRU/hospital					
8) Sterilizations performed					
a) No. of tubectomies performed					
i) With one child					
ii) With two children					
iii) With more than two children					
iv) No. followed					
v) No. of failure cases reported					
b) No. of vasectomies performed					
i) With one child					
ii) With two children					
iii) With more than two children					
iv) No. followed					
v) No. of failure cases reported					
9) IUD inserted					
a) No. of cases screened for IUD					
b) No. of women inserted IUDs					
c) No. of IUD acceptors followed up					
d) No. of dropouts					
10) O.P. Users					
a) No. of O.P. users screened					
b) No. of O.P. acceptors followed					
c) No. of dropouts					
11) Reproductive Health					
a) RTIs/STDs					
i) No.of cases of RTIs/STDs examined					
ii) No. of cases treated					
iii) No. referred to FRU/Hospital					
b) Infertility					
i) No. of couples of Infertility identified					
ii) No. referred to FRU / Hospital					
c) Malignancy					
No. of suspected cases of cancers of reproductive tract referred:-					
i) Referred from PHC					
ii) treated at CHC/PPC/FRU					
iii) Referred to Distt.Hospital					

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage to Total
d) Dysfunctional Uterine Bleeding (DUB)					
No. of cases of menstrual disorders referred to FRU / Hospital					
12. Disease surveillance report (Once in 3 months)*					
a) Vaccine Preventable Diseases					
i. Polio					
ii. Tetanus					
iii. Diphtheria					
iv. Pertussis					
v. Tuberculosis					
b) Other Diseases					
i. Malaria					
1. No. of B.S. taken					
2. No. of Positive cases					
2.1 PF					
2.2 PV					
2.3 Mixed					
3. Presumptive treatment given					
4. Radical treatment given					
5. No. referred out					
6. No. of deaths					
ii. Tuberculosis					
1) No. of sputums examined					
1.1 New cases					
1.2 Follow-up cases					
2) No. of sputum positive cases					
3) No.given SCCs (Short Course Chemotherapy)					
4) No. completed SCCs					
5) No. under treatment					
6) No. referred out					
iii. Leprosy					
1) No. of cases reported					
2) No. of suspects referred					
iv. Epidemics Reported					
1) No. of Epidemics of G.E.					
2) No. of deaths					
3) Other Epidemics if any					

* Note: The disease surveillance part of this report should be submitted only once in three months.

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage to Total
13. Meeting attended / conducted a) Monthly Mos meeting at District b) Monthly Staff Review c) With ICDS staff d) With Block Level officials e) Community Level Leaders/ Representatives f) With Women Groups g) Any other Meetings h) Review of work of NGO working in area done					
14. IEC Activities a) No. of health campaigns conducted b) No. of NGOs contacted and involved c) No. of School Health Camps held					
15. Training a) No. of staff training programmes conducted b) No. of training programmes conducted for non health functionaries					
16. Transport a) No. of cases transported in PHC vehicle i) Tubectomy Cases ii) Emergency obstetric cases iii) Other emergencies					

Technical Assessment Checklist for PHC Medical Officers

Name of the M.O. :
Name of the PHC :

Month :
Year :

Activities	Yes/No	Grading *			
		E	G	A	P
1. New OP Case					
a) History taken					
b) Physical examination done					
c) Provisional diagnosis made					
d) Treatment initiated					
e) Referred to FRU / Hospital					
f) Adequate time spent on each patient					
g) Necessary advise imparted					
2. Examination of AN cases					
a) Correct estimation of gestation period					
b) Correct identification of high risk					
3. Correct assessment and treatment of child with diarrhoea					
4. Correct assessment and treatment of child with ARI					
5. Correct assessment of STD/RTI					
a) STD / RTI cases treated					
b) STD/RTI cases referred to FRU / Hospital					
6. Correct decision taken in an emergency case / delivery case for					
a) Treatment at PHC					
b) Referral outside					
c) Use of drugs - raational or not					
7. FP Methods					
A. Tubectomy					
i) Pre-operative check-up					
ii) Aseptic precautions					
iii) Ability to locate the tubes					
iv) Ligation of the tubes					
v) Skin suturing and ASD					
vi) Post-operative advice					

Activities	Yes/No	Grading *			
		E	G	A	P
B. Vasectomy					
i) Pre-operative check-up					
ii) Preparation of the surgical area - care of asepsis					
iii) Incision and control of intra-operative haemorrhage					
iv) Identification of Vas					
v) Ligation of Vas					
vi) Skin suturing and ASD					
vii) Post-operative advice					
C. IUD insertion					
i) Screening the patient					
ii) Aseptic precautions					
iii) Insertion of IUD					
iv) Inspection of the IUD threads					
v) Post-IUD insertion advice					
7. Records and reports					
a) Complete and update					
b) Accurate					
8. Clean and tidy PHC premises					
9. Provision made for round-the-clock availability of staff.					
10.PHC vehicle available round-the-clock in road worthy condition.					
11.MO staying at head quarters					

Note: The Supervisor is a district level officer and visits the PHC once in two months. The Supervisor will directly observe the skill of the Medical Officer while examining;

1. A new OP case
2. A pregnant woman
3. A child with diarrhoea
4. A child with ARI
5. A person with RTI / STD
6. Any emergency or critical situation occuring during the visit

E = Excellent

A = Average

G = Good

P = Poor

Facility Check List for PHC

PHC _____ Month_____

District_____

Activity	Yes/No
1. PHC Building	Own or Rented
2. PHC Premises Clean and Tidy	Yes/No
3. Equipment	Yes/No
a) Ambulance	Yes/No
b) Cold Chain Equipment	Yes/No
c) B.P. Apparatus	Yes/No
d) Weighing Machine	Yes/No
e) Micro Scope & Lab. Equipment etc.	Yes/No
f) Auto Clave	Yes/No
g) Oxygen Cylender	Yes/No
h) Surgical Equipment relating to PHC expertise	
i) Labour Room Table & Equipment	Yes/No
j) Examination Table	Yes/No
k) Resuscitation Equipment	Yes/No
4. Drugs*	
Vital	
Essential	Yes/No
Desirable	Yes/No
	Yes/No

*Note 1: The supervising officer must make a list of essential facilities and drugs of accute shortage even during his quarterly visit and the same should be brought to the notice of higher ups immediately.

*Note 2: A detailed VED (Vital, Essential and Desirable) categorization of drugs at PHC will be provided to be supervising officer.

FORM 9.3

Technical Assessment checklist

Knowledge and opinion of the community

Name of MO PHC PHC Month

Note: The supervising officer will spend one full day in the village interacting with at least 10 people representing a cross section of the society. He should make it a point to select the cases perferably from those hailing from weaker sections and women. The same village should not be revisited by the subsequent supervising officer.

Two sets of questions are given to the supervisory officer. The first set is common to all barring Dais and Anganwadi workers. The second set of questions is for the specific target groups in addition to the first set of questions.

The main objective of the two set of questions is to asess the community satisfafaction on the overall functioning of PHC and the Medical Officer in particular.

FIRST SET OF COMMON QUESTIONS

Item	Households									Yes / No
	1	2	3	4	5	6	7	8	9	10
a) Did you utilise the services of sub centre/PHC ?										
b) Did you find the behaviour of the PHC staff good?										
c) Does the MO stays at the PHC headquarters ?										
d) Does MO regularly come to the PHC ?										
e) Did the MO spend sufficient time with you during your visit to the PHC?										
f) Are you given adequate drugs at PHC?										
g) Did the PHC or sub centre staff conduct health clinics in your village?										
h) Did the PHC MO visit your village during the last six months?										

SECOND SET OF QUESTIONS FOR DIFFERENT TARGET GROUPS

The persons to be interviewed are :

1. Pregnant woman
2. One recently delivered woman and baby
3. Tubectomised woman/Vasectomised man
4. Dai of the village
5. Anganwadi worker if available
6. Women group representative
7. One youth of the village
8. One village leader
9. One IUD acceptor
10. One CC/OP user

	Yes/No	Comments
Pregnant woman		
Did you register before 16 weeks of pregnancy?		
Have you been given IFA tablets ?		
Have you been informed about danger signals in pregnancy and the need to contact PHC MO ?		
Recently delivered woman		
Is your delivery Institutional ?		
Were you told about the post partem care ?		
Was the child given with BCG vaccination ?		
Were you informed about breast feeding ?		
Mother with two year old child ?		
Did your child get all doses of Immunisation ?		
Was your child affected with Diarrhoea any time ?		
If yes, were you advised about the feed and the use of ORT ?		
Tubectomised woman/Vasectomised man		
Do you have less than two children?		
Are you satisified with the follow up care after the operation?		
Do you have any complications?		

	Yes/No	Comments
Dai		
Are you trained?		
Are you aware of the five cleans?		
Can you identify a high risk case?		
Anganwadi Worker		
Does the ANM seek your cooperation?		
Are there any cases of adverse effect of immunisation?		
Women group representative		
Do the PHC staff keep in touch with your group?		
Do they involve you in Health and FW activities?		
Youth and Youth club member		
Do the PHC seek your cooperation ?		
Were you involved in promoting H and FW issues?		
Village Leader		
Does MO/or other PHC staff seek your cooperation for social mobilisation?		
Are you involved in promoting Environemental santiation?		
IUD acceptor		
Were you told about the advantages and possible side effects?		
Are you satisfied with the services of PHC staff in this regard. ?		
Condom User		
Were you told about the method of using Condoms?		
Are you supplied with the condom by the PHC?		
OP user		
Are you informed about the method of using OP?		
Were you told about the benefits and possible side effects of OP ?		
Are you supplied with OP tablets?		
Have you experienced any complications?		

Name of the MO IC : Month : Form

Name of the CHC/PPC/FRU: Year :

District :

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage to Total
1) O.P. Clinics conducted a) No.of cases examined b) No.referred from PHC's c) No. of High Risk cases identified d) No. treated e) No. referred to Distt.Hospital					
2) Immunisations complications a) Cases of adverse effects of immunization managed b) No. of Immunisation complication attended at periphery					
3) ARI a) No. of cases treated b) No. of deaths due to ARI c) No. of cases referred from PHC d) No. referred to Distt.Hospital					
4) Diarrhoea a) No.of diarrhoeal cases treated b) No.of deaths due to diarrhoea c) No.of cases referred from PHC					
5) Deliveries conducted at CHC/FRU/ PP Centre a) No. of deliveries conducted b) Complicated deliveries referred from PHC c) Complicated deliveries managed at CHC/PP Centre d) Complicated deliveries referred to Distt. Hospital e) Neonatal resuscitation done					
7) MTP performance at CHC/FRU a) No. of MTPs persformed at CHC/PP Centre b) No. referred from PHC c) No. referred to Distt.Hospital d) Complications after MTP					

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage to Total
8) Sterilizations performed					
a) No. of tubectomies performed					
i) With one child					
ii) With two children					
iii) With more than two children					
iv) No. followed					
v) No. of failure cases reported					
b) No. of vasectomies performed					
i) With one child					
ii) With two children					
iii) With more than two children					
iv) No. followed					
v) No. of failure cases reported					
9) IUD inserted					
a) No. of cases screened for IUD					
b) No. of women inserted IUDs					
c) No. of IUD acceptors followed up					
d) No. of IUD Removal for :					
1. Request					
2. Complication					
3. Expulsions					
e) IUD Failure cases reported					
10) O.P. Users					
a) No. of O.P. users screened					
b) No. of O.P. acceptors followed					
c) No. of dropouts					
11) Reproductive Health					
a) RTIs/STDs					
i) No.of cases of RTIs/STDs examined					
ii) No. of cases treated					
iii) No. referred to Distt.Hospital					
b) Infertility					
i) No. of couples of Infertility identified					
ii) No. of couples refered from PHC					
iii) No. of couples treated/cured/ regained fertility					
c) Suspected cancer					
No. of suspected cases of cancers of reproductive tract referred:-					
i) Referred from PHC					
ii) treated at CHC/PPC/FRU					
iii) Referred to Distt.Hospital					

Activity	Annual Service need	Monthly Service need	Achievement		
			Monthly	Cumulative	Percentage to Total
11) Dysfunctional Uterine Bleeding (DUB) No. of cases of menstrual disorders referred to Distt. Hospital : i) Referred from PHC ii) Treated iii) Referred to Distt. Hospital					
12. Meeting attended / conducted a) Monthly Mos meeting at District b) Monthly Staff Review c) With Block Level Official d) Community Level Leaders/ Representative e) With Women Groups f) Any other Meetings					
13. Training a) No. of staff training programmes conducted b) No. of training programmes conducted for non health functionaries					
14. Transport a) No. of cases transported in FRU vehicle/ambulance i) Tubectomy Cases ii) Emergency obstetric cases iii) Other emergencies					

FORM 11

Technical Assessment checklist for FRU Medical Officers

Name of the M.O : Month :

Name of the Institution : Year :

Activities	Yes/No	Grading *			
		E	G	A	P
1. New OP Case					
a) History taken					
b) Physical examination done					
c) Provisional diagnosis made					
d) Treatment initiated					
e) Referred to Hospital					
f) Adequate time spent on each patient					
g) Necessary advise imparted					
2. Examination of AN cases					
a) Correct estimation of gestation period					
b) Correct identification of high risk					
3. Ward Patient					
a) History taken					
b) Physical Examination done					
c) Provisional Diagnosis made					
d) Relevant Investigations done					
e) Treatment Initiated					
f) Adequate time spent on each patient					
g) Behaviour with the patient					
h) Opinion of specialists taken					
i) Referred to Distt. Hospital					
4. MTP case					
a) History taken					
b) LMP recorded					
c) Physical examination done					
d) Concern shown for confidentiality					
5. Correct assessment and treatment of child with diarrhoea					
6. Correct assessment and treatment of child with ARI					
7. Correct assessment of STD/RTI					
a) STD /RTI cases treated					
b) STD/RTI cases referred to FRU/hospsital					
8. Correct decision taken in an emergency case/ delivery case for					
a) Treatment at FRU					
b) Referral outside					

Activities	Yes/No	Grading *			
		E	G	A	P
9. F.P. Methods					
A. Tubectomy					
i) Pre-operative check up					
ii) Asceptive precautions					
iii) Ability to locate the tubes					
iv) Ligation of the tubes					
v) Skin suturing and ASD					
vi) Post-operative advice					
B. Vasectomy					
i) Pre-operative checkup					
ii) Preparation of the surgical area					
iii) Incision and control of intra-operative haemorrhage					
iv) Identification of Vas					
v) Ligation of Vas					
vi) Skin suturing and ASD					
vii) Post-operative advice					
C. IUD Insertion					
i) Screening the patient					
ii) Aseptic precautions					
iii) Insertion of IUD					
iv) Inspection of the IUD threads					
v) Post-IUD insertion advice					
10. Records and reports					
a) Complete and update					
b) Accurate					
11. Clean and tidy FRU premises					
12. Provision made for round-the-clock availability of staff.					
13. FRU vehicle available round-the-clock in road worthy condition.					
14. MO staying at head quarters					

Note: The Supervisor is a district level officer and visits the FRU once in three months. The Supervisor will directly observe the skill of the Medical Officer while examining the cases listed above.

E = Excellent

G = Good

A = Average

P = Poor

Facility Check List for CHC/PPC/FRU

Name of the Institution :
District :

Month :
Year :

Activity	Yes/No
1. FRU Building	Own or Rented
2. FRU Premises Clean and Tidy	Yes/No
3. Equipment	Yes/No
a) Ambulance	Yes/No
b) B P. Apparatus	Yes/No
c) Weighing Machine	Yes/No
d) Micro Scope & Lab. Equipment etc.	Yes/No
e) Auto Clave	Yes/No
f) Oxygen Cylender	Yes/No
g) Surgical Equipment relating to FRU expertise/ responsibility.	Yes/No
i) Labour Room Table & Equipment	Yes/No
j) Examination Table	Yes/No
k) Resuscitation Equipment	Yes/No
l) Neonatal Resuscitation Equipment	Yes/No
m) Anaesthesia Equipment	Yes/No
n) Incinerator	
4. Drugs*	
Vital	Yes/No
Essential	Yes/No
Desirable	Yes/No

*Note 1: The supervising officer must make a list of essential facilities and drugs of acute shortage even during his quarterly visit and the same should be brought to the notice of higher ups immediately.

*Note 2: A detailed VED (Vital, Essential and Desirable) categorization of drugs at PHC will be provided to be supervising officer.

FAMILY REPRODUCTIVE HEALTH CARD

Registration Date : PHC : Subcenter :

Village : Name of head of the HH : EC No. :

Water Source : House Type : Religion/Caste :

Family Size : Males : Females : Total :

Primary Immunisation (Under 1 Year)

Name	Sex	DOB	OPV 0	DPT 1	DPT 2	DPT 3	OPV 1	OPV 2	OPV 3	Measles	Vit A 1

Immunisation (Children 1 - 5 Years)

Name	Sex	DOB	DPT (B)	OPV (B)	Vit A 2	Vit A 3	Vit A 4	Vit A 5	IFA 1	IFA 2	IFA 3

Pregnancy History of EC and Contraceptive Status

Name : Age : Education : If Sterlised, Date :

No. of Pregnancies	Outcome				Children Living		Children Dead
	LB	SB	Abortion		Male	Female	
			Spontaneous	Induced			

Surveillance

Disease/Complications	Name	Diagnosis	Investigations	Treatment	Referral
VPDs					
ADD/ARI					
RTIs STDs					
Other Gyn. Problems					

Death Record

Name	Age	Sex	Death Date	Cause

Family Planning Follow-up by month

	1996											
	1	2	3	4	5	6	7	8	9	10	11	12
Pregnancy/FP Status												
Complications												
	1997											
	1	2	3	4	5	6	7	8	9	10	11	12
Pregnancy/FP Status												
Complications												
	1998											
	1	2	3	4	5	6	7	8	9	10	11	12
Pregnancy/FP Status												
Complications												
	1999											
	1	2	3	4	5	6	7	8	9	10	11	12
Pregnancy/FP Status												
Complications												

ANC Information

Anc Reg Y/N	EDD	Weight *			TT			IFA			BP*			Urine*			HR**	Ref
		1	2	3	1	2	3	1	2	3	1	2	3	1	2	3		

* Record for all 3 ANC visits

** Malpresentation, Twins, Previous LSCS, Anaemia, TB, Toxaemia, Haemorrhage (Use the first letter of word as code. If factor other than these, specify.)

Delivery & PNC Information

Delivery Date	Delivery Place	Delivery by	Outcome	Birth Weight	PNC* Visit	Breast** Feeding	PNC*** Complications	Treated/ Referred

* Mention number of PNC visits

** Mention the number of hours or days after which breast-feeding was initiated

*** Infections; Injury to Genital tract; Haemorrhage; Fever; Sudden death; Uterine problems lactation failure.

FORM

Assessment of Quality and Client Satisfaction

Q1. Has the ANM visited you in last three months? Yes No Not Recorded

If yes, Q1a. Were you satisfied with the amount of time? Yes No Not Recorded

Q2. During last pregnancy did you suffer from any of the following problems?

(a) Swelling of feet (b) Bleeding (c) Excessive tiredness

(d) Convulsions (e) Night blindness (f) None

Q3. Were you advised to go to hospital for delivery ? Yes No Not Recorded

Q4. Where did the delivery take place?

(a) Government Hospital, (b) Private Hospital (c) PHC/HSC

(d) At Home (e) Not recorded

If delivered at Home, Q4a Who conducted the delivery?

(a) ANM (b) Trained Dai (c) Relations (4) Not Recorded

Q4b. Was the Disposable Delivery Kit used? Yes No Not Recorded

Q5. Did the ANM advise you about breast feeding? Yes No Not Recorded

Q6. When did you start breast feeding? _____ Days

Q7. At what age should the baby given supplementary feed? _____ Months

Q8. Do you know the danger signs of ARI? Yes No Not Recorded

Q9. Has ANM told you what to do when your child has diarrhoea?

(a) Continue Feeding (b) Give fluids (c) Specify _____

Q10. Was your baby weighed after birth? Yes No Not Recorded

Q11. Did you have any problems immediately after delivery?

(a) Fever (b) Bleeding (c) Foul smelling discharge (d) None

Q12. Did you get any treatment at that time?

(a) None (b) From ANM (c) From PHC (d) Private doctor

Q13 Do you want any more children? Yes No Not Recorded

If Yes, Q13a. When do you want to have the child ? After _____ Months

Q14. Has the ANM advised you about spacing methods?

(a) IUD (b) Oral Pills (c) Condom (d)Other. Specify _____

Q15. Are you currently using any method?

(a) No (b) Yes: _____ Method

If using, Q15a. Did you experience any problems with the method? Yes No Not Recorded

If Yes, Q15b. Were you able to get treatment for it? Yes No Not Recorded

If Yes, Q15c Where? (a) PHC doctor (b) Private doctor (c) Vaid (d) Home treatment

Q16. Have you used any method in the past and discontinued?

(a) No (b) Yes: IUD / Oral Pills / Condom / Other, Specify_____

Q17 Are you suffering from any of the following health problems?

(a) White discharge (b) Back ache (c) Abdominal pain

If Yes, Q17a. Have you sought treatment for it?

(a) No (b) Yes, From: ANM / PHC / Hospital / Private doctor

Please give your opinions about Government Health Center.

Q17.	Do you find the center well equipped?	Very well	Somewhat	Not well equipped
Q18.	Are the center's timinge convenient?	Yes	No	Not Recorded
Q19.	Is doctor available when you visit?	Always	Sometimes	Never
Q20.	Do you have to wait long for service?	Always	Sometimes	Never
Q21.	Is there privacy where you are examined?	Very much	Somewhat	Not much
Q22.	Are you examined properly?	Very well	Somewhat	Not well
Q23.	Is the staff friendly?	Very much	Somewhat	Not much
Q24.	Are medicines available at the center?	Always	Sometimes	Never
Q25.	Do they explain how to take medicine?	Always	Sometimes	Never
Q26.	Is the treatment effective?	Always	Sometimes	Never

MONTHLY REPORT FROM PHC TO DISTRICT

CAUTION: 1. PLEASE DELETE WHICHEVER ITEM IS NOT APPLICABLE
2. FILL IN BLOCK LETTERS
3. READ INSTRUCTION MANUAL BEFORE FILLING UP

1. GENERAL

1.1 STATE : _____
STATE CODE :

1.2 DISTRICT : _____
DISTRICT CODE :

1.3 PHC : _____
PHC CODE :

1.4 MONTH :

1.5 YEAR :

1.6 REPORTING DATE :

1.7 REPORTING MONTH OF PHC :

1.8 CUMULATIVE MONTHS (Month of the Year) :

2. FAMILY WELFARE

2.1 ELIGIBLE COUPLES CONTACTED :

2.2 OPERATIONS DONE

	VASECTOMY	TUBECTOMY	
		ABDOMINAL	LAPAROS
TOTAL			
PHC			

2.3 STERILISATION CASES FOLLOWED UP:

CONTACTED UP TO MONTH			COMPLICATIONS REPORTED	DEATHS
1	2	3		

2.4 IUD INSERTIONS :

TOTAL	PHC

2.5 IUD CASES FOLLOWED UP:

CONTACTED UP TO MONTH			COMPLICATIONS REPORTED	DISCONTINUED IUD	
1	2	3		REMOVED	EXPELLED

2.6 ORAL PILL USERS:

TOTAL				DISTRIBUTED BY PHC
WOMEN CARRIED AT BEGINNING OF THE MONTH	INITIATED DURING THE MONTH	WOMAN REPORTED COMPLICATIONS	DISCONTINUED DURING THE MONTH	

2.7 NIRODH PACKS DISTRIBUTED :

2.8 MTP DONE :

	MTP	FOLLOWED UP AFTER MTP	COMPLICATIONS REPORTED	ACCEPTORS OF FP METHODS		
				STERILISATION	IUD	OTHERS
TOTAL						
PHC						

2.9

COUPLES USING TRADITIONAL/ INDIGENOUS METHODS	COUPLES USING NATURAL METHOD

3. MOTHER CARE

3.1 ANTE-NATAL CARE

3.1.1 ANTE-NATAL CASES REGISTERED :

3.1.2 CASES HAD THREE CONTACTS :

3.2 NATAL CARE

3.2.1 DOMICILIARY DELIVERIES CONDUCTED BY :

MPW(F) ANM	TRAINED DAIS	UNTRAINED DAIS	OTHERS

3.2.2 DELIVERIES IN PHC :

3.2.3 HIGH RISK CASES REFERRED :

3.2.4 PREGNANCY OUTCOME

	MALE	FEMALE
1. LIVE BIRTHS		
a. UNDER WEIGHT		
b. 2500 GMS. ABOVE		
c. WEIGHT NOT KNOWN		
2. STILL BIRTH		
3. ABORTION		

NB. : ALL FIGURES ARE IN NUMBERS AND PERFORMED / ACHIEVED DURING THE REPORTING MONTH UNLESS OTHERWISE SPECIFIED

4. IMMUNIZATION

		BCG	POLIO				DPT				MEASLES	FULL IMMUNI-ZATION
			1	2	3	B	1	2	3	B		
4.1 LESS THAN 1 YEAR	TOTAL											
	PHC											
4.2 OTHERS	TOTAL											
	PHC											

4.3

	DT 2/3	TT 5 YRS	TT 10 YRS	TT 16 YRS	TT OTHER	
					1	2/3
TOTAL						
PHC						

5. ANAEMIA & VIT'A'

5.1 IFA TAB GIVEN TO	INITIATED	CONTINUING	COMPLETED
a) PREGNANT WOMEN			
b) NURSING WOMEN & IUD ACCEPTORS			
c) CHILDREN 1 TO < 5 YEARS			

5.2 VIT 'A' SOLUTION GIVEN TO CHILDREN 1 TO < 5 YEARS

6. DIARRHOEAL DISEASES

6.1

	UNDER 5 YRS	5YRS & ABOVE
ACUTE CASES RECORDED		
CASES TREATED WITH ORS		
DEATHS OCCURED		

6.2 VOLUNTARY ORS DEPOTS FUNCTIONING : [ ]

7. DEATHS

7.1 CHILD DEATHS	MALE	FEMALE
7.1.1 0 TO 6 DAYS		
7.1.2 7 TO 27 DAYS		
7.1.3 28 DAYS TO < 1 YEAR		
7.1.4 1 YEAR TO < 5 YEARS		
7.2 MATERNAL DEATHS		
7.2.1 BEFORE DELIVERY		
7.2.2 DURING DELIVERY		
7.2.3 WITHIN 6 WEEKS OF DELIVERY		

8. FACILITIES

8.1 TRANSPORT

a) VEHICLE :
i) TOTAL : [ ] ii) ON ROAD : [ ]

b) KMS COVERED :
i) PETROL DRIVEN : [ ] ii) DIESEL DRIVEN : [ ]

c) FUEL CONSUMED (in litres) :
i) PETROL : [ ] ii) DIESEL : [ ]

8.2 X RAY MACHINE : i) TOTAL : [ ] ii) WORKING : [ ]

9. VACANCY POSITION

CATEGORY	SANCTIONED	VACANT
MO (Incl. Specialist)		
DENTAL SURGEON		
STAFF NURSES		
PHARMACIST/COMPOUNDER		
LAB TECH./LAB ASSTT.		
RADIOGRAPHER		
COMPUTOR		
DRIVER		
PARA MEDICAL SUPERVISORS (MALARIA INSP., F.C.E./FILARIA)		

	MALE	FEMALE	MALE	FEMALE
MULTIPURPOSE WORKER				

9.3 Status of Cold Chain Equipments.

Equipment	Total supplied	Total not working	Number not working for more than a month	Number beyond rpr
ILR-300				
D.F.I.300				
ILR-140				
D.F.I. 140				

(excluding those beyond repairs.)

Details of beyond repairs equipments.
(Please attach a separate sheet, if necessary)

Location	Machine Number	Date of Installation	Out of order (Date)

NB :- ALL FIGURES ARE IN NUMBERS AND PERFORMED / ACHIEVED DURING THE REPORTING MONTH UNLESS OTHERWISE SPECIFIED

10. INVENTORY OF DRUGS, VACCINES AND OTHER CONSUMABLES

SL.NO.	ITEM	UNIT	CONSUMPTION	BALANCE STOCK	STOCK SUFFICIENT FOR MONTHS
10.1	ORS PACKETS	NO.			
10.2	FAMILY WELFARE				
10.2.1	NIRODH	NO.			
10.2.2	ORAL PILLS	NO.			
10.2.3	IUD	NO.			
10.3	IRON & VIT'A' SOLUTION				
10.3.1	IFA(LARGE TABLETS)	NO.			
10.3.2	IFA(SMALL TAB)	NO.			
10.3.3	LIQUID IRON (100 ml Bottle)	BOTTLE			
10.3.4	VIT'A' SOLUTION (100 ml Bottle)	BOTTLE			
10.4	IMMUNISATION				
10.4.1	DPT VACCINE	DOSES			
10.4.2	POLIO VACCINE	DOSES			
10.4.3	TT VACCINE	DOSES			
10.4.4	BCG VACCINE	DOSES			
10.4.5	MEASLES VACCINE	DOSES			
10.4.6	DT VACCINE	DOSES			

11. MORBIDITY & MORTALITY (CLINICAL DATA)

	DISEASES	PHC		PHC AREA**	
		CASES	DEATHS	CASES	DEATHS
11.1	ACUTE DIARRHOEAL DISEASES *				
11.2	DIPHTHERIA				
11.3	ACUTE POLIOMYELITIS				
11.4	NEO-NATAL TETANUS				
11.5	TETANUS (Other than 11.4)				
11.6	WHOOPING COUGH				
11.7	MEASLES				
11.8	ACUTE R.I. (Incl. Pneumonia & Bronchitis)				
11.9	TOTAL				

N.B. To be filled up by P.H.C. Doctor

* ALL CASES WITH THESE OR MORE LOOSE MOTIONS AND/OR IRRESPECTIVE OF AETIOLOGY / CAUSATION

** INCLUDING SUBCENTRE AREAS WITHIN PHC BOUNDARIES VERIFIED FROM RECORDS

12. GROUP EDUCATIONAL ACTIVITIES

	NO./SIZE
MEETINGS	
FILM SHOWS	
PUPPET SHOWS	
PUBLIC SEMINARS / SYMPOSIA	
OTHERS (SPECIFY)	

DATE :

SIGNATURE OF M.O. I/C

N.B. :- ALL FIGURES ARE TO BE MARKED AND PERFORATED / ACHIEVED DURING THE REPORTING MONTH UNLESS OTHERWISE SPECIFIED

INSTRUCTION MANUAL
FOR
MONTHLY REPORT FROM PRIMARY HEALTH CENTRE
TO
DISTRICT

ITEM No.:
(Correcsponding to actual proforma)

1. GENERAL

1.1 Write the name of the State in full and give State Code as obtained from district NIC unit.

1.2 Write the name of the District in full and give the district code as obtained from district NIC unit.

1.3 Write the name of the PHC in full and indicate PHC code as obtained from district NIC unit.

1.4 Indicate the month which is being reported on e.g. for January as 01, February as 02 and December as 12

1.5 Indicate the year of report e.g. 90 for 1990, 91 for 1991 etc.

1.6 Indicate the date on which the report is being sent.
First two boxes - for Date e.g. 05
Middle two boxes - for Month e.g. 08
Last two boxes - for Year e.g. 90

1.7 Indicate population during the year in number.

1.8 Indicate number of eligible couples as on First April at the beginning of the year.

2. FAMILY WELFARE

2.1 Total Eligible couples reported by all the subcentres including headquarters sub-centre during the month.

2.2 **'Total':** The reports from all the sub-centre areas including headquarters sub-centre area irrespective of place of operation will get reflected in this row.

'PHC' : The operations done in PHC headquarters only should get reflected in this row.

2.3 Number of cases followed up by all the sub-centres including PHC headquarters sub-centre.

2.4 **'Total':** The reports from all the subcentre areas including headquarters subcentre area irrespective of place of insertion should be shown.

'PHC': The IUD inserted in PHC headquarters including subcentre ANM will get reflected.

2.5 Number of IUD cases followed up by all the subcentres including PHC headquarters sub-centre.

2.6 **Column 1-4 :** Number of women using Oral Pills at the beginning of the month irrespective of source of pill in the total PHC area (including sub-centres). Rest of the columns also relate to same area namely, all sub-centre areas irrespective of source of pill.

Column 5 : Number of Oral Pill cycles distributed by PHC through outlets of subcentres and voluntary organisations.

2.7 Number of Nirodh Pieces distributed by PHC through PHC headquarters outlets, sub-centre outlets and voluntary organisation outlets etc.

2.8 **'TOTAL':** Number of MTP cases done in all the sub- centre areas including headquarters sub-centre area irrespective of the place of operation will get reflected in this row.

'PHC': Number of MTP cases done in PHC headquarters will get reflected in this row.

3. MOTHER CARE

3.1 ANTE NATAL CARE

3.1.1 Ante-natal cases registered by all the subcentres including PHC headquarters sub-centre.

3.1.2 Number of cases followed up by all the sub-centres including PHC headquarters sub-centre for minimum three consultations between the mother and health functionaries including ANM.

3.2 NATAL CARE

3.2.1 Domiciliary deliveries conducted by different categories of personnel in the sub-centre areas including headquarters sub-centre

3.2.2 Deliveries conducted in the PHC Hospital.

3.2.3 Number of high risk cases referred by the PHC to the Tehsil/Dist./any other hospital.

3.2.4 Details of pregnancy outcome in all the sub-centres areas including headquarters sub-centres.

4. IMMUNISATION

4.1 'TOTAL': The total immunisation done in the PHC area irrespective of source of immunisation will get reflected in this row.

'PHC': Immunisation given by the PHC headquarters and/or sub-centres will get reflected in this row.

4.2 As in 4.1

4.3 As in 4.1

5. ANAEMIA & VIT 'A'

The data will be derieved from sub-centre reports and PHC clinic report. Every mother and child gets initiated when they are put on the course. The new initiators will get reflected against the 'INITIATED' column. So long as they are continuing the course and collect the drug, they are reflected against 'CONTINUING' column. The number of beneficiaries who received the final dose in the month, will figure in the 'COMPLETED' column.

6. DIARRHOEAL DISEASES

6.1 The data will be derieved from sub-centre reports.

6.2 Self Explanatory

7. DEATHS

These deaths will have to be detected by sub-centre workers in the respective areas and details should be noted by them in the respective registers for the further administrative follow-up. However,here only the number of deaths(sex-wise) to be shown against respective items. Extra care should be taken to ensure that only correct figures be shown and no death is either missed or over-reported. Every death reported should have its details (Name,age etc.) in the sub-centre registers and PHC records.

8. FACILITIES

8.1 'TOTAL' : Show the total number of vehicles in the box. This is irrespective of whether the vehicle is in order or not. This will take into account only those vehicles which are working for the PHC. If the vehicle is sanctioned against the PHC but is working somewhere else the same should not be taken into account for this report.

'ON ROAD' : Show only the number of vehicles which is in working order. Vehicles sent for servicing, or minor repair should also be taken as in working order.

8.1 b) Show kilometers covered by petrol driven/ diesel driven vehicles during the month in the respective boxes.

8.1.c) Show quantity of petrol/diesel put in the tanks of the vehicles during the month in the respective boxes.

8.2 'TOTAL' : Show total number of XRAY Machine in the PHC as well as in all the sub-centres irrespective of whether they are working or not.

'WORKING' : Show only the number of working refrigerators.

8.3 As in 13.2.

9. VACANCY POSITION

'SANCTIONED' : Please show Number of total posts sanctioned for the PHC including subcentres.

'VACANT' : Indicate number of posts vacant in the PHC including subcentres. Even if a doctor has been posted against the PHC, but is working some where else, the post should be taken as vacant. Similarly

If some doctor stands posted against a post in some other place, but is working in your PHC, the post should be considered as filled in for the purpose of report. Short temporary duties should not be taken into account(not exceeding 15 days). The above classification applies for all the staff.

10. INVENTORY

'STOCK SUFFICIENT FOR MONTHS': Indicate the number of months for which the balance stock is likely to be sufficient without taking into consideration future supplies. Also take into consideration the averge consumption rate and the anticipated sease nal/gross fluctuation in the usage of the item.

11. MORBIDITY AND MORTALITY (CLINICAL DATA)

11.A Here indicate only the number of cases attended by the PHC and deaths in PHC Hospital. (and not at sub-centres)

11.B The cases and deaths in the PHC Area (including all Sub-Centre areas) which have been verified either by the PHC Medical Officers or by qualified Medical Practicioners and line listing provided to PHC authorities.

12. GROUP EDUCATIONAL ACTIVITIES

Indicate total number of meetings/film shows/puppet shows/public seminars/symposia etc. against individual items organised in the PHC area through PHC/sub-centre initiative.

~~WH-11~~
WH-11; 3.5

Draft for comments

Towards a Target-free Population Programme
Health Watch Consultation
25-26 March, Ahmedabad[1]

The backdrop:

A series of regional consultations were organized by NGOs in preparation to the International Conference on Population and Development, Cairo, September, 1994. Organizations working on health and population issues, rural development, environment etc. and groups working with women came together. This was the first time that such a diverse group focused on the population question. For over four decades there was little dialogue among groups who focused on family planning and those who worked on other social and economic issues. Family Planning was viewed with suspicion and many grassroots groups made it a point to distance themselves from the programme, while in their day to day work with poor women they made it a point to respond to the contraceptive needs of men and women. The regional consultations created an opportunity for the two constituencies to come together and reflect on the reasons. It emerged that the main irritant was the public face of a top down family planning programme which primarily focused on meeting method specific targets. The unfortunate situation in 1995-97 further alienated social action groups from the programme.

However, the pre-Cairo consultation created an opportunity for different constituencies to come together and arrive at a common understanding of the complex inter-linkages between population, poverty and development. These consultations also provided space for groups to speak out their problems and concerns. The meetings held in 1993 and 1994 generated a exhaustive list of problems faced on the ground and alternative approaches to reaching primary health care and family planning services. Simultaneously, the government was also taking stock of the family welfare programme. Government of India official paper to Cairo reflected a shift from a "population control" strategy. The importance of a holistic reproductive health approach was suggested. As a first step, the government was planning to remove method specific targets in select areas as a test case. Thus a paradigm shift from a family planning centered approach to a reproductive health approach emerged as the basis for future policies. Government's seriousness in reorienting the family planning programme towards a client centered approach, with an emphasis on quality of care was evident.

After the Cairo conference, Government of India declared one or two

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[1] This draft report has been compiled by Ms Prabeen Singh and Ms Vimala Ramachandran for Health Watch.

817-96

districts in each state as "target-free"districts. By January 1996, the government was planning to do away with method specific targets altogether. In March 1996 a special task-force was set up to develop alternative indicators. Simultaneously, GOI started planning new initiatives, namely: Reproductive and Child Health programme in select districts, revamped CSSM programme, district based micro-planning to generate a holistic health delivery model etcetera.

Health Watch, a network of voluntary organizations, researchers, development activists and experts was asked by GOI to coordinate a series of regional consultations with NGOs to generate discussion on GOI's new approach to health and family planning. This workshop is the first in a series.

Objectives of the consultation:

This round of NGO consultation is designed to take off where the earlier round left off. In 1993 and 1994 NGOs working in a wide range of issues came together for first time to articulate their own experience in the health and family welfare sector. The issues tabled in the first round was taken on board and it was felt that the second round should endeavour to take the debate to another level. After recapturing the main changes initiated by Government in 1995 and 1996, this consultation focused on a few key issues, namely:

a) Feedback on Government of India sub-committee report on removal of targets;

b) Inter-linkages between primary health care, safe motherhood, family planning and reproductive health: drawing upon NGO experiences;

c) Empowering women to access services and making service providers responsive to women's needs;

d) Involving men in primary health care, safe motherhood, reproductive health and family welfare: exploring new ground;

e) Exploring avenues of NGO - government partnership.

Is there a role for NGOs in the changing scenario?

Over the years it has become evident that the government perceives NGOs primarily as service providers and not as partners in policy making, strategizing and programme development. On the other hand many NGOs perceive themselves as catalysts in the development process, providing services being just a part of a much larger identity. While there may be instances of close collaboration between government agencies and voluntary groups, by and large the

relationship has been fraught with mutual suspicion. Over the last decade there have been efforts to allay suspicions and create opportunities for meaningful partnership.

The relationship between the two have been particularly stormy in health and family planning. NGOs are not an undifferentiated mass - while NGOs involved in family planning and population related activities worked in close collaboration with the government, women's organizations, NGOs involved in primary health care, human rights groups, rural development agencies and the like made it a point to publicly distance themselves from the family planning programme of the government. The main irritant was a target based approach which gave primary importance to the realization of method specific family planning targets. However, in the changed scenario, where targets themselves have been abolished, the distance between the two constituencies may be reduced.

Given new opportunities, it would be possible to delineate specific areas of collaboration or partnership, namely:

** Drawing upon micro level experiences in the non-government sector with a view to adapt the generic lessons to national programmes. Essentially this involves systematic efforts to forge linkages between micro level experiences and macro policies and programmes of the government. Government's resolve to move towards a holistic reproductive health approach with an emphasis on quality of care has provided a golden opportunity to forge such linkages;

** Given "hands on" experience of voluntary organizations, the government could draw upon them to participate in planning, design and monitoring national programmes and adapting them to different regions. In this context the key issue is how NGOs can be strategically located in government programmes, keeping in mind the comparative advantage and specific expertise of voluntary groups.

** Recognizing that the entire weight of all service delivery programmes fall on the shoulders of the extension worker (ANMs for example). Ensuring a good working relationship between the community and service providers is a difficult task. NGOs could be involved in building such bridges and help develop support systems for field level functionaries.

Implications of going target-free:

Mr S Ramasundaram outlined the new initiatives taken by GOI and the implications of declaring the health and family welfare programme "target-free". It was acknowledged that the entire system cannot change overnight and that transition from a target oriented programme to one based on holistic health and quality of life indicators will be painful. Drawing upon the experience of Tamil

Nadu, he emphasizes the critical role of ANMs in reorientation of the family welfare programme. Though their capacities are vastly overstretched, ANMs are probably the only category of personnel who can still be counted on to deliver some services. There is a trend (in Tamil Nadu) towards reducing the numbers of male workers for various reasons (costs, unionization, indiscipline, less scope of work). Non-health departments which had ruthlessly pursued the objective of sterilization targets were no longer called upon to do so as a result of reforms in 1991-92, and it was noted that in spite of this, population growth rate did not accelerate. The reasons for this are attributed to the role of ANMs in advocating total health programmes for women and children rather than focusing on birth control alone.

The Government's 15 point programme of 1993 gave a further impetus to MCH and FW services relying on ANMs to deliver these services. At the same time, the Child Survival and Safe Motherhood (CSSM) programme was being introduced in batches in districts. The focus was on additional training of ANMs in order to enable them to deliver the full range of MCH and FW services. It was realized that ANMs have to be treated as key members of the health delivery team rather than as subordinate extension staff. ANMs came up with innovative ideas such as the suggestion to abolish the motivator certificate and motivator fee. In the absence of the motivator certificate, the ANM was given credit if the acceptor's address fell within the ANMs jurisdiction. This procedure also ensured that there was no competition among the ANMs themselves.

Year end statistics for 1994-95 revealed that for the first time in nearly thirty years, Tamil Nadu achieved the GOI target in all the four contraceptive methods. Nearly three crore rupees were saved in TA and motivator fees. Above all, the ANMs showed that they were the most important people in the implementation of the FW programme and not the staff of other departments, not even the male staff of the health department.

The discussion centered around how the basic approach and the mind-set can be changed. While there is a recognition of the need for change at the policy level, the mind-set across the country is still dominated by a population control strategy. Unless we bring about a change in the perspective of service providers down the line, health administrators and others involved with health and family welfare - new indicators and goals will have little meaning. A new list of monitoring indicators or the notion of self-determined "targets" will continue to be perceived as in the old way. There is also a danger of the programme becoming "responsibility-free". The importance of locating the new indicators in the context of the paradigm was emphasized. This session concluded with the question whether NGOs can play a strategic role in actualizing a paradigm shift.

Forging inter-linkages between primary health care, safe motherhood, family welfare and reproductive health:

This session focused on tracing the evolution of health programme of select organizations with a view to look at inter-sectoral linkages. CINI, a group working in West Bengal started working with children in 1974. Initially services were provided through out-patient clinics, gradually by 1980 they started 'under-five clinics' in urban slums and in rural areas. This led them to initiating training with a view to strengthen preventive and promotive health and some curative services through semi-literate health workers. Training of semi-literate workers involved them in literacy and income generation programmes, organizing meeting of Mahila Mandals and finally this led them to look at women's health, contraception and now reproductive health. Intensive training of village dias was a logical outcome. Now CINI is involved in integrated health services for women and children, literacy and income generation activities, awareness and confidence building of women and service providers. The Mahila Mandals are the nodal point where awareness, literacy, health services, contraception, and economic activities converge. In the initial phase almost all curative health service were provided by qualified doctors. Now almost all services are provided by community based health care workers who are supported by qualified doctors.

The experience of SEWA Rural, Jhagadia which had been managing a Primary Health Centre since 1989 brings out the difficulties in balancing good quality health care, ability to respond to needs of the community through innovations and the pressure to meet targets. They were able to strike a balance between seemingly irreconcilable objectives by adopting a spirit of comprehensive care, inter-linking various vertical programmes and focusing on quality of care. People's needs were taken as the point of departure and conscious effort made to keep curative services on the same level as preventive health care, including addressing water and sanitation issues. Health workers are involved in setting their own targets (including FP) followed by reflection on achievement, analysis of strengths and shortfalls - all within a quality framework. One of the innovative methods adopted by SEWA Rural is to functionally integrate the PHC and the ICDS programme - with one complimenting the other. For example, a common supervisor takes care of all health and ICDS programme in a geographically distinct, but smaller area. The aanganwadi worker, who is always present in the village, weighs the new born, promotes breast feeding and assists the family in proper care in the first few days. Male multipurpose workers also play a crucial role in MCH. Maintaining motivation levels and team spirit is the key for effective cooperation between workers of different programmes.

Sahayog a small group working in the hills of Uttar Pradesh shared their experience of working in a difficult terrain where the existing primary health care system of the government is

practically dysfunctional. The presentation focused on women's heavy workload, its impact on their health and general nutritional status of women and the need to ensure government primary health care system starts working. The basic issue in this region is the reluctance of doctors and other service providers to work in a difficult terrain, especially if they are not recruited from the hills.

The position, skills, motivation, empowerment and back-up system of the ANM emerged as key issues. Any effort to forge inter-linkages would have to start by enabling the service providers to coordinate with each other and acquire the necessary confidence to work in a more holistic manner. A four-fold approach adopted in Andhra Pradesh provided a good analytical framework to steer the discussion into empowerment of women., namely:

Step one Changing mind-set - prioritizing issues in population and development, sensitization of policy makers, administrators, service providers and technical professional.

Step two Strengthening knowledge and skills of service providers and technical support professionals, enhancing communication and organizational skills;

St three Creating mechanisms for mobilization of the community - harnessing support of the community, improving the credibility of government services and service providers and forging networks in the community;

Step four Departmental support and motivation - change in attitude of supervisors, guidance for workers at all levels, building accountability systems and transparent monitoring system with agreed set of indicators.

Empowering women to access services and making services responsive to women's needs:

The Tamil Nadu's experience reinforces the critical role of ANMs in a target-free programme and had brought the issue of empowerment of service providers (especially women) to the fore. While the empowerment of women in general is important, in this case the empowerment of ANMs emerged as a key variable in reorienting the family welfare programme in Tamil Nadu. Over the past two years in Tamil Nadu, ANMs have become more aware of their rights. They now fix their own targets for each of the MCH and FW activities. Their commitment to their work and the resultant successes are the outcome of a continuing dialogue between them and other functionaries. However, empowerment of ANMs alone is not enough, concrete steps need to be taken to empower women in general.

Several factors need to be considered in the issue of women's

empowerment starting with woman's recognition of her fertility status as a source of her own power, her freedom to choose her own sexual partner, control over her own body, access to information and resources, and participation in decision making. Empowerment of women does not imply the 'disempowerment' of men, it really is ability of and space for women to dialogue with men, the power to negotiate and articulate their demand.

SEWA, Ahmedabad and SARATHI, Panchmahals and Baroda shared their experience of working with women and empowering them to articulate their health problems and gain access to services. Dr Prakashamma's presentation in the earlier session gave a good analytical framework, i.e, looking at women in a holistic manner and not confining attention to a specific period in her life (girl child, adolescent, mother, middle-age and old). From the adolescent stage to menopause her requirement for reproductive health services, maternal and child health services and interventions to ensure motherhood is safe may be an intensive period. This should not get precedence over other aspects of a women's life.

SAARTHI - a voluntary organization working in Panchmahals District of Gujarat outlined their strategy and shared their experience. What does empowerment really mean in the area of women's health? In order to work in a gender sensitive manner the first step is to develop the confidence and self-esteem of ANMs - the key functionary in rural areas. Their ability to identify with women as women provided an excellent starting point. SAARTHI's has simultaneously focused attention on women as service providers and recipients. The common point being their identity as women. SAARTHI's approach is to "start with the self". They look at empowerment at four different levels, namely:

Intrapersonal empowerment	Building self-confidence, shedding of "sharam" or in other words a sense of shame associated with one's body, owning one's own body and ability to articulate ones needs;
Interpersonal empowerment	Increasing control within relationships. Women's control over their bodies critically hinge on their ability to negotiate within relationships.
Empowerment as a group	Appropriating and accessing health services that rightfully belong them as a group;
Empowering the community	Organizing, demanding and receiving health care, dealing with issues which are health related, e.g. violence.

Focus group discussions provide the basis for building rapport and also identifying needs. In many focus group discussions ANMs could

not answer several technical questions that were raised. They made a list of issues on which they wanted technical training. At first, SAARTHI thought of calling a clinician to provide training. However, on reconsideration, they adopted another approach. Each ANM was asked to pick one topic. She then went to libraries, to doctors and accessed other sources. They got together again and shared the knowledged with their colleagues. This process de-mystified the learning process and empowered them.

Drawing upon their field experience, empowerment for SEWA meant the process whereby each group articulates its needs and determines priorities. The first step towards empowerment is women coming together in groups at different. As members of a group women are able to exert pressure on the public health system. Women's empowerment therefore leads to enhanced ability to initiate action at individual and collective levels; and gaining greater control over decision making processes, over households and community resources. Women's groups have tremendous potential - they can monitor programmes, manage health-care and child-care cooperatives and set priorities for action.

In the discussions that followed focused on formation and sustainability of women's groups, building rapport between women's groups and service providers in a mutually strengthening relationship and bringing violence against women centre-stage in reproductive health programmes. National programme for reproductive health should draw upon the experience of NGOs - in particular their experience of empowering the ANMs and enhancing her skill and motivation. In this context, the importance of revamping the training programme for ANM was identified as an important area for action in the immediate future. This assumes a sense of urgency in the light of the Panchayati Raj Act and devolution of administrative powers to the Panchayats.

Convergence of different social sector (health, education etc) and economic programmes happens at the village level with women's groups functioning as the nodal point for articulating demand and accessing services. Experience of many micro-level programmes have demonstrated that when women do come together as a group, they do not confine their interest to any one area or issue. Groups that come together for credit and savings articulate health issues and vice-versa.

The main challenge is one of bringing women together as a group and sustaining that group identity over a period of time. Women may not always come together for health alone, however they may readily come together around another issue which may be perceived by them as being of prime importance. Some groups take little time to get off the ground while others take over a year or two. It is therefore important to recognize the existence of such differences and plan for it. The government could draw upon lessons from the NGO sector in organizing and sustaining women's groups.

Involvement of Men and Male Responsibility

CINI and URMUL trust shared their experience involving men in health programmes. As their efforts have been rather recent, they decided to conduct focus group discussions.

Some startling issues emerged in focus group discussions, namely:

-- Most men felt that women consulted other women on their health problems and there was no real need for men's involvement, except when a case involved hospitalization;

-- The local dai (midwife) was competent to handle most problems;

-- Pregnant women need care, good nutrition etc.;

-- Birth control devices should be adopted by women because the men have to do the hard work. Operations will weaken men. Women do not need much energy for household work;

-- Early marriage was necessary because it provided security for the girls, it reduced expenses for the parents and was socially acceptable;

-- Men had little role in participating in women's health problems but they were willing to be educated and to be trained so that they could educate other men.

-- Full consent of family for abortion. Most of them did not seem to be aware of complications following abortions;

-- Reluctance to talk about STDs and AIDS and reproductive health problems of men.

During discussions it emerged that most groups have not really worked with men on health issues - either in involving them in MCH or in addressing the latent fears about contraception, vigour and strength. This areas has been neglected and demand urgent attention. There is a need to discuss male vulnerability and their own fears, and for males to come to terms with their own sexuality right from childhood. It is important to find out how men think and feel about their own sexuality. Just as with women there should be "know your own body" sessions with men and adolescent boys.

In poor families men also get up early and perform the domestic chores - especially when men and women have to go for wage labour. The experience of SEWA was interesting. Men showed interest in reproductive health and were willing to undergo training. Fora for men to come together and discuss their problems was welcomed. In joint discussions with women, men get defensive about themselves. At meetings held by the Medico Friends Centre men have an opportunity to discuss themselves in a spontaneous manner.

Generally it is felt gender sensitization can become a mechanical exercise if men themselves are not given the space to freely present their own point of view.

Wrap-up:

One of the major aspects in NGO functioning is the flexibility they exhibit in working with people and their ability to respond to the needs as and when they emerge. This is absent in government programmes. While the need for government to work in departments is appreciated, there is still a lot of room effective inter-departmental coordination. This is possible at the field level where all programmes converge. A community fund at the disposal of the Mahila Mandal could enable the community to plan for and implement specific inputs - for example a fund to transport critically ill people to hospitals (especially women and children), to pay for a school-mother to escort girls to middle school outside the village, build water harvesting system or provide safe sanitation etc.

The specific problems of each area would require region specific strategies. For example health extension work in Uttarakhand would differ from the harsh terrain of Bundelkhand in Uttar Pradesh. National programmes should be designed for region specific adaptation.

Some concerns expressed by the group:

-- Are we overloading the health worker (ANM) without planning to strengthening and encouraging them, enhancing their self-confidence and their skills and above all empowering them in a system where they are the most disempowered functionary?

-- How do we ensure simplification of the multitude of forms that she has to fill out?

-- If the government agrees to work towards district plans for primary health care which includes reproductive health, maternal and child health, family planning and safe motherhood components - then NGOs can be involved at the planning stage and also participate in ongoing implementation, monitoring and training. Government could initiative this through district level committees where people from different walks of life could be involved - namely NGOs, medical practitioners, social workers etc.

-- The training curriculum of ANM and other health workers needs to be modified to integrate an empowerment approach.

Communicating the paradigm shift:

While alternative indicators are an essential prerequisite to operationalise a paradigm shift in Health, Population and Development it was felt that the new concept should be communicated directly to all levels of administration. Guidelines and reporting formats cannot capture the conceptual nuances and the rationale for a paradigm shift. If is therefore important to work towards a time-bound plan to disseminate knowledge and information about the paradigm shift.

A well-knot and coordinated team could work around a time bound plan. This team comprising of a few officials (including young IAS probationers), social workers involved in the sector (especially those who have been involved in the population debate over the last three years), social scientists, researchers, good communicators etc. could work together and develop a good workshop design. This group could break up into teams of five and fan out to all the states.

Similar teams could be set up at the state level who would prepare a plan for district and block level workshops. The national team could work in coordination with the state team after an intensive orientation workshop.

Health administrators, service providers, staff of training and technical institutions, staff of specialized research institutions etc would be oriented in three day workshops. The main purpose of this workshop would be cover a wide range os issues and enable health care providers, administrators and support institutions to internalize the paradigm shift. The issues covered in the workshops could include the following:

-- Develop an understanding of the complexities involved population and development, linkages between population, poverty and development and analysis of India family planning programme since the 1950s - its strengths and weaknesses;

-- Understand and appreciate the importance of the paradigm shift, its implication in day to day functioning of health and family welfare programmes,

-- Understand and appreciate the new set of indicators; clarify any doubts and modify indicators to suit regional requirements;

-- What is reproductive health, how is it different from MCH/FP and CSSM.

-- Balancing outreach and quality of care - need for a

caring health delivery system;

-- How do you form a women's groups or a men's support group? Improtance of a strong community group in a health care programme - even though the group may not be exclusively preoccupied with health and family planning;

-- How do you forge inter-linkages between different vertically implemented programmes;

-- How do you forge effective linkages between health care and other social sector programmes like water and sanitation;

The list of issues could be expanded and modified to suit each region.

Feedback on the GOI task force report on alternative indicators[2]:

We welcome the initiative MOHFW has taken to alter the prevailing system, of method specific targets for family planning. We have reviewed the report of the committee appointed to develop an alternative system of indicators (submitted to MOHFW on 18 March, 1996). Given below are some observations and comments for consideration:

I **Recommendations on emphasis on Reproductive Health in Appendix 1 and Table 2.**

1. This should be a combined activity report of the subcenter team of M & F workers, and not an individual worker's report.

2. The proposed alternative system carries heavy emphasis on MCH and Family Planning, reflecting few of the elements considered essential for operationalizing a comprehensive Reproductive Health approach. We would like to see included references to essential reproductive health services as follows:

   In Appendix 1 (ANM activity report), item 26 (number of cases)
   RCH INDICATORS - RTI's referred, STDs referred, STD/RTI numbers counselled for partner treatment and behaviour, infertility cases referred, abortion / MTP cases referred and followed up, septic abortions referred and followed up, Hysterotomies cases reported, long-term women's problems referred (prolapse, post-menopausal bleeding

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[2] See Annexure I for specific recommendations on indicators.

etc.)

Delete some items on MCH if there is a constraint of space for accommodating item on RH described above.

3. Suggestions for further simplification, modification and/or rationalization are in Annexure I.

II Recommendations on the supervisor's monitoring system (Appendix 2)

i) The supervisor may assess some aspects of technical quality in discussion with clients (for eg treatment of IUD complications etc.) Technical assessment therefore need not be limited to observation of worker-client interaction.

ii) The system should also reflect the RH approach. Part 2 of the checklist should not be limited to just "Eligible Couples" (married women between the age group 15-45), as other women have a variety of reproductive health needs, as do men. It is suggested that 7 women and 3 men be met, who represent persons with other RH problems also.

iii) In Part 3 of the Supervisory checklist, there is need to include an item to assess whether clients have been checked for anaemia. It is suggested that item 13 (advised for contraception) be deleted. The checklist needs to more accurately reflect the RH approach. Thus, items such as observing communication and counselling skills, group meeting facilitation skills, conscious efforts to include men, etc. need to be assessed.

III Recommendations on Family Reproductive Health Record (Appendix 3a)

In addition to RTIs and STDs include abortion, operations (hysterectomies & others), infertility etc. Disease surveillance should include problems which affect reproductive health - example: anaemia (it is important to monitor this among adolescent girls), TB, malaria, menstrual disorders, uterine problems and effect of violence on health.

There should be a note before the surveillance section which clearly states that men's and adolescents histories are very important and should be recorded consciously

IV Recommendations on Assessment of Quality and Client Satisfaction (Appendix 4b)

We find this survey to be quite cursory. We would suggest a more comprehensive survey to assess, namely:

i) client satisfaction and provider - client interaction (communication, counselling etc.)
ii) technical quality of services (to assess if medical standards are being adhered to)
iii) coverage of services

We believe that having a more comprehensive survey will reduce the burden of data to be collected through service statistics. The outline of such a survey needs to be developed in greater detail at this stage itself. Such a survey should be organized periodically at the district level.

V **Recommendations for Indicators for Evaluation of Sub Centres (Appendix 4)**

i) Add coverage and impact indicators such as anaemia in adolescent girls; safe MTPs rate, infertility prevalence rate. We particularly suggest inclusion of infertility as effective intervention in several areas (RTI, MTP etc) will show up in reduced levels of infertility.

We understand that formats are being developed for monitoring male MPWs, and that a checklist is being developed that can be used by lay persons, such as Panchayat members. We welcome these initiatives, particularly the latter. We hope there will be such a "non-medical" checklist for each tier of the health system.

We look forward to receiving the survey format once it has been developed in more detail, as well as the monitoring formats for PHC, CHC, District Hospitals, etc.

We hope we will have the opportunity to review the revised version of the proposed alternative system when it is available.

Annexure I

Suggestions for simplification, modification and/or rationalization on Reproductive Health in Appendix 1 and Table 2

i) Add to item 1 (ANC registration): 1b: "Number of unwed pregnancies registered" (Qual)

ii) Remove 5 (ANC completed 3 visits), 6 (ANC clinics conducted); modify 7 as "ANC examined 3 or more times" (qual) - more relevant

iii) The criteria for referral for item no. 8 (Appendix 3a, 2nd page, under head of "ANC Information") - need revision - essentially in context of Safe Motherhood approach, where every pregnant woman is at risk, and the most important referral criteria are complications as and when they occur.

iv) Modify items 9b thus: "Non-institutional Deliveries by untrained persons" (qual)

v) Modify item 12: "Birth weights recorded within 1 week" (wts recorded later than 1 week after birth should not be reported as birth wt.)

vi) Reduce Low Birth weight cut-off to 2 kg. (item 13, 2.0 kg instead of 2.5 kg)

vii) Specify criteria for HR newborn referral (item 14): (we suggest only important criteria for this purpose: gestational age less than 8 completed calendar months, or birth weight less than 2 kg, or failure in breast feeding (either failure in establishing breast feeding, or later reduction or cessation of breast feeding))

viii Add item: No. of PNC complications (a) referred (task) and (b) getting institutional care (qual)

ix) Add item: No. of live births in which breast feeding established within 3 days of birth (qual)

x) Modify items no. 8, 11, 14 and 19: the thrust should be on how many women actually got institutional care (a parameter that assesses whole system), instead of counting only "referrals". We suggest, for a start, we count both, referrals as well as those who got care (For example, 8a: Number of ANCs referred (task), 8b: Number of ANCs getting care at institutions (qual))

xi) Modify item 11 to 11a and 11b as above. Plus add 11c: "Number of pregnancies terminated by unauthorized personnel" (qual)

xii) Modify Item 18: specify "2 doses a year" for Vitamin A.

xiii) Add item:
- Number of newly married couples registered (task)
- Number of such couples contacted at least 3 times (qual)

(Identifying young couples, and sensitizing them to aspects of fertility, sexuality and related matters will be a critical investment for the success of all RCH programmes)

xiv) Add item :
- Number of couples with infertility referred (task)
- Number of infertile couples receiving institutional care (qual)

xv) Item 23 of Table 2 and 26 of Appendix 1: As regards RTIs and STDs referred, we suggest following modifications:

- No. of women with vaginal discharge treated

(Mostly "non-serious" conditions like trichomoniasis, candidiasis and bacterial vaginosis, which can be clinically managed by the ANM, within her current repertoire of drugs - metronidazole and genital violet, even without necessarily performing internal examination)

- No. of men with urethral discharge (and their wives, who are usually asymptomatic) referred.

(this will "catch" most cases of symptomatic "serious" STDs like gonorrhoea and chlamydia, which need "higher" antibiotics, and therefore to be seen by a doctor. However, with training, and provision of appropriate drugs to health workers, even this can be managed by them using the syndromic approach. Obviously, this is a good example of where to involve male health workers)

xvi) Add to item 23 of Table 2 and 27 of Appendix 1: (all these are good examples of where close coordination with male worker would be useful)

- Number of cases of severe anemia treated
  - Men
  - Women

- Number of blood smears taken for malaria
- Number of new TB detections
- Number of TB cases completing treatment
- Total number of patients (all conditions) treated
  - Men
  - Women
  - Under 5 children

xvii) Modify/add to item 24 (Vital Events recorded) thus :

- Pregnancy outcomes :
  - ♦ Live births (any gestation)
  - ♦ Still births (after 28 weeks gestation)
  - ♦ Abortions (before 28 weeks)
    - Spontaneous
    - MTPs
    - Induced

- Neonatal Deaths
- Total infant deaths (or post neonatal deaths)
- Total U5 deaths (or 1-5 year child deaths)
- Number of deaths of women of 15-45 years
- Number of maternal deaths

Remove from Appendix 1 items 22 (IUDs discontinued), 23 (regular OCP users) and 24 (condom pieces distributed): These are better monitored by an annual report from workers on contraceptive prevalence. This may be determined by an annual survey if need be. Monthly reporting is of not much use. Add along with above indicators, to be reported annually: "Proportion of sex workers in the area using barrier methods" (qual). This will be an important determinant of STD/AIDS control.

xviii) Add item to monitor number of women's group meetings held and items discussed.

Agenda Item No. I WH-11, 3-6

DEPARTMENT OF FAMILY WELFARE

Agenda Item No. 1

Target-Free Approach in Family Welfare Programme

1.0 During 1995-96, it was decided to experiment with replacement of contraceptive targets in the States of Kerala, Tamil Nadu, Union Territory of Chandigarh and 18 Districts in major States. List of Districts at Appendix-I. Although no target has been given for any of the contraceptive methods namely sterilisation, IUD, OP users and CC users but information of number of acceptors for each method is being collected from these States/Districts. Apart from these, information regarding quality improvement as a result of doing away with the targets is also being collected from the Districts involved in target free approach. Following is the information being collected from these districts:

i. Of the total acceptors of sterilisation, nuber with 2 or less than 2 children, number with 3 children and with more than three children.

ii. Of the total acceptors of spacing methods, number of couples with wife's age less than 30.

iii. Total number of immunisation sessions planned and number of sessions actually held.

iv. Proportion of institutional deliveries and deliveries by trained personnel in relation to the total estimated number of deliveries.

v. Number of health institutions providing MTP services and the number of women treated for complications following unsafe abortions. Number of health institutions providing emer-gency obstetric care.

vi Number of polio and neonatal tetanus cases reported.

vii. Number of planned IEC sessions on diarrhoeal diseases and ARI and actually held. Number of pneumonia cases in children under 5 years of age identified and treated. (Expected number of cases of pheumonia can be taken to be 10 to 20 times the estimated number of deaths which is roughly 25% of the total deaths in children under 5 years of age).

An analysis of the feed-back received on the target free States and Districts has been compiled which can be seen at Appendix II.

2.0 On the 26th and 27th October, 1995 a two days conference of CMOs/DHOs of target free districts was organised at New Delhi to review the qualitative and quantitative achievements of Family Welfare Programme in target-free districts. Following recommendations were made by the participants in the conference to evolve new strategies for improving the quality of service under Family Welfare Programme.

(i) Supervision of Health workers on the basis of job functions , rather than number of sterilisations, etc.

(ii) Focus of the service on client need and client satisfaction.

(iii) Ensuring availability of medical and paramedical personnel at the service facility at the date and time announced in advance.

(iv) Effective supervision of the health workers functions through sample checking of beneficiaries.

(v) Visits to sub-centres and villages by Medical Officers as per pre-announced time schedule.

(vi) Non-deployment of health workers for other activities like election work.

(vii) Development of coordination with field functionariesof other programmes like Agriculture Extension workers, Anganwadi Workers.

(viii) Close inter-action with the people of the area to understand their needs, and convenient timings for visits/providing services.

(ix) Adoption of flexible timings to suit existing transport facilities from villages to the PHCs.

(x) Improving cleanliness in the service facility.

(xi) Ensuring availability of the essential medicines and contraceptives.

(xii) Development of quality indicators for monitoring the programme at State Capital levels.

(xiii) Concurrent evaluation to assess client perception and client satisfaction.

It has been decided to extend the Target Free Approach throughout the country in the year 1996-97 through a system of decentralised planning. The copies of three D.O. letter written by Secretary (FW), Government of India to the States outlining the new approach is enclosed herewith.

(1) copy of letter dated 9-2-96.

(2) copy of letter dated 27-3-96.

(3) copy of letter dated 3-4-96.

D.O. No. M.11015/15/94-E&I.

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
परिवार कल्याण विभाग
निर्माण भवन, नई दिल्ली-110011

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DEPARTMENT OF FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI-110011

J. C. PANT I.A.S.
Secretary
Phone : 301 84 32
Fax No. : 301 88 87

February 09, 1996.

Dear

Sub:- Target Free Approach in Family Welfare Programme.

Please refer to the discussions in the meeting of State Secretaries on 1-2 February, 1996 on the issue of extending the Target Free Approach all over the country in 1996-97. This could be converted to an excellent opportunity to make family welfare in India a truly peoples' programme.

2. As discussed in the Conference, grass-root workers may get together to give an estimate of likely acceptance of various family welfare activities in 1996-97 for every quarter in their area of jurisdiction to form part of their PHC level Family Welfare and Health Care (FWHC) Plan for 1996-97. The PHC family welfare and health care (FWHC) plan should also contain the materials and supplies required to accomplish the activities estimated by grass-root level workers as well as the non-governmental agencies, village pradhans, primary school teachers in the area and population covered by that PHC. A draft format for the PHC plan as is being used in Tamil Nadu was circulated in the meeting as part of the Agenda Notes (copy enclosed). You may like to initiate this exercise of involving the total health personnel, village pradhans, primary school teachers and NGOs working in each Primary Health Centre in your State on the basis of this format or with such modification in it as you deem necessary. A detailed format for preparing PHC FWHC plan is under preparation at our level and could be made available before the end of March, 1996. However, the preparation of your family welfare and health care (FWHC) plan need not wait for this detailed format. The performance of each PHC would need to be evaluated against their own plan by the district health and family welfare system at the end of every quarter to advise them suitably. There would also be need to tune the IEC activities in the PHC areas and the districts to promote this bottom up approach of planning and implementation of a sensitive programme like family welfare.

Women should be stressed

3. All the PHC family welfare plans would need to be aggregated into the District Family Welfare Plans and the district family welfare plans would similarly need to be aggregated into the State Family Welfare Plan. A time-table for preparation of the plans at various levels may be set. I would suggest that the PHC plans may be finalised by 30th April, 1996, the district level plans by 15th May, 1996 and State level plans by 31st May, 1996. We would like to have your state level family welfare plan by the first week of June, 1996.

This is a typical top down imposed schedule - it will take more than a month to reorient people to the new task.... 2/-
An order from the top with a monthly time schedule is the antithesis of the process being initiated
Target Free approach from Target oriented approach needs extensive reorientation of the system - otherwise it is populism at best

4. A system of evaluating the performance of each district every quarter may be worked out at the state level. A similar exercise to evaluate the performance of each state would be carried out at the national level. This exercise would need sensitisation of the entire health and family welfare organisation in the state with the Deputy Commissioners/District Magistrates playing a leading role to activise the district health and family welfare system in active collaboration with panchayati raj dignitaries, primary school teachers and active non-governmental agencies.

Have the District magistrates / Deputy Commissioners / Panchayat Raj dignitaries / School teachers / NGO's been sensitised? If so how?

Yours sincerely,

(J.C. PANT)

D.O. No. M.11015/15/94-E&I.

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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
DEPARTMENT OF FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI-110011

सत्यमेव जयते

J. C. PANT I.A.S.
Secretary
Phone : 301 84 32
Fax No. : 301 88 87

March 27, 1996.

Dear

Sub:- Target Free Approach in Family Welfare Programme with effect from 1st April, 1996.

In continuation of my earlier letter of even number dated 9th February, 1996, I sincerely hope that you must have taken all necessary steps and done the preparatory work for implementation of the Family Welfare Programme in your state with effect from 1st April, 1996 on a Target Free basis.

2. A two-day workshop was held in New Delhi on the subject of Development of Quality Indicators to monitor Family Welfare Programme under Target Free Approach. Lot of action points had emerged after the two day deliberations. I am enclosing a copy of the Guidelines based on the Action Points which emerged along with a copy of the Format for preparation of PHC level Family Welfare and Health Care Plan for further necessary action at your end. Detailed guidelines relating to quality indicators, format for periodical reports and monitoring system are being prepared and would be sent to you shortly.

Yours sincerely,

(J.C. PANT)

Guidelines for Preparation of the plan

Objective

The objective of the plan may be stated in terms of improvement in the coverage and acceptance of various health & family welfare services provided through the Primary Health Centre and the Sub-Centres under the PHC.

Strategies

The strategies to be adopted may be expressed in terms of :-

i. improving availability of the medical and para-medical personnel at the PHC/Sub-Centre at the timings indicated in advance.

ii. maintaining the premises clean and hygienic.

Most crucial part

iii. organising meetings with Panchayat members, Primary School teachers, women's groups, youth clubs, anganwadi workers, ex-servicemen etc. to prepare the plan and to spread health and family planning messages.

iv. stocking adequate quantity of medicines and supplies in advance.

v. raising local resources to supplement the support given by the Government to augment the supply of medicines, etc.

vi. organising Swasthya Melas with the help of community support.

vii. utilisation of local NGOs and private practitioners including ISM&H in preventive and promotive health education and distribution of oral pills and condoms.

etc.

Organisation of Services

The expected need for various services should be first assessed in the beginning of the year and indicated in the format. The places where these services will be made available should also be indicated in the plan - along with the days on which such services will be available, for instance in the case of sterilsation, days on which sterilisation will be done in the PHC may be indicated. Similarly, days of immunisation sessions in various sub-centres/villages may be indicated in the Plan, keeping in view the PPI posts also.

The timings of OPD, special sessions for counselling for family planning, timings for follow-up of contraceptive acceptors etc. may also be clearly indicated in the Plan.

Local-specific IEC activities should be a vital component of PHC Plan. The type of IEC activities to be organised may be finalised in consultation with the community leaders and all the activities proposed for the year should be included in the Plan.

Review of implementation of Plan

The system of reviewing implementation may be specified in the Plan. Such review could be done through monthly meetings of the staff, as well as with members of the village panchayats of the PHC area etc. every quarter.

A format for listing the activities to be planned is attached.

While the whole shift of planning emphasis is from top down to bottoms up - there is some problems in the expectations of the system in terms of the time required for 'process building', 'relearning of old ways of doing things', changing attitudes.
Flexibility / Diversity of Strategies / approaches / Framework is a pre-requisite for the bottoms up process. Dose of MIS pushed from the top - too early and too unrealistically will reaffirm coercion, cynicism and corruption. Democratization is a difficult process and rewriting history is a gradual process. Planners must first be oriented to this 'shift' Remember It's a very good move but needs cautious / careful and realistic implementation

PHC FAMILY WELFARE & HEALTH CARE PLAN

1. GENERAL

1.1 State _____ 1.4 Year _____

1.2 District _____ 1.5 Population of PHC _____

1.3 PHC _____ 1.6 Eligible couples on 1st April _____

2. PERFORMANCE & EXPECTED DEMAND

	SERVICE	PERFORMANCE LEVEL IN LAST YEAR 1.4.95-31.3.96	EXPECTED NEED IN NEXT YEAR AS COMPILED FROM SUB-CENTRE ACTION PLAN
	(1)	(2)	(3)
2.1	FAMILY WELFARE		
2.1.1	Male Sterilisation		
2.1.2	Female Sterilisation		
2.1.3	IUD Insertion		
2.1.4	Oral Pill Users		
2.1.5	Nirodh Users		
2.1.6	Follow-up Sessions		

	(1)	(2)	(3)
2.2	MOTHER CARE		
2.2.1	Ante-Natal Care		
2.2.1.1	ANC cases registered		
2.2.1.2	ANC cases with three contacts		
2.2.1.3	Detection & treatment of anaemic mothers		
2.2.1.4	TT to AN mothers (Total)		
2.2.1.4.1	TT(1)		
2.2.1.4.2	TT(2) / Booster		
2.2.1.5	Detection & referral of high risk mothers		
2.2.2	Natal Care		
2.2.2.1	Deliveries in PHC & Sub-centres		
2.2.2.2	Domiciliary deliveries conducted		
2.2.2.2.1	by LHV/ANM		
2.2.2.2.2	by Trained dai		
2.2.2.2.3	by Untrained dai		
2.2.2.2.4	by others		
2.2.2.3	High risk cases referred		
2.2.3	Post-Natal Care		
2.2.3.1	Birth weight recording of new born live birth		
2.2.3.2	Detection and referral of high risk new born		

	(1)	(2)	(3)
2.3	IMMUNISATION		
2.3.1	B.C.G.		
2.3.2	O.P.V.		
2.3.2.1	OPV routine		
2.3.2.2	OPV for PPI		
2.3.3	D.P.T. (1,2,3)		
2.3.4	Measles (after 9 months)		
2.3.5	DPT (18 months)		
2.3.6	OPV (18 months)		
2.3.7	D.T .(5 years)		
2.3.8	T.T. (10 years)		
2.3.9	TT (16 years)		
2.4	ANAEMIA & VIT.'A'		
2.4.1	Anaemia treatment given to :-		
2.4.1.1	Pregnant women		
2.4.1.2	Nursing mothers & IUD acceptors		
2.4.1.2	Children below 3 years of age		
2.4.2	Vitamin A solution given to children 9 months to 3 years age		

2.5	DIARRHOEAL DISEASES		
2.5.1	Acute cases recorded		
2.5.2	Cases treated with ORS		
2.6	RESPIRATORY INFECTIONS		
2.6.1	Pneumonia cases recorded		
2.6.2	Cases treated with Cotrimoxzole		
2.6.3	Pneumonia cases referred		

3. MATERIALS AND SUPPLIES :-

	Items	Stock Position on Ist April	Additional quantity required in				
			Ist Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
3.1	Contraceptives						
3.1.1	Nirodh (pieces)						
3.1.2	Oral Pill (cycles)						
3.1.3	IUD's						
3.1.4	Tubal Rings						
3.2	Dai Kits						
3.3	Vaccines (doses)						
3.3.1	DPT						
3.3.2	OPV						
3.3.3	TT						
3.3.4	BCG						
3.3.5	Measles						
3.3.6	DT						
3.4	Prophylactics						
3.4.1.	IFA Tablets (large)						
3.4.2	IFA Tablets (small)						
3.4.3	Vit. 'A' Sol. (160 ml)						
3.5	ORS Packets						
3.6	Cotrimoxzole						
3.6.1	Tablets (paediatric)						

4.0 EQUIPMENT & FACILITIES

		TOTAL AVAILABLE	IN WORKING ORDER	ADDITIONAL REQUIREMENT
4.1	Vehicle			
4.2	Refrigerator			
4.2.1	I.L.R			
4.2.2	Cold Box			
4.2.3	Deep Freezer			
4.2.4	Vaccine Carrier			
4.3	Xray Machine			
4.4	IUD Kits			
4.5	Examination Table			
4.6	Weighing Machine			
4.6.1	Adult			
4.6.2	Infant			
4.7	BP Instrument			
4.8	Needles			
4.9	Syringes			
4.10	Autoclave			
4.11	Steam Steriliser Drums			
4.12	O.T. Table			
4.13	MTP Suction Apparatus			
4.14	Equipment for Infant Resuscitation			

5.0	**Information, Education and Communication**	
5.1	Action taken to mobilise (a) The medical fraternity Allopathic, Ayurvedic, Unani & Homeopaths (b) The para medicals including Dais (c) Primary School Teachers (d) Panchayat Members (e) Ex-servicemen (army & civil) (f) N.G.O. activities (g) Anganwari worker	
5.2	Counselling facilities at PHC & Subcentre	
5.3	Action taken to mobilise (a) Village folk dances & singers (b) Street plays (c) Puppettiers (d) Video films (e) Radio (f) Film shows	
5.4	Urging Panchayat Members to prepare village level family welfare & health care plans	

6.0 VACANCY POSITION

	Category	Sanctioned		Vacant	
5.1	MO (Including Specialist)				
5.2	Dental Surgeon				
5.3	Staff Nurses				
5.4	Pharmacist/Compounder				
5.5	Lab. Technician/Lab. Asstt.				
5.6	Radiographer				
5.7	Computer				
5.8	Driver				
5.9	Para-medical supervisosrs (Malaria Inspector, BEE,PHN,LHV)				
5.10	Multi-purpose worker	Male	Female	Male	Female

SUB-CENTRE ACTION PLAN

A. GENERAL

PHC _____ Sub-centre _____

Population of Sub-centre _____ Name of ANM/_____
(rounded to nearest thousand) Female Health Worker

B. SERVICES

Sl. No.	Services	Method of assessing demand of the area of sub-centre		Felt need of the population of the sub-centre	
		Coverage norm 1996-97	Methodology (Example of a state with birth rate of 20 & 5000 population per sub-centre)	Annual	Month
(1)	(2)	(3)	(4)	(5)	(6)
1.	A.N. Registration MCH, Nutritional Counselling, & Prophylaxis for Nutritional Anaemia	100%	Population X BR = 5000 X 20/1000 = 100 Add 10% pregnancy wastage = 10 110		
2.	Early A.N. Registration (i.e. within 16 weeks)	60% of the AN Mother	110 X 60/100 = 66		
3.	Detection and referral of high risk pregnancies (15% of AN Mothers will be high risk Mothers)	100% of the High Risk Mothers	110 X 15/100 = 16.7 = 17		
4.	Detection and Treatment of Anaemic Mothers	50% of the AN Mothers	110 X 50/100 = 55		
5.	T.T. AN Mothers	100% of AN Registered	110		
6.	3 visits completed AN Mothers	Minimum 3 visits to be given.	CSSM Schedule of AN visits to be followed 110 mothers to be completed with minimum of 3 visits		
7.	Institutional Delivery (GH + PHC + HSC + PNH)	25% of the expected delivery	100 X 25/100 = 25		
8.	Skilled attention at delivery (Institution + Health Worker + Trained Dai)	95% of the expected delivery	100 X 95/100 = 95		
9.	Growth Monitoring of the New Born Live Births	95% of birth weight recording	100 X 95/100 = 95		

10.	Detection and referral of high risk new born	10% of the live births	10		
11.	Infant Immunisation (BCG, DPT, OPV, Measles) (DPT/OPV Boosters) (DT at 5 years)	100% of the infants	100		
12.	Vit. 'A' Solution for the children upto 5 years to be given in campaign twice a year	100% of the children upto 3 years	$20 \times \frac{5000}{1000} \times 3 = 300$		
13.	Diarrhoea cases treated with ORS each child in 0-5 years age group is likely to get 2 episodes of diarrhoea in a year	100% of Episodes	$20 \times \frac{5000}{1000} \times 5 \times 2 = 1000$		
14.	ARI/Pneumonia cases (upto 5 years)	100%	Each child in 0-5 years is likely to get 2 episodes of ARI in a year. 10% of ARI cases are likely to be pneumonia cases		
15.	F.P. Acceptance	Acceptance of contraception by all eligible couples in the area	(a) number of couples with 3 or more children (i) number already accepted a permanent method (ii) number expected to accept a permanent method during the year (b) number of couples with 2 children (i) number already accepted a permanent method (ii) number expected to accept a permanent method (iii) number expected to continue with/ accept a spacing method IUD OP Condom (c) number of couples with less than 2 children (i) number expected to continue with/ accept a spacing method IUD OP Condom		

C. EQUIPMENTS

1.	IUD Kit	Available / Not Available
2.	Examination Table	Available / Not Available
3.	Weighing Machine	Available / Not Available
4.	BP Instrument	Available / Not Available
5.	Delivery Kits	Available / Not Available
6.	Steam Sterilisers	Available / Not Available
7.	Syringes & Needles	Available / Not Available
8.	Immunisation Cards	Available / Not Available

D. FACILITIES & HELP AVAILABLE TO SUB-CENTRE

1. Number of Trained Dais available _____
2. Number of Anganwadis working _____
3. Number of Voluntary ORS Depot functioning _____
4. Number of Private Medical Practitioners (MCH, ISM & H) _____
5. Number of Primary School Teacher Male_____Female_____
6. Number of Panchayat Members Male_____Female_____

~~WH-1317~~
WH-1137

Workshop on Population Issues and Women's Health : A New Approach
IIHFW, Hyderabad

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INVOLVEMENT OF NGOs AND PEOPLE'S ORGANISATION (COMMUNITY) IN HEALTH PROGRAMMES IN RURAL AREAS

- GVVSDS PRASAD *

Health is an important requirement of people and the country is aiming at achieving health for all by 2000 AD. The task of providing health cover to people particularly in the rural areas was taken up by the government while the urban dwellers had other options. Health services are provided through Primary Health Centres (PHCs), sub-centres, Anganwadi centres etc. The delivery of these services is fraught with several problems including non-availability of medicines, doctors & other para medical personnel, amenities, equipment and even quality of services rendered. One of the main reasons for this is the whole set up is not accountable at least directly to people with consequent apathy and non involvement. This is more or less the same story with many programmes.

The need for making people responsible for these services and the personnel accountable to people was well recognised. Effective involvement of people in the programmes through awareness can increase the efficacy of the programmes and their usefulness. This link between people and the government personnel with direct accountability is missing.

Andhra Pradesh has a rich tradition of voluntary work and a number of voluntary organisations (Non-government organisations or NGOs) are working in the State. They are primarily engaged in organising people - forming them into Mahila Mandals, Sanghams, Youth Clubs etc. These formations bring into development work organised communities which take up a number of activities like thrift & credit, income generation programmes etc. This is also an effort to rebuild the village community which is destroyed systematically in the development process to become crowds. Any development activity presupposes an organised community that can dynamically respond and absorb a programme. In the absence of an organised community as a partner in development programmes the success would be minimal.

The experience of the NGOs and the peoples' organisations that are created including DWCRA groups, CBCS groups can be made use of for providing a more qualitative, reliable and people oriented health programme particularly in the rural areas. The organised community backed by an NGO will then take the responsibility for the health services in a geographical area with the support of

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the government. This transfer of responsibility and resources to the community/NGO will enable the community to do the following:

1. Health policy for the geographic area say, a Mandal keeping in mind the government policy for the State and the Country.

2. Health Education for the community - health as a way of life - creating health awareness. Personal Hygiene, sanitation, nutrition, health problems due to superstitions, water borne diseases, preparation of drinking water, first aid, health competitions etc. Simple remedies for common ailments - use of medicinal plants, herbs etc.

3. Immunisation to protect children from the dreaded diseases and to reduce child mortality rate.

4. Family planning and promotion of small family norm. Organising facilities for permanent and temporary methods of birth control.

5. Health training - to Dayees, members of Mahila mandals, youth clubs and other leaders to create a cadre of community health workers in the area.

6. Health delivery - organising health facilities for treatment with a base hospital and mobile service units.

7. Health camps with expert doctors at regular intervals to meet the special health needs of the area.

8. Referral service with hospitals in Hyderabad for major problems.

9. Documentation of the work and experience to develop health priorities for the area and suitably modify the health services.

10. Suggestions to the government for any policy support, programme support etc. based on the experience gained by the community. policy changes needed.

The task is comprehensive and an enabling atmosphere is required to make community health a reality. Policy support from the government is necessary with a working model/arrangement for this purpose. An outline for this purpose is given below:

1. A geographic area, say a Mandal is entrusted to the community for health cover.

2. This community should have been functioning for two or three years as a cohesive group with activities like thrift, credit, income generation and community oriented programmes. The group should have been involved in activities on health, education, social issues, etc. They must be having necessary systems, records and should

be functioning as an institution with democratic process. In essence, the community should be able to own the programme - conceptualise, plan and implement the programme with the support from the government and other sources. Proven record of such initiatives indicates the strength of the community.

3. This community should preferably be backed by an NGO of considerable standing and reputation who is willing to support the community in shouldering the responsibility of health care.

4. The legal holder for this programme can be the community/NGO.

5. All the resources, manpower, infrastructure will be placed at the disposal of the community for managing the programme.

6. In case of staff, the existing persons either can continue in the area under the administrative control of the community or new staff can be appointed by the community for this purpose from out of the funds made available by the government.

7. The community/NGO should make all endeavours for mobilising additional resources to strengthen the health services and their quality.

8. This should be a long-term commitment from all parties concerned though a pilot phase can also be contemplated for better understanding of the problems that might be encountered.

9. The expected outcome should be defined in the beginning in terms of FP adoption, immunisation status, number of patients treated, number of safe deliveries in the area etc. The services should be an improvement over the earlier pattern.

10. A memorandum of understanding (MOU) is desirable between the community and the government which spells out the details of the arrangement and clarity of roles. A model MOU is provided below:

11. The present staff - medical and para medical should be taken into confidence, discuss the programme with the respective associations if necessary before a final decision is taken. This approach calls for a new orientation to those who work in this experiment as they will be accountable to the community in which they work. This was not the case before.

12. It is desirable that in a given area the total staff is recruited by the community/NGO for this purpose, orient and train them suitably and conduct the programme. This will give an opportunity to the community/NGO to mould the personnel in the programme as per the requirements.

13. Financial autonomy and flow should be ensured with sufficient provisions with a flexible approach. The funds should be made available in advance to enable the programme to be conducted smoothly. Financial problems not only disrupt the programme but will cause a lasting damage to the community and the NGO which affects their reputation and other works in the area.

14. Necessary financial systems, records shall be maintained by the community/NGO for the amounts received with necessary transparancy, accountability and efficiency. Periodic audit of the finances, monitoring and evaluation of the programme should be undertaken to assess the impact of the programme. This will enable the community to reflect on the performance and strive to improve in future.

15. Capacity building of the community and the NGO should be a priority to ensure better results. While these are high on commitment and enthusiasm, are low on procedures, systems, financial management etc. Imparting managerial skills and methodology for systematic implementation of the programme will go a long way in improving the health status.

16. The very existance of a large number of NGOs and the communities they have built is a positive factor to recon with an appropriate strategy with policy support for utilising this vast potential is equally essential.

17. It should not be that a programme is entrusted by the government to the community but it should be undertaken in partnership. The atmosphere in which the programme is implemented plays a significant role in the success of the programme. It is not a contract granted to the community but joining the community in their aspirations for better health.

18. Government can do much more than merely entrusting health programme and the resources to the community. The support in terms of information, campaigns, training, access to institutions and linkages. Propagate such community based programmes which can gradually spread in the State.

19. The community should be able to innovate appropriate approaches in realising the objective of health for all. It should be village based preventive approach rather than merely a curative approach.

20. It is necessary to see the health programme by the community in a larger context. The community once it has become strong enough should be entrusted with other responsibilities like education, sanitation, rural energy, poverty alleviation and other programmes. The role played by NGO then, will be a supportive one and that of the government, providing enablilng atmosphere, policy support, financial resources and other support.

21. The programme should aim at self reliance over a period of time. In that case, the strength of the programme increases much beyond the support extended by the government. For this and other purposes, the community should generate resources through income generation programmes, donations etc.

22. The services should be charged for to ensure sustainability. While the poor get a cover with a family card for a nominal payment, those who can afford will pay full charges for the services. This goes without saying that the services should be qualitative and competitive.

June 27, 1996

Draft

Review of Manual on Target Free Approach in Family Welfare Programme, Ministry of Health and Family Welfare, May 1996

Almost since its inception in the mid-1960's, the family planning programme approach based on contraceptive method-specific targets, incentives and disincentives, espoused until recently by the government of India, has come in for criticism from a broad spectrum of social actors. The principal criticism has been that it is intrinsically distortionary of the health and welfare goals of the programme. There is ample direct evidence of these distortionary effects from the field in many parts of the country. The casualty in this has been women's access to health care, the quality of the family planning services provided through the public system, and the morale of the department's personnel.

A change in programme direction has been long overdue. When the Ministry of Health and Family Welfare (MOHFW) announced in April 1995 that each state could experiment with one or two target-free districts, and when this was extended in April 1996 to make the entire country free of targets, this was greeted by many health activists as a positive step. But how to move a programme that has been dependent on targets for almost 30 years, and make it refocus its priorities towards meeting people's (and especially women's) reproductive health needs through quality services? A major concern of the ministry's has been to devise alternative indicators to evaluate the performance of field staff once targets are gone. Some programme managers are nervous that the fertility transition that is under way in the country will stall if field level staff are not under the pressure of targets.[1]

The Manual under review here is a detailed attempt to spell out procedures for planning, monitoring and evaluation of field level work in the target-free era, and to devise alternative performance indicators for field-level personnel from the auxiliary-nurse-midwife on upwards. This review examines the following: the Manual's general approach, the adequacy of its conception of reproductive health and quality of care, its approach to the role and empowerment of women, and the specific procedures for planning, monitoring and evaluation of programmes.

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[1] "While there are no two opinions about the need to remove numerical targets for the sake of quality of service, there is a concern that such a move, when taken country-wide, may lead to decline in performance initially." (Manual, p 1).

General Approach

The Foreword to the Manual states clearly that, "From now onwards the centrally determined targets will no longer be the driving force behind the programme. The demand of the community for quality services would be expected to become the driving force behind the programme making it a people's programme." To what extent does the rest of the Manual live up to the expectations generated by the Foreword? The picture is mixed.

Strengths

On the positive side, the Manual is clear that the prerequisites for the target-free approach (p 8) should include the withdrawal of motivator certificates and fees, that targets be abolished for both non-health and health staff, that district collectors should not be evaluated on the basis of FP performance. Further, and perhaps for the first time, it emphasizes needs assessment as a prerequisite both for planning at the PHC and sub-centre level, and for evaluation of staff. This needs assessment is to be done in consultation with a number of local level functionaries including panchayat pradhans and anganwadi workers (p 12). An additional positive feature throughout the Manual is a stronger emphasis on maternal health than has been the case till now.

Weaknesses

But there are also some flaws that weaken the general approach. While the Foreword to the Manual emphasizes the importance of decentralizing and improving programme quality, the Introduction that follows (and sets the tone for the rest of the Manual) justifies the target-free approach mainly in terms of efficient reduction of the birth rate. Unlike the Training Guidelines also recently issued by MOHFW, the Manual does not clearly acknowledge the programme's past weaknesses in meeting women's health needs, but focusses on its weakness in being able to reduce the birth rate.

But without a clear assessment of why the programme was unable to meet women's health needs in the past, the primary justification for the shift to the reproductive health and rights approach is left unstated. Whether this ambivalence in approach - emphasizing decentralization and quality of services on the one hand and marginalizing women's involvement on the other - reflects uncertainty at very high levels in MOHFW is unclear. But the result is a Manual that gives no role to local women in planning, monitoring or evaluation at the local level. Unless this flaw is set right, the Programme once again runs the danger of going off at a tangent to women's health.

Reproductive health and Quality of Services

The new integrated reproductive and child health (RCH) approach is defined (p 3) to include FP + CSSM + RTIs/STDs/AIDS + a client-centred approach.

Strengths

Reproductive morbidity and service quality are included in the definition of RCH. There is a stronger emphasis on maternal health (ante-natal, post-natal and emergency care) in the procedures laid down, and more importance to making abortion safe and accessible.

Weaknesses

The RCH definition is too narrow, and the implications of reproductive morbidity for the kind of health or FP services provided is unevenly spelled out. First, although it may be legitimate to start with a definition of RCH that is primarily MCH focussed, this can surely only be a starting point. It is well known that a significant proportion of maternal mortality is caused by the effects of anaemia and poor nutrition carried over from young ages (itself a result of both poverty and gender bias). Women's reproductive morbidity is closely associated with gender biases and male sexual behaviour, and carries over into post-menopausal years as well. The definition of RCH must include the health of young girls and older women, and programmes for men. Problems of irregular and post-menopausal bleeding, prolapse, infertility, cervical cancer, and a range of long-term problems need to be addressed. If this is to be done in a phased manner, the phasing needs to be clearly specified.

The treatment of RTI's in the Manual is uneven. Ideally RTIs /STDs should be discussed in terms of prevention and cure / management, in relation to family planning services, in the context of maternal and infant care, and in relation to HIV prevention. Each of these is a complex issue with implications for how services are provided, and for the training of health providers. These linkages are missing in the report.

The illustrative list of services to be provided at sub-centres and PHCs (pp 3-5) does not mention RTIs. Neither does the data base required for preparation of the PHC plan (pp 14-15), or the PHC plan itself (Form 3). Without these, it is not clear how counselling for RTI/STD at the subcentre level and referral of cases from the subcentre to the CHC can be an "expected outcome of the programme" (p 11). RTI/STD and infertility referral have been included in the ANM activity form (Forms 1 & 4) in response to comments on an earlier draft, but this has not been properly integrated into the body of the Manual or into the training requirements. RTI treatment is included in the checklist for MOs, but clearly not at lower levels. The monthly fax report to be sent to GOI will include FP methods information, child immunization, tetanus toxoid doses given, and MTP, vitamin A and ORS. The R in RCH seems practically to disappear here.

Empowering women

Weaknesses

As mentioned earlier, there is no role envisaged for local women in planning, monitoring or evaluating the programme, even though the Manual spells out the need for ANMs to work closely with anganwadi workers and TBAs, and to consult panchayat members, local medical practitioners etc. This is a serious flaw in the approach for two reasons. On the one hand, it once again marginalizes the most important stakeholders of the programme. Who is likely to have better knowledge and awareness of their health needs, and of how well or poorly the programme is working than women themselves? Many of the best experiences (governmental and non-governmental) in providing health services have worked because those served have played a central role in planning the programmes. Furthermore, given the prevalence of gender bias in communities and among service personnel, women's health all too often gets short shrift unless women themselves have a central role.

A second reason why the approach is flawed has to do with the monitoring and evaluation requirements of the new programme. If women's groups could be centrally involved, top-down monitoring and evaluation becomes less necessary. In the absence of such stakeholder involvement, the alternative monitoring system suggested by the Manual is cumbersome and complex.

Procedures for planning, monitoring and evaluation

Planning

The PHC will prepare both subcentre action plans and the PHC plan for services in consultation with various health functionaries, primary school teachers, panchayat pradhans etc. On the basis of this needs assessment, activity norms for ANMs will be set. Interestingly, the basis of the norms set in form 2 (pp 33-34) appears arbitrary and once again tilted against maternal health. (For example the norm for early antenatal registration is only 60% while the child health norms are around 95 -100%.) The availability (though not adequacy) of equipment and facilities is also to be checked; here access to clean water and toilets is excluded. The PHC plan is then to be drawn up and aggregated upwards to arrive at district and state plans.

Monitoring and evaluation

The ANM will submit monthly reports with details on 27 sets of activities; her performance will be assessed by the LHV through both direct observation of her skills and practices, and by asking the opinion of the community once each month. Similar assessments of the PHC medical officers will be done by the Block MO. ANM record keeping is not being changed at present, but there is to be a pilot attempt to shift to client

based records such as health cards.

Strengths

Once a year independent agencies will conduct client sample surveys in each district of programme coverage, quality and client satisfaction.

Weaknesses

As already pointed out, the forms are still using a very narrow concept of reproductive health, mainly focussing on MCH.

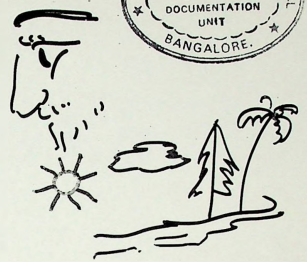
The reporting requirement for ANMs seems cumbersome, and therefore open to misrepresentation. The crosscheck on the ANM's activies is to be provided by the LHV's survey of the community's opinion, but in the absence of an active group of women in the community, this may not work very well.

Overall, the principal need at present is to develop a system by which women's groups at the local level can be empowered to play a greater and pivotal role in planning, monitoring and evaluation.

Gita Sen
Indian Institute of Management
Bangalore

(1)

OVERVIEW OF ELEMENTS WHICH MAKE FOR A WOMAN-SENSITIVE AND HOLISTIC HEALTH-CARE SYSTEM



SHIRDI PRASAD TEKUR
COMMUNITY HEALTH CELL
BANGALORE

HOLISM ?

A + B + C + D + ...
MCH + CSSM + AW + ...

LOOKING AT ALL ANGLES ?

BEING OPEN AND UNBIASED ?

Where does this go?

That still doesn't complete the picture

A COMPREHENSIVE LOOK?

BEING IDEALISTIC?

Practical?

BE PRAGMATIC!

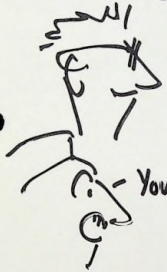
BROAD UNDERSTANDING OF POVERTY DISADVANTAGE WELL-BEING

BROADER BASIS for SOCIAL ACTION

WHY WOMAN-SENSITIVITY ?

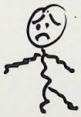
- Ardha Nareeshwara
  Prakruthi & Purusha
  Cosmic imbalance

PHILOSOPHICAL?



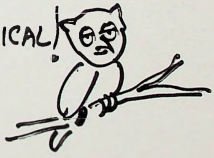
- Adverse sex ratio
  risk, disadvantage,
  vulnerability
- the statistics say so
- You gotta get things moving!

SCIENTIFIC?



POLITICAL ?

PRACTICAL!



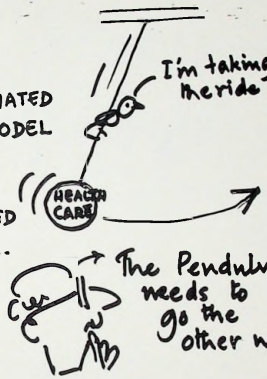
LET'S ACCEPT

- THE BETTER HALF OF HUMANITY HAS BEEN <u>NEGLECTED</u>
- The value systems they represent are ERODING.

THE HEALTH-CARER IN EVERY FAMILY IS BEING HANDICAPPED

- TOP-DOWN
- MALE DOMINATED
- WESTERN MODEL
- TECHNOLOGY ORIENTED
- MEDICALIZED

etc ... etc...



WOMENS' HEALTH STATUS is determined by

- BIOLOGICAL FACTORS
- SOCIAL, ECONOMIC, CULTURAL INFLUENCES
- HEALTH SERVICES

and, of course, INDIVIDUAL Factors influenced by all these.

ALL THESE ARE

- INTER-RELATED
- INTER-ACTIVE

BIOLOGICAL FACTORS

- Better survival ability < at birth / in life expectancy
- Fewer manifestations of stress-diseases - D/M, H.T., etc. / CVS / CNS disease
- Reproductive age gp. especially
  - +ve as above
  - −ve, Anaemia
    - Protein malnutrition
    - Damage to Reprod. tract
    - Depressions - double that of men
- Higher risk per exposure to uro-genital disease - STD/HIV - Papilloma virus → Ca Cx.
- Morbidity due to stress disease more than in men after menopause.

Is that all?

No,
We don't have enough studies yet!

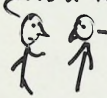
We have focussed only on the WOMB so far!

SOCIAL, ECONOMIC, CULTURAL INFLUENCES

The SOCIALLY DISADVANTAGED position is often related to

ECONOMIC VALUE....

It's a technology driven world



— and commercialized!

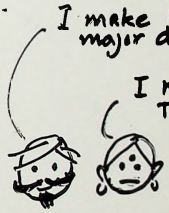
- lower wages
- menial/arduous tasks
- multiple roles & responsibilities
- Hazards of work even at home!

etc... etc...

CULTURAL NORMS....

- Discrimination womb to tomb
- female infanticides
- early marriages
- unwanted pregnancies
- family & health responsibilities
- lesser education/family resources

etc ... etc...

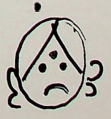


— It exposes us to abuse ⟨ Physical / sexual

— perpetuates discrimination & misery

— & NO control over DECISIONS affecting our OWN LIVES!

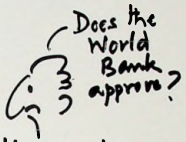
IT'S BUILT IN THE SAME ETHOS



Surely, the Health Services cannot tackle all these!

& it's none of our business too!

- Take the LIFE-CYCLE approach -- you CAN make a dent... by being SENSITIVE



Areas that need to be addressed...

1. Infancy & childhood
   - Sex selection.
   - Discriminatory child care.
2. Adolescence
   - Family life education
   - prevent
     - early marriage/child bearing
   - address
     - anaemia/malnutrition.
   + ALL ABOVE
3. Reproductive years
   - Address ALL ABOVE
   + Pregnancy & related problems
   + Gynaecological problems.
4. Post-reproductive years
   - Address all health problems on TOP PRIORITY basis.

   esp. Under-nutrition, Osteoporosis, Osteo-arthritis + CVS/CNS disease + Gynaec. cancers.

ANYTHING ELSE HEALTH SERVICES CAN DO ?

Yes...
Gear-up to tackle

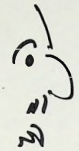
- Gender based violence
  ~ in all phases of life cycle
- Depression / Disability / lack of powers for Decision making
- Hazards of work
  - at home
  - at work-spot
  - in environment

AIN'T THIS ALL MEDICAL?

EXACTLY!
Get on towards preventing them for a start

That's the challenge!
Where do we begin?

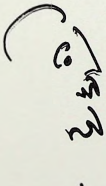
ASK US &
WE'LL TELL YOU.



ISN'T THAT PRETTY HOLISTIC?

Not yet....

HOLISM means, being open to more possibilities which we can become aware of as we start working



Keeping some slots open always?

- Being flexible, adaptable, accountable, accessible etc.. - to US.

A tall order!

NOT AT ALL.. If you are SENSITIVE

- EDUCATE ALL
  - Policy makers
  - Decision makers
  - Service providers
  - Men
  - us too!

INVEST MORE IN FEMALE EDUCATION

You mean... in health? beyond literacy?

- INVOLVE ALL
  - ~ give more credence to our needs.
- IMPROVE ACCESS TO SERVICES
  - ~ esp. for women who bear the brunt of any illness in a family.
  - ~~=~~ - design delivery strategies to meet our needs

- IMPROVE
  - provider competence
  - Informed choice
  - Continuity of care
  - Privacy

  ] to address our needs.

MOST IMPORTANT —
CONSULT US BEFORE
YOU START OFF...

HEALTH WATCH

UPDATE

ISSUE - 1 JUNE 1995

SUMMARY OF THE DISCUSSIONS HELD AT THE NGO MEETING IN AHMEDABAD, DECEMBER 1-2, 1994

INTRODUCTION

There has been a growing concern in India among scholars, researchers, women's groups, non-governmental organizations (NGOs), etc. that the demographic rationale for lowering the birth rate has become the overarching concern of the government such that the larger developmental goals as well as individual health needs or reproductive goals are lost sight of. The developmental approach recognizes the interrelations between population, resources and environment for sustainable development and well-being of mankind. It also emphasizes the need for a holistic, integrated and decentralized approach to both population and development. It implies that, subject to the resolution of inter-group conflicts, and to the extent possible, planning, implementation and monitoring of all developmental activities must be undertaken by local people in accordance with their own needs and priorities. Essential to the developmental approach is viewing women as active and empowered participants in the development programmes.

The Programme of Action (POA) adopted at the International Conference on Population and Development (ICPD) held in Cairo in September 1994, to which India is a signatory, has incorporated this approach, which has been articulated by women's organizations throughout the world. The active involvement of women's organizations during the regional and national consultations as well as during the three preparatory committee meetings held in New York prior to the Cairo conference has helped to define women's position on population policies and programmes. It requires a shift in the population policy objectives from the concern with population size or numbers to provision of reproductive health services of acceptable quality with a proper acknowledgement of women's reproductive rights.

PARTNERSHIP WITH THE GOVERNMENT : THE PROCESS

In India some of the same concerns were voiced during the meetings of the grassroots level workers organized by the NGOs in different states between October 1993-January 1994, prior to the ICPD. These meetings also brought out that the official health and family welfare programme in its present form puts no or little emphasis on participatory management, quality of care and reproductive health. These issues were taken up for further discussion in three national thematic meetings held during February - April 1994 at Bangalore, Ahmedabad and New Delhi.

The Indian NGOs attending the last preparatory committee meeting had established a channel of dialogue with the official delegates. This process of meeting and attempting to strike a meaningful partnership between GO and NGOs had continued in Cairo. In fact, before going to Cairo some of the representatives of the NGOs had met with the members of the official delegation in New Delhi to understand the respective positions on various issues of population and development.

In Cairo, two major decisions were taken to strengthen this process: a) Government would call a meeting of the NGOs to further the dialogue and b) NGOs themselves would meet prior to the meeting with the Government to identify the key issues which call for discussion with the government. A meeting of the NGOs was held in Ahmedabad during December 1-2, 1994. About 35 participants, representing diverse points of view, were invited to the meeting of whom 20 were able to participate.

PRIORITY ISSUES

In the context of the concerns expressed in the ICPD document, the group which met in Ahmedabad identified the following as priority issues which call for serious discussion and dialogue between the government and the NGOs at this time.

1. Removal of Method-Specific Contraceptive Targets, Incentives and Disincentives for Family Planning

In view of the decline in fertility experienced in many parts of the country and the distortions that have marked the family planning programme, the time is ripe for removing the method specific contraceptive targets from the programme, discontinuing incentive payments to the acceptors or to the providers and any form of disincentives for the non-acceptors. In this context, there is a need to a) developing alternative performance indicators including some based on MCH services and provision of primary health care; b) implementing target-free programme with emphasis on making full information available to people and on meeting their health and reproductive goals, in a phased manner in collaboration with NGOs; c) reviewing the experiences when the target approach is replaced by people-based approach.

2. Expansion of services with emphasis on reproductive health and on quality of services

The current health and family welfare programmes should be expanded to include reproductive health services with an emphasis on quality of care. This could be done by a) starting a programme for reproductive health which includes facilities for diagnosing and treating reproductive tract infections, infertility and sexually transmitted diseases, etc. However, these facilities should be integrated into the existing programmes and not established as separate vertical activities; b) improving MTP services both in terms of access, safety and quality; c) improving quality of contraceptive services along with emphasis on male responsibility. Resources used for incentive payments at various levels could be channelled into the implementation of the new approach.

3. Increasing Resource Allocation for Primary Health Care

Resource allocation for improving access and quality of primary health care is essential. Increased allocations are required for a) strengthening, developing and where required, increasing the number of local health functionaries; b) strengthening and expanding health infrastructures like primary health centres and subcentres; c) improving the range of primary health care services including enhanced supply of drugs at the primary health centres.

4. Regular Dialogue with NGOs

This began prior to the Cairo Conference and should be continued and strengthened in the years ahead. Initially, this could be done by a) involvement of NGOs in the six-monthly meetings of health and family welfare secretaries at the centre (similar meetings at the state level would be useful and need to be organised regularly); b) active participation by NGOs in sensitization and training programmes on the Cairo Programme of Action for health and family welfare functionaries; c) active participation by the NGOs in discussions on resource allocation for health and family welfare.

We urge the government and the NGOs to consider these recommendations seriously, initiate the process of wider discussion and dialogue and also implement these as part of the commitment to people's health and well-being that we collectively made at Cairo.

Leela Visaria, GIDR
Mirai Chatterjee, SEWA
December 14, 1994

NEWS ITEM

(From Times of India (Ahmedabad Edition) of February 22, 1995)

FP PRIZES PRESENTED: Forty-one motivators and employees have been awarded incentive cash prizes for outstanding family planning performances in Hansot and Ankleshwar talukas in 1993-94 at Hansot. Ms. Jashuben R. Patel, a teacher, was the first among other prize winners. Mr. J.B. Choudhary, TDO, Hansot, said the taluka achieved 87 per cent result with 379 sterilisation operations against the target of 433 operations. Mr. Mukeshpuri, DDO, Broach who gave away the prizes called upon the employees and motivators to cross the target in both Hansot and Ankleshwar talukas.

Note on Meeting of State Secretaries for Family Welfare
April 3, 1995, Vijyan Bhavan, New Delhi

As a follow up of the note prepared by Health Watch in December, 1994 and the discussions held in Delhi during December 16-17, 1994 and Jaipur in February 1995, the Ministry of Health and Family Welfare agreed to inviting some Health Watch members to a meeting of State Secretaries on April 3, 1995.

The Secretary of Family Welfare finally selected the following persons based on areas of work i.e. research, grassroots organisation etc.

1. Gita Sen : To present an overview on the outcome of ICPD
2. Banoo Coyaji : To make a presentation on reproductive health in the context of primary health care

Vimla Ramachandran and Mirai Chatterjee were also present and supplemented to Gita's presentation, with examples from Mahila Samakhya and SEWA's experiences, respectively.

Gita, Dr. Coyaji, Mirai, Ena and Wasim Zaman, Country Director, UNFPA met on April 2, 1995 to connect with each other and prepare for the meeting of the 3rd of April 1995. Vimla was in touch with the group as well.

The Meeting

a. Pre-Lunch Session:

The meeting of State Family Welfare (FW) Secretaries was chaired by Mr. Shunglu, assisted by the two joint Secretaries Ms. Adarsh Misra and Mr. K.S. Sugathan. The inauguration, was by the minister of state for health, Dr. C. Silvera. Mr. Dayal, Secretary, Health also spoke briefly. The Minister and Mr. Dayal left soon after the inauguration session. However, all state secretaries remained present.

Gita's Presentation went off very well. It was, as usual clear, concise and digestible. Vimla and Mirai added on a bit. Then Dr. Banoo Coyaji made a presentation giving a historical perspective which was very interesting and useful. After this the floor was opened for discussion.

Instead of focussing on issues like removal of targets, specifically raised by Gita, a discussion on what an NGO is and merits and demerits of NGOs followed! Some clarifications on ICPD's Programme of Action were also sought. In short, it was not a very substantive discussion.

b. Post-Lunch Session

We were invited to stay on for the post lunch session. Mr. Sugathan started out by saying that in 1995-96 the focus was to be on qualitative improvement of services. Also, he mentioned that government functionaries outside of the FW department will be discouraged from monitoring family planning services. Each state secretary presented her/his 1994-95 targets and the proposed ones for 1995-96. There was also some discussion of the accuracy of data collection-spot checks had been carried out. Further, each Secretary specifically mentioned at least one or two districts in her/his state which will be target free during 1995-96 (see attached list).

When the Punjab Secretary spoke, Mr. Shunglu specifically asked her whether she planned to use injectables since people in Punjab could afford to pay for these. He also mentioned that Depo Provera has been cleared by the Drug Regulation department and that it is available on the open market. The punjab Secretary responded by saying that the doctors in her state were not keen to use injectables yet, partly because of the controversy surrounding these in recent years. Finally Kerala and Meghalaya requested that their states be completely target free. Most of us, except for Dr. Banoo Coyaji, stayed only till the afternoon tea break. We need to get Banoo's help to add what went on thereafter. Rajasthan, U.P., West Bengal and Tamil Nadu Secretaries were to speak and then they were to discuss the sex-determination bill passed by the Parliament.

Implications/Outcome of State Secretaries Meeting and Health Watch's Participation

1. We have made some progress in that two of our suggestions (i.e. dialogue with government and participation in state secretaries meeting and removal of targets in a phased manner in some districts) have been acted upon.

2. All states gave names of districts with high family planning performance as their choice for target free areas. If at least some of the "difficult" districts had been selected, then we would have had a better chance to see how a target free approach by government can work in such areas.

3. The atmosphere vis a vis NGO's seems to be quite positive. The two joint secretaries and secretaries of some southern states (Kerala, Tamil Nadu, Karnataka) and of Maharashtra are particularly open and supportive. We need to build on this, take their support and keep up the pressure for dialogue and constructive debate followed by action. The time is definitely ripe for us to now start talking of Health Watch. The government needs to know that we are an organised group of people, representing various organisations, but committed to the implementation of the ICPD Programme of Action.

4. We will have to get at least a part time coordinator for Health Watch to work out of the current secretariat at GIDR. Leela is agreeable to guide someone in keeping track of us all and our strategies for action. She already has someone in mind.

5. Our next action should be to start constructive dialogue with our state secretaries in our home states. We mentioned this several times to the Secretary and Joint Secretary. We hope that they will write to the state secretaries suggesting meetings with a wider group of NGOs at state level. (See the attached letter that Gita Sen has written to Mr. Shunglu.)

6. It was clear that the states are only too happy to do away with targets! What is to be seen is, however, what sort of performance indicators will replace these and who will decide on these. Some clue to these questions are covered in Mr. Shunglu's note to the state secretaries (See Attached Note).

7. It was very clear that despite the centres protestations to the contrary at our December 1994 meeting with the government, it is the **centre** and not the states which sets the tone and calls the shots vis-a-vis any changes we would like to see. As one State Secretary put it: "The centre is where the States' money for family planning comes from. So of course we do what they tell us!.

8. We can start dialogue with our state secretaries regarding the target free districts, how performance will be monitored etc. A letter from the centre will help but we may as well begin. Our impression is that states need help with performance indicators.

Mirai Chatterjee
April 6, 1995

Attachment 1
List of States and Their Target Free Districts

States	Target Free Districts
1. Andhra Pradesh	E. Godavari
2. Assam	Sibsagar
3. Bihar	Patna
4. Maharashtra	Satara & Wardha
5. Gujarat	Valsad
6. Haryana	Ambala
7. Himachal Pradesh	Sirmour
8. Jammu & Kashmir	Jammu
9. Karnataka	Mandya
10. Kerala	Whole State
11. Madhya Pradesh	Narsinghpur
12. Meghalaya	Whole State
13. Manipur	Vishnupur
14. Punjab	Fatehgar Sahib
15. Orissa	Bhubaneshwar(?)
16. U.P.	Sitapur, Agra
17. Rajasthan	Dausa, Tonk
18. West Bengal	Hoogly
19. Tamil Nadu	Whole State

Attachment 2

Agenda Item No.2:

Review of the Family Planning Performance During 1994-95 and Expected Level of Achievement for 1995-96

(a) Review of the progress of family planning performance in relation to expected levels ofAchievements during 1994-95 (up to January, 1995).

Based on the latest performance figures received from the various states/UTs, the Table below summarises the position in relation to expected level of achievements (ELAs) by methods of family planning at national level during the year 1994-95 (up to January 1995).

Methods	Achievements# 1994-95 (April 94(Corresto Jan 95)	1993-94	% Increase (+) or decrease (-) ponding period)	%Achievement of proportionate ELAs
1	2	3	4	5
Sterilisation	32.46	32.06	(+)1.2	82.9
IUD insertions	49.49	43.14	(+)14.7	84.4
Eq. C.C. Users	134.59	139.42	(-) 3.5	63.6
Eq. O.P. Users	37.06	30.79	(+) 20.3	70.2
Total Acceptors	253.60	245.41	(+)3.3	

Achievement figures are provisional.

Expected Level of Achievements - State-wise

Classification of 17 major States in relation to percentage achievement of proportionate ELAs by family planning methods during 1994-95 (up to January, 1995) is given in the Table below.

% Achvt.	Sterilisations	IUD insertions	Eq. C.C. Users	Eq. O.P. Users
100% and Above	Gujarat Kerala Madhya Pr. Maharashtra Tamil Nadu	Gujarat Tamil Nadu	Gujarat Karnataka Tamil Nadu	Gujarat Madhya Pr. Punjab Tamil Nadu
75-100%	Andhra Pr. Haryana Karnataka Orissa Punjab Rajasthan West Bengal Himachal Pr.	Haryana Karnataka Kerala Madhya Pr. Maharashtra Orissa Punjab Uttar Pr.	Andhra Pr. Haryana Madhya Pr. Maharashtra Orissa Punjab Uttar Pr. Himachal Pr.	Andhra Pr. Haryana Karnataka Maharash Orissa Rajasthan Uttar Pr.
50-75 %	Uttar Pr.	Andhra Pr. Assam Rajasthan Himachal Pr	Assam Kerala Rajasthan West Bengal Jammu & K.*	Kerala West Ben. Himachal Pr
25-50%	J & K.*	Bihar * West Bengal J & K.*	Bihar*	Assam Bihar* J & K.*
Less than 25%	Assam Bihar *			

*Figures are up to November 1994

A statement showing state-wise position by Family Planning methods is enclosed (Annexure-2.1)

(b) Expected Level of Achievement for 1995-96

With reference to the discussions held in the last meeting of the state secretaries regarding replacement of the contraceptive targets and the abolition of condom targets, it has now been decided to adopt a pilot approach in 1995-96. It is proposed that one district from each of the major states may be excluded from all contraceptive targets. The selected district will not be given any contraceptive target for any of the four methods, namely sterilisation, IUD, OP users and CC users but information of the number of acceptors for each method will be continued to be collected. In addition, information on quality improvement as a result of target removal will also be collected. The district selected for exclusion should be reasonably well performing with indicators above the state average vis-a-vis immunisation, couple protection, female literacy and infrastructure. In the selected district, in addition to the number of acceptors for each method, following indicators relating to qualitative aspects of FP and MCH will be monitored.

i Of the total acceptors of sterilisation, number with 2 children, number with 3 children and with more than 3 children.
ii Of the total acceptors of spacing methods, number of couples with wife's age less than 30.
iii Total number of immunisation sessions planned and number of sessions actually held.
iv Proportion of institutional deliveries and deliveries by trained personnel in relation to the total estimated number of deliveries.
v Number of health facilities providing MTP services and the number of women treated for complications following unsafe abortions. Number of health facilities providing emergency obstetric care.
vi Number of polio and neonatal tetanus cases reported.
vii Number of planned IEC sessions on diarrhoeal diseases and ARI and actually held. Number of pneumonia cases in children under 5 years of age identified and treated. (Expected number of cases of pneumonia can be taken to be 10 to 20 times the estimated number of deaths which is roughly 25% of the total deaths in children under 5 years of age.)

2. Given the demographic goals, the expected levels of acceptance under sterilisation, IUD insertions and OP users required during 1995-96 for each State/UT has been worked out and the states have been asked to suggest the expected level of users of these methods based on the assessment of voluntary demands, after excluding the ELAs in respect of the district which is to be exempted of all targets.

3. All the State governments were requested to intimate ELAs for sterilisation, IUD and OP for the year 1995-96 and the districts selected for target free approach vide d.o letter No.M.11015/15/94-E&I dated 9/13th February, 1995. Replies have been received from Andhra Pradesh, Kerala, Tamil Nadu, Sikkim and A&N Islands. In case of other States it is presumed that ELAs as indicated in the enclosed statement are acceptable to the State governments. It is suggested that no targets should be allotted to other departments like Revenue Dept., etc.

4. In case of condom users, no ELAs are to be fixed as decided in the last meeting of State Secretaries and the States have been asked to let us know the expected demand for condom based on the assessment of voluntary demand taking into account the requirement for FP and AIDS control for 1995-96 so as to ensure timely and adequate supplies.

5. The declining male acceptance of FP in the recent past has been a matter of concern. While several reasons have been assigned for declining male participation, it also appears that the non-involvement of the male health worker is a significant reason for poor male participation. While we need to reverse this process through a sustained IEC campaign, it is also suggested that adoption of targets for vasectomy for male multipurpose workers could significantly improve male participation. It has, therefore, been proposed to the states that the target for male sterilisation be kept at 10 % out of total sterilisation, and in those States where the participation level is 10% or more the target may be kept at 15% of the total during 1995-96.

May 1, 1995

Mr. V.K. Shunglu
Secretary
Ministry of Health and Family Welfare
Nirman Bhavan New Delhi 110 011

Dear Mr. Shunglu:

This is just a brief note to express my appreciation for your efforts to continue the dialogue with NGOs and other members of civil society on how best to move forward in the family welfare program post Cairo. On our side, the opportunity to meet a number of the state secretaries during the meeting in early April was useful.

In order to build on the good start made, there need to be a series of dialogues and workshops in the states, both to sensitise more government personnel to the Cairo agenda, and to begin a process of systematic dialogue about the best way to move forward from the era of targets, incentives and poor quality of care. Your leadership in this is vital, since the states do look to you for direction and guidance. I hope that you will provide this so that the experiment of replacing method-specific targets can become a genuinely fruitful one.

With best wishes,
Sincerely,

Gita Sen
Professor

cc. Mr. Wazim Zaman, UNFP

for private circulation only

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Women advocating change
Working for a sensitive women's health programme in India

Vimala Ramachandran

Since the mid-seventies women's organisations, social activist groups, radical political parties and other community based organisations have consistently raised their voice against contradictory positions taken by the government on population and family planning. At one level, in the Bucharest conference, India came out with the slogan - "development is the nest contraceptive". At another level, back home - the government intensified its efforts to control population growth. The darkest period was the emergency years (1975-77) when excesses committed in the programme brought the government down. After a lull of a few years, the renamed (not revamped) Family Welfare programme came back with a bang - with one significant different. The targets were to be women - male sterilisation had proved politically volatile. Tubectomy camps, laproscopy techniques coupled with incentives and disincentives became the one point programme of the government. The entire might of the administration was geared towards achieving targets. This approach continued through the eighties.

The first glimmer of doubt was expressed by the Planning Commission in their approach paper to the Eighth Plan. It said "in spite of massive efforts in the form of budgetary support and infrastructure development, the performance of the family welfare programme has not been commensurate with inputs. Right from the beginning the achievement of the set of goals has been unsatisfactory, resulting in the resetting of targets,... While the Seventh Plan targets of achieving CPR of 42% was achieved, this was not matched by commensurate decline in the birth rate, possibly because of improper selection of cases... Containment of population is not merely a function of couple protection or contraception but is directly correlated with female literacy, age of marriage of the girls, status of women in the community, IMR, quality and outreach of health and family planning services and other socio-economic parameters....The Family Welfare Programme has essentially remained a uni-sector programme of the Ministry of Health and Family Welfare...(it) has also suffered on account of centralised planning and target setting from the top... Monitoring mechanism under the programme has been reduced to a routine target reporting exercise incapable of identifying roadblocks and applying timely correctives."

Community based groups, social activists and women's organisations started raising their voice against the family welfare programme. Almost all of them made it a point to distance themselves from it. Activists in the women's movement and women's organisation critiqued the programme from the outside. By the early nineties this became very sharp - so much so that the Ministry of Health and Family Welfare started looking upon women's groups as adversaries. Women's groups agitated against human rights violations in the form of family planning, harmful technologies and abysmal quality of health care services. Women's development programmes within the government like WDP, Rajasthan and Mahila Samakhya - made a conscious efforts to not only distance themselves from Family Planning but also actively campaigned for women's right to make her own decisions and right to dignity.

Where did all this lead? Right through the eighties and in the first half of the nineties, there was little dialogue between the two constituencies - family planning wallahas and women's groups. As a result voluntary organisations, demographers part of the population lobby and family planning associations were identified with the establishment. Government propaganda, lessons in school text books, media stories about population bomb, international advocacy for reduction in population growth (including policies of IMF and the World Bank) etc. created a situation whereby the two extreme positions received public attention, namely: one who said that population has to be controlled at any cost as it is the root cause of poverty and the other which argued that high population growth rate is a symptom of poverty, ill-health and lack of social security. Middle of the roaders who argued for a more nuanced and balanced view of the population - poverty linkages were either silent or their adocacy ineffective.

By the time we were approaching the mid point of the nineties an appreciable softening among the population hardliners became evident. Many decades of pumping money into contraceptives and sterilisation did not yield desired results. Evidence from many poor counties demonstrated that human development indicators are not necessarily correlated with economic prosperity. Quality primary health care, maternal and child survival programmes, good sanitation and primary education can turn the tide. When infant mortality decreases and people feel assured about the survival of their children family size begins to decline. Globally the efforts to develop human development indicators and ranking countries according to quality of life forced demographers and population control wallahas to rethink. The environment question, carrying capacity of the planet also pointed towards consumption patterns among the rich and the poor across the world and within countries. All these effectively diffused the population bomb.

In India a few women's organisation, social activists, researchers and officials recognised the historical opportunity. By 1993 it was evident that a significant section of policy makers and administrators within government were talking about the need to overhaul the family welfare programme. Target fatigue had set in. A draft note for discussion among Secretaries to Government of India made the round in the early nineties. Some senior civil servants reached out to talk to women activists. Preparatory activities for the Cairo conference provided a glimmer of hope. Intensive lobbying at the national level at a time where the population, poverty and development issues was being reopened globally could bring about change. There was considerable evidence of internal debate between women's health advocates and population control lobbies within international organisations. Reproductive rights and reproductive health became central to the debate.

Within India efforts to bring together women's groups, advocates for primary health care, demographers, family planning groups, environmentalists and other concerned activists started in 1993. The initial reaction was one of mutual suspicion. Some women's groups refused to co-ordinate regional consultations if it was being funded and supported by some donor agencies, others refused to come together with "family planning wallahs". The more establishment friendly groups were apprehensive about sharing a platform with women activists - calling them a shrill and unreasonable lot.

Many civil servants expressed cynicism about the success of efforts to initiate dialogue between traditional adversaries.

With a lot of hesitation and apprehension the first group of people met to talk about the Cairo draft Programme of Action and whether it is relevant for India. This meeting immediately turned into a forum to ventilate feelings about the family planning programme. The Cairo document was barely touched! In one meeting population, development, poverty, the inter-linkages between them etc. was not even discussed. The entire discussion centred around immediate health problems of the people. At the other end of the spectrum, another turned into a vitriolic attack on India's population control policy. In all eighteen meeting were organised by one group as preparatory activities for the ICPD conference. Simultaneously women's groups in different parts of the country organised their own meetings to talk about the Cairo agenda and whether it has any relevance in India. Existing health networks like Medico Friends Circle and Voluntary Health Association of India initiated their own consultative process.

The Cairo conference was a turning point. The entire debate centred around women's control over her own body, her right to say "No" and "Enough" - abortion, invasive contraceptive technologies, male responsibility, right to treated with respect and dignity, rights of people within unconventional relationships, family reunification rights, forced migration - all these issues turned Cairo into a women's conference.

In the immediate post-Cairo phase persistent efforts by a core group of people determined to see concrete changes in India's policy and programmes worked from within and outside government to keep the debate alive. Among women's groups there was a debate on the need to keep channels of communication with government open and work towards removal of family planning targets, improving quality of health care services and sensitive women's reproductive health programme.

Forging strategic alliances became the first point of conflict. Given the fact that a large proportion of India's family welfare and health programmes are funded by multilateral agencies like UNFPA and the World Bank - would it be appropriate to open channels of communication with them and the government simultaneously? There were no easy answers? It was evident that advocating for change involves walking a tight rope. Providing constructive criticism, alternative strategies, concrete inputs into programme design, monitoring indicators etc. may result in a few changes. We would also have to live with some not-so-desirable components. We may also be identified with some new initiatives - with little control over the key processes and outcomes. In short, it is a risky business to advocate for change and enter into partnership with government and funding agencies to concretise broad policy level statements into concrete programmes. A small group of people involved in the pre-Cairo consultative process decided that it was worth the risk. Health Watch - a network of like minded NGOs, activists, researchers and concerned citizens was thus formed in December 1994. It took almost a year to work out a common agenda and carve a role for itself in the present scenario.

A second round of region-wise consultations begin in Hyderabad on 28 and 29 June, 1996. Women's groups, voluntary organizations working on health, environment, human rights, education, contraceptive services, etc., social activists, researchers,

A turning point

The international conference on population

President Hosni Mubarak at the opening of the conference... a momentous event.

INDU K. MALLAH

IN Cairo, Egypt, the cradle of civilisation, a new chapter in history was carved on the tablet of time between September 5 and 13 at the International Conference on Population and Development (ICPD) – a momentous event.

It was a historic conference in many ways. Convened by the United Nations, it was a successor to the 1974 World Population Conference held in Bucharest and the 1984 International Conference on Population held in Mexico City. The ICPD spelt out actions to address issues related to rapid population growth and affirmed that people have the right to decide freely and responsibly the number and spacing of their children, and to have the information, education, and the means to do so.

An article of the preamble to the Programme of Action states: "The present Programme of Action recommends to the international community a set of important population and development objectives, including both qualitative and quantitative goals that are mutually supportive and are of critical importance to these objectives. Among these objectives and goals are: sustained economic growth in the context of sustainable development; education, especially for girls; gender-equity and equality; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family-planning and sexual health."

Another article states: "While the ICPD does not create any new international human rights, it affirms the application of universally recognised human rights standards to all aspects of population programmes. It also represents the last opportunity in the 20th century for the international community to address collectively the critical challenges and inter-relationships between population and development. The Programme of Action will require the establishment of common ground, with full respect for the various religious values and cultural backgrounds. The impact of this conference will be measured by the strength of the specific commitments made here and the consequent actions to fulfil them, as part of a new global partnership among all the world's countries and peoples, based on a sense of shared but differentiated responsibility for each other, and for our planetary home."

And the first paragraph in the preamble to the Principles in Chapter II states: "The implementation of the recommendations contained in the Programme of Action is the sovereign right of each country with national

laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally-recognised international human rights."

In his keynote address at the inauguration of the ICPD, Egyptian President Hosni Mubarak, who received the U.N. population award for this year, called for avoidance of extremism, discussion and dialogue, particularly between the North and the South, and an exchange of opinions in an ambience of democracy in order to find a common denominator.

U.N. Secretary-General Dr. Boutros Boutros-Ghali called the conference "a turning point for the all-important population issue." He made a plea for tolerance and urged the participants not to impose any one belief or culture on the entire international community. He, however, warned that tolerance should not result in meaningless compromises but reflect a political will to solve over-population and underdevelopment in the world.

U.S. Vice-President Al Gore called for a "holistic" solution to the population question "which is rooted in faith and a commitment to basic human values of the kind enshrined in all of our major religious traditions and principles increasingly shared by men and women all over the world: the central role of the family, the importance of the community, the freedom of the human spirit, the inherent dignity of every individual woman, man and child on this planet, political, economic and religious freedom, and universal and inalienable human rights."

Impressive though these speakers were, it was a field-day for the women delegates. Addressing the plenary session, Dr. Nafis Sadik, Secretary-General of the ICPD, said that differences over the Draft Programme of Action to be adopted were the "result of misunderstanding of the content or the intent of the draft. All of this can be done without in any way infringing national sovereignty. Each nation will address the issue according to its own laws and practice."

Norwegian Prime Minister Gro Harlem Brundtland urged delegates to be realistic about abortion and sex education. "Morality becomes hypocrisy if it means accepting mothers suffering or dying in connection with unwanted pregnancies, illegal abortions, and unwanted children," she said.

Pakistan Prime Minister Benazir Bhutto's speech was high on rhetoric: "I dream of a Pakistan, of an Asia, of a world, where every pregnancy is planned and every child conceived is

The labour of the rich

Of India's population policy

IMRANA QADEER

THE media termed it a "low profile" performance. But the Indian delegation's stance at the International Conference on Population and Development (ICPD) in Cairo marked yet another step in walking the razor's edge – between what the Indian people really need and what their rulers want.

Under the benevolent patronage of the Rockefeller and Ford Foundations, India was the first nation to adopt a family planning programme. The neo-Malthusian principle underlying the programme, though, was first enunciated by Dr. Karan Singh, then Union Health Minister, in April 1976: "Indisputably we are facing a population explosion of crisis dimensions which has largely diluted the fruits of the remarkable economic progress that we have made over the past two decades." This principle has been the basis for the evolution of policy ever since.

The reluctance of Karan Singh's Ministry to force the pace of the programme, in spite of the perceived "crisis", was soon abandoned under the Emergency. But the coercion of targets bred a massive public reaction. Consequently, the Janata Government's Draft National Health Policy of 1979 retreated into talking only of health services. The succeeding Congress Government was still wary of neo-Malthusian principles, so a 1980 Working Group on Population outlined a strategy for promoting "demand" for family planning services by reducing infant and maternal mortality through comprehensive health care.

Thus, the early 1980s saw a significant expansion of the health services infrastructure. However, before any radical transformation could take place, the Malthusian principle quickly reasserted itself. Under the Seventh Plan, investment in the family planning programme shot up from 15 per cent to 25 per cent of the health budget, and it usurped the entire health services through the earlier thrust on integration.

This transition, though, did not produce any results. Experts ascribed this to "poor management", and a revised strategy was constructed in 1986 to "go beyond" the family planning programme. In practice this hollow slogan expected that biogas, smokeless *chulhas* and pressure cookers would "reduce the workload at home and release women for work". Understandably enough, population control strategies remained consistently ineffective. This became yet another pressure point for multilateral aid agencies to push for "structural reforms". National policy planners suddenly became "aware" of the years of accumulated evidence that emphasised that people themselves were expressing a need for family planning services. But this "need" was subtly distorted to focus on women. In the name of women's "choice" and "reproductive rights," policy legitimised the 20 million spent by the Population Council on researching a single (and controversial) hormonal contraceptive – Norplant. Such injectables and vaccines became an integral part of the agenda for the Structural Adjustment Programme (SAP).

Prior to Cairo, the Indian Government was thus faced with two dilemmas. The first was that under SAP it no longer had any money for welfare services, but neither could it again coerce people into controlling family size. The second lay in the worldwide recognition, from Bucharest to Rio de Janeiro, that population numbers were not the crucial factor in underdevelopment. The genius of the policy planners lies in how they have grasped both dilemmas and, through a process of clever manipulation, used their opponent's arguments to justify their own case. Two policy documents presented in Cairo clearly demonstrate this genius.

India's country statement for the ICPD is the first of these documents. It parrots the ICPD line. Emphasising the link between population and development, it transforms "targets" into "goals" and underlines the need for women's education, employment, improved status, nutrition and health.

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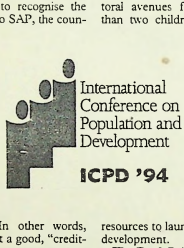
Having made all the politically correct statements, it subtly changes course and focusses on family planning as a "basic need". Surer, but comparatively more dangerous, contraceptives are thus made acceptable to fulfil this need. And, of course, this has to be seen in the context of SAP. "Until these reforms are achieved the cost could be high, in terms of continuing cuts in employment, in lower growth of financial allocations for priority in agriculture, social sector and infrastructure, and limitation of resources for environmental protection."

However, forced to recognise the political opposition to SAP, the country statement genuflects in that direction: "There are real risks to the poor from the reforms." Then the buck is passed on: "Poverty and social sector programmes must be supported by significant concessional funding from multilateral agencies and bilateral donors." In other words, India is a beggar, but a good, "creditworthy" one!

The second, even more brilliant, document is the Population Policy Draft prepared by the Swaminathan Committee. It surpasses the country statement in its appropriation of radical language to cover up a series of contradictory statements and half-truths. Thus, it is convinced that "development which is not equitable is not sustainable," and that an "enabling environmnt and empowering mechanisms" are needed to improve the quality of life of the poor. The rise in pollution is attributed to "the lifestyle of the rich" (and also the increasing population). It proposes to continue the Minimum Needs Programme (to address inequality) and the integration of maternal and child health and family planning with general health services. Its major concern is with gender inequality and the discrimination against women. The committee enthusiastically espouses the cause of women through new inheritance laws, better educational and job opportunities and improved health care. It further recommends the setting up of a high-power Population and Social Development Commission to plan, implement and monitor the entire strategy for equitable development.

Having paid its respects to all the minor gods in the pantheon, the Swaminathan Committee returns resoundingly to the principal deity: "Population, poverty and environmental degradation have close linkages, and the quest for food, education, health and work for all will remain illusory unless success is achieved in limiting the growth of population"! For limiting this growth, the Draft Policy quietly suggests legislative steps, including cutting off of employment, promotional and electoral avenues for those with more than two children. It even suggests that since the Army has done such good work in planting trees it would do equally well in "promoting small family norms". And it neatly sidesteps the question of where, within a shrinking budget, its high-power Commission will obtain the resources to launch any form of social development.



The Draft Policy, thus, is a magnificent piece of sound and fury that signifies the surreptitious and ever-more-powerful return of an internationally discredited Malthus. It has a preamble that eulogises development but has no clues about how to achieve it except through population control. It advances a set of alternative strategies for tackling the discredited family planning programme and gender inequality which eventually boil down to "choice" within a set of hormonal contraceptives. And it disguises the malevolence of coercion under a paean to "efficiency" and "political will".

This Draft Policy, emerging from the low profile of Cairo, is now on the table of Parliament. It tells India's donors how keen the Indian Government is to please them – if so permitted by its political opponents. Will Parliament, as the responsible voice of the Indian people, be able to restrain this headlong plunge into a mythical "liberalisation"? Or will the mighty labours of the Swaminathan Committee, aggravated by the distorted fear of epidemics, lead our legislators into the recurring trap of multilateral debt, technology, and domination? ■

nurtured, loved, educated and supported. I dream of a Pakistan, of an Asia, of a world not undermined by ethnic divisions brought upon by population growth, starvation, crime, and anarchy. I dream of a Pakistan, of an Asia, of a world, where we can commit our social resources to the development of human life, and not to its destruction. That dream is far from the reality we endure..." Playing to a home gallery, she affirmed that Pakistan would not endorse any clause repugnant to Muslims, though she veered around to say, "Leaders are not elected to let a narrow-minded minority dictate an agenda of backwardness. We are committed to an agenda for change."

All the three women-speakers received thunderous ovations.

Earlier, on September 5, addressing the NGO Forum at the Cairo Indoor Sports Stadium, Egypt's First Lady Suzanne Mubarak said the ICPD offered a great opportunity to reach a new understanding on policies that will help upgrade the quality of life and wellbeing of all peoples. "The success of any population programme greatly depends on the free choice of the people involved," she said.

Shuttling between the plenary session of the U.N. and the seminars and discussions at the NGO Forum, one had the feeling of living in split time with the pendulum swinging from the rational, at the conference, to the emotional at the NGO Forum.

The Indian delegation to the ICPD was led by Union Minister for Health and Family Welfare B. Shankaranand, and included Union Minister of State for External Affairs Salman Kursheed and Dr. M. S. Swaminathan. Nearly 200 Indian NGOs representing various voluntary organisations, such as the Self-Employed Women's Association (SEWA) and the All India Women's Conference, were present. In all there were nearly 14,000 delegates from 183 countries.

Before the conference got under way, there were threats by fundamentalists warning delegates to stay away from the conference or face the consequences. Security in Cairo was tight and there was no untoward incident. But there was high drama within the conference venue, with the Vatican taking an intransigent stand on abortion and fundamentalists trying to hijack the conference agenda by deflecting attention away from the main issues and protesting para 8.25, which, as Nafis Sadik pointed out, had become synonymous with controversy.

The para says, "In no case should abortion be promoted as a method of

family planning. All governments and relevant inter-governmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the impact of unsafe abortions as a major public concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Any measures or changes related to abortion within the health-system can only be determined at the national or local level, according to the national legislative process..."

Given the cautious wording of this para, and the sovereignty clause in Chapter II, one wonders what all the controversy and excitement were about.

At both the U.N. and the NGO forums, there was rhetoric and more rhetoric; there was dialogue and dissension; there were strident voices, gentler voices, there were fundamental tones and tolerant tones. There were petitions and demonstrations; there was tension and humour; there was controversy and consensus. But it was a long and convoluted process to arrive at that consensus. As Dr. Maher Mahran, who presided over the closing session of the ICPD, said: "It was a long and protracted delivery." Much of the controversy and heated debate centred around the Vatican's uncompromising stand; the Muslim fundamentalists also joined it. "Strange bed-follows" a newspaper columnist dubbed them, while another newspaper ran a column under the headline "Between the devil and the deep Sea." And at the NGO forum, delegates went around with badges saying, "I'm poped out."

Women's voices dominated both the U.N. and the NGO forums. Newspaper reporters made much of Jane Fonda's and Sushmita Sen's appearances at the ICPD. African women, whose presence was very strong, vociferously debated crucial issues like poverty, female circumcision and so on. The Indian delegates' balanced and dignified presence was in sharp contrast to the shrillness and stridency of some of the Western feminists. "The empowerment of women" was a phrase which resounded and reverberated in the halls of both forums. But Indians have always lived with the concept of woman-power as shakthi, as I had mentioned in my paper on a holistic approach to family welfare.

The Programme of Action calls for an increase in funding for global population programmes from the present 5 billion to about 17 billion by the year 2000. The funding requirement is expected to rise to 18.5 billion in 2010 and 20.5 billion in 2015. The specific

details of these funding proposals are expected to be taken up at the forthcoming U.N. General Assembly session in New York.

The closing session of the ICPD took place amidst tight security. Summing up, Nafisa Sadik said: "This has been an outstanding conference... You have drafted a programme of action for the next 20 years... which shows us the path to a better reality. It contains highly specific goals and recommendations in the mutually-reinforcing areas of infant and maternal mortality, education and reproductive health, and family-planning; but its effect will be more far reaching than that. This programme of action has the potential to change the world. Energetic and committed implementation will bring women at last into the mainstream of development; it will protect women's health, promote their education and encourage and reward their economic contribution. It will ensure that every pregnancy is intended and every child is a wanted child; it will protect women from the results of unsafe abortion; it will protect the health of adolescents, and encourage responsible behaviour. It will combat HIV/AIDS; it will promote and education for all and close the gender gap in education; it will protect and promote the integrity of the family."

The Programme of Action will now be placed before the General Assembly. As with the proceedings, the outcome of the ICPD also met with divided opinion. There were the cynics who said the conference was another wasteful exercise in futility. They sneered at the sacrosanct sovereignty clause in Chapter II of the Programme of Action, which, they claim, is legally non-binding. Some feminists were furious that abortion had eclipsed other major issues. But, on the whole, the response was overwhelmingly positive. It was rightly felt that the conference was a forum which resolved many contentious issues, though many still remain, and that it has cut across the North-South divide. Others, like Pakistan's former caretaker Prime Minister Moeenuddin Qureshi, pointed out that against the backdrop of threats made by Muslim fundamentalists, the fact that the conference took place at all was a major achievement.

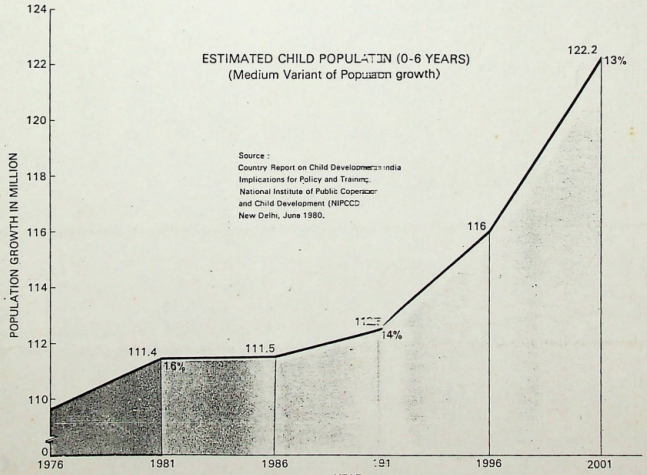
My personal assessment is that the ICPD was a momentous meeting of the international community. Its holistic approach to issues and concern with the democratic process frequently found articulation in the phrase 'freedom of choice'. It achieved many things: It demonstrated beyond doubt that fundamentalistic forces could not blackmail or hold the international community to ransom. From that perspective alone it could be called a run-away success. The consensus (not to be confused with unanimity), though with reservations, was significant because it was achieved after so much debate. Even more significant was that it set off a revolutionary process in the participants' thinking. No one who attended the ICPD would have returned home the same. So many doors have been opened in the minds, so many questions raised in the interaction. Real revolution has to start in people's minds and hearts, and the spirit and motivation have to come from within. No one can force it on another.

Is there a meeting point between rhetoric and reality, between fundamentalism and freedom of religious expression, and confrontation and consensus? Where does one person's right end and another's begin? Where does the role of the Government end and that of an NGO begin? And where indeed does policymaking end and practical action begin? These were some of the questions that reverberated in the conference halls and corridors. Perhaps the answers are yet to be found. But, one hopes, they will be found sooner than later. ■

ESTIMATED CHILD POPULATION
(0 – 6 years)

The number of pre-school children (0 – 6 years) is estimated to reach 122 million at the close of this century. Population projections are made under varying assumptions regarding the future course of fertility and mortality.

There will be an increment in the absolute number of children in each quinquennium, but their proportion to the country's total population will consistently reduce at 13 per cent under medium variant of future population growth.



In addition, local cultural beliefs and alternative systems of health care have been frequently ignored and little value has been placed on community participation. War and civil strife has a devastating effect on the lives of large numbers of people and a negative impact on their health and development.

There has been increasing awareness of the adverse impact on health of many economic and health policies and a realization that a purely technological approach to health care could not solve major global health problems, especially those resulting from poverty. Policy-makers now recognized the importance of targeting the socio-economic, environmental and political determinants of health.

A new global health policy for the twenty-first century

A strengthened relationship between WHO and NGOs, based on a recognition of each other's comparative advantages and on common goals, would be a powerful combination of interests.

To be successful, this new relationship should be based on clear principles and joint policies and plans. One of the priorities of the Geneva consultation was to define this new partnership and to identify specific mechanisms for cooperation.

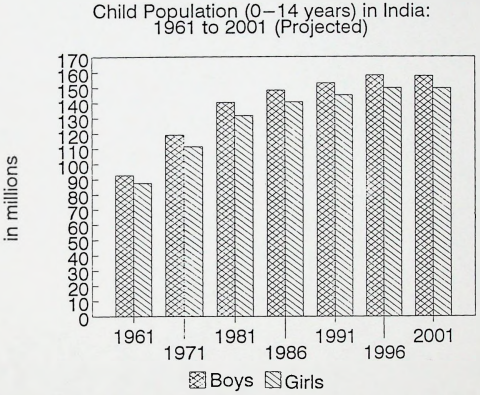
Determinants of health		
Macro factors	**Proximate factors**	**Biological Factors**
Political	Safe, sufficient food	Genetic
Economic	Water & sanitation	
Educational	Industry actions	
Environmental	Social networks	
Technology	Social capital	
	Behaviour	
	Culture	
	Health services	

NGOs are particularly adapted to address the multiplicity of these global health challenges, as they are already working in all these sectors.

A New Global Health Policy for the Twenty-First Century:
An NGO Perspective
(Outcome of a Formal Consultation of NGOs at Geneva
-2/3 May 97)
WHO Publication

CHILDREN IN INDIA

There are an estimated 300 million children between 0 and 14 years of age in India today, representing a little over one-third of India's population.



Source: Census of India (1981) and Report of the Expert Committee on Population Projections quoted in National Institute of Public Cooperation and Child Development (1993).

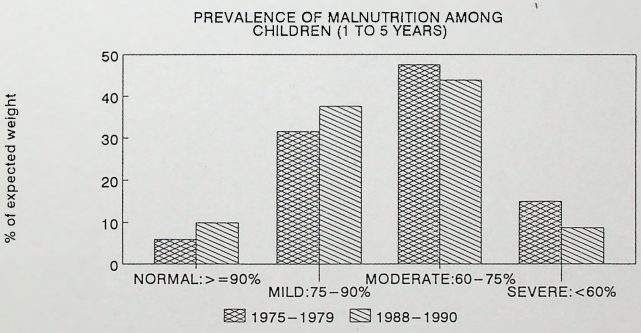
As the graph indicates, despite the reduction in the birth rates from 41.9 per 1,000 population in 1960-61 to 29.5 in 1990-91, the child population has continued to increase. It is expected to reach a high of 307 million in 1996 after which there is likely to be a gradual reduction in child population with the decline in birth rates.

Also, there were an estimated 7.8 million fewer girls than boys in 1991. The female-to-male ratio works out to 0.949.

The Right to be a child - UNICEF India Background paper 1994.

Recent studies also point out that children in urban slums and poor neighbourhoods in urban areas live under particularly vulnerable conditions of health and nutritional well-being. The risk of a slum child receiving a calorie-deficient diet, for instance, is reported to be twice as high as compared to those of children from middle income and low income families.

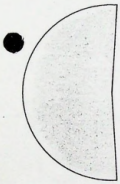
Government of India has taken several steps to address the problem of malnutrition. The Integrated Child Development Services (ICDS) launched in 1975 has expanded to become the largest nutrition programme in the world with 3,066 projects covering 16.2 million children in the age group of 0 to 6 years and 3.2 million pregnant women. The package of services provided under this programme includes supplementary feeding, immunization, health check-up, referral services, non-formal pre-school education and nutrition and health education. India's performance in terms of food production has also been impressive over the last few years, with record level of 180 million tonnes of foodgrain produced in 1992-93. The country has built up a food buffer stock of 23 million tonnes, and has in place a network of more than 400,000 fair price shops for public distribution of essential commodities to the poor at lower-than-market prices. Despite these and other programmes like the use of ORT and universal immunization, nutritional deprivation and hunger are the norm, with over 43.8% (1988-90) children suffering from moderate malnutrition and about 37.6% (1988-90) from mild malnutrition.

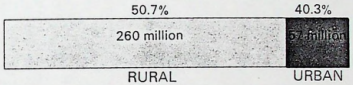


Source: National Institute of Nutrition (1993).

Government of India's Nutritional Policy recognizes that nutrition is a multisectoral issue, and has called for evolving a mix of both direct nutrition interventions as well as development policy instruments which will create conditions of improved nutrition. The Oslo Initiative for a World Alliance for Nutrition and Human Rights observes that "in order to ensure sound nutrition as much attention has to be given also to child care and protection and promotion of child health as to food security." Efforts to develop more such integrated approaches will need to be reinforced and strengthened.

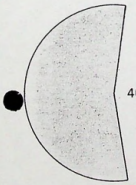
POPULATION BELOW POVERTY LINE

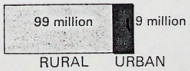




Source : Yojana, Vol. XXV.5
16-31 March, 1981.

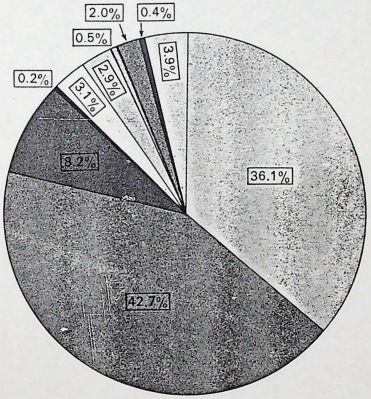
CHILDREN BELOW POVERTY LINE





Source : Statement of Planning Minister
in Lok Sabha, 26 Feb. 1981

CHILD WORKERS BY NATURE OF ACTIVITY 1971

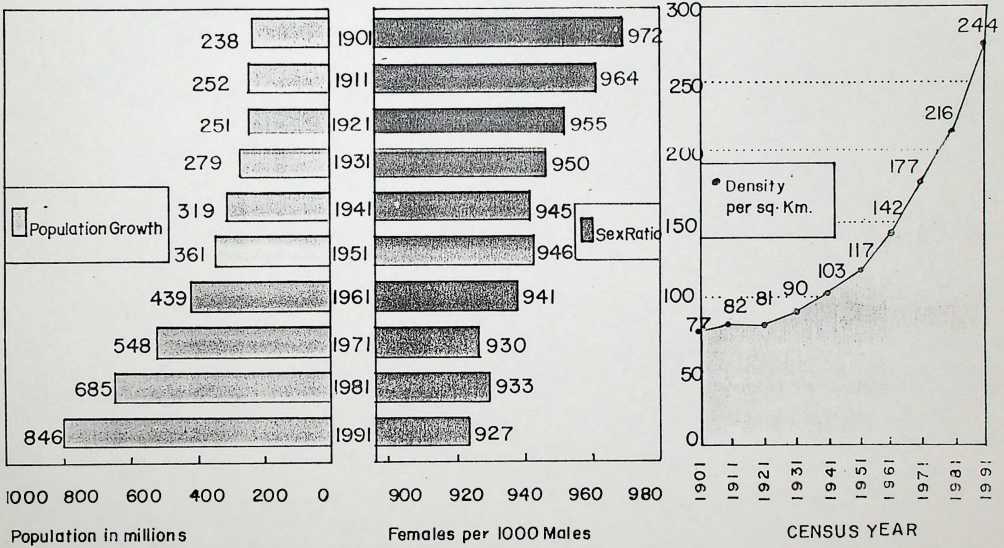


PERCENTAGE OF CHILD WORKERS WITH RESPECT TO TOTAL CHILD WORKERS

- Cultivators
- Agricultural labourers
- Livestock, Forestry, Fishing & Plantations, Orchards and allied activities
- Mining and quarrying
- Household Industry
- Other than Household Industry
- Construction
- Trade and Commerce
- Transport, Storage and Communication
- Other Services

CHART NO-I

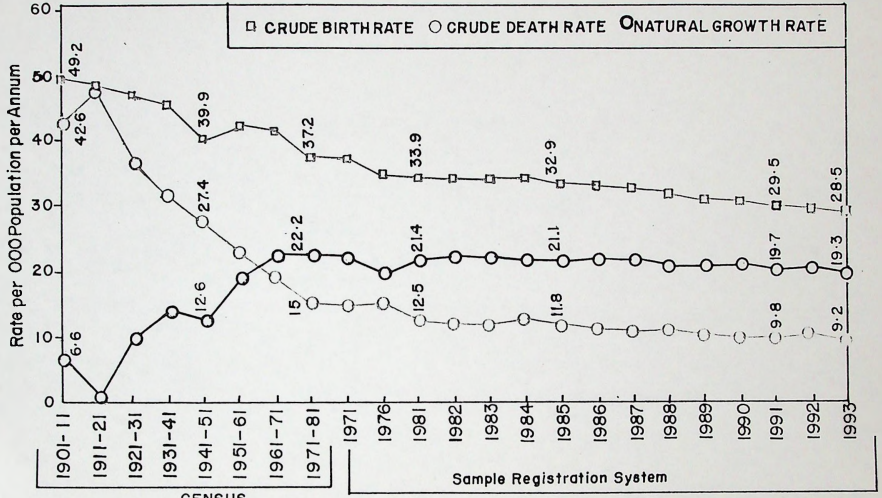
POPULATION IN INDIA 1901-91



SOURCE : REGISTRAR GENERAL OF INDIA

CHART NO-3

BIRTH RATE, DEATH RATE AND NATURAL GROWTH RATE IN INDIA
1901 - 1993



SOURCE: REGISTRAR GENERAL OF INDIA

2000 World Population Data Sheet

of the Population Reference Bureau

Demographic Data and Estimates for the Countries and Regions of the World

Book Edition

PRB

Table of Contents

BOOK EDITION

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Data prepared by PRB demographers Carl Haub and Diana Cornelius
Design and production: Heather Lilley, PRB

2000 World Population Data Sheet Highlights

■ *The impact of the current pace of world population growth can be appreciated when we consider that the 6 billion mark was reached last year and the next billion will arrive in only about 13 years.*

■ *Over the next half century, Africa is projected to become home to a larger share of world population; Africa's population will increase from 13 percent of the world's population in 2000 to 16 percent by 2025, and to 20 percent by 2050. During the same time, Europe's population is projected to decline from 12 percent of the current world total to 7 percent by 2050. Asia's proportion of world population is projected to decline slightly, from 61 percent today to 58 percent by 2050. Changes are not projected for the proportions of world population living in the Americas and Oceania.*

■ *India's population officially reached 1 billion on May 11, 2000. With over one-third of its population under age 15, India's population will continue to grow for many decades, and India is likely to become the world's largest country in population by mid-century.*

■ *Although the use of modern family planning methods has increased worldwide, nearly two-thirds of women in less developed countries (apart from China) are not using modern contraception. In sub-Saharan Africa, nearly 90 percent are not using modern contraception.*

World's Largest Countries in 2000

Rank	Country	Population (millions)
1	China	1,265
2	India	1,002
3	United States	276
4	Indonesia	212
5	Brazil	170
6	Pakistan	151
7	Russia	145
8	Bangladesh	128
9	Japan	127
10	Nigeria	123
11	Mexico	100
12	Germany	82
13	Philippines	80
14	Vietnam	79
15	Egypt	68

World's Largest Countries in 2050

Rank	Country	Population (millions)
1	India	1,628
2	China	1,369
3	United States	404
4	Indonesia	312
5	Nigeria	304
6	Pakistan	285
7	Brazil	244
8	Bangladesh	211
9	Ethiopia	188
10	Congo, Democratic Republic of (Zaire)	182
11	Mexico	152
12	Philippines	140
13	Russia	128
14	Vietnam	124
15	Egypt	117

PRB *Population Reference Bureau* ■ *1875 Connecticut Ave., NW, Suite 520* ■ *Washington, DC 20009-5728 USA* ■ *Tel.: (202) 483-1100* ■ *Fax: (202) 328-3937*
■ *E-mail: popref@prb.org* ■ *Web site: www.prb.org*

Despair and Hope: The HIV/AIDS Epidemic

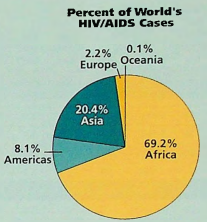
More people died of AIDS in 1999 than in any previous year. The 2.6 million deaths in 1999 brought the estimated total number of deaths since the beginning of the epidemic to 16.3 million.

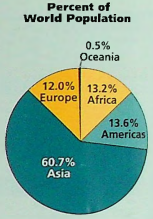
The annual number of deaths from AIDS is not expected to peak for many years because of the large number of people already infected. The Joint United Nations Programme on HIV/AIDS and the World Health Organization estimate that in 1999, 5.6 million people became infected with the human immunodeficiency virus (HIV), which causes the life-threatening illness AIDS. Nearly 34 million people currently live with HIV/AIDS.

The AIDS epidemic affects people of all ages. About half of all people who [illegible] worldwide—0.1 percent

Africa Dealt Worst Blow

Infection rates are not equally distributed around the globe. Ninety-five percent of people who are infected with HIV live in developing countries. The highest concentration of people with the HIV infection is in Africa, which accounts for 13 percent of the world's population but 69 percent of the cases of HIV infection. By contrast, Asia contains 61 percent of world population and 20 percent of HIV cases. The Americas have 14 percent of world population and 8 percent of HIV cases. Europe contributes 12 percent of world population and 2 percent of its population lives with an HIV infection. Half of 1 percent of world population lives in Oceania and those countries have an even lower percent of HIV cases





who are infected. One reason for this difference by gender is that women contract the disease at younger ages and may be more likely to become infected during any single exposure.

HIV/AIDS is having a devastating effect on life expectancy in some countries. A child born in Southern Africa in the early 1950s could expect to live to age 44. By the early 1990s, life expectancy in this region had risen to nearly 60 years. But because of AIDS, that gain is expected to be lost. A child born in Southern Africa between 2005 and 2010 is expected to live just 45 years. (See the demographic data for the current life expectancies in other countries.)

Uganda Provides Hope for Africa

However, there is a glimmer of hope in Africa. In Uganda the rate of new HIV infections has declined since the early 1990s when three in 10 pregnant women in the capital city of Kampala were HIV positive. President Yoweri Museveni has openly discussed the problem since 1986. People at all levels of society—political, community, and religious leaders—have been involved in the campaign to halt AIDS in Uganda, and it has made a major impact on the epidemic in this country. Still, it took several years to begin to see declines in the rate of new infections. It is not clear whether other African countries will repeat this experience. There have been recent signs of government leadership in halting the spread of HIV in Kenya and Tanzania; the presidents of these two countries have stated that the countries need to deal with HIV in order to curb the epidemics in sub-Saharan Africa.

Thai Effort Successful

In Asia, Thailand's experience shows even more dramatically the effects that concerted action by the government,

(Continued on page 9)

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The AIDS epidemic affects people of all ages. About half of all people who contract AIDS are under age 25. Over 90 percent of the children under age 15 who contract HIV are born to mothers with HIV. Women can pass HIV to their children during pregnancy or delivery and through breastfeeding. Over the course of the epidemic, AIDS has left over 11.2 million children under age 15 without their mothers and many of those same children without a father. While some therapies can lengthen the life of someone with AIDS, there is still no cure for AIDS.

The elderly population is affected indirectly by HIV/AIDS, as older people become the primary caretakers of their own children who are dying of AIDS and also may become caretakers of grandchildren orphaned by AIDS.

Africa Dealt Worst Blow

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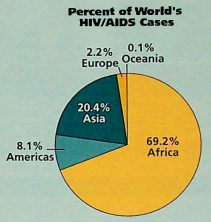
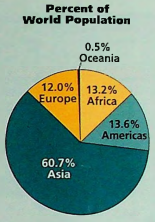
In sub-Saharan Africa about one in every 30 people is infected with HIV. Just over half of these people live in the countries of Eastern Africa. Over 8 million people live with the HIV infection in five Eastern African countries: 1.2 million in Mozambique, 1.4 million in Tanzania, 1.5 million in Zimbabwe, 1.6 million in Kenya, and 2.6 million in Ethiopia.

In Western Africa, Nigeria has the largest population of people living with HIV—2.3 million. Nearly 3 million people in South Africa are infected with HIV—the highest number of any country in Africa.

New evidence in Africa indicates that more women than men are infected with HIV on that continent—perhaps 12 or 13 women are infected for every 10 men who are infected. One reason for this difference by gender is that women contract the disease at younger ages and may be more likely to become infected during any single exposure.





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(Continued on page 9)

Demographic Data and Estimates for the Countries and Regions of the World

	Population mid-2000 (millions)	Births per 1,000 pop.	Deaths per 1,000 pop.	Natural Increase (annual, %)	"Doubling Time" in Years at Current Rate	Projected Population (millions) 2025	2050	Infant Mortality Rate[a]	Total Fertility Rate[b]	Percent of Population at Age <15	65+	Life Expectancy at Birth (years) Total	Male	Female	Data Avail. Code[c]	Percent Urban	Percent of Adult Population 15-49 with HIV/AIDS	Percent of Married Women Using Contraception All Methods	Modern Methods	Govt. View of Birth Rate[d]	GNP Per Capita, 1998 (US$)	Area, Density, and Capital City Area of countries (square miles)	Population per square mile	Capital City
Eastern Africa	**246**	**42**	**18**	**2.4**	**29**	**390**	**584**	**102**	**6.0**	**45**	**3**	**46**	**45**	**47**		**20**	**10.4**	**19**	**14**		**260**	**2,456,184**	**100**	
Burundi	6.1	42	17	2.5	28	10.5	16.1	75	6.5	48	3	47	46	47	C	8	8.3	—	—	H	140	10,745	563	Bujumbura
Comoros	0.6	38	10	2.8	25	1.1	1.8	77	5.1	42	3	59	57	62	B	29	0.1	21	11	H	370	861	671	Moroni
Djibouti	0.6	39	16	2.3	30	1.0	1.3	115	5.8	41	3	48	47	50	D	83	10.3	—	—	H	—	8,958	71	Djibouti
Eritrea	4.1	43	13	3.0	23	8.4	13.7	82	6.1	43	3	55	52	57	C	16	3.2	8	4	H	200	45,405	91	Asmara
Ethiopia	64.1	45	21	2.4	29	115.0	187.9	116	6.7	45	3	46	45	47	C	15	9.3	*4*	*3*	H	100	426,371	150	Addis Ababa
Kenya	30.3	35	14	2.1	33	34.4	38.7	74	4.7	46	3	49	48	49	B	20	11.6	39	32	H	350	224,081	135	Nairobi
Madagascar	14.9	44	14	2.9	24	28.5	46.9	96	6.0	45	3	52	51	53	B	22	0.1	19	10	H	260	226,656	66	Antananarivo
Malawi	10.4	41	22	1.9	36	12.6	14.7	127	5.9	46	3	39	38	40	C	20	14.9	22	14	H	210	45,745	227	Lilongwe
Mauritius	1.2	17	7	1.1	66	1.4	1.5	19.4	2.0	26	6	70	67	74	A	43	0.1	*75*	*60*	S	3,730	788	1,510	Port Louis
Mozambique	19.1	41	19	2.2	32	20.6	22.9	134	5.6	46	2	40	40	39	B	28	14.2	6	5	H	210	309,494	62	Maputo
Reunion	0.7	20	5	1.4	49	1.0	1.2	9	2.2	30	6	74	70	79	B	73	*z*	*73*	*67*	—	—	969	739	St. Denis
Rwanda	7.2	43	20	2.3	30	8.0	8.9	121	6.5	45	3	39	39	40	D	5	12.8	*21*	*13*	H	230	10,170	711	Kigali
Seychelles	0.1	18	7	1.1	65	0.1	0.1	9	2.0	28	7	70	67	73	B	59	—	—	—	H	6,420	174	472	Victoria
Somalia	7.3	47	18	2.9	24	14.9	25.5	126	7.0	44	3	46	45	48	D	24	0.3	—	—	S	—	246,201	29	Mogadishu
Tanzania	35.3	42	13	2.9	24	59.8	88.3	99	5.6	45	3	53	52	54	C	20	9.4	24	16	H	220	364,900	97	Dar-es-Salaam
Uganda	23.3	48	20	2.9	24	48.0	84.1	81	6.9	49	2	42	42	43	B	15	9.5	15	8	H	310	93,066	251	Kampala
Zambia	9.6	42	23	2.0	35	14.3	20.3	109	6.1	45	3	37	37	38	B	38	19.1	26	14	H	330	290,583	33	Lusaka
Zimbabwe	11.3	30	20	1.0	69	9.5	9.3	80	4.0	44	3	40	41	39	B	32	25.8	54	50	H	620	150,873	75	Harare
Middle Africa	**96**	**46**	**16**	**3.0**	**23**	**185**	**303**	**106**	**6.6**	**46**	**3**	**49**	**48**	**51**		**32**	**4.3**	**10**	**3**		**320**	**2,553,151**	**38**	
Angola	12.9	48	19	3.0	23	25.1	36.9	125	6.8	48	3	47	45	48	D	32	2.1	—	—	S	380	481,351	27	Luanda
Cameroon	15.4	37	12	2.6	27	24.7	34.7	77	5.2	43	3	55	55	56	C	44	4.9	19	7	H	610	183,568	84	Yaounde
Central African Republic	3.5	38	18	2.0	34	4.9	6.4	97	5.1	44	4	45	43	46	C	39	10.8	15	3	S	300	240,533	15	Bangui
Chad	8.0	50	17	3.3	21	17.3	31.5	110	6.6	44	3	48	46	51	B	22	2.7	4	1	S	230	495,753	16	N'Djamena
Congo	2.8	40	16	2.4	29	4.6	6.9	109	5.3	43	3	48	45	50	C	41	7.8	—	—	H	680	132,046	21	Brazzaville
Congo, Dem. Rep. of (Zaire)	52.0	48	16	3.2	22	105.3	181.9	109	7.2	48	3	49	47	50	C	29	4.4	*8*	*3*	S	110	905,351	57	Kinshasa
Equatorial Guinea	0.5	41	16	2.5	28	0.8	1.1	108	5.6	43	4	50	48	52	D	37	1.2	—	—	S	1,110	10,830	42	Malabo
Gabon	1.2	38	16	2.2	32	2.0	2.7	87	5.4	39	6	52	51	54	C	73	4.3	—	—	L	4,170	103,347	12	Libreville
Sao Tome and Principe	0.2	43	9	3.4	20	0.3	0.5	51	6.2	47	4	64	63	66	B	44	—	—	—	H	270	371	432	Sao Tome
Southern Africa	**50**	**26**	**13**	**1.3**	**52**	**43**	**43**	**51**	**3.1**	**35**	**5**	**54**	**53**	**55**		**42**	**13.5**	**53**	**52**		**3,100**	**1,032,730**	**48**	
Botswana	1.6	32	17	1.6	45	1.2	1.2	57	4.1	41	4	44	43	45	C	49	25.1	—	—	H	3,070	224,606	7	Gaborone
Lesotho	2.1	33	13	2.1	33	2.4	2.8	85	4.4	41	5	53	52	55	C	16	8.4	*23*	*19*	H	570	11,718	183	Maseru
Namibia	1.8	36	20	1.7	42	2.3	3.8	68	5.1	44	4	46	47	45	B	27	19.9	*29*	*26*	H	1,940	318,259	6	Windhoek
South Africa	43.4	25	12	1.3	55	35.1	32.5	45	2.9	34	5	55	54	57	B	45	12.9	56	55	H	3,310	471,444	92	Pretoria
Swaziland	1.0	41	22	1.9	37	1.6	3.1	108	5.9	47	3	38	36	39	C	22	18.5	*21*	*19*	H	1,400	6,703	150	Mbabane

For notes, see page 10.

NORTH AMERICA

Demographic Data and Estimates for the Countries and Regions of the World

	Population mid-2000 (millions)	Births per 1,000 pop.	Deaths per 1,000 pop.	Natural Increase (annual, %)	"Doubling Time" in Years at Current Rate	Projected Population (millions) 2025	2050	Infant Mortality Rate[a]	Total Fertility Rate[b]	Percent of Population at Age <15	65+	Life Expectancy at Birth (years) Total	Male	Female	Data Avail. Code[c]	Percent Urban	Percent of Adult Population 15-49 with HIV/AIDS	Percent of Married Women Using Contraception All Methods	Modern Methods	Govt. View of Birth Rate[d]	GNP Per Capita, 1998 (US$)	Area, Density, and Capital City: Area of countries (square miles)	Population per square mile	Capital City
NORTH AMERICA	**306**	**14**	**9**	**0.6**	**124**	**374**	**444**	**7**	**2.0**	**21**	**13**	**77**	**74**	**80**		**75**	**0.7**	**77**	**70**		**28,230**	**7,699,508**	**25**	
Canada	30.8	11	7	0.4	178	36.0	40.2	5.5	1.5	19	12	79	76	81	A	78	0.3	80	66	S	19,170	3,849,670	8	Ottawa
United States	275.6	15	9	0.6	120	337.8	403.7	7.0	2.1	21	13	77	74	79	A	75	0.8	76	71	S	29,240	3,717,796	74	Washington, DC
LATIN AMERICA & THE CARIBBEAN	**518**	**24**	**6**	**1.8**	**39**	**703**	**823**	**35**	**2.8**	**33**	**5**	**70**	**66**	**73**		**74**	**0.6**	**68**	**59**		**3,880**	**7,946,649**	**65**	
Central America	**136**	**26**	**5**	**2.1**	**33**	**192**	**232**	**34**	**3.1**	**38**	**4**	**71**	**68**	**74**		**67**	**0.4**	**62**	**53**		**3,230**	**957,452**	**145**	
Belize	0.3	32	5	2.7	26	0.4	0.5	34	3.9	41	4	72	70	74	B	50	1.9	*47*	*42*	S	2,660	8,865	29	Belmopan
Costa Rica	3.6	22	4	1.8	39	5.8	7.0	13	3.2	33	5	77	75	79	B	45	0.6	*75*	*65*	S	2,770	19,730	182	San Jose
El Salvador	6.3	30	7	2.4	29	9.8	13.6	35	3.6	36	5	70	67	73	B	58	0.6	60	54	H	1,850	8,124	773	San Salvador
Guatemala	12.7	37	7	2.9	24	22.3	32.2	45	5.0	44	3	64	61	67	B	39	0.5	38	31	H	1,640	42,042	301	Guatemala
Honduras	6.1	33	6	2.8	25	8.6	11.0	42	4.4	42	3	68	66	71	B	45	1.5	50	41	H	740	43,278	142	Tegucigalpa
Mexico	99.6	24	4	2.0	36	132.5	152.1	32	2.7	37	5	72	69	75	B	74	0.4	65	56	H	3,840	756,062	132	Mexico City
Nicaragua	5.1	36	6	3.0	23	8.7	11.6	40	4.4	44	3	68	66	71	B	63	0.2	60	57	H	370	50,193	101	Managua
Panama	2.9	22	5	1.7	41	3.8	4.3	21	2.6	32	5	74	72	77	C	56	0.6	—	—	S	2,990	29,158	98	Panama City
Caribbean	**36**	**22**	**8**	**1.3**	**52**	**46**	**51**	**47**	**2.6**	**30**	**7**	**69**	**66**	**71**		**61**	**1.8**	**—**	**—**		**—**	**90,618**	**401**	
Antigua and Barbuda	0.1	22	6	1.6	45	0.1	0.1	*17*	2.2	28	8	71	69	74	B	37	—	—	—	S	8,450	170	400	St. John's
Bahamas	0.3	21	5	1.5	45	0.4	0.5	18.4	2.2	32	5	74	70	77	A	84	3.8	—	—	H	—	5,359	58	Nassau
Barbados	0.3	14	9	0.5	130	0.3	0.3	14.2	1.8	24	10	75	72	77	A	38	2.9	—	—	S	—	166	1,560	Bridgetown
Cuba	11.1	14	7	0.7	103	11.7	10.6	7	1.6	22	9	75	73	78	C	75	*z*	—	—	S	—	42,803	260	Havana
Dominica	0.1	16	8	0.8	83	0.1	0.1	*14.6*	1.9	38	7	78	75	80	A	—	—	—	—	S	3,150	290	262	Roseau
Dominican Republic	8.4	28	6	2.2	32	12.1	14.9	47	3.1	36	4	69	67	71	B	62	1.9	64	59	H	1,770	18,815	449	Santo Domingo
Grenada	0.1	29	6	2.3	30	0.2	0.2	*14*	3.8	43	5	71	68	73	B	34	—	*54*	*49*	H	3,250	131	747	St. George's
Guadeloupe	0.4	17	6	1.1	61	0.5	0.5	10.0	2.0	26	9	77	73	80	A	48	—	—	—	—	—	660	680	Basse-Terre
Haiti	6.4	33	16	1.7	40	9.6	11.9	103	4.7	40	4	49	47	51	C	34	5.2	18	14	H	410	10,714	599	Port-au-Prince
Jamaica	2.6	22	7	1.6	45	3.3	3.8	24	2.6	31	7	71	70	73	B	50	1.0	66	63	H	1,740	4,243	615	Kingston
Martinique	0.4	15	6	0.9	81	0.5	0.5	9	1.8	24	11	78	75	82	C	81	—	—	—	—	—	425	961	Fort-de-France
Netherlands Antilles	0.2	17	6	1.1	62	0.3	0.3	14	2.2	27	7	75	72	78	B	—	—	—	—	—	—	309	715	Willemstad
Puerto Rico	3.9	17	8	0.9	75	4.2	4.2	11.3	2.1	25	10	74	70	79	A	71	—	78	68	—	—	3,456	1,133	San Juan
St. Kitts-Nevis	0.04	20	11	0.9	82	0.1	0.1	*24*	2.2	31	9	67	64	70	C	43	—	—	—	H	6,190	139	309	Basseterre
Saint Lucia	0.2	19	6	1.2	56	0.2	0.2	16.8	2.5	33	6	72	71	72	A	48	—	—	—	H	3,660	239	656	Castries
St. Vincent & the Grenadines	0.1	19	7	1.2	59	0.1	0.2	*20.4*	2.0	37	7	73	71	74	A	44	—	—	—	H	2,560	151	744	Kingston
Trinidad and Tobago	1.3	14	7	0.7	103	1.5	1.5	16.2	1.7	28	6	71	68	73	A	72	0.9	—	—	H	4,520	1,981	654	Port-of-Spain

For notes, see page 10.

LATIN AMERICA & THE CARIBBEAN

OCEANIA

Demographic Data and Estimates for the Countries and Regions of the World

Area, Density, and Capital City

	Population mid-2000 (millions)	Births per 1,000 pop.	Deaths per 1,000 pop.	Natural Increase (annual, %)	"Doubling Time" in Years at Current Rate	Projected Population (millions) 2025	Projected Population (millions) 2050	Infant Mortality Rate[a]	Total Fertility Rate[b]	Percent of Population at Age <15	Percent of Population at Age 65+	Life Expectancy at Birth (years) Total	Life Expectancy at Birth (years) Male	Life Expectancy at Birth (years) Female	Data Avail. Code[c]	Percent Urban	Percent of Adult Population 15-49 with HIV/AIDS	Percent of Married Women Using Contraception All Methods	Percent of Married Women Using Contraception Modern Methods	Govt. View of Birth Rate[d]	GNP Per Capita, 1998 (US$)	Area of countries (square miles)	Population per square mile	Capital City
South America	**345**	**23**	**6**	**1.7**	**42**	**465**	**540**	**34**	**2.7**	**32**	**5**	**69**	**66**	**73**		**78**	**0.6**	**72**	**63**		**4,270**	**6,898,579**	**50**	
Argentina	37.0	19	8	1.1	62	47.2	54.5	19.1	2.6	29	9	73	70	77	A	90	0.7	—	—	S	8,030	1,073,514	35	Buenos Aires
Bolivia	8.3	30	10	2.0	34	12.2	15.5	67	4.2	40	4	60	59	62	B	62	0.1	48	25	S	1,010	424,162	20	La Paz
Brazil	170.1	21	6	1.5	45	221.2	244.2	38	2.4	30	5	68	64	71	B	78	0.6	77	70	S	4,630	3,300,154	52	Brasilia
Chile	15.2	18	5	1.3	54	19.5	22.2	10.5	2.4	29	7	75	72	78	A	85	0.2	—	—	S	4,990	292,135	52	Santiago
Colombia	40.0	26	6	2.0	34	58.3	73.3	28	3.0	33	4	69	65	73	B	71	0.4	72	59	S	2,470	439,734	91	Bogota
Ecuador	12.6	27	6	2.1	33	17.8	21.2	40	3.3	35	4	69	67	72	B	63	0.3	57	46	H	1,520	109,483	116	Quito
French Guiana	0.2	27	3	2.4	29	0.4	0.6	18	3.4	36	4	74	71	77	C	79	—	—	—	—	—	34,749	6	Cayenne
Guyana	0.7	24	7	1.7	40	0.8	0.8	63	2.7	35	4	66	63	69	C	36	2.1	—	—	S	780	83,000	8	Georgetown
Paraguay	5.5	32	6	2.7	26	9.4	12.6	27	4.3	41	4	70	68	72	B	52	0.1	57	48	H	1,760	157,046	35	Asuncion
Peru	27.1	27	6	2.1	32	39.2	47.9	43	3.4	34	5	68	66	71	B	72	0.6	64	41	H	2,440	496,224	55	Lima
Suriname	0.4	26	7	1.9	37	0.5	0.4	29	2.4	33	5	70	68	73	D	69	1.2	—	—	S	1,660	63,039	7	Paramaribo
Uruguay	3.3	16	10	0.7	107	3.9	4.2	14.5	2.3	25	13	74	70	78	A	92	0.3	—	—	L	6,070	68,498	48	Montevideo
Venezuela	24.2	25	5	2.0	34	34.8	42.2	21.0	2.9	37	4	73	70	76	A	86	0.7	—	—	S	3,530	352,143	69	Caracas
OCEANIA	**31**	**18**	**7**	**1.1**	**65**	**39**	**44**	**29**	**2.4**	**26**	**10**	**74**	**72**	**77**		**70**	**0.1**	**61**	**56**		**15,400**	**3,306,692**	**9**	
Australia	19.2	13	7	0.6	110	22.8	24.9	5.3	1.7	21	12	79	76	82	A	85	0.1	67	63	S	20,640	2,988,888	6	Canberra
Fed. States of Micronesia	0.1	33	7	2.6	27	0.2	0.3	46	4.7	44	4	66	65	67	C	27	—	—	—	H	1,800	270	440	Palikir
Fiji	0.8	22	7	1.5	46	1.1	1.3	13	3.3	35	3	67	65	69	C	46	0.1	—	—	S	2,210	7,054	115	Suva
French Polynesia	0.2	21	5	1.6	44	0.3	0.4	10	2.6	31	3	72	69	74	C	54	—	—	—	—	—	1,544	150	Papeete
Guam	0.2	28	4	2.4	29	0.2	0.3	9.1	3.5	32	5	74	72	77	A	38	—	—	—	—	—	212	720	Agana
Kiribati	0.1	33	8	2.5	28	0.2	0.2	62	4.5	40	3	62	59	65	C	37	—	—	—	H	1,170	282	326	Tarawa
Marshall Islands	0.1	26	4	2.2	31	0.2	0.3	31	6.6	49	3	65	63	67	C	65	—	—	—	H	1,540	69	978	Majuro
Nauru	0.01	19	5	1.4	48	0.02	0.02	25	3.7	43	1	61	57	65	B	100	—	—	—	S	—	9	1,360	Yaren
New Caledonia	0.2	21	5	1.7	42	0.3	0.3	7	2.7	31	5	72	69	77	C	59	—	—	—	—	—	7,174	30	Noumea
New Zealand	3.8	15	7	0.8	89	4.4	4.5	5.5	2.0	23	12	77	74	80	A	85	0.1	75	72	S	14,600	104,452	37	Wellington
Palau	0.02	18	8	1.0	68	0.03	0.03	19	2.5	28	6	67	64	71	C	71	—	—	—	S	—	178	108	Koror
Papua-New Guinea	4.8	34	10	2.4	29	7.7	9.5	77	4.8	40	4	56	56	57	C	15	0.2	26	20	H	890	178,703	27	Port Moresby
Solomon Islands	0.4	37	6	3.1	23	0.8	1.1	25	5.4	43	3	71	69	74	C	13	—	—	—	H	760	11,158	39	Honiara
Tonga	0.1	27	6	2.1	33	0.2	0.2	19	4.2	43	4	71	70	72	C	32	—	—	—	S	1,750	290	372	Nuku'alofa
Vanuatu	0.2	35	7	2.8	25	0.3	0.3	39	4.7	44	3	65	64	67	C	18	—	—	—	S	1,260	4,707	41	Port-Vila
Western Samoa	0.2	31	6	2.5	28	0.2	0.2	25	4.2	39	4	68	65	72	C	21	—	—	20	H	1,070	1,097	161	Apia

For notes, see page 10.

Demographic Data and Estimates for the Countries and Regions of the World

	Population mid-2000 (millions)	Births per 1,000 pop.	Deaths per 1,000 pop.	Natural Increase (annual, %)	"Doubling Time" in Years at Current Rate	Projected Population (millions) 2025	Projected Population (millions) 2050	Infant Mortality Rate[a]	Total Fertility Rate[b]	Percent of Population of Age <15	Percent of Population of Age 65+	Life Expectancy at Birth (years) Total	Life Expectancy at Birth (years) Male	Life Expectancy at Birth (years) Female	Data Avail. Code[c]	Percent Urban	Percent of Adult Population 15-49 with HIV/AIDS	Percent of Married Women Using Contraception All Methods	Percent of Married Women Using Contraception Modern Methods	Govt. View of Birth Rate[d]	GNP Per Capita, 1998 (US$)	Area, Density, and Capital City: Area of countries (square miles)	Area, Density, and Capital City: Population per square mile	Capital City
ASIA	3,684	22	8	1.4	48	4,723	5,267	56	2.8	32	6	66	65	68		35	0.3	62	57		2,130	12,262,691	300	
Asia (Excl. China)	2,420	26	8	1.7	40	3,292	3,898	64	3.3	35	5	64	63	65		38	0.5	50	43		2,910	8,566,591	283	
Western Asia	**189**	**28**	**7**	**2.1**	**33**	**300**	**396**	**55**	**4.0**	**37**	**4**	**68**	**66**	**70**		**65**	**z**	**—**	**—**		**3,620**	**1,823,873**	**104**	
Armenia	3.8	10	6	0.4	161	4.1	3.8	15	1.3	25	9	75	71	78	B	67	z	*22*	—	L	460	11,506	331	Yerevan
Azerbaijan	7.7	15	6	0.9	77	9.8	11.5	17	1.9	33	6	72	68	75	B	52	z	—	—	S	480	33,436	231	Baku
Bahrain	0.7	22	3	1.9	37	1.7	2.9	8	2.8	31	2	69	68	71	B	88	0.2	62	31	S	7,640	266	2,594	Manama
Cyprus	0.9	14	8	0.6	124	1.0	1.1	8	1.9	24	10	77	74	79	C	64	0.3	—	—	L	11,920	3,571	247	Nicosia
Georgia	5.5	9	8	0.2	462	4.8	4.2	15	1.2	24	11	73	69	76	B	56	z	41	20	L	970	26,911	203	Tbilisi
Iraq	23.1	38	10	2.8	25	41.0	54.9	127	5.7	43	3	59	58	60	C	68	z	—	—	S	—	169,236	137	Baghdad
Israel	6.2	22	6	1.5	45	8.3	9.4	6.0	2.9	29	10	78	76	80	A	90	0.1	—	—	L	16,180	8,131	766	Jerusalem
Jordan	5.1	33	5	2.9	24	8.8	12.0	34	4.4	42	3	69	68	70	B	78	z	53	38	H	1,150	34,444	148	Amman
Kuwait	2.2	24	2	2.2	32	3.8	4.4	13	3.2	29	1	72	72	73	B	100	0.1	—	—	S	—	6,880	318	Kuwait
Lebanon	4.2	23	7	1.6	43	5.6	6.5	35	2.4	30	6	70	68	73	D	88	0.1	—	—	S	3,560	4,015	1,046	Beirut
Oman	2.4	43	5	3.9	18	5.2	9.0	25	7.1	46	3	71	69	73	B	72	0.1	24	18	H	—	82,031	29	Muscat
Palestinian Territory	3.1	41	5	3.7	19	7.4	11.2	27	6.0	47	3	72	70	73	B	—	—	—	—	—	1,560	2,417	1,283	—
Qatar	0.6	20	2	1.8	38	0.8	0.8	20	4.2	27	1	72	70	75	C	91	0.1	—	—	S	—	4,247	139	Doha
Saudi Arabia	21.6	35	5	3.0	23	40.0	54.5	46	6.4	42	3	70	68	71	C	83	z	—	—	S	6,910	829,996	26	Riyadh
Syria	16.5	33	6	2.8	25	26.9	35.3	35	4.7	45	3	67	67	68	B	51	z	*40*	*28*	S	1,020	71,498	231	Damascus
Turkey	65.3	22	7	1.5	46	88.0	100.7	38	2.5	30	5	69	67	71	B	66	z	64	38	H	3,160	299,158	218	Ankara
United Arab Emirates	2.8	24	2	2.2	32	3.8	4.2	16	4.9	33	2	74	73	76	C	84	0.2	28	24	S	17,870	32,278	88	Abu Dhabi
Yemen	17.0	39	11	2.8	25	38.6	69.3	75	6.5	49	3	59	58	61	B	26	z	21	10	H	280	203,849	84	Sana'a
South Central Asia	**1,475**	**28**	**9**	**1.9**	**37**	**2,037**	**2,451**	**75**	**3.6**	**38**	**4**	**61**	**60**	**62**		**29**	**0.6**	**46**	**40**		**510**	**4,157,320**	**355**	
Afghanistan	26.7	43	18	2.5	28	48.0	76.2	150	6.1	43	3	46	46	45	D	20	z	—	—	H	—	251,772	106	Kabul
Bangladesh	128.1	27	8	1.8	38	177.3	210.8	82	3.3	43	3	59	59	58	B	20	z	49	42	H	350	55,598	2,305	Dhaka
Bhutan	0.9	40	9	3.1	22	1.4	2.0	71	5.6	43	2	66	—	—	D	15	z	8	—	H	470	18,147	48	Thimphu
India	1,002.1	27	9	1.8	39	1,363.0	1,628.0	72	3.3	36	4	61	60	61	B	28	0.8	48	43	H	440	1,269,340	789	New Delhi
Iran	67.4	21	6	1.4	48	90.8	102.9	31	2.9	39	5	69	68	71	B	63	z	73	56	H	1,650	630,575	107	Tehran
Kazakhstan	14.9	14	10	0.4	161	14.6	13.0	21	1.7	29	7	65	59	70	B	56	z	66	54	L	1,340	1,049,151	14	Astana
Kyrgyzstan	4.9	22	7	1.5	47	5.8	6.1	26	2.8	37	6	67	63	71	B	34	z	60	49	S	380	76,641	64	Bishkek

For notes, see page 10.

Demographic Data and Estimates for the Countries and Regions of the World

	Population mid-2000 (millions)	Births per 1,000 pop.	Deaths per 1,000 pop.	Natural Increase (annual, %)	"Doubling Time" in Years at Current Rate	Projected Population (millions) 2025	2050	Infant Mortality Rate[a]	Total Fertility Rate[b]	Percent of Population at Age <15	65+	Life Expectancy at Birth (years) Total	Male	Female	Data Avail. Code[c]	Percent Urban	Percent of Adult Population 15-49 with HIV/AIDS	Percent of Married Women Using Contraception All Methods	Modern Methods	Govt. View of Birth Rate[d]	GNP Per Capita, 1998 (US$)	Area, Density, and Capital City Area of countries (square miles)	Population per square mile	Capital City
Maldives	0.3	35	5	3.0	23	0.5	0.7	27	5.4	45	3	71	71	72	B	25	0.1	18	—	H	1,130	116	2,469	Male
Nepal	23.9	36	11	2.5	28	38.0	49.3	79	4.6	41	3	57	58	57	B	11	0.2	29	26	H	210	56,826	421	Kathmandu
Pakistan	150.6	39	11	2.8	25	227.0	285.0	91	5.6	43	3	58	58	59	C	33	0.1	18	13	H	470	307,375	490	Islamabad
Sri Lanka	19.2	18	6	1.2	60	23.9	25.9	17	2.1	35	4	72	70	74	B	22	0.1	66	44	S	810	25,332	757	Colombo
Tajikistan	6.4	21	5	1.6	43	8.4	9.5	28	2.7	44	4	68	66	71	B	27	z	21	—	H	370	55,251	115	Dushanbe
Turkmenistan	5.2	21	6	1.5	48	6.8	7.5	33	2.5	40	4	66	62	69	B	44	z	20	—	S	—	188,456	28	Ashkhabad
Uzbekistan	24.8	23	6	1.7	40	31.5	33.8	22	2.8	40	4	69	66	72	B	38	z	56	51	S	950	172,741	144	Tashkent
Southeast Asia	**528**	**24**	**7**	**1.7**	**41**	**717**	**836**	**46**	**3.0**	**34**	**4**	**65**	**63**	**67**		**36**	**0.6**	**56**	**48**		**1,240**	**1,735,448**	**304**	
Brunei	0.3	25	3	2.2	32	0.5	0.7	24	3.4	34	3	71	70	73	B	67	0.2	—	—	S	—	2,228	149	Bandar Seri Begawan
Cambodia	12.1	38	12	2.6	27	21.2	29.0	80	5.3	43	3	56	54	58	B	16	2.4	22	16	H	260	69,900	173	Phnom Penh
East Timor	0.8	34	16	1.8	39	1.2	1.4	143	4.6	42	2	46	45	47	B	—	—	—	—	—	—	5,741	137	Dili
Indonesia	212.2	24	8	1.6	44	273.4	311.9	46	2.8	34	4	64	62	66	B	39	0.1	57	55	H	640	735,355	289	Jakarta
Laos	5.2	41	15	2.6	26	8.4	11.8	104	5.6	44	4	51	50	52	C	17	z	25	21	H	320	91,429	57	Vientiane
Malaysia	23.3	25	5	2.1	34	37.0	48.2	8	3.2	34	4	72	70	75	C	57	0.6	—	—	H	3,670	127,317	183	Kuala Lumpur
Myanmar	48.9	30	10	2.0	35	68.1	87.8	83	3.8	37	4	54	53	56	C	26	1.8	17	14	S	—	261,228	187	Yangon
Philippines	80.3	29	7	2.3	31	117.3	139.6	35	3.7	38	4	67	66	69	B	47	0.1	49	32	H	1,050	115,830	693	Manila
Singapore	4.0	13	5	0.8	84	8.0	10.4	3.2	1.5	22	7	78	76	80	A	100	0.2	65	—	L	30,170	239	16,714	Singapore City
Thailand	62.0	16	7	1.0	70	72.1	71.9	22	1.9	24	5	72	70	75	B	31	2.2	72	70	S	2,160	198,116	313	Bangkok
Vietnam	78.7	20	6	1.4	48	109.9	123.7	37	2.5	34	6	66	63	69	B	24	0.2	75	56	H	350	128,066	615	Hanoi
East Asia	**1,493**	**15**	**7**	**0.8**	**85**	**1,669**	**1,585**	**29**	**1.8**	**24**	**8**	**72**	**70**	**74**		**38**	**0.1**	**81**	**78**		**3,880**	**4,546,050**	**328**	
China	1,264.5	15	6	0.9	79	1,431.0	1,369.0	31	1.8	25	7	71	69	73	B	31	0.1	83	81	S	750	3,696,100	342	Beijing
China, Hong Kong SAR[e]	7.0	7	5	0.3	256	8.6	7.6	3.2	1.0	17	11	80	77	82	A	95	0.1	—	—	—	23,660	413	16,949	—
China, Macao SAR[e]	0.4	10	3	0.7	96	0.6	0.8	6	1.2	25	8	77	75	80	B	99	—	—	—	—	—	8	57,628	Macao
Japan	126.9	9	8	0.2	462	120.9	100.5	3.5	1.3	15	17	81	77	84	A	78	z	64	57	L	32,350	145,869	870	Tokyo
Korea, North	21.7	21	7	1.5	48	25.7	26.4	26	2.3	28	6	70	67	73	C	59	z	—	—	S	—	46,541	466	Pyongyang
Korea, South	47.3	14	5	0.9	82	53.3	51.1	11	1.5	22	7	74	71	78	B	79	z	77	66	S	8,600	38,324	1,234	Seoul
Mongolia	2.5	20	7	1.4	50	3.4	4.1	34	2.7	35	4	63	60	66	C	52	z	57	41	S	380	604,826	4	Ulan Bator
Taiwan	22.3	13	6	0.7	97	25.3	25.2	6.6	1.5	21	8	75	72	78	A	77	—	—	—	—	—	13,969	1,593	Taipei

For notes, see page 10.

Acknowledgments, Notes, Sources, and Definitions

Acknowledgments

The authors gratefully acknowledge the assistance and cooperation of staff members of the International Programs Center of the U.S. Census Bureau; the Population Division and the Statistics Division of the United Nations (UN); the Population and Migration Division of the Council of Europe; the Institut national d'etudes démographiques (INED), Paris; the World Bank; and Ralf Ulrich, CEO, Eridion GmbH, Germany, in the preparation of this year's *Data Sheet*. Suzanne Baker, PRB Policy Fellow, produced many of the population projections in this year's *Data Sheet*.

Notes

(—) indicates data unavailable or inapplicable
z = Less than 0.5 percent
[a] Infant deaths per 1,000 live births
[b] Average number of children born to a woman during her lifetime
[c] A=complete data ... D=little or no data
[d] H=too high; S=satisfactory; L=too low
[e] Special Administrative Region
[f] The former Yugoslav Republic

The *Data Sheet* lists all geopolitical entities with populations of 150,000 or more and all members of the UN. These include sovereign states, dependencies, overseas departments, and some territories whose status or boundaries may be undetermined or in dispute. **More developed regions**, following the UN classification, comprise all of Europe and North America, plus Australia, Japan, and New Zealand. All other regions and countries are classified as **less developed**. Country regional designations also follow UN practice. As a result, North America does not include countries of Latin America classified as less developed.

World and Regional Totals: Regional population totals are independently rounded and include small countries or areas not shown. Regional and world rates and percentages are weighted averages of countries for which data are available; regional averages are shown when data or estimates are available for at least three-quarters of the region's population.

Sub-Saharan Africa: All countries of Africa except the Northern African countries of Algeria, Egypt, Libya, Morocco, Tunisia, and Western Sahara.

World Population Data Sheets from different years should **not be used as a time series**. Fluctuations in values from year to year often reflect revisions based on new data or estimates rather than actual changes in levels. Additional information on likely trends and consistent time series can be obtained from PRB, and are also available in UN and U.S. Census Bureau publications.

Sources

The rates and figures are primarily compiled from the following sources: official country statistical yearbooks and bulletins; United Nations *Demographic Yearbook, 1998* (forthcoming) and *Population and Vital Statistics Report, Data Available as of 1 April 2000* (forthcoming) of the UN Statistics Division; *World Population Prospects: The 1998 Revision* of the UN Population Division; the UN Statistical Library; *Recent Demographic Developments in Europe, 1999* of the Council of Europe; *Population* 54:4-5 (INED) *La conjoncture démographique*, by Alain Monnier; and the data files and library resources of the International Programs Center, U.S. Census Bureau. Other sources include recent demographic surveys such as the Demographic and Health Surveys, Reproductive Health Surveys, special studies, and direct communication with demographers and statistical bureaus in the United States and abroad. Specific data sources may be obtained by contacting the authors of the *2000 World Population Data Sheet*.

For countries with complete registration of births and deaths, rates are those most recently reported. For more developed countries, nearly all vital rates refer to 1998 or 1999, and for less developed countries, for some point in the late 1990s.

Definitions

Mid-2000 Population

Estimates are based on a recent census, official national data, or UN and U.S. Census Bureau projections. The effects of refugee movements, large numbers of foreign workers, and population shifts due to contemporary political events are taken into account to the extent possible.

Birth and Death Rate

The annual number of births and deaths per 1,000 total population. These rates are often referred to as "crude rates" since they do not take a population's age structure into account. Thus, crude death rates in more developed countries, with a relatively large proportion of high-mortality older population, are often higher than those in less developed countries with lower life expectancy.

Rate of Natural Increase (RNI)

The birth rate minus the death rate, implying the annual rate of population growth without regard for migration. Expressed as a percentage.

Population "Doubling Time" at *Current* Rate

The number of years it would take for the population to double *if* the rate of natural increase remained constant. Based upon the *unrounded* RNI, this column provides an indication of potential growth associated with a given RNI. It is not intended to forecast the actual doubling of any population. Projections for 2025 and 2050 should be consulted for a more plausible expectation of future growth or decline.

Projected Population in 2025 and 2050

Projected populations based upon reasonable assumptions on the future course of fertility, mortality, and migration. Projections are based upon official country projections, series issued by the UN or the U.S. Census Bureau, or PRB projections.

Infant Mortality Rate

The annual number of deaths of infants under age 1 year per 1,000 live births. Rates shown with decimals indicate national statistics reported as completely registered, while those without are estimates from the sources cited above. Rates shown in italic are based upon less than 50 annual infant deaths and, as a result, are subject to considerable yearly variability.

Total Fertility Rate (TFR)

The average number of children a woman would have assuming that current age-specific birth rates remain constant throughout her childbearing years (usually considered to be ages 15 to 49).

Population Under Age 15/Age 65+

The percentage of the total population in these ages, which are often considered the "dependent ages."

Life Expectancy at Birth

The average number of years a newborn infant can expect to live under *current* mortality levels.

Data Availability Code

Provides a general indication of data availability. An "A" indicates a country with both complete vital statistics (birth and death data) and either a national-level census within 10 years or a continuous population register. If a country has complete vital statistics or a continuous population register and a national-level census within 15 years, they are rated "B." Also rated "B" are countries that have one of the three sources necessary for an "A" plus either a usable national survey or a sample registration system within 10 years. "C" indicates that at least a census (within 15 years), a survey (within 10 years), or sample registration system is available. "D" indicates that little or no reliable demographic information is available and that estimates are based on fragmentary data or demographic models. Countries whose demographic situations have been seriously disrupted and for which there are few recent data are also coded "D." There can be considerable variation in the quality of data within the same category.

Percent Urban

Percentage of the total population living in areas termed "urban" by that country. Typically, the population living in towns of 2,000 or more or in national and provincial capitals is classified "urban."

Percent of Adult Population Ages 15 to 49 With HIV/AIDS

The estimated percentage of adults with HIV/AIDS at the end of 1997. These data are compiled by UNAIDS and the World Health Organization.

Contraceptive Use

The percentage of currently married or "in-union" women of reproductive age who are currently using any form of contraception.

"Modern" methods include clinic and supply methods such as the pill, IUD, condom, and sterilization. Data are from the most recent available national-level surveys, such as the Demographic and Health Survey, Reproductive Health Survey programs, and the UN Population Division *Levels and Trends of Contraceptive Use as Assessed in 1998*. Other sources include direct communication with national statistical organizations and the databases of the United Nations Population Division and the U.S. Census Bureau. Data refer to some point in the 1990s. Data prior to 1994 are shown in italics.

Government View of Current Birth Rate

This population policy indicator presents the officially stated position of country governments on the level of the national birth rate. Most indicators are from the UN Population Division, *Global Population Policy Data Base, 1999*.

GNP Per Capita

Gross National Product includes the value of all domestic and foreign output. Estimates are from The World Bank, *World Development Report, 2000* (forthcoming).

Despair and Hope: The HIV/AIDS Epidemic

Sources:

Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), *AIDS Epidemic Update: December 1999*.

Population Reference Bureau, *2000 World Population Data Sheet*.

Werasit Sittitrai, Associate Director, Department of Policy, Strategy and Research, UNAIDS, "HIV Prevention Needs and Successes: A Tale of Three Countries," unpublished paper based on a speech at the Office of AIDS Research Advisory Council, National Institutes of Health, Bethesda, MD, April 28, 1999. Available online: www.unaids.org.

Karen Stanecki, U.S. Census Bureau presentation at population seminar, National Press Club, Washington, DC, Jan. 18, 2000.

UNAIDS, *Report on the Global HIV/AIDS Epidemic June 1998*.

Note:

The regional figures were calculated by PRB using country level data from the 1998 UNAIDS report cited above. The 1999 UNAIDS report cited above provides updated regional prevalence data. Those data are not reported here because the regions differ from those used on the *Data Sheet*. For these latest data, and future updates, go to: www.unaids.org.

Reviewer: Chris Elias, Senior Associate and Country Representative, The Population Council, Bangkok, Thailand.

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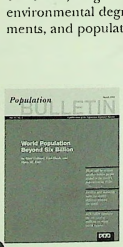
The story of world population includes many statistics—birth rates, death rates, rates of population increase, maternal mortality rates, and so on—but the story first and foremost is about people. This report provides a quick, clear, and comprehensive discussion of world population trends in the 21st century: the status of women, longer life spans, more young people, environmental degradation, population movements, and population stories. (WPMTJN) $5.00



World Population Beyond Six Billion

This *Population Bulletin* chronicles the demographic history of the world and the changes in population in less developed and more developed countries. It has a rich store of data about population before 1900, from 1900 to 1950, from 1950 to 2000, and from 2000 to 2050. It describes a new world vision of what to do about population issues and draws attention to particular population groups, such as the elderly, women, children and adolescents, migrants, and people at high risk of HIV/AIDS. (BUL54.1) $7.00

America's Diversity: On the Edge of Two Centuries

This second issue of *PRB Reports on America* uses population data from the 1890s and the 1990s to show that immigration and diversity were as much a part of our turn-of-the-last-century conversations as they are of our current conversations about the kind of country that America was founded to be—and about the country it has become. (ROA1.2) $5.00

International Population Handbook

The new 4th edition of this international handbook contains new data from many countries that illustrate the rates, ratios, and concepts of demography. The 4th edition also contains a new section of factors that affect fertility, a revised glossary of terms, a trilingual thesaurus, and a list of sources for demographic information, including Web sites. (HBINT4) $10.00 (Also available in Arabic, French adapted for Francophone Africa, and Spanish adapted for Latin America)

Building on Global Gains in Health, Education, and Rights: The Cairo Consensus

In 1999, national leaders renewed their commitment to a 20-year agreement adopted at the 1994 International Conference on Population and Development. The ICPD+5 review highlighted goals, achievements, benchmarks, and obstacles that define and challenge this new approach to population and development. (IBUILDFS) $3.00

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PRB

The World's Youth 2000

Table of Contents

Overview

There are more young people on Earth than ever before. At the turn of the new century, 1.7 billion people are between the ages of 10 and 24, and the vast majority live in less developed countries. Meeting the needs of youth today is critical for a wide range of policies and programs, because the actions of young people will shape the size, health, and prosperity of the world's future population.

This report and its accompanying data sheet give a profile of today's youth, providing data on population, education, and health, with a special focus on sexual and reproductive health. (The data tables appear in the Appendix, on pages 17–24.) Young people's needs vary tremendously depending on their stage of life—puberty, adolescence, and early adulthood—and on the context in which they live. While this diversity makes it difficult to make generalizations about young people, the action plans adopted at recent international conferences make it possible to identify critical needs and compare progress in health and education against agreed-upon goals.

Overall, young people's health and educational prospects are improving, and marriage and childbearing are occurring at later, more mature stages of life, compared with previous generations. Nevertheless, some concerns remain. For example:

- Despite increasing attention given worldwide to education, secondary school enrollments are still low in many parts of the world, and girls' school enrollments still lag behind boys'.
- Complications of pregnancy, childbirth, and unsafe abortion are the major causes of death for women ages 15 to 19.
- Young people ages 15 to 24 have the highest infection rates of sexually transmitted infections (STIs), including HIV/AIDS.
- Statistics on rape suggest that between one-third and two-thirds of rape victims worldwide are age 15 or younger.

At both the 1994 International Conference on Population and Development (ICPD) and its five-year review in 1999, participants identified adolescents as a particularly vulnerable group. At these world conferences, governments committed "to meet the needs of adolescents and youth for information, counseling, and high-quality sexual and reproductive health services" as a way to "encourage them to continue their education, maximize their potential, and prevent early marriage and high-risk childbearing."[1] Recent program experiences shed light on practical ways to provide young people with the information, social support, and services they need to protect themselves from sexual and reproductive health problems.

Introduction: The World of 1.7 Billion Youth

At the turn of the 21st century, 1.7 billion people—more than one-fourth of the world's six billion people—are between the ages of 10 and 24, making this group the largest ever to enter adulthood (see Box 1). Eighty-six percent of 10-to-24-year-olds live in less developed countries. The proportion of youth in these countries is significantly higher than in more developed countries, as shown in Figure 1.

Box 1:

Who are "Youth"?

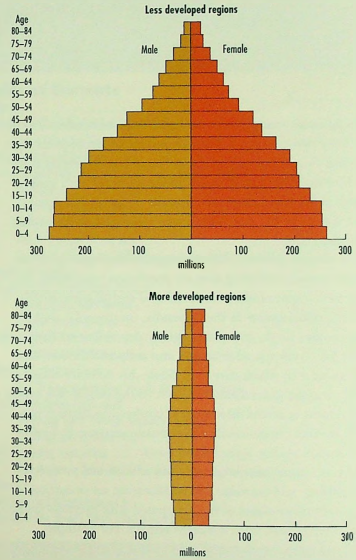
In this report, we define youth or young people as in the 10-to-24 age group, which includes preteens and teenagers (ages 10 to 19) and young adults (ages 20 to 24). We use the terms "adolescents" and "teenagers" interchangeably, though the period of transition known as adolescence may differ from place to place and between boys and girls.

Times are changing for young people around the world, in ways that affect their lives both positively and negatively. The current generation of young people is the healthiest, most educated, and most urbanized in history (see Figure 2 for urbanization trends in less developed countries). While urbanization brings greater access to education and health services, it also carries greater exposure to the risks of drug and alcohol abuse, violence, and sexually transmitted infections (STIs), including HIV/AIDS. Modernization tends to create more employment opportunities, but it may also bring about a loss of traditional cultures and separation from extended families.

The context in which young men and women live greatly influences the course of their lives. Some young people are married and considered adults in their societies; others are still in school and considered dependent children. Many young people are sexually active and have become parents themselves, but may not have achieved the legal adult age as defined by their country or state. "Adolescence" is a modern term meaning

Figure 1:

Population by age and sex: Less and more developed regions, 2000



Note: Data reflect projections for 2000.
Source: United Nations Population Division, 1998.

a period of life that starts at puberty and ends at the culturally determined entrance to adulthood (social maturity and economic independence).

Around the world, the onset of puberty is occurring earlier and the age of marriage is rising. Thus, young people are facing a longer period of time during which they are sexually mature and may be sexually active before marriage. While adolescence is generally a healthy period of life, many young people are exposed to health risks associated with sexual activity, including exposure to STIs, unintended pregnancies, and complications from pregnancy and childbirth. Young people often have inadequate or misleading information on sexuality and reproductive health and lack access to reproductive health care.

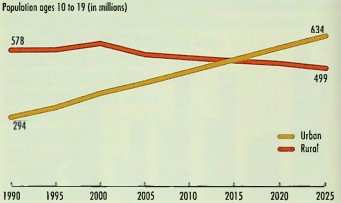
Improving young people's health is a critical goal in and of itself, with long-term benefits to society as a whole. In addition, the extent to which the reproductive health needs of this generation are met will greatly affect global population growth. In particular, the decisions these young people make regarding family size and the timing of births will make today's youth the "critical cohort" in determining the size of world population for years to come.

Educating Girls and Boys

Recent world conferences have called for universal access to and completion of primary education, and for reducing the "gender gap"—differences in boys' and girls' enrollment—in secondary education. Policymakers increasingly recognize that advancing women through greater educational opportunities is key to economic and social development.

In more developed regions, most girls and boys attend both primary and secondary school. In less developed regions, progress has been made in increasing enrollment levels, but only 57 percent of boys and 48 percent of girls were enrolled in secondary education as of the mid- to late-1990s (see Education columns on pages 18–24 in the Appendix). The gap between boys' and girls' enrollments is most apparent at the secondary level. However, in some regions where enrollment rates are very low for both girls and boys, merely raising girls' enrollments will not be sufficient. Efforts must be made to increase access to education for all.

Figure 2:
Adolescent population in less developed countries by urban and rural areas, 1990–2025

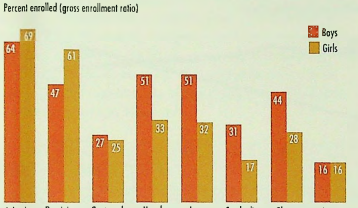


Source: United Nations Population Division, World Population Prospects 1992 and 1996.

Global school enrollment figures mask significant regional and country differences (see Figure 3, next page). In Ghana, for example, 44 percent of boys and only 28 percent of girls are enrolled in secondary school. In Colombia, on the other hand, more girls than boys are enrolled in secondary school: 69 percent of girls and 64 percent of boys. The data also mask important differences among countries and localities in retention rates, attendance, and school quality. For instance, in Côte d'Ivoire, 27 percent of primary school students had to repeat a year of school in 1995, and in Brazil, this figure was 18 percent.[2]

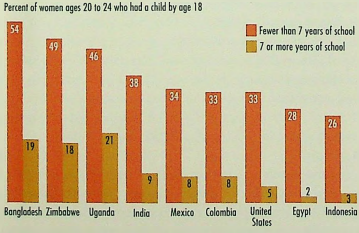
In some of the poorest countries, fewer than half of young women receive a basic education, that is, at least seven years of school.[3] Many young women are becoming wives and mothers or are taking on household responsibilities rather than continuing their education. Several factors explain girls' lower level of

Figure 3:
Girls' and boys' secondary school enrollment, selected countries



Source: 1999 UNICEF Statistical Yearbook.

Figure 4:
Mother's education and childbearing, selected countries



Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

secondary school enrollment: parents' perception that secondary education is more beneficial for their sons than for their daughters; worries about girls' safety outside the village environment; and limited job opportunities for women in sectors that require higher education. Decades of research have shown that educated women have greater control of their reproductive lives, such as decisions about the number and spacing of their children (see Figure 4). Research also shows that women with more education have healthier children.

Recent progress has been promising. Between 1985 and 1995, access to education improved worldwide, particularly for girls and particularly at the secondary level.[4] Young women in less developed regions are now more educated than their mothers. For example, young women ages 15 to 19 in Morocco are four times more likely than their mothers to have completed seven years of schooling. In Sudan, this figure is nine times.[5] Nevertheless, education levels are still low in these countries, as in many others, and governments need to increase them.

The Sexual and Reproductive Lives of Young Men and Women

Marriage

Age of marriage is one of many aspects of young people's lives that is currently in transition. Overall, marriage before age 18 is less common than it was a generation ago; however, there is much regional variation. Figure 5 illustrates a range from as low as 3 percent in Germany to 73 percent in Bangladesh. (Data on marriage include formal unions that are legally or religiously sanctioned, as well as informal, cohabiting unions.) Compared with levels 20 years ago, early marriage has declined by one-fourth in India and Bangladesh and by about one-half in Indonesia. However, average age at marriage is still relatively young in these countries, as in Bangladesh, where the average age is 14.2.

In sub-Saharan Africa, the proportion of married adolescents has decreased over the last 20 years. Nonetheless, at least one-fourth of 15-to-19-year-old women are married in many sub-Saharan African countries, and about half of 15-to-19-year-old women in Mali, Mozambique, Niger, Chad, and Uganda are married. In much of Latin America and the Caribbean, early marriage is as common for young women today as it was for their mothers: Between 20 percent and 40 percent of women in this region form their first union before age 18.[6]

Marrying later in life has a number of implications for young people. Young women who marry later are more likely to have a basic education than those who marry early. Subsequently, women with more education tend to be healthier and more prosperous, and have fewer and healthier children. However, later marriage combined with increased premarital sex among adolescents puts young people at greater risk of unintended pregnancies, unsafe abortion, births outside of marriage, and STIs, including HIV/AIDS.

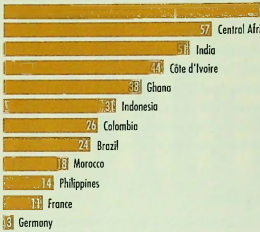
Adolescent Sexual Activity

Premarital sexual activity is common in many parts of the world and is reported to be on the rise in all regions.[7] In many countries, young women and men are under strong social and peer-group pressure to engage in premarital sex. Moreover, some features of modern life may increase both the desire and opportunity for sexual activity: the mass media, the breakdown of traditional families and mores, and increased migration, urbanization, and materialism. For a substantial minority of young women, early sexual activity is not consensual (see page 9).

As shown in Table 1, in Kenya there is more than a three-year gap between age at first intercourse and age at marriage; in Brazil, it is slightly more than two years. Surveys show that, on average, 43 percent of women in sub-Saharan Africa and 20 percent in Latin America have had premarital sex before age 20. Sexual activity among adolescents is even higher in some developed countries: 68 percent of teenage women in the United States and 72 percent in France have had premarital sex by age

Figure 5:

Percentage of women married* by age 18, selected countries



*Includes formal marriage and cohabiting unions.
Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

Table 1:

Age at marriage and age at first sexual intercourse among young women,* selected countries

Country	Median age at marriage**	Median age at first intercourse
Cameroon	18.0	15.9
Kenya	20.2	16.8
Niger	15.3	15.3
Bolivia	20.9	19.0
Brazil	21.0	18.8
Guatemala	19.2	18.6
Haiti	20.5	18.7
Indonesia	19.9	19.8
Philippines	22.7	22.8

*Among women 25 to 29 years old.
**Includes formal marriage and cohabitation. Median age indicates that half the women surveyed entered their first union before this age and half after this age.
Source: Demographic and Health Surveys (Calverton, MD: Macro International).

20.[8] Sex before marriage is more common among young men than among young women, however. In many societies, sex is viewed as a sign of maturity and status for adolescent boys, while for young girls it is forbidden and shameful.[9] (See Box 2 for more discussion of young men.)

Serious risks and consequences accompany increased premarital sex, particularly when combined with inadequate information and reproductive health services. Increased sexual activity places youth at greater risk of unintended pregnancies and STIs, including HIV/AIDS (see section on HIV/AIDS, page 10). Many unintended pregnancies end in abortion, but complete data on abortion are only beginning to be available (see Figure 6). Unsafe abortions, which are sometimes self-induced, can result in severe illness, infertility, and death. Even in places where safe abortion services exist, access is often restricted for teenage girls. Complications from unsafe abortion are the leading cause of death among teenagers in some countries.[10]

Adolescent Childbearing

Of the 15 million young women ages 15 to 19 who give birth every year, 13 million live in less developed countries.[11] Thirty-three percent of women in less developed countries give birth

Box 2:

Reaching Young Men

Young men typically report having their first sexual experience earlier than women and also tend to marry later. Therefore, they experience a longer period of time in which they maybe sexually active outside of marriage. Yet, while health specialists increasingly recognize that young people need support and information to take control of their sexual and reproductive lives, the focus on women's health often leaves men out of the picture. In fact, health communications and services are much less likely to target young men than young women.

Cultural standards about what is acceptable sexual behavior for young men and women complicate the issue of adolescent reproductive health. In some societies, young men are encouraged or pressured to take part in sexual behaviors that are risky, such as having multiple partners or having their first sexual experience with a sex worker. Yet services often do not provide youth with the means to protect themselves and their partners from infections and unintended pregnancies. Limited access to condoms and other contraceptives, even where they are affordable, remains a major barrier to use. Other barriers to use include attitudes and misconceptions. For instance, some young men believe that they should use condoms when having intercourse with sex workers but not with girlfriends.

Program efforts to reach young men are now underway in many countries. Reproductive health programs for young men primarily encourage responsible sexual behavior. They can also support other positive behaviors and attitudes, such as staying in school, re-examining their perceptions of gender roles and responsibilities, supporting female partners in their reproductive health needs and decisions, and avoiding violence and drug and alcohol abuse.

Program planners need to distinguish young men's needs from those of young women and differentiate young men by age groups, as developmental and emotional changes occur rapidly during adolescence. Some of the venues for reaching young men include community sites such as discos, pool halls, sports events and marketplaces; the workplace; youth-friendly/male-friendly clinics; and multipurpose youth centers. Information channels for reaching young men include the mass media (radio, television, and popular music), and face-to-face communication through peer education and counseling.

Percentage of single, sexually active adolescent men and number of partners they had in one year, selected countries

Country	Percent sexually active	Average number of partners in 12 months
Brazil (Rio de Janerio)	61	2.6
Kenya	54	1.6
Côte d'Ivoire	43	2.4
Tanzania	37	2.5
Thailand	29	3.8
Togo	18	2.0
Philippines (Manila)	15	1.8

Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

Source: C. Green, "Reaching Young Men with Reproductive Health Programs," *In FOCUS* (Washington, DC: Pathfinder International, 1998).

before the age of 20, ranging from a low of 8 percent in East Asia to 55 percent in West Africa. In more developed countries, about 10 percent of women give birth by age 20; however, in the United States, the level of teen childbearing is significantly higher, at 19 percent. Significant differences also exist between countries in the same region (see Figure 7, and Teen Population columns on pages 18–24 in the Appendix). For example, in Senegal, 43 percent of women ages 20 to 24 gave birth by age 20, compared with 70 percent in Mali.

Early pregnancy and childbearing are typically associated with less education and lower future income for young mothers. For unwed teens in some countries, motherhood can result in social ostracism. In other settings, teens may choose to become pregnant to gain status with their peers, improve their relationship with family members, or because they have few other life opportunities outside of motherhood.[12] These circumstances carry different policy and service implications.

Young women and their children face serious health risks from early pregnancy and childbearing. More adolescent girls die from pregnancy-related causes than from any other cause.[13] In fact, maternal mortality among 15-to-19-year-old women is twice as high as for women in their 20s. Because adolescent women have not completed their growth, in particular height and pelvic size, they are at greater risk of obstructed labor (when the birth canal is blocked), which can lead to permanent injury or death for both the mother and the infant. Infants of young mothers are also more likely to be premature and have low birth weights. In many countries, the risk of death during the first year of life is 1.5 times higher for infants born to mothers under age 20 than for those born to mothers ages 20 to 29.[14] For all women, first births are higher risk than subsequent births, and for teens, the risks are greater still. Because adolescents have less experience, resources, and knowledge about pregnancy and childbirth than older women, they and their children suffer when obstetric emergencies occur.

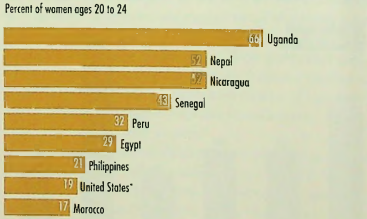
Figure 6:

Number of abortions per 1,000 adolescent women ages 15 to 19, selected countries

Source: *Into a New World: Young Women's Sexual and Reproductive Lives* (New York: Alan Guttmacher Institute, 1998).

Figure 7:

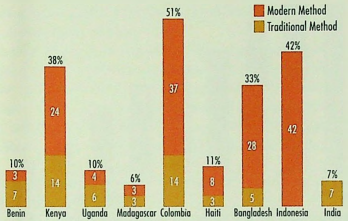
Percentage of women giving birth by age 20, selected countries



*1995 National Survey of Family Growth (Hyattsville, MD: National Center for Health Statistics).

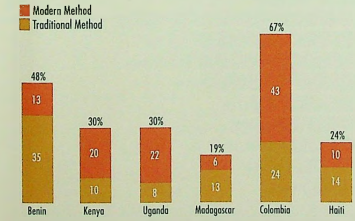
Source: Demographic and Health Surveys, 1995-1998 (Calverton, MD: Macro International).

Figure 8:
Contraceptive use among married 15-to-19-year-old women, selected countries



Source: Demographic and Health Surveys (Calverton, MD: Macro International).

Figure 9:
Contraceptive use among single, sexually active 15-to-19-year-old women, selected countries



Source: Demographic and Health Surveys (Calverton, MD: Macro International).

Impact of Adolescent Childbearing on Future World Population

The reproductive decisions of today's youth will have a dramatic effect on future world population growth. United Nations demographic projections illustrate how small differences in levels of childbearing can result in large differences in population size. For instance, the UN projected in 1998 that if women have on average two children, world population would rise to 9.4 billion by 2050. However, if women average 2.5 children, world population would reach 11 billion by 2050.[15]

Timing of births is also critical. Projections show that if today's young women begin childbearing two and a half years later than the current average age at first birth, population size by 2100 would be 10 percent lower than if no change in timing of birth occurred. Similarly, if they waited five years to have their first births, population size would be 20 percent lower than it would be if current patterns continue.[16]

Use of Contraception

Generally speaking, adolescent women are less likely than women over age 20 to use contraceptive methods. Reasons for this include lack of information, misinformation, and fear of side effects, along with geographic, social, cultural and economic barriers to access and use of family planning. Typically, family planning services are designed to serve married, adult women. Unmarried teens may find service providers hostile or unhelpful, especially where strong cultural or religious beliefs condemn sexual activity among unmarried adolescents. Teens may be unwilling to disclose their sexual activity to parents or service providers. Also, the sporadic and unplanned nature of adolescent sexual activity can be an obstacle to consistent contraceptive use.

Surveys indicate that between 12 percent and 42 percent of married adolescent women in less developed countries who say they would prefer to space or limit births are not using family planning. If sexually active unmarried teens were included, the

unmet need numbers would certainly be higher.[17] Married adolescent women can benefit from contraceptive use by delaying first births until their bodies are physically mature enough to carry a healthy pregnancy to term, and by delaying subsequent births.

Contraceptive use varies substantially by region and country (see Figure 8, and Teen Population columns on pages 18–24 in the Appendix). Only 13 percent of married adolescents ages 15 to 19 use contraception in sub-Saharan Africa, compared with 55 percent in Latin America and the Caribbean. In Latin America and the Caribbean, 11 percent of married adolescents in Haiti use contraception, compared with 51 percent in Colombia. Turning to Asia, in India 7 percent use contraception, compared with 42 percent in Indonesia.

The breakdown between use of modern and traditional methods also varies from one country to another. Modern methods typically used by youth include condoms, oral contraceptive pills, and hormonal injections. Traditional methods include the calendar or rhythm method, herbal methods, and withdrawal. In India, of the 7 percent who use any method of contraception, none are using a modern method. In Indonesia, by contrast, nearly all of the 42 percent of married adolescent women using contraception are using modern methods (see Figure 8).

Figures 8 and 9 also highlight differences between the contraceptive practices of married and unmarried adolescents. In several countries in Latin America and the Caribbean, unmarried teens are just as likely to use contraception as their married counterparts. In sub-Saharan Africa, unmarried adolescents are more likely to use contraception than married teens. In Benin, for example, 47 percent of single, sexually active 15-to-19-year-old women use a method of contraception (traditional and modern combined), compared with 9 percent of their married peers. While contraceptive use among married adolescents has increased significantly in parts of Asia, less is known about the contraceptive practices of unmarried youth in the region, as they are often excluded from national surveys.

Sexual Violence Against Young Women

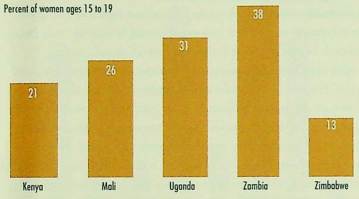
Sexual Abuse and Coercion

Adolescent sexual activity exists throughout much of the world, yet the extent to which it is nonconsensual is only recently being assessed. Sexual abuse includes rape, sexual assault, sexual molestation, sexual harassment, economic exchange for sex, and incest. Because sexual violence and exploitation are abuse of power, young people are especially at risk, and the violations can have devastating and long-lasting consequences. Also, because most youth reproductive health programs are geared toward young people engaging in consensual sex, the different and urgent needs of those who have been sexually abused are not met.[18]

Women are more vulnerable than men to violence and abuse at all stages of life through infanticide, incest, child prostitution, sex trafficking, rape, partner violence, psychological abuse, sexual harassment, rape as a weapon of war, and harmful traditional practices such as forced early marriage, female genital cutting, and bride burning. Statistics on rape suggest that between one-third and two-thirds of rape victims worldwide are 15 years old or younger.[19] While boys are also victimized, girls are more likely to be subjected to sexual abuse and are at risk of becoming infected with HIV and other STIs at a much younger age than boys. Other risks include unintended pregnancies, physical injury, and psychological trauma. Studies also show that young people who have been victims of sexual abuse are more likely to engage in high-risk sexual behavior than those who have not been abused.[20]

Sexual exploitation of children and adolescents is a multibillion-dollar illegal industry, according to UNICEF. Some young people become prostitutes in order to make money. In many places, such as Bangladesh, Brazil, Nepal, the Philippines, and Thailand, young people are lured or forced into prostitution.[21] Similarly, economic deprivation leads many young women in sub-Saharan Africa and elsewhere into sexual relationships with older men—sometimes known as "sugar

Figure 10:
Unmarried adolescent women who have recently* received money or gifts in exchange for sex, selected sub-Saharan African countries



*Zimbabwe: within the past 4 weeks; Uganda: last sexual encounter; other countries: within the past 12 months.
Source: Demographic and Health Surveys (Calverton, MD: Macro International).

daddies"—who provide money and other necessities, such as clothing and school supplies and fees, in exchange for sex (see Figure 10).

Female Genital Cutting

Between 100 million and 180 million women around the world have undergone female genital cutting (FGC), also known as female circumcision and female genital mutilation, in which parts of the female genitalia are cut away. Some 600 girls are at risk every day. FGC is a serious health issue, with effects including hemorrhage, shock, pain, and various infections and other complications that can significantly damage a girl's health over her lifetime. Because FGC violates a woman's right to good health and bodily integrity, it is also a human rights issue. FGC occurs primarily in Africa, but is also practiced by minority groups and African immigrants in other regions.

In recent years, communities and countries have begun to make progress toward the internationally agreed-upon goal of eradicating FGC. Local efforts in diverse setting are starting to build a body of knowledge about how best to address FGC. These efforts include developing alternative rites of passage for adolescent girls; public declarations against FGC by families and community members; and empowerment and advocacy programs for women and girls. Systematic evaluation of these efforts will be needed to determine the most promising approaches for ending the practice.

Youth and the HIV/AIDS Crisis

About half of all people infected with HIV are under age 25, according to World Health Organization estimates, and in less developed countries, up to 60 percent of all new infections are among 15-to-24-year-olds.[22] In this age group of newly infected people, there are twice as many young women as young men.

Adolescents are at high risk of contracting HIV and other STIs because, among other reasons, they often have multiple short-term sexual relationships and do not consistently use condoms. They also tend to lack sufficient information and understanding of HIV/AIDS: their vulnerability to it, how to prevent it, and the self-confidence necessary to protect themselves. STIs other than HIV (such as chlamydia and gonorrhea) are also a serious threat to adolescents. Worldwide, the highest reported rates of STIs are found among young people ages 15 to 24. In more developed countries, two-thirds of all reported STI infections occur among men and women under age 25, and in less developed countries, the proportion of infected young people is even higher.[23]

Young people face special obstacles in obtaining diagnosis and treatment of HIV/AIDS and other STIs, even where services are available. They usually lack information about STIs, their symptoms, the need for treatment, and where to obtain services. They are also reluctant to seek care, and providers may be hesitant to treat them. Because females with chlamydia and gonorrhea, the most common STIs, often do not show symptoms, and because having another STI increases an individual's susceptibility to HIV, young people are at high risk of contract-

ing and spreading these infections.[24] They may also face legal and/or institutional obstacles to using services, such as negative provider attitudes or requirements for parental, spousal, or partner consent before testing or treatment. Additionally, young people often believe (incorrectly) that STIs will simply go away if untreated or that they will not recur if treated.

Young women are particularly vulnerable to STIs for both biological and cultural reasons. Adolescent women have fewer protective antibodies than do older women, and the immaturity of their cervixes increases the likelihood that exposure to infection will result in the transmission of the disease.[25] Sexual violence and exploitation, lack of formal education (including sex education), inability to negotiate with partners about sexual decisions, and lack of access to contraception and reproductive health services work together to put young women at especially high risk. Additionally, women in many societies are not accustomed to discussing issues of reproductive health and sexuality with others, which further increases their vulnerability.

A Call for HIV/AIDS Education

Policymakers are giving greater attention today to the need for AIDS education, prevention, and treatment. It is estimated that over 30 million adults and children worldwide are living with HIV or AIDS, but most do not know they are infected. An overwhelming majority, 95 percent of HIV-infected people, live in less developed countries.[26] In 1999, at the five-year review of the ICPD, governments established the goal of giving at least 90 percent of young men and women ages 15 to 24 access to preventive methods by 2005 in order to reduce vulnerability to HIV infection.[27] These methods include female and male condoms, voluntary testing and counseling, and follow-up. The Health column on pages 18–24 in the Appendix shows, as of 1993, whether or not countries had HIV/AIDS education included in their school curriculum. More current data are needed to determine the extent of policy responses to the HIV/AIDS crisis.

Despite the urgent need for raising public awareness, cultural and institutional barriers stand in the way of educating people about the risks of HIV and ways to prevent it from spreading. Many parents and educators have long been concerned that sex education may increase sexual activity among young people. However, a recent assessment by the Joint United Nations Programme on HIV/AIDS (UNAIDS) reveals that HIV and sexual health education promotes safer sexual practices and does not increase sexual activity.[28] According to the report, effective programs help delay first intercourse and protect sexually active youth from STIs, including HIV, and from unintended pregnancy. UNAIDS also reports that sexual health education is most effective when started before the onset of sexual activity.

Socially Marginalized Youth

There is increasing concern for young people who are disconnected from their families and social institutions, such as schools, religious institutions, youth clubs, or the workplace. These "socially marginalized" youth are vulnerable to sexual exploitation and are at a disproportionately high risk of unintended pregnancies and STIs, including HIV/AIDS. They often lack access to health information, counseling, legal protection, and health and other services. Living or spending most of their time on the streets, the only social support they receive is typically from peers living under similar circumstances. Counting these young people is as difficult as reaching them with assistance. Nevertheless, statistics show that significant numbers of youth need information and services beyond what is provided by traditional and school-based programs.

- The UN estimates that 404 million youth under the ages of 18—or 38 percent of youth in less developed countries—do not attend school.
- UNICEF estimates that approximately 100 million young people work on the streets in activities such as picking up garbage, hawking small goods, parking and washing cars,

shining shoes, and begging. Approximately 10 percent of these youths actually live on the streets, with no connection to their families or a permanent home.

- A homeless teenage girl in the United States is 14 times more likely to become pregnant than a girl with a home.[29]
- A study of 143 Guatemalan street youth showed that all had been sexually abused: the majority by family members, often stepparents, or other people they knew. These youths frequently cited physical, emotional, and sexual abuse as their reasons for leaving home.[30]

A new group of socially marginalized youth, AIDS orphans, is often shunned by their communities and neglected. Like other orphans in general they have higher rates of malnutrition, stunting, and illiteracy. Socially isolated because of the stigma of the disease, AIDS orphans are more vulnerable to abuse and exploitation and may be left to fend for themselves on the streets. These youth are often left with care-taking responsibilities for younger siblings and may have a harder time staying in school. The UN predicts that HIV/AIDS will orphan 13 million children—that is, leave them without a mother or both parents—by the end of 2000. At the latest count, 90 percent of the 8.2 million children who have already been orphaned due to AIDS live in sub-Saharan Africa.[31]

In many places, children over age five are no longer a main target of health services, as their survival is relatively assured. The health needs of many youth are neglected until, as is too often the case, adolescent girls seek health services when they are pregnant. Likewise, boys, who are at high risk of accidents, violence, and substance abuse, often only seek services when they become victims of these social ills (see Box 3).

Box 3:

Keys to Reaching Socially Marginalized Youth

- Since many socially marginalized youth live in situations characterized by violence and distrust, programs need to establish an environment of respect, acceptance, and stability.
- To make initial contact, outreach programs find youth in places where they spend most of their time, such as on the streets. For example, programs in Guatemala, Honduras, and Mexico have outreach teams providing street youth with emergency medical care, HIV education, informal education, and counseling.
- Drop-in centers and shelters offer young people a place to rest and be safe. Transitional homes and group homes prepare youth for independent living or help reunite them with their families.
- Programs can work with the members of the community who have already earned young people's trust, such as market or street vendors, shopkeepers, or health care providers.

Source: C. Stevens, "Reaching Socially Marginalized Youth," *In FOCUS* (Washington, DC: Pathfinder International, 1999).

Policy and Program Approaches

Meeting adolescents' needs for sexual and reproductive health information and services is vital to young people's future. At several international conferences and conventions in the 1980s and 1990s, governments repeated their commitment to a universal agenda for action to improve the health of adolescents, as follows[32]:

- Provide health education to adolescents, both men and women, including information on sexuality, responsible sexual behavior, reproduction, voluntary abstinence, family planning, unsafe abortion, STIs including HIV/AIDS, and gender roles.
- Encourage parental involvement and promote adult communication and interaction with adolescents.
- Use peer educators to reach out to young people.
- Provide integrated health services to adolescents that include family planning information and services for sexually active adolescents.
- Make health services adolescent-friendly by ensuring confidentiality, privacy, respect, and the high-quality informa-

tion necessary for informed consent and by including youth in program design.
- Increase opportunities for women's education and employment.
- Take measures to eliminate all forms of violence against women and end trafficking in women.
- Eradicate female genital cutting.

Research and program experience suggest that policymakers and health providers need to remove the legal and institutional barriers that keep young people from using existing family planning and reproductive health services. In addition, information and services need to be designed to accommodate the unique needs of adolescents and young adults.

Informing Youth through Sexuality Education

Sexuality education for youth has long been hampered by adult concerns that knowledge will promote promiscuity among unmarried teens. However, worldwide reviews of studies by WHO and UNAIDS[33] conclude that sexuality education does not encourage early initiation of intercourse, but instead can delay first intercourse and lead to more consistent contraceptive use and safer sex practices (see also section on HIV/AIDS education, page 11).

It is vital to reach adolescents early with information, before the onset of sexual activity. Schools are a key location for reaching large numbers of young people; however, as many youth are not in school, community-based approaches are also needed in many areas. Specialists in adolescent reproductive health suggest the following elements for a successful sex and HIV education program[34]:
- Give a clear message on risky sexual behaviors. Focus on reducing a few key behaviors that lead to unintended pregnancy or HIV/STI infection.
- Use a behavior change framework to define and evaluate activities.
- Provide basic, accurate information about the risks of unprotected intercourse and ways to avoid unprotected intercourse.
- Include activities that address social pressures on sexual behavior. Provide modeling and practice of communication, negotiation, and refusal skills.
- Employ a variety of teaching methods designed to involve the participants and have them personalize the information. Use teachers and peers who believe in the program they are implementing, and provide training for them.
- Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.

Building Links with Services

Increasing knowledge is only the first step in the prevention of unintended pregnancies and STIs, including HIV. To be effective, educational programs (in or out of school) need to inform youth about what kinds of services they may need and where to get them. While school-based clinics may be an effective way to provide services to students, community-based clinics are needed to reach the large numbers of out-of-school youth. Community outreach may also be needed to reach young men, street children, prostituted teens, and other marginalized groups, who may not feel comfortable using services designed for mothers and their children.

A number of program models incorporate youth-friendly components in existing health services.[35] Multiservice centers for youth are only one approach to meeting these needs; linking social services through referral systems may be a more realistic option in many settings. Some programs try to bring services to locations where young people study, work, or socialize. Regardless of the venue, the basic components of a youth-friendly service include specially trained providers, privacy, confidentiality, and accessibility.[36]

Box 4:

Case in Point—MEXFAM's Adolescent Program in Mexico

In 1986, MEXFAM, Mexico's largest private family planning provider, began an adolescent program in urban areas called *Gente Joven* or "Young People." The program's decentralized, community-based approach, which uses youth promoters for outreach activities, is flexible and adaptable to local circumstances. Designed to reach out to adolescents on their own turf, such as schools, clubs, recreation centers, gang hangouts, and sports facilities, the program has reached over 4 million young people since its inception. *Gente Joven* is built around youth-to-youth activities, allowing adolescents to take a more dynamic role in providing information and services to their peers. The program's integrated approach includes three main elements:

- reproductive health and sex education;
- collaboration between adult coordinators and youth volunteers; and
- integrated participation and action—young people, parents, and teachers are all involved.

Gente Joven recognizes that young people will explore their sexuality regardless of societal constraints; therefore, it promotes safe, healthy, and responsible sex. The program confronts the strong negative attitudes many adults have toward adolescent sexuality by working to sensitize parents, teachers, and local politicians through films, discussions, pamphlets, and radio programs. Overall, key approaches to the success of this program include:

- **Youth-centered approach.** Youth-to-youth promotion ensures that the program does not diverge from the needs and expressed desires of the youth themselves.
- **Intensive training.** Staff and volunteers are trained in counseling, communication, and sex education.
- **Dedicated staff and volunteers.** *Gente Joven* has been instrumental in motivating and developing leadership potential in young volunteers.
- **High-impact educational materials.** *Gente Joven's* award-winning videos, guides to using them, and other materials go to the heart of youth's concerns.
- **Flexibility with accountability.** The program gives its coordinators the flexibility to build on their own talents but maintains consistency with overall program goals through monitoring and evaluation.

Overall, *Gente Joven* has been credited with greatly improving intergenerational communication on sexuality. Five years after the program's inception, MEXFAM reported that in schools where the number of pregnancies was very high, teen pregnancies dropped dramatically after the introduction of *Gente Joven's* 10-hour course. The program addresses issues that are important to youth in a frank and open manner, encouraging reflection and discussion on the major decisions that they confront.

Source: "Mexico: *Gente Joven*, MEXFAM's Adolescent Program" in *Family Planning Programs: Diverse Solutions to a Global Challenge* (Washington, DC: Population Reference Bureau, 1994); latest data from MEXFAM's website at www.mexfam.org.mx/.

Other Promising Approaches

Programs targeting youth can use a variety of communication approaches to provide sexual and reproductive health information, encourage dialogue on sensitive topics, and help youth develop the knowledge and confidence needed to safeguard their health. Box 4 describes an innovative example. Peer counseling—where young people are trained to talk to their peers—can take place in schools, the workplace, or other public places frequented by youth. Messages can also be delivered via the mass media and entertainment, such as popular songs, soap operas, videos, television spots, billboards, sporting events, and theater performances. Combining entertainment with education has proven appealing and successful in reaching youth in many settings. In addition, telephone hotlines and radio call-in shows give youth an opportunity to discuss their concerns anonymously with trained counselors. Pharmacies and social marketing programs are also beginning to target young adults as consumers of health products, especially condoms.

Young people have a variety of special needs that differ from one setting to another. A key aspect of the design of youth programs is the involvement of young people in helping to determine the program approaches and components that best respond to their concerns. In doing so, young people gain new skills and self-confidence as they make decisions that

impact their future and that of future generations.

Ideally, countries will develop a comprehensive, multifaceted strategy for reaching youth. Providing young people with reproductive health information, counseling, and services can be both challenging and controversial, because of cultural sensitivities about adolescent sexuality. Nevertheless, recent trends in adolescent health and sexual activity, and particularly the HIV/AIDS pandemic, call for urgent attention, public discussion, and policy action. ■

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Definitions of selected terms in report and data tables

- The **percent enrolled in secondary school** is the ratio of the total number enrolled in secondary school to the applicable age group, or the gross enrollment ratio.

- The **total fertility rate (TFR)** is the average number of children that would be born to a woman during her lifetime assuming the age-specific birth rates of a given year.

- **Births attended by trained personnel** are births attended by a physician, nurse, or trained midwife; definitions of medical personnel vary from country to country and some data may include traditional birth attendants.

- **Percent of adult population infected with HIV** are provisional estimates supplied by the World Health Organization (WHO) and based on official country estimates when available. When not available, WHO figures are based on HIV sero-prevalence studies, reported AIDS cases, population size and structure, and the predominant modes of transmission.

- **Percent using contraception** is the percent of married women ages 15 – 19/sexually active, single women 15 – 19 who are currently practicing a form of family planning. Single, sexually active teens are those who reported intercourse within four weeks prior to the survey.

- **Modern methods of contraception** include clinic and supply methods such as the pill, IUD, condom, and sterilization. **Any method of contraception** includes modern methods as well as traditional methods.

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APPENDIX

The World's Youth 2000 Data Tables

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19									
	Population Ages 10-24 (millions) 2000	2025	Population Ages 10-24 (% of Total) 2000	% Enrolled in Secondary School 1980 Males	Females	% Enrolled in Secondary School Latest Year Males	Females	Average Age at First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate Males	Females	% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20[c]	% Births Attended by Trained Personnel	% Using Contraception (females) Single Any/Modern Method	Married* Any/Modern Method
WORLD	**1,663**	**1,796**	**27**	**54**	**44**	**63**	**56**	**22**	**2.9**	**12**	**71**	**—**	**—**	**554**	**17**	**27**	**19**	**—**	**31**	**—**	**—/—**	**20/—**
More Developed	241	198	20	88	89	99	102	25	1.5	10	99	—	—	81	—	—	6	—	—	—	—/—	—/—
Less Developed	1,423	1,597	29	43	30	57	48	21	3.2	12	63	—	—	474	18	29	21	—	33	—	—/—	19/—
Less Developed (Excl. China)	1,105	1,321	31	38	27	52	42	20	3.7	13	53	—	—	373	23	36	26	—	42	47	—/—	22/—
AFRICA	**256**	**401**	**33**	**26**	**15**	**38**	**33**	**20**	**5.3**	**12**	**48**	**—**	**—**	**86**	**—**	**—**	**26**	**—**	**47**	**50**	**—/—**	**14/13**
Sub-Saharan Africa	210	352	33	19	10	29	23	19	5.8	—	46	—	—	70	—	—	29	—	52	50	—/—	13/11
NORTHERN AFRICA	**56**	**63**	**33**	**47**	**29**	**63**	**57**	**21**	**3.6**	**7**	**49**	**—**	**—**	**19**	**21**	**40**	**12**	**—**	**24**	**51**	**—/—**	**19/—**
Algeria	10.3	12.0	33	40	26	65	62	24	3.8	3	77	0.1	Y	3.5	11	31	9	—	—	—	—/—	—/—
Egypt	22.1	22.8	32	66	41	83	73	19	3.3	10	39	z	N	7.6	26	44	14	—	29	41	—/—	21/1
Libya	2.0	2.3	35	88	63	95	95	—	4.1	7	81	0.1	Y	0.7	2	14	—	—	—	—	—/—	—/—
Morocco	9.1	9.1	32	32	20	44	34	20	3.1	8	45	z	Y	3.0	28	52	10	—	17	47	—/—	32/30
Sudan	9.8	13.6	33	20	12	23	20	24	4.6	6	31	1.0	Y	3.5	22	38	15	—	26	68	—/—	4/—
Tunisia	3.0	2.9	32	34	20	66	63	25	2.8	3	79	z	Y	1.0	5	22	4	—	13	81	—/—	11/—
WESTERN AFRICA	**73**	**122**	**33**	**24**	**12**	**31**	**22**	**18**	**5.9**	**12**	**38**	**—**	**—**	**25**	**—**	**—**	**37**	**—**	**55**	**39**	**41/14**	**5/2**
Benin	2.1	3.6	34	24	8	26	11	19	6.3	10	80	2.1	N	0.7	46	71	29	9	50	82	47/13	9/3
Burkina Faso	3.9	7.7	33	4	2	11	6	18	6.8	12	42	7.2	Y	1.3	—	—	44	4	62	31	31/14	1/z
Côte d'Ivoire	5.2	7.5	35	26	11	34	16	18	5.2	13	45	10.1	N	1.8	34	56	—	19	—	51	47/16	11/4
Gambia	0.4	0.6	29	16	7	30	19	—	5.6	15	44	2.2	Y	0.1	—	—	53	—	—	—	—/—	—/—
Ghana	6.6	11.3	33	50	31	44	28	19	4.5	11	41	2.4	Y	2.2	—	—	20	8	49	63	45/23	20/13
Guinea	2.5	3.9	34	24	10	20	7	—	5.5	18	31	2.1	—	0.8	—	—	—	—	—	39	—/—	3/2
Guinea-Bissau	0.4	0.6	30	10	2	—	—	*18*	5.8	17	27[a]	2.3	N	0.1	34	77	—	—	—	—	—/—	—/—
Liberia	1.2	2.3	38	31	12	—	—	20	6.2	17	58[b]	3.7	—	0.4	39	62	32	41	64	62	—/12	2/—
Mali	3.8	6.8	34	12	5	17	8	16	6.7	14	47	1.7	—	1.3	—	—	49	6.9	70	50	29/16	5/2
Mauritania	0.9	1.5	32	17	4	21	11	23	5.5	12	47	0.5	—	0.3	41	58	14	—	84	45	—/—	—/—
Niger	3.4	7.1	32	7	3	9	5	15	7.5	15	39	1.5	N	1.1	72	88	60	10**	70	37	—/8	6/—
Nigeria	36.7	57.6	33	25	13	36	30	17	6.0	12	31	4.1	N	12.4	—	—	37	10.2	54	29	40/13	1/1
Senegal	3.1	5.3	33	15	7	20	12	18	5.7	11	47	1.8	Y	1.0	48	70	28	9**	43	44	—/16	6/2
Sierra Leone	1.5	2.6	31	20	8	22	13	18	6.3	17	25[a]	3.2	Y	0.5	—	—	58	—	—	—	—/—	—/—
Togo	1.5	2.8	33	50	16	40	14	19	6.1	10	82	8.5	Y	0.5	23	56	19	16.5	38	85	56/25	15/4

Notes

a: Data prior to 1990

b: Among 18-24-year-olds

c: % ever married women ages 15–19 who are mothers

d: Among women ages 15–24

e: Among women currently ages 20–24

f: Delivery in public facilities

*: May include formal and/or informal unions

**: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.

z: number rounds to zero

7.1: Numbers in italics indicate data prior to 1985.

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20[c]	% Births Attended by Trained Personnel	% Using Contraception (females)	
	2000	2025	2000	Males	Females	Males	Females	All Women							Males	Females					Single Any/Modern Method	Married* Any/Modern Method
EASTERN AFRICA	**82**	**140**	**33**	**12**	**7**	**18**	**13**	**19**	**6.0**	**11**	**43**	**—**	**—**	**27**	**29**	**41**	**30**	**—**	**53**	**60**	**—/15**	**13/—**
Burundi	2.2	3.7	33	4	2	8	5	22	6.5	4	19[a]	8.3	Y	0.7	38	46	6	3[**]	27	37	—/10	4/—
Comoros	0.2	0.4	35	30	15	24	19	19	5.1	9	85	0.1	N	0.1	26	40	10	—	29	88	—/—	11/5
Djibouti	0.2	0.3	32	16	9	17	12	19	5.8	3	79[a]	10.3	N	0.1	—	—	7	—	—	—	—/—	—/—
Eritrea	1.2	2.1	32	—	—	24	17	17	6.1	10	21	3.2	—	0.4	—	—	33	—	47	23	—/—	3/1
Ethiopia	20.1	38.2	32	12	6	14	10	18	6.7	12	14[b]	9.3	N	6.5	47	62	42	—	—	—	—/—	—/—
Kenya	11.1	13.1	37	23	16	26	22	20	4.7	11	92	11.6	Y	3.7	8	11	15	8	46	91	30/20	37/24
Madagascar	4.7	8.9	30	—	—	16	16	19	6.0	13	77	0.1	Y	1.5	—	—	28	11.1	57	75	18/6	6/3
Malawi	3.6	6.6	33	7	3	21	12	—	5.9	12	55	14.9	Y	1.2	31	48	36	—	63	53	11/7	11/6
Mauritius	0.3	0.3	27	51	49	63	66	23	2.0	10	97	0.5	N	0.1	9	8	11	—	—	—	—/—	46/—
Mozambique	6.2	10.4	32	8	3	9	5	17	5.6	10	44	14.2	N	2.1	33	67	45	11	65	47	7/5	1/1
Reunion	0.2	0.2	27	—	—	—	—	28	2.2	5	—	z	—	0.1	5	2	3	—	—	—	—/—	—/—
Rwanda	2.7	4.1	35	4	3	12	9	23	6.5	5	26	12.8	N	0.9	—	—	8	7[**]	25	37	—8/	11/—
Somalia	3.2	7.2	32	11	4	—	—	20	7.0	15	2[a]	0.3	—	1.1	—	—	—	—	—	—	—/—	—/—
Tanzania	11.2	19.0	33	4	2	6	5	18	5.6	11	47	9.4	N	3.7	—	—	23	11.9	52	54	14/12	7/4
Uganda	7.3	15.5	34	7	3	15	9	18	6.9	13	38	9.5	Y	2.4	24	34	47	3.6	66	44	29/22	10/4
Zambia	3.3	5.3	36	22	11	34	21	18	6.1	12	47	19.1	Y	1.1	22	27	25	9.5	63	49	16/13	17/9
Zimbabwe	4.2	4.5	36	17	12	52	45	19	4.0	12	69	25.8	Y	1.4	3[b]	3[b]	19	14[**]	47	71	37/34	—/—
MIDDLE AFRICA	**30**	**61**	**32**	**—**	**—**	**31**	**19**	**19**	**6.6**	**16**	**64**	**—**	**—**	**10**	**—**	**—**	**28**	**—**	**—**	**—**	**—/—**	**6/—**
Angola	4.1	8.2	32	20	9	—	—	—	6.8	16	15[a]	2.1	N	1.3	—	—	—	—	—	—	—/—	—/—
Cameroon	4.9	8.6	32	24	13	32	22	18	5.2	13	64	4.9	Y	1.6	—	—	34	13.5	54	58	73/20	15/3
Central African Republic	1.2	1.8	33	21	7	15	6	17	5.1	15	67	10.8	Y	0.4	—	—	39	11.2	61	70	25/10	13/2
Chad	2.4	4.5	32	—	—	15	4	16	6.6	15	32	2.7	N	0.8	—	—	47	3.7	71	37	14/10	3/1
Congo, Dem. Rep. of (Zaire)	16.4	1.9	32	—	—	32	19	20	7.2	16	80[a]	4.3	Y	5.4	—	—	24	—	—	—	—/—	3/—
Congo, Rep. Of	0.9	34.6	32	89	60	62	45	22	5.3	12	—	7.8	Y	0.3	6	13	16	—	—	—	—/—	—/—
Gabon	0.3	0.6	28	35	13	32	19	—	5.4	17	—	4.4	Y	0.1	—	—	—	—	—	—	—/—	—/—
SOUTHERN AFRICA	**15**	**16**	**31**	**—**	**—**	**82**	**96**	**26**	**3.1**	**10**	**80**	**—**	**—**	**5**	**15**	**14**	**6**	**—**	**—**	**—**	**—/—**	**63/63**
Botswana	0.6	0.7	35	17	20	61	68	25	4.1	9	78[a]	25.1	Y	0.2	11	5	6	26	55	86	—/35	17/—
Lesotho	0.7	1.1	32	14	21	25	36	—	4.4	9	50	8.4	Y	0.2	—	—	17	—	—	—	—/—	—/—
Namibia	0.6	0.8	32	—	—	58	67	—	5.1	11	67	19.9	N	0.2	14	8	7	16.4	42	76	29/27	21/17
South Africa	12.4	13.1	31	—	—	88	103	26	2.9	10	82	12.9	—	4.1	15[b]	15[b]	5	—	—	—	—/—	66/64
Swaziland	0.3	0.5	33	39	37	55	54	29	5.9	10	56	18.5	Y	0.1	15	13	—	—	—	—	—/—	—/—

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20[c]	% Births Attended by Trained Personnel	% Using Contraception (females)	
	2000	2025	2000	Males	Females	Males	Females	All Women	(TFR)	Births by Ages 15-19	Personnel			2000	Males	Females		(females)			Single Any/Modern Method	Married* Any/Modern Method
ASIA	**1,031**	**1,048**	**28**	**48**	**34**	**62**	**51**	**21**	**2.8**	**11**	**65**	**—**	**—**	**342**	**19**	**31**	**20**	**—**	**29**	**—**	**—/—**	**16/—**
ASIA (Excl. China)	714	772	29	45	31	57	44	21	3.3	—	51	—	—	242	26	41	27	—	40	38	—/—	18/—
WESTERN ASIA	**57**	**78**	**31**	**49**	**31**	**63**	**48**	**22**	**4.0**	**8**	**74**	**—**	**—**	**19**	**6**	**20**	**15**	**—**	**—**	**—**	**—/—**	**—/—**
Armenia	1.0	0.8	28	—	—	100	79	—	1.3	12	96	0.1	—	0.3	—	—	15	—	—	—	—/—	—/—
Azerbaijan	2.2	1.9	29	—	—	73	81	24	1.9	4	99	z	Y	0.7	—	—	9	—	—	—	—/—	—/—
Bahrain	0.2	0.2	25	70	58	91	98	25	2.8	4	98	0.2	—	0.1	1	1	6	—	49[c]	100	—/—	30/—
Cyprus	0.2	0.2	24	90	90	96	99	25	1.9	4	100[a]	0.3	Y	0.1	z	z	—	—	—	—	—/—	—/—
Georgia	1.1	1.0	23	—	—	78	76	24	1.2	12	—	z	—	0.4	—	—	17	—	—	—	—/—	—/—
Iraq	7.6	12.5	33	76	38	51	32	22	5.7	4	54[a]	z	Y	2.5	—	—	18	—	—	—	—/—	4/—
Israel	1.6	1.8	26	67	77	89	87	23	2.9	4	99[a]	0.1	Y	0.5	1[b]	2[b]	6	—	—	—	—/—	—/—
Jordan	2.2	3.6	33	79	63	—	—	22	4.4	4	97	z	N	0.7	2	3	8	—	17	98	—/—	33/19
Kuwait	0.7	0.7	33	84	76	64	66	23	3.2	6	99[a]	0.1	Y	0.2	4	11	11	—	54[c]	98[f]	—/—	8/—
Lebanon	0.9	1.0	29	59	61	78	84	—	2.4	5	85	0.1	N	0.3	—	—	—	—	—	—	—/—	—/—
Oman	0.8	1.7	33	17	6	68	66	19	7.1	7	93	0.1	—	0.3	—	—	36	—	61[c]	88[c]	—/—	3/—
Qatar	0.1	0.2	23	64	68	80	79	23	4.2	9	98	0.1	—	0.04	5	6	10	—	48[c]	92[d]	—/—	16/—
Saudi Arabia	6.7	12.0	31	36	23	65	57	22	6.4	10	90	z	N	2.2	4	16	15	—	—	—	—/—	—/—
Syria	5.9	7.5	36	57	35	45	40	22	4.7	6	54	z	Y	2.0	10	35	—	—	—	—	—/—	—/—
Turkey	19.6	19.2	29	44	24	68	48	24	2.5	9	76	z	N	6.8	3	10	13	—	25	81	—/—	34/16
United Arab Emirates	0.6	0.7	26	55	49	77	82	23	4.9	11	99	0.2	—	0.2	8	11	17	—	—	—	—/—	—/—
Yemen	5.8	12.9	32	7	4	53	14	17	6.5	7	43	z	N	1.8	15	60	26	—	45	50	—/—	9/3

Notes

a: Data prior to 1990
b: Among 18-24-year-olds
c: % ever married women ages 15–19 who are mothers
d: Among women ages 15–24
e: Among women currently ages 20–24
f: Delivery in public facilities

*: May include formal and/or informal unions
**: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.
z: number rounds to zero
Y.Y: Numbers in italics indicate data prior to 1985.

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20*	% Births Attended by Trained Personnel	% Using Contraception (females)	
	2000	2025	2000	Males	Females	Males	Females								Males	Females					Simple Any/Modern Method	Married* Any/Modern Method
SOUTH-CENTRAL ASIA	**458**	**503**	**31**	**38**	**20**	**55**	**37**	**20**	**3.6**	**15**	**36**	**—**	**—**	**156**	**36**	**57**	**36**	**—**	**47**	**33**	**—/—**	**12/—**
Afghanistan	6.3	14.4	28	16	4	32	12	—	6.1	11	9[3]	z	—	2.0	52	87	53	—	—	—	—/—	—/—
Bangladesh	46.5	46.2	36	26	9	25	13	14	3.3	18	8	z	N	16.6	58	71	48	—	63	14	—/—	33/28
Bhutan	0.7	1.2	31	3	1	—	—	—	5.6	6	15	z	N	0.2	—	—	—	—	—	—	—/—	—/—
India	300.2	307.3	30	39	20	59	39	20	3.3	18	34	0.8	N	102.0	20	44	38	—	49	34	—/—	7/—
Iran	24.8	22.1	37	52	32	81	73	22	2.9	5	86	z	N	8.4	6	15	22	—	—	—	—/—	34/—
Kazakhstan	4.6	3.9	28	—	—	82	91	21	1.7	12	100	z	—	1.5	z	z	12	—	29	99	—/—	39/24
Kyrgyzstan	1.4	1.5	31	112	108	75	83	20	2.8	6	98	z	—	0.5	—	—	12	—	37	97	—/—	29/21
Nepal	7.8	11.2	33	33	9	51	33	16	4.6	13	10	0.2	N	2.6	26	51	43	—	52	14	—/—	7/4
Pakistan	49.1	77.5	31	20	8	33	17	22	5.6	9	18	0.1	N	15.9	56	74	24	—	31	17	—/—	3/—
Sri Lanka	5.5	5.0	29	52	57	72	78	24	2.1	5	94	0.1	Y	2.0	9	10	7	—	16	82	—/—	20/—
Tajikistan	2.0	2.4	33	—	—	83	74	22	2.7	4	79	z	—	0.7	z	z	14	—	—	—	—/—	—/—
Turkmenistan	1.4	1.6	32	—	—	—	—	24	2.5	3	96	z	—	0.5	—	—	6	—	—	—	—/—	—/—
Uzbekistan	7.8	8.5	32	117	94	100	88	20	2.8	5	98	z	—	2.6	—	—	13	—	25	100	—/—	16/15
SOUTHEAST ASIA	**157**	**155**	**30**	**40**	**35**	**53**	**49**	**21**	**3.0**	**9**	**64**	**—**	**—**	**53**	**4**	**5**	**14**	**—**	**26**	**48**	**—/—**	**34/30**
Cambodia	3.3	4.7	29	—	—	31	17	23	5.3	2	31	2.4	N	1.2	3	8	5	—	—	—	—/—	—/—
Indonesia	63.6	61.1	30	35	23	55	48	19	2.8	11	54	0.1	N	21.3	2	3	17	—	31	32	—/—	42/42
Laos	1.7	3.0	31	25	16	34	23	—	5.6	9	—	z	N	0.5	—	—	—	—	—	—	—/—	—/—
Malaysia	6.5	7.0	29	50	46	59	69	24	3.2	4	99	0.6	Y	2.3	3	4	8	—	—	—	—/—	—/—
Myanmar	14.0	12.7	31	—	—	29	30	22	3.8	5	56	1.8	N	5.0	12	18	16	—	—	—	—/—	—/—
Philippines	24.0	27.6	32	60	69	77	78	22	3.7	6	64	0.1	N	7.9	4	1	8	z	21	51	—/—	18/11
Singapore	0.7	0.7	19	60	60	74	70	27	1.5	2	100[3]	0.2	Y	0.2	1	1	1	—	—	—	—/—	—/—
Thailand	17.3	14.2	29	30	28	38	37	23	1.9	20	71[3]	2.2	Y	5.6	1	2	17	—	24	61	—/—	43/—
Viet Nam	25.3	23.7	32	44	40	48	46	21	2.5	5	85	0.2	Y	8.6	7	7	8	—	19	76	—/—	18/15
EAST ASIA	**359**	**312**	**24**	**59**	**45**	**77**	**70**	**23**	**1.8**	**1**	**91**	**—**	**—**	**115**	**3**	**8**	**4**	**—**	**8**	**—**	**—/—**	**14/—**
China	317.1	276.2	25	54	37	74	67	22	1.8	1	89	0.1	Y	100.9	3	8	4	—	8	—	—/—	11/—
Hong Kong	1.5	1.1	22	63	65	71	76	27	1.0	3	—	0.1	Y	0.5	—	—	2	—	—	—	—/—	—/—
Japan	22.6	18.3	18	92	94	103	104	27	1.3	1	100[4]	z	Y	7.5	—	—	1	—	2	—	—/—	39/—
Korea, North	5.5	5.5	23	—	—	—	—	—	2.3	z	100[3]	z	—	1.7	—	—	—	—	—	—	—/—	—/—
Korea, South	11.0	9.5	23	82	74	102	102	25	1.5	1	98	z	—	3.8	—	—	1	—	—	—	—/—	—/—
Mongolia	0.9	0.8	34	85	95	48	65	24	2.7	9	100	z	—	0.3	—	—	3	—	22	—	—/—	—/—
Taiwan	5.5	—	25	81	80	—	—	—	1.5	—	—	—	—	1.9	—	—	1	—	—	—	—/—	—/—

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions) 2000		Population Ages 10-24 (% of Total) 2000	% Enrolled in Secondary School 1980 Males		% Enrolled in Secondary School Latest Year Males	Females	Average Age of First Marriage* All Women	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions) 2000	% Illiterate Males	Females	% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20**	% Births Attended by Trained Personnel	% Using Contraception (females) Single Any/Modern Method	Married* Any/Modern Method
NORTH AMERICA	**64**	**65**	**21**	**91**	**92**	**99**	**98**	**25**	**2.0**	**14**	**99**	**—**	**—**	**22**	**—**	**—**	**4**	**—**	**19**	**—**	**—/—**	**—/—**
Canada	6.2	6.3	20	87	89	105	105	26	1.5	8	99[2]	0.3	Y	2.1	—	—	2	—	—	—	—/—	—/—
United States	57.7	59.1	21	91	92	98	97	25	2.1	15	99[2]	0.8	Y	19.4	—	—	5	—	19	—	—/—	—/—
LATIN AMERICA	**155**	**163**	**30**	**41**	**43**	**—**	**—**	**21**	**2.8**	**14**	**85**	**0.5**	**—**	**52**	**9**	**7**	**15**	**—**	**35**	**—**	**——**	**55/—**
CENTRAL AMERICA	**42**	**46**	**31**	**46**	**42**	**56**	**57**	**20**	**3.1**	**13**	**84**	**—**	**—**	**14**	**6**	**7**	**19**	**—**	**38**	**—**	**—/—**	**29/—**
Costa Rica	1.2	1.4	30	44	51	47	52	22	3.2	15	98	0.6	N	0.4	3	2	15	—	—	95	—/38	53/30
El Salvador	2.0	2.3	32	26	23	35	39	19	3.6	15	87	0.6	Y	0.7	14	13	22	11**	46	88	—/—	23/19
Guatemala	3.8	6.1	34	20	17	27	25	19	5.0	12	35	0.5	Y	1.3	18	27	24	1	45	91	—/—	15/12
Honduras	2.2	3.0	33	29	31	29	37	19	4.4	13	61	1.5	Y	0.7	—	—	23	—	49	—	—/—	28/—
Mexico	30.6	30.1	31	51	46	64	64	21	2.7	13	91	0.4	—	10.1	4	4	18	5**	35	—	—/—	30/—
Nicaragua	1.7	2.5	33	40	45	52	62	18	4.4	17	61	0.2	—	0.6	3	2	26	—	52	91	—/—	40/38
Panama	0.8	0.8	29	58	65	60	65	22	2.6	16	86	0.6	Y	0.3	5	5	19	—	—	—	—/—	24/—
CARIBBEAN	**11**	**11**	**28**	**—**	**—**	**49**	**55**	**20**	**2.6**	**15**	**79**	**1.8**	**—**	**4**	**26**	**21**	**20**	**—**	**—**	**—**	**—/—**	**—/—**
Cuba	2.4	1.9	21	79	83	76	85	20	1.6	21	99	z	—	0.8	—	—	27	—	—	—	—/—	—/—
Dominican Republic	2.5	2.6	30	—	—	47	61	19	3.1	16	96	1.9	N	0.8	18	14	23	2.9	39	99	58/42	35/29
Haiti	2.9	3.5	35	14	13	21	20	21	4.7	8	21	5.2	—	1.0	47	43	15	5.4	32	71	23/10	11/8
Jamaica	0.7	0.7	29	63	71	63	67	20	2.6	18	91	1.0	Y	0.3	18	6	7	—	—	—	—/—	68/65
Puerto Rico	1.0	0.9	25	—	—	—	—	22	2.1	17	—	—	—	0.3	10	8	15	—	—	—	—/—	—/—
Trinidad and Tobago	0.4	0.3	31	73	75	72	75	22	1.7	12	98[1]	0.9	Y	0.1	1	1	20	7**	30	—	—/18	42/—
SOUTH AMERICA	**102**	**106**	**30**	**38**	**42**	**—**	**—**	**21**	**2.7**	**14**	**86**	**—**	**—**	**35**	**9**	**6**	**13**	**—**	**34**	**93**	**63/54**	**50/41**
Argentina	10.0	10.6	27	53	62	73	81	23	2.6	12	97	0.7	Y	3.3	2	1	10	—	—	—	—/—	—/—
Bolivia	2.6	3.7	31	42	32	40	34	21	4.2	9	47	0.1	N	0.9	3	7	11	10**	36	67	—/—	31/10
Brazil	50.9	48.5	30	31	36	—	—	21	2.4	16	92	0.6	N	17.4	15	9	14	8.8	32	97	66/61	54/47
Chile	3.9	4.2	26	49	56	72	78	23	2.4	10	100	0.2	N	1.3	2	1	10	—	—	—	—/—	—/—
Colombia	12.4	14.3	29	40	41	64	69	21	3.0	16	85	0.4	Y	4.1	5[b]	4[b]	14	4.9	36	95	67/43	51/—
Ecuador	4.0	4.3	31	53	53	50	50	20	3.3	12	64	0.3	N	1.3	3	3	17	6**	53	61	—/—	27/19
Guyana	0.2	0.2	29	76	80	71	76	24	2.7	12	71	2.1	—	0.1	—	—	12	—	—	—	—/—	—/—
Paraguay	1.8	2.6	32	29	29	46	48	21	4.3	9	61	0.1	N	0.6	4	4	16	5.6	37	95	23/13	37/30
Peru	8.1	8.4	31	63	54	72	67	21	3.4	10	56	0.6	—	2.7	3	5	12	2.2	32	81	70/33	46/31
Uruguay	0.8	0.8	24	61	62	75	90	23	2.3	15	96[1]	0.3	N	0.3	2	1	11	—	—	—	—/—	—/—
Venezuela	7.4	8.5	31	18	25	33	46	21	2.9	16	69[1]	0.7	Y	2.3	5	3	18	—	—	—	—/—	—/—

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate (TFR)	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20**	% Births Attended by Trained Personnel	% Using Contraception (females)	
	2000	2025	2000	Males	Females	Males	Females	All Women						2000	Males	Females					Single Any/Modern Method	Married* Any/Modern Method
EUROPE	149	109	21	86	88	97	102	24	1.4	9	99	—	—	50	—	—	7	—	—	—	–/–	–/–
NORTHERN EUROPE	18	16	19	86	90	117	132	26	1.7	7	100	—	—	6	—	—	2	—	—	—	–/–	–/–
Denmark	0.9	0.9	17	105	104	120	122	28	1.7	3	100[a]	0.1	Y	0.3	—	—	1	—	—	—	–/–	–/–
Estonia	0.3	0.2	23	126	127	100	108	23	1.2	15	—	z	—	0.1	z	z	7	—	—	—	–/–	–/–
Finland	1.0	0.8	19	94	105	110	125	27	1.7	3	100	z	—	0.3	—	—	1	—	—	—	–/–	–/–
Ireland	0.9	0.9	25	85	95	113	122	26	1.9	5	—	0.1	—	0.3	—	—	1	—	—	—	–/–	–/–
Latvia	0.5	0.3	22	—	—	82	85	23	1.2	11	—	z	Y	0.2	z	z	8	—	—	—	–/–	–/–
Lithuania	0.8	0.5	23	—	—	85	88	22	1.3	13	—	z	N	0.3	z	z	—	—	—	—	–/–	–/–
[redacted]way	0.8	0.8	18	92	96	121	116	26	1.8	4	100[a]	0.1	Y	0.3	—	—	1	—	—	—	–/–	–/–
Sweden	1.6	1.4	18	83	93	128	153	28	1.5	2	100[b]	0.1	Y	0.5	—	—	1	—	—	—	–/–	–/–
United Kingdom	11.1	9.8	19	82	85	120	139	26	1.7	8	100[b]	0.1	Y	3.7	—	—	3	—	—	—	–/50	–/–
WESTERN EUROPE	33	28	18	88	90	112	111	26	1.5	3	99	—	—	11	—	—	2	—	—	—	–/–	–/–
Austria	1.5	1.2	18	98	87	105	102	26	1.3	6	100	0.2	Y	0.5	—	—	4	—	—	—	–/–	–/–
Belgium	1.8	1.5	18	90	92	142	151	25	1.6	4	100[a]	0.1	Y	0.6	—	—	5	—	—	—	–/–	–/–
France	11.6	10.5	20	77	92	112	111	26	1.8	3	99	0.4	Y	3.9	—	—	1	—	7	—	–/–	50/–
Germany	13.9	11.1	17	93	89	105	103	26	1.3	4	99	0.1	Y	4.6	—	—	2	—	—	—	–/–	–/–
Netherlands	2.8	2.3	18	95	90	134	129	27	1.6	1	100[a]	0.2	Y	0.9	3	3	1	—	—	—	–/–	–/–
Switzerland	1.3	1.1	17	—	—	—	—	28	1.5	1	99[a]	0.3	—	0.4	—	—	1	—	—	—	–/–	–/–
EASTERN EUROPE	71	47	23	92	92	87	92	22	1.2	14	99	—	—	24	z	z	12	—	—	—	–/–	–/–
Belarus	2.4	1.6	23	—	—	91	95	23	1.3	13	100[b]	0.2	—	0.8	z	z	10	—	—	—	–/–	–/–
Bulgaria	1.7	1.0	21	85	84	77	76	22	1.1	20	100[a]	z	—	0.6	1	1	16	—	—	—	–/–	–/–
Czech Republic	2.2	1.3	22	113	116	97	100	22	1.1	10	—	z	Y	0.7	—	—	7	—	24[d]	—	–/–	51/27
Hungary	2.1	1.3	21	72	67	96	99	22	1.3	10	100[a]	z	N	0.6	1	1	8	—	—	—	–/–	–/–
Moldova	1.2	0.9	27	78	79	79	82	22	1.5	9	—	0.1	—	0.4	z	z	14	—	—	—	66/40	78/48
[redacted]	9.5	6.5	25	75	80	98	97	22	1.4	7	99[b]	0.1	—	3.4	—	—	5	—	—	—	–/–	–/–
Romania	5.3	2.8	24	102	86	79	78	22	1.3	16	100[a]	z	N	1.6	1	1	11	—	20	—	–/–	43/9
Russia	34.6	23.3	24	95	97	83	91	23	1.2	17	99	0.1	Y	11.9	z	z	13	—	—	—	–/–	–/–
Slovakia	1.3	0.9	25	—	—	92	96	21	1.4	12	—	z	N	0.4	z	z	—	—	—	—	–/–	–/–
Ukraine	11.1	7.2	22	—	—	88	94	—	1.3	13	100	0.4	—	3.8	—	—	15	—	—	—	–/–	–/–

Notes

a: Data prior to 1990
b: Among 18-24-year-olds
c: % ever married women ages 15–19 who are mothers
d: Among women ages 15–24
e: Among women currently ages 20–24
f: Delivery in public facilities

*: May include formal and/or informal unions
**: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.
z: number rounds to zero
7.1: Numbers in italics indicate data prior to 1985.

	POPULATION			EDUCATION				MARRIAGE AND FERTILITY			HEALTH			TEEN POPULATION, AGES 15 – 19								
	Population Ages 10-24 (millions)		Population Ages 10-24 (% of Total)	% Enrolled in Secondary School 1980		% Enrolled in Secondary School Latest Year		Average Age at First Marriage*	Total Fertility Rate	% TFR Attributed to Births by Ages 15-19	% Births Attended by Trained Personnel	% of Adult Population Infected With HIV, Ages 15-49, 1997	AIDS Education Included in School Curriculum, 1993	Population Ages 15-19 (in millions)	% Illiterate		% Currently Married* (females)	% Single, Sexually Active (females)	% Giving Birth by Age 20[c]	% Births Attended by Trained Personnel	% Using Contraception (females)	
	2000	2025	2000	Males	Females	Males	Females	All Women						2000	Males	Females					Single Any/Modern Method	Married* Any/Modern Method
SOUTHERN EUROPE	**27**	**19**	**19**	**74**	**73**	**95**	**99**	**25**	**1.3**	**5**	**—**	**—**	**—**	**9**	**z**	**z**	**6**	**—**	**—**	**—**	**—/—**	**—/—**
Albania	0.9	0.8	28	70	63	37	38	22	2.2	7	99[a]	z	N	0.3	—	—	—	—	—	—	—/—	—/—
Bosnia-Herzegovina	0.9	0.7	23	—	—	—	—	23	1.6	10	97	z	—	0.3	—	—	—	—	—	—	—/—	—/—
Croatia	0.9	0.7	21	—	—	81	83	24	1.5	6	—	z	Y	0.3	z	z	9	—	—	—	—/—	—/—
Greece	2.0	1.3	19	85	77	95	96	25	1.3	5	97[a]	0.1	—	0.7	1	z	14	—	—	—	—/—	—/—
Italy	9.2	6.6	16	73	70	94	95	26	1.2	3	—	0.3	Y	2.9	z	z	5	—	—	—	—/—	—/—
Macedonia	0.5	0.5	24	—	—	64	62	23	1.9	10	95	z	—	0.2	—	—	—	—	—	—	—/—	—/—
Portugal	2.0	1.4	20	34	40	106	116	25	1.5	7	90[a]	0.7	—	0.6	1	1	9	—	—	—	—/—	—/—
Slovenia	0.4	0.3	21	38	39	90	93	24	1.2	7	—	z	Y	0.1	z	z	2	—	—	—	—/—	—/—
Spain	7.6	4.9	19	85	89	116	123	26	1.2	3	96[a]	0.6	Y	2.5	z	z	4	—	—	—	—/—	—/—
Yugoslavia	2.4	2.0	23	—	—	60	64	24	1.6	10	93	0.1	—	0.8	1	1	—	—	—	—	—/—	—/—
OCEANIA	**7**	**8**	**24**	**63**	**64**	**111**	**113**	**25**	**2.4**	**6**	**93**	**—**	**—**	**2**	**—**	**—**	**6**	**—**	**—**	**—**	**—/—**	**—/—**
Australia	3.9	4.1	21	70	72	150	155	26	1.7	6	100	0.1	Y	1.3	—	—	1	—	—	—	—/—	—/—
Fiji	0.3	0.3	32	53	57	64	65	23	3.3	9	96[a]	0.1	—	0.1	2	2	13	—	—	—	—/—	—/—
New Zealand	0.8	0.9	22	82	84	110	116	27	2.0	8	99[a]	0.1	Y	0.3	—	—	2	—	—	—	—/—	—/—
Papua New Guinea	1.5	2.2	32	15	8	17	11	21	4.8	3	53	0.2	Y	0.5	—	—	19	—	—	—	—/—	—/—

Notes

a: Data prior to 1990
b: Among 18-24-year-olds
c: % ever married women ages 15–19 who are mothers
d: Among women ages 15–24
e: Among women currently ages 20–24
f: Delivery in public facilities

*: May include formal and/or informal unions
**: Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.
z: number rounds to zero
7.1: Numbers in italics indicate data prior to 1985.

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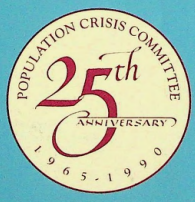
POPULATION CRISIS COMMITTEE

Twenty-five Year History



1965-69

VITAL STATISTICS

	1965	1970
World Population (in billions)	3.308	3.632
Average Family Size Worldwide (in number of children)	5.0	4.8
Annual Population Increment (in millions)	68	75
World Contraceptive Use as Percent of Fertile Age Couples	27	35
Number of Governments Subsidizing Family Planning	21	55
U.S. Foreign Aid for Family Planning (in millions)	$2.0	$74.6

"No single individual was more important to this effort than General William Draper."
UNFPA Executive Director Nafis Sadik on Draper's role in UNFPA founding.

First PCC Executive Director, Phyllis Piotrow, and first PCC National Chair, Kenneth Keating, former Republican senator from New York.

U.S. Senate hearings on the "population crisis" chaired by Senator Ernest Gruening (D-AK). Seated left to right, Senator Clifford Hanson (R-WY), Chairman Gruening, Senator Joseph D. Tydings (D-MD), later PCC Honorary Chair, 1967.

"Let us in all our lands — including this land — face forthrightly the multiplying problems of our multiplying populations and seek the answers to this most profound challenge to the future of all the world. Let us act on the fact that less than five dollars invested in population control is worth a hundred dollars invested in economic growth."
President Lyndon B. Johnson, 1965.

65

1965 Congressional hearings, chaired by U.S. Senator Ernest Gruening (D-AK), on U.S. government response to rapid world population growth push for high level attention in foreign aid program. Hearings continue for three years with extensive media coverage.

1965 *Griswold v. Connecticut* ruling by the Supreme Court legalizes contraceptive use by married couples.

67

1967 U.S. House and Senate authorize foreign aid funds for family planning in new Title X of the Foreign Assistance Act and earmark $35 million for fiscal year 1968.

68

1968 Congress mandates Center for Population Research within the National Institutes of Health to support contraceptive development and demographic research.

1968 Congress earmarks $50 million in fiscal year 1969 for population assistance.

Extent of Population Crisis Committee Involvement

Major *Moderate* *Minor*

"Population increases have become a serious concern…The population growth rate is too often the highest, where hunger is already the most prevalent."

President John F. Kennedy, 1963.

Indian Ambassador, Dr. P.K. Banerjee accepts PCC Victor Fund Report at 1968 ceremony in U.S. Congress. General William Draper, U.S. Representatives Edward Roybal (D-CA) and George Bush (R-TX) and others look on.

"Once, as President, I thought and said that birth control was not the business of our Federal Government. The facts changed my mind …I have come to believe that the population explosion is the world's most critical problem."

Former President Dwight D. Eisenhower, 1968.

PCC Up Close

1965 Hugh Moore, William Draper, Jr., Kenneth Keating and Cass Canfield found Population Crisis Committee (PCC) with Phyllis Piotrow as Executive Director.

1965 General Draper uses new Victor Fund to raise $4.5 million in private funds for IPPF over three years, representing over a third of IPPF's budget.

1965 General Draper succeeds Senator Keating as PCC Chair.

1968 PCC Victor-Bostrom Fund raises an additional $7 million for IPPF by 1974.

1969 Ambassador James Riddleberger becomes PCC Chair and Draper becomes Honorary Chair.

1969 General Draper appointed by President Nixon to UN Population Commission and later as Special Consultant to UNFPA.

General William Draper with Mrs. Avabai Wadia and officials of the Indian Family Planning Association in 1967.

1968 Agency for International Development (AID) provides first grant of $3.5 million to the International Planned Parenthood Federation (IPPF).

1968 AID makes first purchase of contraceptives for Third World distribution.

1968 Paul Ehrlich publishes *The Population Bomb.*

1969 Richard M. Nixon becomes President of the United States.

1969 United Nations Fund for Population Activities (UNFPA) founded with support from United States, Japan, West Germany, Sweden and United Kingdom.

1969 AID establishes Office of Population headed by R.T. Ravenholt, which by 1972 assumes consolidated global responsibility for U.S. population assistance.

1970-74

VITAL STATISTICS

	1970	1975
World Population (in billions)	3.632	3.967
Average Family Size Worldwide (in number of children)	4.8	4.3
Annual Population Increment (in millions)	75	76
World Contraceptive Use as Percent of Fertile Age Couples	35	45
Number of Governments Subsidizing Family Planning	55	79
U.S. Foreign Aid for Family Planning (in millions)	$74.6	$110.0

PCC founder Hugh Moore with General William Draper.

"The green revolution has won a temporary success in man's war against hunger and deprivation; it has given man a breathing space...But the frightening power of human reproduction must also be curbed; otherwise, the success of the green revolution will be ephemeral only."

Norman Borlaug, later PCC Board member, accepting Nobel Peace Prize for work on the Green Revolution, 1971.

"He spoke for all of us who have worked for years in the field of population. And, what we in this field have achieved — or will achieve — will be, I believe, a testament to the man and a monument to his memory."

Eulogy of General Draper by UNFPA Executive Director Rafael Salas, 1975.

U.S. official delegates to the 1974 World Population Conference in Bucharest. From left to right, General Draper, CEQ Chairman and later PCC Board member Russell Peterson, and HEW Secretary Caspar Weinberger.

70

1970 President Nixon initiates Commission on Population Growth and the American Future.

1970 Congress amends Public Health Services Act to establish domestic Title X family planning program, also named for sponsor U.S. Senator Joseph Tydings (D-MD).

1970 First post-colonial censuses in Africa.

71

1971 India becomes second major developing country to legalize abortion and first to market subsidized contraceptives through commercial outlets.

1971 China launches its first successful family planning program emphasizing "later, longer and fewer."

1971 Comstock Act defining contraceptive information as obscene repealed by Supreme Court.

72

1972 *New York Times* supplement on population highlights Rockefeller Commission recommendations; circulated to two million high school students.

1972 Population assistance becomes line item in foreign aid budget with a $125 million appropriation.

1972 World Fertility Surveys begin.

1972 Following medical testing, AID approves new menstrual regulation kit for overseas distribution.

"When future generations evaluate the record of our time, one of the most important factors in their judgment will be the way in which we responded to population growth..."

President Richard M. Nixon, 1969.

Lawrence Kegan, former PCC Executive Director and President.

General and Mrs. William Draper with Dr. R.T. Ravenholt of AID (far left) and Philippines health official Dr. Flora Boyan.

PCC Up Close

1970 Lawrence Kegan named PCC Executive Director.
1970 General Andrew O'Meara assumes PCC Chair.
1971 Senator Tydings retires from U.S. Senate; joins PCC Board; later named National Co-Chair.
1971 On leave from PCC, Dr. Piotrow completes book, *World Population Crisis: The U.S. Response* with forward by George Bush.
1972 Hugh Moore dies. Hugh Moore Award established. Recipients through 1989 include Malcolm Potts, R.T. Ravenholt, Nafis Sadik, Fernando Tamayo, Fred Sai, Ryoichi Sasakawa, Mechai Viravaidya, Haryono Suyono.
1973 Robert Wallace named National Co-Chair with Senator Tydings.
1974 PCC granted consultative status with United Nations.
1974 Russell Peterson, former Governor of Delaware and Chair of the Council on Environmental Quality, joins PCC Board; launches efforts to link population, environment and natural resources.
1974 General Draper and Drs. Peterson and Piotrow, active members official U.S. delegation to World Population Conference, Bucharest.
1974 Robin Chandler Duke named National Co-Chair with Senator Tydings and Mr. Wallace; assumes responsibility for PCC New York office.
1974 General Draper dies.

PCC National Co-Chair Robin Chandler Duke on the speaker's circuit.

1973 Supreme Court legalizes abortion in *Roe v. Wade.*
1973 Amendment by U.S. Senator Jesse Helms (R-NC) bans use of foreign aid funds for abortion.
1973 Mexico abandons pro-natalist policy, launches strong national family planning program for 1974.

1974 Gerald R. Ford becomes President of the United States.
1974 World Population Year and Bucharest Conference. World Population Plan of Action adopted by 135 countries.
1974 130 nations support resolution on food and population at World Food Conference.
1974 Japan and Germany double contributions to UNFPA and IPPF following 1973 parliamentary tours to developing countries.

1975-79

PCC National Co-Chair Joseph Tydings, moving force behind early international exchanges of parliamentarians on population issues.

VITAL STATISTICS

	1975	1980
World Population (in billions)	3.967	4.414
Average Family Size Worldwide (in number of children)	4.3	3.8
Annual Population Increment (in millions)	76	77
World Contraceptive Use as Percent of Fertile Age Couples	45	51
Number of Governments Subsidizing Family Planning	79	101
U.S. Foreign Aid for Family Planning (in millions)	$110.0	$185.0

"Without controlling the growth of population, the prospects for enough food, shelter and other basic needs for all the world's people are dim. Where existence is already poor and precarious, efforts to obtain the necessities of life often degrade the environment for generations to come." President Jimmy Carter, 1977.

Select Committee on Population hearings, Committee Chairman James Scheuer (D-NY) and U.S. Representative Paul Simon (D-IL), 1977.

"To put it simply: excessive population growth is the greatest single obstacle to the economic and social advancement of most of the societies in the developing world." World Bank President Robert McNamara, later PCC Board member, 1979.

Julia Henderson, longtime Secretary-General of the International Planned Parenthood Federation, later PCC Board member and SPF Committee Chair.

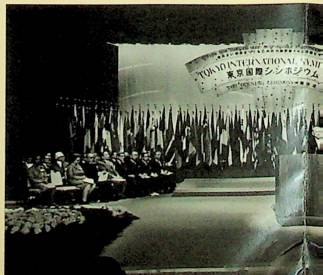
75

1975 World population passes 4 billion.

1975 International Women's Year Conference in Mexico City.

76

1976 Total donor country support for population program tops quarter billion dollars annually.



Ryoichi Sasakawa opens Tokyo International Symposium, 1976.

Ambassador Edwin Martin, PCC Executive Committee Chair, addresses Tokyo International Symposium, 1976.

"The rapid growth of the human race presents one of the greatest challenges to man's ingenuity that we have ever encountered." *President Gerald R. Ford, 1974.*

PCC Board members Gordon Wallace, Tom Lilley and Robin Duke honored by Mr. and Mrs. Ryoichi Sasakawa.

PCC Up Close

1975 Draper World Population Fund established with initial contribution of 200 million yen from Ryoichi Sasakawa.
1975 Ambassador Edwin Martin joins PCC; takes on responsibility for diplomatic liaison activities.
1975 Victor-Bostrum Reports renamed Draper Fund Reports.
1975 PCC establishes Special Projects Fund (SPF) under Mr. Wallace.
1975 Dr. Piotrow rejoins PCC as Executive Director.
1975 Sharon Camp joins PCC; later named Director, Education and Public Policy and Vice President.
1976 William Gaud, former AID Administrator, becomes PCC National Chair.
1976 Senator Robert Taft, Jr. (R-OH), co-author of international population aid legislation, retires from U.S. Senate and joins PCC Board.
1976 Tokyo International Symposium co-sponsored by PCC and Japan Science Society.
1976 Following death of Mr. Gaud, Fred Pinkham becomes National Chair and later President.
1978 Dr. Piotrow leaves to head major population program at Johns Hopkins; becomes Secretary of PCC Board.
1978 Julia Henderson retires as IPPF Secretary-General; joins PCC Board.
1979 Ambassador Marshall Green retires as State Department Population Coordinator; joins PCC Board and volunteer diplomatic liaison team.
1979 New SPF program, established by Gordon Wallace, to support efforts by Africans to eradicate female circumcision.

77

1977 Jimmy Carter becomes President of the United States.
1977 Expanded parliamentary exchanges on population issues lead to new international working group.
1977 Cumulative AID population assistance tops $1 billion.
1977 *Global 2000* report calls for stronger commitment to population and conservation work.
1977 Congress establishes Select Committee on Population.

79

1979 R.T. Ravenholt forced out as head of now decentralized population program.
1979 International Conference of Parliamentarians on Population and Development in Colombo, Sri Lanka.
1979 Pledges to UNFPA top $100 million.

1980-84

VITAL STATISTICS

	1980	1985
World Population (in billions)	4.414	4.845
Average Family Size Worldwide (in number of children)	3.8	3.7
Annual Population Increment (in millions)	77	84
World Contraceptive Use as Percent of Fertile Age Couples	51	51
Number of Governments Subsidizing Family Planning	101	117
U.S. Foreign Aid for Family Planning (in millions)	$185.0	$288.8

"World population has grown faster, and to higher numbers, than Malthus would ever have imagined...It is not *inevitable that history will vindicate his dire prediction of human numbers outrunning global resources. We have a choice. But that choice must be made now. Opportunity is on our side. But time is not."*

A.W. Clausen, World Bank President, and later PCC Board member, 1984.

Ambassador James Riddleberger, first head of U.S. foreign aid program and later PCC Chair and volunteer.

"... the population explosion ... has been vastly exaggerated."

Future president Ronald Reagan at presidential campaign debate on foreign policy, 1980.

PCC President Fred Pinkham being shown new State Family Planning Commission training center in Nanjing, China, by Professor Pang Gun Fang, 1985.

80

1980 First in series of regional parliamentary conferences in Africa, Asia, Europe and Latin America.

81

1981 Carter Administration submits last foreign aid budget request; proposes population aid level of $345 million for fiscal year 1982.

1981 Ronald Reagan becomes President of the United States; Reagan slashes population aid request to $211 million.

1981 Campaign by Under Secretary of State James Buckley to eliminate population program blocked.

1981 Office of Management and Budget attempt to eliminate foreign aid for population squashed.

82

1982 AID approves consensus document for Administration titled *AID Policy Paper: Population Assistance.*

1982 AID withdraws support from major family planning publications.

1983 Political threat to Pathfinder Fund's $8 million AID grant resolved through Congressional action, but only after concessions on abortion.

Tom Lilley, former Vice President Ford Motor Company and longtime PCC Treasurer.

"Anyone using any method of artificial contraception will go straight to hell."
WOOMB founder John Billings speaking on Tanzanian national radio during U.S. government-funded tour of Africa.

PCC Up Close

1980 PCC budget tops $2 million.
1980 PCC diplomatic liaison team of Ambassadors Martin and Green and Dr. Pinkham initiate series of calls on political leaders in key developing countries.
1980 Special Projects Fund sets up International Women's Health Coalition.
1981 Tom Lilley, PCC Treasurer for six years, dies, succeeded by Gerald Fischer.
1981 PCC founding member of Global Tomorrow Coalition.
1982 Ambassador Riddleberger dies.
1983 PCC Board approves major new media liaison program.
1983 William Westmoreland, Senator Taft, Ambassador Green and other PCC representatives brief Reagan White House and national security officials on foreign policy implications of rapid population growth.
1983 J. Joseph Speidel, former Acting Director, AID Office of Population, becomes PCC Vice President.
1984 PCC media program attracts national attention with appearances on major television network news and talk shows.

Ambassador Marshall Green, PCC Board member and executive volunteer, is welcomed to Presidential Palace to make population presentation to Egyptian President Mubarak and senior officials.

"First and most important . . . population growth is, of itself, a neutral phenomenon."
James Buckley, reading from official U.S. statement at Mexico City, 1984.

1983 Last-ditch effort fails to get Food and Drug Administration (FDA) approval of the injectable contraceptive Depo-Provera.

1983 Congress earmarks funds for UNFPA after Administration proposes major drop in U.S. contribution.

1984 At the International Conference on Population in Mexico City, U.S. legislators, world press and foreign leaders castigate Reagan White House and U.S. delegation led by James Buckley for retreat on world population efforts and restrictive new abortion policies.

1984 U.S. government releases impounded remainder of U.S. contribution to UNFPA after assurances on abortion.

1984 Congress signals displeasure over Reagan policies by increasing population aid budget to record $290 million for fiscal year 1985.

1985-89

VITAL STATISTICS

	1985	1990
World Population (in billions)	4.845	5.317
Average Family Size Worldwide (in number of children)	3.7	3.5
Annual Population Increment (in millions)	84	93
World Contraceptive Use as Percent of Fertile Age Couples	51	57
Number of Governments Subsidizing Family Planning	117	130
U.S. Foreign Aid for Family Planning (in millions)	$288.2	$238.8

U.S. Representative John Porter (R-IL), first chair of the Congressional Coalition on Population and Development, and PCC Vice President Sharon Camp brief Congressional gathering on foreign aid budget problems.

"But it is not just the American financial contribution that is needed; we believe that the United States must resume its leadership role in international population assistance…The nations of the world have joined together for the past 20 years in supporting international family planning…The continued absence of United States support is a blow to that consensus and to the millions in the developing world that benefit from UNFPA programmes."

UNFPA Executive Director Nafis Sadik commenting on White House decision not to renew support for UNFPA, 1989.

Longtime PCC Board members, former U.S. Senator Robert Taft, Jr. (R-OH) and Frances Loeb.

Gordon Wallace, PCC Board member and executive volunteer, meets with Rachel Marshall of Liberia on campaign to eradicate female circumcision.

PCC Board member and chair for resources development Wendy Morgan with PCC Board member and General Counsel, J. Edward Day.

85

1985 U.S. government suspends support for IPPF and cuts UNFPA contribution by $10 million; public scrutiny forces Administration to retain funds for other family planning organizations.

1985 DKT Memorial Fund sues government to overturn Mexico City abortion policy; case dismissed by appellate court in 1989.

1985 Nairobi International Conference on Women highlights women's right to family planning.

1985 Congress blocks AID policy concessions to religious conservatives on natural family planning, restores principle of informed consent.

1985 AID support for natural family planning tops $7.8 million, up from $400,000 in 1980.

86

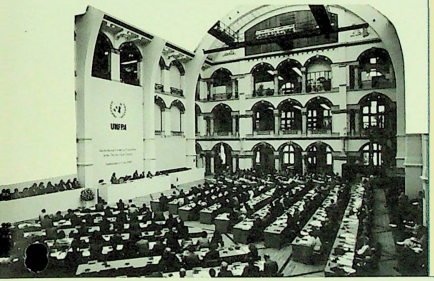
1986 U.S. expenditures on population aid drop by $50 million to $238 million.

1986 U.S. government withdraws entirely from UNFPA; most UNFPA funds directed to other family planning programs.

PCC President Joseph Speidel with Indian medical colleague from Parivar Seva Sanstha.

"I strongly support family planning programs which do not condone or encourage abortion or coercive measures. I believe that the current Kemp-Kasten law, along with the Mexico City policy, must be maintained without dilution, in order to preserve both the pro-life and pro-human rights character of the population assistance program."

President George Bush threatening to veto foreign aid bill over restoration of funds for UNFPA, 1989.



International Forum on Population in the 21st Century held in Amsterdam,1989, calls for major increases in global spending for family planning by the year 2000.

PCC Up Close

1985 Catherine Cameron becomes Director, Special Projects Fund, and later Vice President.

1986 PCC leads new 50-organization coalition to save development assistance appropriation from first Gramm-Rudman budget squeeze.

1987 Dr. Speidel succeeds Dr. Pinkham as PCC President.

1987 PCC reaches U.S. audience of 100 million with *Human Suffering Index* wall chart.

1987 New style PCC Briefing Paper in three languages, *Access to Birth Control*, reaches worldwide audience through first PCC international media campaign.

1988 PCC budget tops $3 million.

1988 PCC and Pathfinder Fund make extensive field study of impact of Reagan era policies on Third World family planning programs; circulated to U.S. policymakers and press.

1988 PCC launches new Population Policy Information Kits in three languages for foreign officials and activists.

1988 PCC study, *Poor, Powerless and Pregnant*, reaches worldwide audience of over 500 million.

1988 PCC media materials on new French pill RU-486 the basis of hundreds of news stories.

1989 PCC critique of World Bank population program covered by the media and acted on by Congressional committees.

1989 PCC handling of U.S. release of UNFPA *State of World Population* report produces expanded media coverage.

PCC National Co-Chair Robert Wallace with Board members John Musser and Nancy Lilley Stein.

87

1987 Planned Parenthood Federation of America sues AID in anticipation of move to defund PPFA's international program (FPIA).

1987 UNFPA Executive Director for 18 years, Rafael Salas, dies suddenly in Washington, D.C., during effort to restore U.S. funds. UN Secretary-General names Dr. Nafis Sadik as successor.

1987 World population passes 5 billion mark; events worldwide mark "Day of Five Billion."

88

1988 *Blueprint for the Environment* signed by major U.S. environmental groups calls for 1990 budget for U.S. population assistance of $500 million.

1988 French Minister of Health orders new French abortion pill, RU-486, back on the market, calling it the "moral property of women."

89

1989 George Bush becomes President of the United States.

1989 Joint Congressional/Administration move to eliminate line-item budgets for population aid blocked by major mobilization.

1989 President Bush vetoes $14 billion foreign aid bill over new $15 million Congressional earmark to reestablish U.S. contribution to UNFPA.

1989 American women's organizations mobilize, following *Webster* decision by Supreme Court allowing state regulation of abortion.

The Population Crisis Committee (PCC) is a private non-profit organization. PCC seeks to stimulate public awareness, understanding and action towards the reduction of population growth rates in developing countries through voluntary family planning and other actions needed to solve world population problems.

Population Crisis Committee
1120 19th Street, N.W., Suite 550
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(202) 659-1833
Fax: (202) 293-1795
Telex: 440450
Cable: CRISIS WASHINGTON

1990 cont.

Listing of Population Organizations: Their Purposes, Budgets and Key Personnel

Choices for the Next Century

1991 Our Diminishing World: The Land/Population Crisis

Population Politics

1991 World Population Report

Refunding of UNFPA Passes 234 to 188

Zimbabwe: Potential Model in the Midst

Half the Sky: Women and Development

The Demographic Imperative and the Politics of International Population

Strategies for Survival: The Population/Environment Connection

1992 Turkey: An Enclave of Hope

The Horn of Africa

International Family Planning: Charting a New Course

Desperate Departures: The Flight of Environmental Refugees

Each issue generally is available for $3.50.

Wrap of Commons - lock's end throwing into large farms.

population standing in the way of Development - or some Mcnamara - should. link camel carts to Lohn.

February, 1993

TOWARD THE 21st CENTURY
A Monograph Series by The Population Institute

Year	Title
1988	Population and Global Survival: A Vision for the Nineties
	The City Upon a Hill: Utopian Dreams Meet Urban Reality in the 21st Century
	Regional Powder Kega: Charting U.S. Security in an Exploding World
	Population & Environment: The Growing Imbalance, the Growing Imperative
	Family Planning: A Basic Human Right
	Population and Development: Relearning Some Hard Lessons
	A Continent in Crisis: Building a Future for Africa in the 21st Century
1989	Focus Indonesia: A Family Planning Success Story
	That Special Relationship: Building a Peace That will Last in Central America
	The Remarkable Journey: Two Decades of UNFPA Leadership
	Strategic and Critical Materials: The United States' Precarious Future
	The Struggle to Refund UNFPA
	The 1989 Soeharto Global Statesman in Population Award Presented to President Robert Mugabe of Zimbabwe
1990	The Apocalyptic Cycle: Overpopulation, Illiteracy, Poverty
	A Realistic Solution to Global Warming
	Rapid Population Growth and Tensions in the Middle East
	The Long, Dry Season: Population and Water
	Foreign Debt and Population
	The World's Dwindling Forests

A CHILD BORN TODAY . . .

We live in a world of 5.5 billion people, which grew last year by an unprecedented 97 million, the largest annual increase ever recorded. Three billion young people will enter their reproductive years within this generation. Consequently, a child born today can expect by the year 2000 a world in which:

- Almost one-half of the world's forests will be gone;
- One-fifth of the world's plant and animal species will be extinct;
- Deserts will claim an area one-and-a-half times the size of the United States;
- The air we breathe will contain one-third more carbon dioxide than it now does;
- Acid rain will have destroyed many more lakes and fish;
- Regional fresh water shortages will be up by 35 percent;
- Available agricultural land will be further depleted, forcing even more people to move to already overcrowded cities.

The shortsightedness of the present generation dangerously narrows the options of the next generation. Time is a luxury we do not have. Urgent action is required now to ensure a reasonable quality of life and a stable and secure world for a child born today.

The Population Institute
107 Second Street, NE
Washington, D.C. 20002
Tele: 202/544-3300

FACTS ABOUT THE POPULATION CRISIS

General

- With the world's population now exceeding five billion, we will witness three billion young people entering their reproductive years just within the next generation.

- 40 percent of the developing world's population is under age 15 and about to enter their most productive childbearing years.

- By no later than the year 2020, the combined populations of Asia and Africa will be 6 to 8 billion people, significantly more than now live on the entire planet.

- 500 million women want and need family planning but lack either information or means to obtain it.

Health

- 15 million infants under age one will die this year -- 42,000 each day -- many because their mothers did not know how to allow appropriate intervals between pregnancies.

- Nearly 1,500 women die every day because of complications from pregnancy and abortion, many of which might not be necessary if unwanted pregnancies were avoided through family planning.

Security

- Poverty in Central America is a cause of political unrest in the region. There are now 118 million people living on the land between the Rio Grande River and the Isthmus of Panama. By the year 2025, there will be 204 million.

- From the Arab nations in the north to South Africa, the African continent faces internal and external unrest. Today, the continent's population is 680 million; 20 years from now it will be 1,155, and 1.65 billion by 2020.

- Egypt, a nation of 55 million people and a key force for stability in the Middle East, faces serious economic problems today. There will be 69 million Egyptians by the year 2000; 105 million by 2025.

Economy

- Unemployment in many countries of the developing world is as high as 30 percent.

- To accommodate their growing populations, the nations of the world will have to produce 800 million new jobs by 2000.

- In 1950, only one city in the developing world had a population greater than 5 million; by the year 2000, there will be 46 such cities.

Environment

- 65 countries which depend on subsistence farming may be unable to feed their populations by the year 2000.

- 25 billion tons of arable topsoil vanish from the world's cropland every year.

- Enough timberland to cover 40 Californias will disappear by the end of this century.

- Acute shortages of fuel will affect 350 million people by the year 2000.

- At least 1.7 billion people, nearly one-third of the planet's population, lack an adequate supply of drinking water.

The Population Institute, September 1992

TOWARD THE 21ST CENTURY

THE POPULATION INSTITUTE

Number 7, 1991

THE DEMOGRAPHIC IMPERATIVE AND THE POLITICS OF INTERNATIONAL POPULATION

Origins of International Population Programs

In 1958 President Eisenhower appointed a committee of 10 distinguished gentlemen to study the U.S. military assistance program. One of the concerns they were asked to address was whether the mix of military and economic aid was appropriate. The President named General William Draper as chairman and the committee came to be known as the Draper Committee.[1]

The committee's terms of reference did not mention population as an issue for consideration. None of the members had ever before been involved in population or birth control causes and none had any particular knowledge of the subject when they were appointed.

The population issue came up the day following the establishment of the committee when long time population activist Hugh Moore sent Draper a long telegram admonishing him that his committee would be remiss if it failed to deal with the population program. President Eisenhower also raised the issue with Draper although the following year Eisenhower repudiated the committee's recommendations relating to population. Looking toward the 1960 election and the possibility that the Democrats might nominate a Catholic[2] as their candidate for president, Eisenhower concluded that the Republicans should not become associated with the politically sensitive birth control issue. To do so, he reasoned, might drive Catholic voters who (he assumed) were already disposed to vote for their co-religionist even further into the Democratic camp.[3]

This paper was prepared by James W. Brackett, longtime chief demographer for the Agency for International Development, who served for four years as the chief demographer for the Population Institute.

At a White House press conference in July 1959, Draper presented his committee's recommendations, including one calling on the United States to use its considerable resources to help countries curb run away population growth.[4]

Broadening Interest in Population Problem

During the 1960s General Draper and a long list of other prominent public minded citizens worked to build a consensus that something must be done to curb run away population growth that served as a brake on the economies of poor nations. In 1967, following several years of Congressional prodding, the Agency for International Development (AID) set up a population unit and hired a small staff with expertise in demography, public health, communications, biomedical research, and other fields needed to develop an international population program.

Growing Population Budgets

In 1968 the Congress earmarked $35 million of foreign aid money for population activities.[5] The following year, the earmarking was $50 million, then $75 million. The increases continued for several years, reflecting a broad although not universal consensus by members of both political parties that something had to be done to curb run away population growth. AID records show that $4,490,864 were programmed for population activities for the fiscal years between 1963 and 1991.[6]

The United Nations Population Fund (UNFPA) recently published an accounting of all international donor assistance for population activities through calendar year 1989. The total was $8.8 billion. The U.S. government's international population budget for these same years was $4 billion or about 45 percent of the total. If donations from private American foundations are included, the United States contributed about half the population assistance during the period. UNFPA's own budget from its beginning in 1967 through 1990 was about $2.3 billion.

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A Candy Bar or Coke From Each American

By Washington standards none of these figures are big bucks. The U.S. foreign aid budget from the end of the Second World War through 1991 was about $300 billion. The U.S. population account is only 1.5 percent of that total. The U.S. defense budget is approximately $300 billion annually. The total U.S. contribution for population activities averages about $18 for each of the 250 million Americans counted in the 1990 census. Spread over a quarter century, it is 72 cents a year. In some places you can still buy a coke or a candy bar for 72 cents.

But for ordinary Americans who must pay the bills, $4.5 billion earmarked for one of the world's most serious problems cries for an

accounting. How AID used a quarter century of precious time may be even more critical than how it spent the money, although the two are not separable.

A Ticking Bomb

The population problem has been compared to a ticking bomb or a metastasizing cancer. There is some urgency in taking effective action to defuse the bomb or retard the process of the cancer.

World population did not have to be 5.4 billion in 1991 or six billion in 1997.

In 1960, about a year after Draper released his report, world population reached three billion and the annual increase in world population was about 55 million. When AID got around to establishing a population unit eight years later, there were 3.5 billion human beings on earth and the annual increment in world population was 71 million. World population is now 5.4 billion with an annual increment of 95 million. About 1997, world population will likely reach six billion, double its size in 1960. The annual increment that year will be 100 million.

In A Single Human Lifetime

Six billion also means that for the first time in human history world population will have tripled during a single human lifetime. World population reached two billion sometime around 1930. It grew slowly during the 1930s, so anyone born before about 1935 who is still alive in 1997 can say world population tripled during his or her lifetime.[7] Moreover, many of that generation may experience a quadrupling of world population. The world could have eight billion people by 2015 when people born in 1935 will be eighty years old. No person who lived during any previous period in human history experienced even a doubling of world population.[8]

Population Growth Peaked -- Temporally

World population did not have to be 5.4 billion in 1991 or six billion in 1997. The world population growth rate peaked at 2.1 percent around 1970 and then declined to 1.6 percent toward the end of the 1970s. The annual increment in world population also peaked, temporarily, as it turned out, at about 78 million in the early 1970s, and then declined to about 70 million by the end of that decade.[9]

Had the trends in growth rates recorded during the period 1965 to 1979 continued and spread worldwide, the world population growth rate by now might be around one percent and the annual increase in world population about 55 million, its level in 1960. But between the latter half of the 1970s and the first half of the 1980s, the down trends in growth rates reversed. The United Nations estimates the world growth rate during the 1980s at 1.7 percent. The Population Reference Bureau's Data Sheet for 1990 placed the

world growth rate at 1.8 percent. Their 1991 data sheet lowered the estimate to 1.7 percent.

Births Decline -- Then Rise Once Again

The number of births worldwide also peaked -- temporally -- at 612 million for the five year period 1970-74 and then declined to 603 million for the period 1975-79. But then the number of births shot up to 642 million during 1980-84 and to 687 million during 1985-89, according to United Nations data.

Table 1 shows numbers of births for five year periods for the world and its major regions as well as increases/decreases between five year periods. Figure 1 shows the increases/decreases as bars. While only China and the Developed Countries recorded actual decreases in births, in most other regions increases in the numbers were markedly lower during the 1970s, indicating a lower growth *rate*. But then between 1975-79 and 1980-84 there was an explosion of births.

Fertility Rates Follow Similar Pattern

Fertility rates followed a pattern similar to growth rates. The fertility measure used here is the total fertility rate which indicates the number of births an average woman will have during her reproductive lifetime if the pattern of births by age for a particular period remains in effect. A decline of 1.0 indicates that women on average are having one fewer baby.

In the early 1960s the average number of lifetime births for all women in the world was 5.0. For the period 1970-74 the rate had declined to 4.5 and for 1975-79 to 3.8. These are averages for five year periods. By the end of the 1970s the rate was probably around 3.5.

World fertility for 1980-84 was 3.6. By the end of the decade the rate had declined slightly -- to 3.4.

Patterns of fertility change were similar for all regions except Africa.

Although the levels of fertility varied among major world regions, the patterns of change were similar for all developing regions except Africa. In Subsahara Africa fertility remained high and constant at about 6.7 lifetime births per woman until near the end of the 1980s when the rate declined by about five percent. For North Africa there was a slow continued decline through the mid 1980s and then a sharper decline during the latter half of the decade.

For other developing regions, fertility rates declined sharply through the 1970s. Then the declines slowed in the 1980s. The pattern is best seen as decreases in fertility rates between five year periods. (See Figure 2 and Table 2.)

Why the Reversal?

What caused the reversal?

During the 1960s General Draper and others were able to broaden the base of support for population programs. Members of both political parties

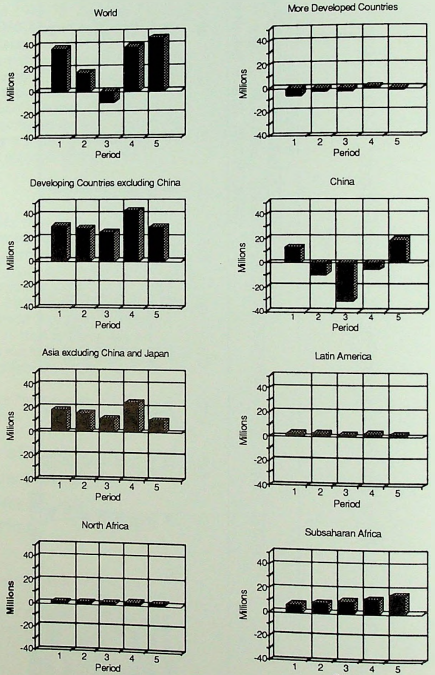
Table 1.-- Births in Major World Regions For Five Year Periods: 1960 to 1990

(Millions)

Region	Births						Increases/Decreases Between				
	1960-64	1965-69	1970-74	1975-79	1980-84	1985-89	1960-64 and 1965-69	1965-69 and 1970-74	1970-74 and 1975-79	1975-79 and 1980-84	1980-84 and 1985-89
World	559	596	612	603	642	687	37	16	-9	38	46
More Developed	98	92	90	87	88	86	-6	-2	-2	1	-2
Less Developed	462	504	522	516	554	602	43	18	-6	38	48
LDC excl China	331	361	388	413	456	485	30	27	25	43	29
China	131	144	134	103	98	117	13	-9	-31	-6	19
Asia excl China & Japan	209	227	243	255	280	290	18	15	12	25	10
Latin America	48	51	54	56	59	61	3	3	2	3	2
North Africa	16	18	19	21	23	24	1	1	2	2	1
Subsahara Africa	56	63	71	82	94	109	7	9	11	12	16

Source: Based on United Nations data.

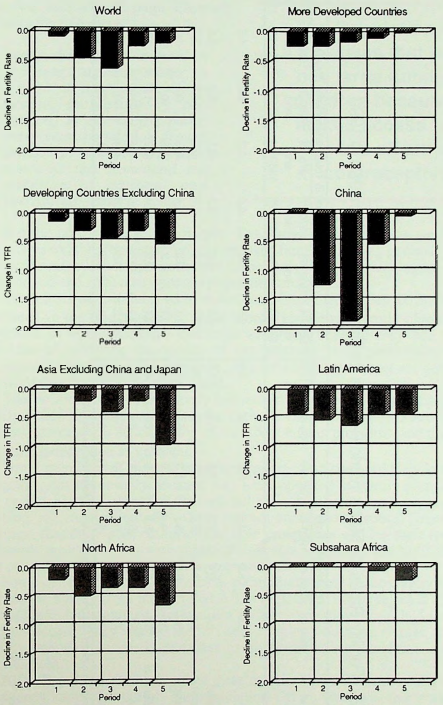
Figure 1.-- Increase / Decrease in Numbers of Births in Major World Regions Between Five Year Periods:1960 to 1990



Source: Based on data from the United Nations Population Assessment 1990 James W. Brackett P. O. Box 3089 Shepherdstown, WV 25443 USA

Note: See notes to figures for definition of periods.

Figure 2.-- Declines in Total Fertility Rates for Major World Regions Between Five Year Periods:1960 to 1990



Source: Based on data from United Nations and Population Reference Bureau
Note: See text for definition of periods.

James W. Brackett P. O. Box 3089 Shepherdstown, WV 25443 USA

Table 2.-- Fertility Rates for Major World Regions for Five Year Periods: 1960 to 1990

Region	Total Fertility Rate						Decrease in Total Fertility Rates Between							
	1960-64	1965-69	1970-74	1975-79	1980-84	Ca. 199(	1960-64 and 1965-69	1965-69 and 1970-74	1970-74 and 1975-79	1975-79 and 1980-84	1980-84 and PRB 1991	1960-64 and PRB 1991	1960-64 and 1975-79	1975-79 and Ca. 1990
World	5.0	4.9	4.5	3.8	3.6	3.4	-0.1	-0.4	-0.6	-0.2	-0.2	-1.6	-1.1	-0.4
More Developed	2.7	2.4	2.2	2.0	1.9	1.9	-0.3	-0.2	-0.2	-0.1	-0.0	-0.8	-0.7	-0.1
Less Developed	6.1	6.0	5.4	4.5	4.2	3.9	-0.1	-0.6	-0.9	-0.3	-0.3	-2.2	-1.6	-0.7
LDC excl China	6.2	6.0	5.7	5.3	5.0	4.4	-0.1	-0.3	-0.4	-0.3	-0.5	-1.7	-0.9	-0.8
China	5.9	6.0	4.8	2.9	2.4	2.3	0.1	-1.2	-1.9	-0.5	-0.1	-3.6	-3.0	-0.6
Asia excl China & Ja	6.1	6.1	5.9	5.5	5.2	4.3	-0.1	-0.2	-0.4	-0.2	-1.0	-1.8	-0.7	-1.2
Latin America	6.0	5.5	5.0	4.4	3.9	3.5	-0.4	-0.5	-0.6	-0.4	-0.5	-2.5	-1.6	-0.9
North Africa	7.1	6.9	6.4	6.0	5.7	5.0	-0.2	-0.5	-0.3	-0.4	-0.7	-2.1	-1.1	-1.0
Subsahara Africa	6.7	6.7	6.7	6.7	6.6	6.4	-0.0	0.0	-0.0	-0.1	-0.2	-0.3	-0.0	-0.3

Source: Based on United Nations and Population Reference Bureau data

acknowledged the urgent need to do something to slow population growth. George Bush was one of many strong supporters. In 1972 while he was ambassador to the United Nations, Mr. Bush wrote the Forward to Phyllis Piotrow's *World Population Crisis: The United States Response*. He referred to the bipartisan nature of support for population programs and the need for action to solve the problem.
His two and a half page Forward includes the following:

> *Today, the population problem is no longer a private matter. In a world of nearly four billion people, increasing by two percent, or 80 million more, every year, population growth and how to restrain it are public concerns that command the attention of national and international leaders.*

The Population Office view was that people had large numbers of children because they lacked access to safe and effective contraceptives.

But the political base was fragile. The Catholic Hierarchy as well as some conservative Protestant groups opposed family planning generally -- and government involvement therein particularly. Political ideologues on both the left and right also opposed population programs.

The leftists were influenced by outmoded Marxist ideologies the Soviets discarded in the mid-1960s.[10] These ideologies viewed family planning programs in non-communist countries as threats because they had the potential of relieving the misery of the working class, thus delaying communist revolutions.[11] Apparently, Marxists in the West had not gotten the word that their ideology was passé.

The political right was heavily influenced by religious opposition to family planning, particularly from the Catholic Church. They also strongly opposed government action in any area to solve human problems, and many viewed contraception as immoral.[12]

Some members of the academic community also opposed population programs, not necessarily because they were opposed to family planning per se but because they felt foreign aid should be used for education, housing, job creation, etc. first. They had not understood General Draper's message, that these poor countries had little prospect of solving their socio economic problems even with substantial foreign aid unless and until they first controlled run away population growth.

Some of the academic opposition, particularly from demography and economics, sprang from the fact that AID's population office rejected their theories which maintained that couples in the developing world had large families because they wanted them. These couples would not change their fertility behavior except in response to improved living standards, their theories held.

AID's Population Office rejected these theories (although many others in the agency supported them). The Population Office view was that people had large numbers of children because they lacked access to safe and effective contraceptives. The road to fertility reduction lay in satisfying the unmet demand for family planning.[13] If after satisfying this unmet demand,

developing nations still had a problem of excess fertility, actions to create more demand would be in order.

The emergence of the abortion issue, particularly following the 1973 Supreme Court ruling in *Roe v. Wade* and *Doe v. Bolton*, invigorated family planning opponents to fight contraception, sterilization, and abortion on all fronts.

Politicians Play to Family Planning Foes

While a large majority of Americans continued to support family planning both domestically and internationally, they were not fanatics on the subject. At election time they looked at a candidate's voting pattern on a broad series of issues they felt were important, family planning being only one.

On the other hand, family planning foes *were* fanatics. They didn't much care what positions the candidates took on a wide range of topics as long as his or her record was "pure" on family planning and abortion.

Both political parties played up to the single issue extremists. Although family planning foes had been given occasional plums by earlier administrations, Carter was the first to make major concessions. By the end of the Carter Administration the population program which had been by far the most effective of AID activities, was in shambles. The people who were responsible for the earlier successes had been removed or isolated. They were replaced by accommodating bureaucrats and political appointees with no records of accomplishment in *any* field.

The Reagan Administration is often blamed for destroying the U.S. international population program, but that had largely been accomplished before Reagan's arrival on the scene. Reagan continued the destructive actions initiated by Carter.

Neither the Congress nor the Administrations cared much about what happened to population funds. Family planning foes siphoned off as much as they could. When contracts were awarded to unqualified contractors, those in a position to stop the waste of taxpayers' funds looked the other way or were willing participants.

The crown to (Carter's) pessimistic outlook was the Global 2000 report.

Limits to Growth -- No Limits to Growth

Carter made a great to-do about the limits to growth. The crown to his pessimistic outlook was the Global 2000 report.

Reagan adopted the counter theme *There are no limits to growth.* He called for Americans to feel good about themselves. Neither of these presidents understood that the truth lay somewhere between their conflicting views. The world is not going to hell in a hand basket in the next five minutes but neither is the sky perpetually rosy.

International Conference on Population, 1984

If there were no limits to growth, then population growth must not be a problem. At the International Conference on Population in Mexico City in 1984 the head of the American delegation, James Buckley, dismissed the population problem. Population is neither good nor bad, he said. It is neutral. Then he gave his -- and presumably Reagan's -- solution to the problem -- free markets.[14]

Population growth in developing countries is the result of a surplus of births over deaths.

Buckley pointed to the "Little Tigers" of the Pacific rim, Singapore, Taiwan, Hong Kong, and South Korea, as examples of countries that had used the free market to solve their population problems. Evidently, he had no knowledge of the real history of these nations. All adopted strong government run programs to curb fertility. Only *after* these programs succeeded in sharply reducing fertility did their economies take off.[15]

Buckley also tried to get authority from the White House to announce at Mexico City that the United States was terminating all international population activities, but the White House did not approve.

Population Not "Neutral"

Population is, of course, not neutral. The migration of large numbers of people to North America, first from Europe and Africa, and later from all over the world, had a positive impact on the development of the United States. In fact, our Declaration of Independence acknowledges the positive nature of immigration in its bills of indictment against George III. The Declaration states:

> *He has endeavored to prevent the population of these States; for that purpose obstructing the Laws for Naturalization of Foreigners; refusing to pass others to encourage their migrations hither, and raising the conditions of new Appropriations of Lands.*

When the first European colonists arrived on these shores four centuries ago, North America was sparsely populated with almost limitless natural resources. The adults who came here could find employment almost immediately after disembarking or they could go into the wilderness and stake out land claims or engage in the fur trade.

Population growth in developing countries is wholly different. Rather than adults trained at the expense of sending countries, their population growth is the result of a surplus of births over deaths. Their new citizens must be fed, clothed, housed, and educated 15 to 20 years before they have the potential to become productive.

But virtually all developing countries already have serious problems of unemployment and underemployment. When these new citizens reach working age, many will not be able to find meaningful employment.

Politics Disrupt Population Programs

The negative actions taken by the Carter Administration and continued under Reagan played a major role in reversing the downturn in population growth worldwide. These actions sent a signal to forces around the world that curbing runaway population growth was no longer a priority. The Congress kept appropriating funds for population programs, and everyone looked the other way as AID spent these funds on a wide range of activities, many with little impact on contraceptive use.

AID financial records are a muddle, even for someone familiar with the system. Understanding the budget is not helped by AID's unwillingness to release information, even under the Freedom of Information Act.

By piecing together fragmentary and often inconsistent financial data, country by country guesstimates were made of how AID programmed $2,121,394,000. That is only 47 percent of the $4.7 billion population program. While large sums were spent in the United States and other developed countries, surely considerably more than half of the total must have been programmed to developing countries.

AID Population Budgets and Fertility Change

By the fall of 1967 AID had assembled a staff of six or seven professionals and two or three secretaries in its population unit.

In early 1968 the Congress earmarked funds for the population program for the first time. The staff could then begin to do something no one else had ever done -- design and execute a program to reduce fertility.

The staff and its Director, Dr. R. T.Ravenholt, were allowed to operate for about 10 years, albeit often in a state of siege with the old line bureaucrats who put their feet in the spokes at every opportunity. But, by the summer of 1977, Carter Administration operatives had taken away most of the authority of the central Population Office and had started the systemic removal or isolation of key staff members. Many programs continued for a period despite the negative atmosphere, but at a greatly diminished level of effectiveness.

The starting period for fertility declines was 1960-64, the years just before AID launched its population program.

One means of judging the impact of the political actions and the relative effectiveness before and after 1977 is to look at the relationship between budgets for the two periods and fertility declines.

The budget periods chosen were 1965 through 1977 for the first period and 1978 through 1988 for the second. The first period is actually a little shorter than the budget data indicate. Very little population money was available prior to 1968, so the effective period is 1968 to 1977, or nine years. The second period, 1978 to 1988, is eleven years.

The starting period for fertility declines was 1960-64, the years just before AID launched its population program. The ending dates for the first period was 1975-79. The second period begins with 1975-79 and ends with circa 1990.

During the first period AID's population budget in current dollars was about one billion. The budget for the period 1965 to 1988 was $3.6 billion. Thus, on a current dollar basis, those in charge of the population program for the first period had about 28 percent of the budget while those in charge for the second had 72 percent.

If the numbers are adjusted for inflation using the U.S. cost of living index, 43.5 percent of the funds were available during the first nine years and 56.5 percent during the second eleven years.

Nearly 70 percent of the decline in fertility in developing countries and 51 percent of the decline in developing countries other than China occurred prior to 1980.

Nearly three-fourths of the worldwide fertility decline between 1960-64 and 1990 occurred between 1960-64 and 1975-79. While AID did not have population programs in all countries of the world, the negative attitude of AID and the Carter and Reagan Administrations went far beyond countries with bilateral programs. Moreover, family planning foes demanded and got concessions in U.S. domestic programs. Poor women in the United States were denied access to abortion and contraception, forcing them to have babies they did not want and could not support -- and forcing the American fertility rate higher.

Nearly seventy percent of the decline in fertility in developing countries and 51 percent of the decline in developing countries other than China occurred prior to 1980. (See Figure 3)

Actually, the comparison is even more unfavorable to those in charge during the second period than the numbers indicate. As stated earlier, in 1968, there were few models the Office of Population could use as a basis for designing family planning delivery systems. These systems had to be developed from scratch or adapted from public health programs.

People, both in the United States and in the developing countries, had to be trained. Programs to educate foreign leaders about the importance of slowing population growth had to be launched.

Those who took over the Population Office in the late 1970s had at hand most of the tools required to press ahead with program actions, but they failed to use them effectively. The dedication to getting the job done that prevailed during the first period was no longer present.

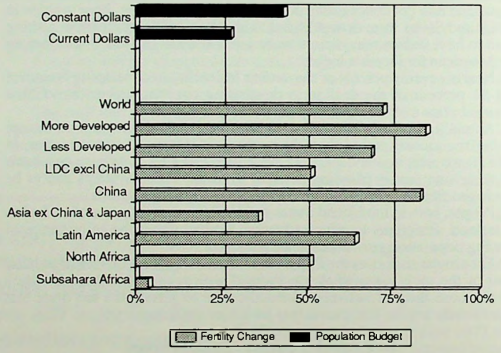
Individual Country Comparisons

Fifty countries were selected as the focus for special analysis. To be selected, a country had to have received either a minimum of ten million dollars from AID or a minimum of $0.50 per capita between 1965 and 1991. The combined population of these countries in 1991 is 2.2 billion. The populations of individual countries range from seven thousand (Anquilla) to 859 million (India). (See Table 3)

In the early 1960s women in these 50 countries averaged 6.2 births during their reproductive lifetimes. Today, they average 4.4, a decline of only 1.8 children over a quarter century. The fertility rate for all developing countries combined declined by 2.2 children during the same time period.

Figure 3.– AID Population Budget for 1965-77 as a Percent of Population Budget for 1965 to 1988 (Black Bars) and Fertility Change 1960-65 to 1975-79 as a Percent of Fertility Change for 1960-65 to Circa 1990 (Grey Bars)

(See text for explanation)



Source: See text. *James Brackett P. O. Box 3089 Shepherdstown, WV 25443 USA*

Table 3.-- Countries Receiving a Minimum of $10 Million or $0.50 Per Head of U. S. Population Funds During the Years 1965 to 1991

Country	Population 1991 (1000)	Population funds FY1965-91 $1000	Funds Per Head	Total Fertality Rates 1960 -64	Circa 1990	Differ-ence
Total	2,176,890	$2,042,156	$0.94	6.2	4.4	-1.8
Barbados	257	$358	$1.39	4.3	1.8	-2.5
Thailand	58,814	$57,475	$0.98	6.4	2.2	-4.2
2.3 or Less	59,071	$57,833	$0.98	6.4	2.2	-4.2
Jamaica	2,489	$22,161	$8.90	5.6	2.6	-3.0
St Kitts	40	$21	$0.53		2.7	
Colombia	33,613	$37,859	$1.13	6.8	2.9	-3.9
2.4 to 2.9	36,142	$60,041	$1.66	6.7	2.9	-3.8
Indonesia	181,366	$191,961	$1.06	5.4	3.0	-2.4
Panama	2,466	$9,126	$3.70	5.9	3.0	-2.9
Anquilla	7	$9	$1.29		3.2	
Costa Rica	3,111	$10,677	$3.43	7.0	3.3	-3.7
Brazil	153,322	$79,602	$0.52	6.2	3.3	-2.9
Dominican Re	7,321	$10,737	$1.47	7.3	3.6	-3.8
Ecuador	10,752	$21,963	$2.04	6.9	3.8	-3.1
St. Lucia	153	$93	$0.61		3.8	
Mexico	85,721	$92,094	$1.07	6.8	3.8	-2.9
India	859,192	$108,953	$0.13	5.8	3.9	-1.9
3.0 to 3.9	1,303,411	$525,215	$0.40	5.9	3.7	-2.2
Peru	21,996	$41,375	$1.88	6.9	4.0	-2.9
Philippines	62,338	$139,658	$2.24	6.6	4.1	-2.5
Tunisia	8,362	$37,940	$4.54	7.2	4.1	-3.1
Morocco	26,182	$53,537	$2.04	7.2	4.5	-2.7
Paraguay	4,397	$4,797	$1.09	6.8	4.5	-2.3
Egypt	54,452	$153,556	$2.82	7.1	4.5	-2.5
El Salvador	5,419	$51,785	$9.56	6.9	4.6	-2.3
Belize	228	$243	$1.07		4.8	
Grenada	83	$218	$2.63		4.9	
Bolivia	7,464	$9,628	$1.29	6.6	4.9	-1.7
Bangladesh	116,601	$306,798	$2.63	6.7	4.9	-1.8
Botswana	1,258	$2,115	$1.68	6.9	4.9	-2.0
4.0 to 4.9	308,780	$801,650	$2.60	6.8	4.5	-2.3

Table 3.-- Countries Receiving a Minimum of $10 Million or $0.50 Per Head of U. S. Population Funds During the Years 1965 to 1991

Country	Population 1991 (1000)	Population funds FY1965-91 $1000	Funds Per Head	Total Fertality Rates 1960 -64	Circa 1990	Difference
Laos	4,113	$5,073	$1.23	6.2	5.0	-1.2
Honduras	5,298	$39,482	$7.45	7.4	5.3	-2.1
Guatemala	9,467	$38,529	$4.07	6.9	5.3	-1.6
Nicaragua	3,871	$5,856	$1.51	7.3	5.5	-1.8
Zimbabwe	10,019	$10,692	$1.07	7.5	5.6	-1.9
5.0 to 5.9	32,768	$99,632	$3.04	7.0	5.4	-1.7
4.0 to 5.9	341,548	$901,282	$2.64	6.8	4.6	-2.2
Zaire	37,832	$14,876	$0.39	5.9	6.1	0.1
Nepal	19,612	$44,409	$2.26	5.9	6.1	0.2
Swaziland	817	$1,906	$2.33	6.5	6.2	-0.3
Nigeria	122,471	$29,773	$0.24	6.9	6.2	-0.7
Ghana	15,509	$21,061	$1.36	6.9	6.3	-0.6
Haiti	6,287	$32,054	$5.10	6.3	6.4	0.1
Senegal	7,533	$25,057	$3.33	7.0	6.5	-0.5
Gambia	884	$817	$0.92	6.5	6.5	0.0
Somalia	7,691	$16,418	$2.13	6.6	6.6	0.0
Pakistan	117,490	$178,596	$1.52	7.0	6.6	-0.4
Kenya	25,242	$63,498	$2.52	8.1	6.7	-1.4
Liberia	2,730	$9,149	$3.35	6.7	6.8	0.0
6.0 to 6.9	364,098	$437,614	$1.20	6.8	6.4	-0.4
Mali	8,339	$7,388	$0.89	7.1	7.1	-0.0
Afghanistan	16,645	$20,475	$1.23	7.0	7.1	0.1
Tanzania	26,869	$12,324	$0.46	6.9	7.1	0.2
Togo	3,811	$2,016	$0.53	6.6	7.2	0.6
Malawi	9,438	$7,605	$0.81	7.0	7.7	0.7
Rwanda	7,518	$10,363	$1.38	7.7	8.1	0.5
7.0 or More	72,620	$60,171	$0.83	7.6	7.3	-0.4

Source: See text for sources.

Allocations to Specific Countries

No country received an exorbitant amount of AID population funds on a per capita basis. El Salvador received the most -- $12.68 based on 1975 population -- enough to buy a five year supply of oral contraceptives for one woman at prices AID sometimes pays.

India received the least on a per capita basis -- $0.13 per person, a piddling amount for the world's second most populous country.

In terms of total dollars Bangladesh received the most -- $307 million. That works out to about four dollars per head. Other international donors -- the United Nation, The United Kingdom, Sweden, Canada, Japan, etc. also invested large sums in Bangladesh's population program, perhaps even more than the United States. Yet, fertility in Bangladesh remains high. A quarter century ago Bangladesh women averaged 6.7 births during their reproductive lifetimes. The average is now 4.9.

Bangladesh is one of the four or five poorest countries on earth and can least afford a fertility rate of nearly five births per woman.

Bangladesh is one of the four or five poorest countries on earth and can least afford a fertility rate of nearly five births per woman. It was overpopulated in the early 1960s when it had half as many people as it has today.

U.S. population funds tended to go to countries that made only modest progress in reducing fertility. The left pie chart in Figure 4 shows the allocation of U.S. population funds by recent fertility levels. The right chart shows the population of all developing countries in these ranges. Nearly seventy percent of AID population funds went to countries with recent fertility rates of 4.0 or higher where only 30 percent of developing country population now live. On the other hand countries with fertility levels at or below "replacement" received only six percent of AID's country allocations even though they contain 34 percent of developing country population.

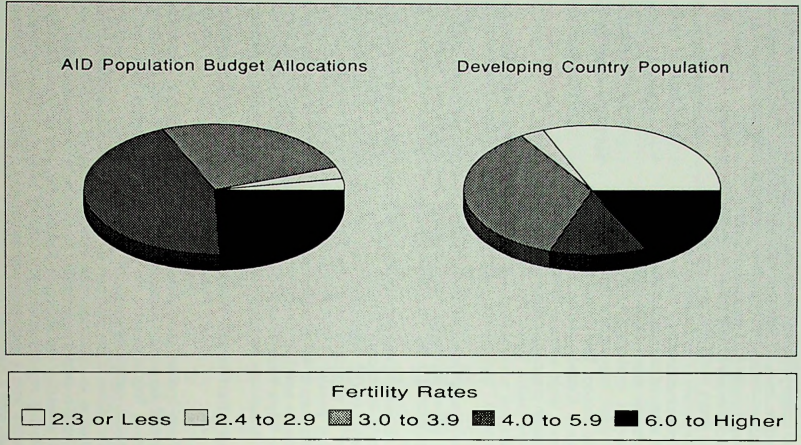
Nearly Half of the World's Population Live in Countries with "Replacement" Fertility

There is some good news. Today, 2.5 billion people worldwide -- 47 percent of the world's population -- live in countries with fertility levels at or below "replacement," the point at which couples have just enough children to replace themselves.[16]

The slices in the pie chart in Figure 5 show the proportion of world population in countries with various levels of fertility. Virtually all developed countries have fertility levels at or below "replacement."

The smaller pie in Figure 5 shows the split between developed and developing regions among low fertility nations. Thirty-eight developed countries with a combined population of 1.2 billion and 22 developing nations with a combined population of 1.3 billion have fertility rates at or below "replacement." China is predominate among low fertility developing countries. However, Thailand, South Korea, Taiwan, Cuba, Singapore, and Hong Kong also have low fertility rates. In fact, Hong Kong's fertility

Figure 4.-- Population and AID Population Budget Allocations by Fertility Range



See text for sources.
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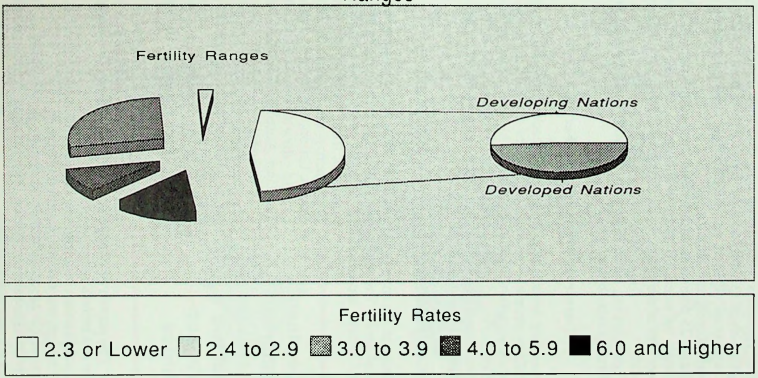
Figure 5.-- Proportion of World Population in Countries With Specific Fertility Ranges



Source: Based on data from the Population Reference Bureau.
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Four developed nations with a combined population of 3 million had fertility rates of 2.3 to 2.9. No developed country had a higher rate

rate of 1.2 is the lowest of any country except the Vatican whose fertility rate is near zero.

Countries With Moderate Fertility

Twenty-four countries -- 20 developing and four developed -- with a combined population of 132 million have fertility rates between 2.4 and 2.9. Among the countries defined as "developing" are Argentina, Chile, Colombia, North Korea, and Jamaica.

Beyond these, 25 countries with a combined population of 1.5 billion have fertility rates between 3.0 and 3.9. Indonesia, Brazil, and Venezuela are in the lower end of the range. India, Mexico, Turkey, and Malaysia are at the upper end.

Thus, 67 developing countries with a combined population of 2.9 billion have fertility rates below 4.0.

Countries With Higher Fertility

The discouraging news is that after three decades of population program activity 1.3 billion people -- nearly a quarter of the world's population -- live in countries with fertility rates of 4.0 or higher. Three quarters of a billion live in countries with fertility rates of 6.0 or higher and 165 million live in countries where women average seven or more children during their reproductive lifetimes.

Geographical Pattern of Recent Fertility

The shadings on the map in Figure 6 indicate recent patterns of fertility by geographical areas. The white areas indicate fertility levels at or below "replacement." These areas include virtually the entire northern tier of countries from Canada and the United States across the Atlantic to Europe, the Soviet Union, China, and Japan. They extend down from East Asia to Thailand, Australia, and New Zealand.

On the other end of the spectrum are many countries in Africa and West Asia where women still average six or more lifetime births.

The countries that recorded either no change or increases are with but two exceptions in Sub-Saharan Africa.

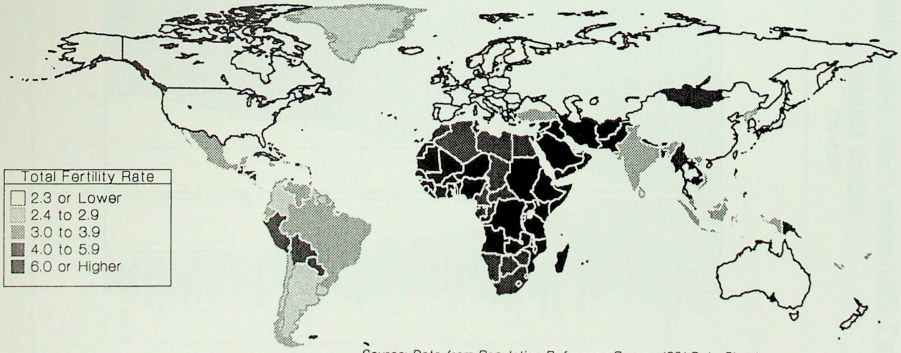
Long Term Changes in Fertility

Figure 7 shows changes in fertility rates between 1960 and circa 1990 for 149 countries. The pattern of change is a continuum from Thailand's decline of 4.2 children to Gabon's increase of 0.9.

One hundred fourteen countries recorded at least some decline. Fifteen registered no change, and twenty recorded increases.

The countries that recorded either no change or increases are with but two exceptions in Sub-Saharan Africa. The two non-African countries on the list are Afghanistan and Romania.

Figure 6.--Fertility Levels Ca. 1991



Source: Data from Population Reference Bureau 1991 Data Sheet
Map constructed by James Brackett P. O. Box 3089 Shepherdstown, WV 25443 USA using Harvard GeoGraphics

Figure 7- Decreases in Fertility Between 1960-64 and Ca. 1990 by Country

Panel One

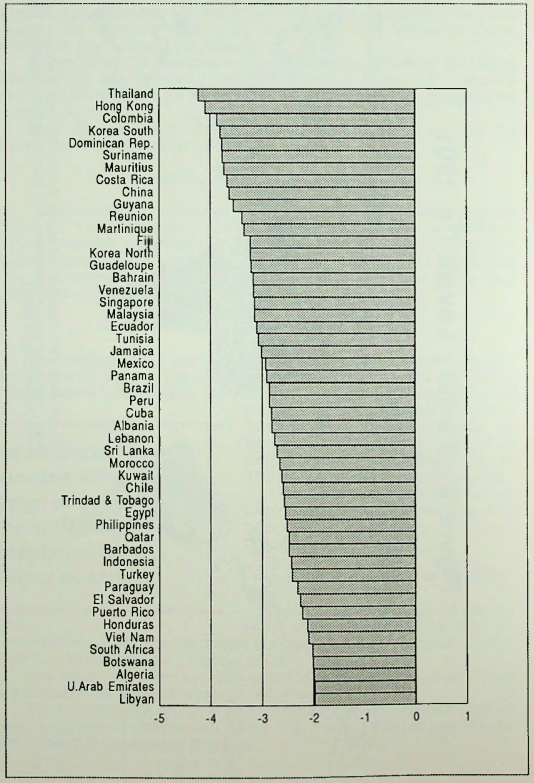


Figure 7.-- Decreases in Fertility Between 1960-64 and Ca. 1990 by Country

Panel Two

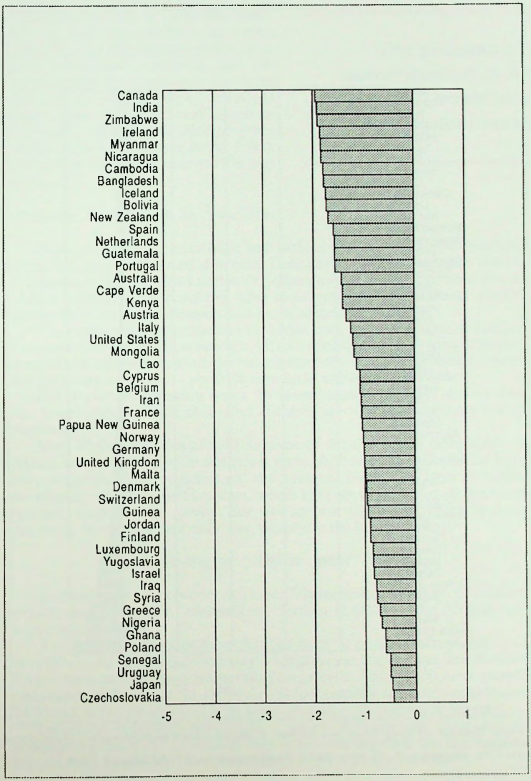
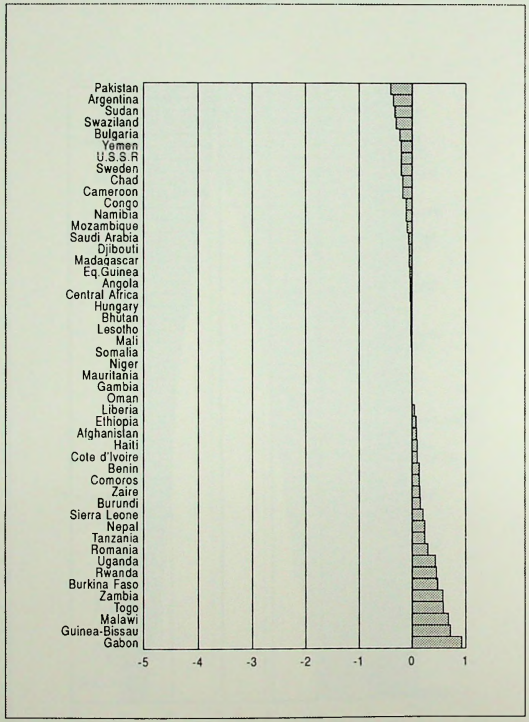


Figure 7-- Decreases/Increases in Fertility Between 1960-64 and Ca. 1990 by Country

Panel Three



Source: Based on data from the United Nations and the Population Reference Bureau

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Romania: A Window on a Right of Life State

Romania's sad history has been well publicized. It is a game preview of what is in store for any country where the so-called "right to life" gain power. Both abortion and contraception were outlawed and couples were pressured to produce babies. Women who failed to do so were punished. Women had more children than they could feed, so the children ended up in state institutions, unloved and ill-nourished. In the institutions they were subjected to bizarre medical experiments, including small injections of blood, much of it collected from sailors and dock workers in the Black Sea port of Constanta where AIDs was rampant.[17]

The process of modernization in Africa may also contribute to fertility increases.

Possible Reductions in Sterility

Some African countries have had serious sterility problems resulting from sexually transmitted diseases. Despite the AIDs pandemic that is devastating much of Africa currently, some countries may have been able to reduce sterility by reducing the incidence of Gonorrhea, genital tuberculosis, and other diseases that cause secondary sterility.

The process of modernization in Africa may also contribute to fertility increases. It is the tradition in some African societies for a woman to abstain from sexual intercourse until she weans her baby. Women typically breast-fed for a very long time -- up to 24 months in some cases.

But taboos are breaking down. Women breast-feed for a shorter time and fewer Africans wait until after children are weaned to resume sexual relations.

Most of the increases as well as some of the decreases, particularly in Africa, are probably due to statistical error. Although most countries have laws requiring birth registration, the systems rarely function in poorer developing countries. Fertility data, where they are available at all, are more typically collected by survey. Surveys are not taken very often in these countries. Many have had only one, usually in the last few years.

The Meaning of "Replacement" Fertility

Logically, when a country achieves "replacement" fertility, population growth should stop. But "replacement" fertility is not the same thing as zero population growth.

Although 60 countries have fertility rates at or below "replacement," only five -- the Falklands, Germany, Hungary, the Isle of Man, and Vatican City -- have zero or negative population growth. Another 20 have growth rates below 0.5 percent. In 1990, the 60 low fertility countries contributed 24.3 million people to world population growth -- 26 percent of the total.

Of course, if fertility remains at or below "replacement" long enough, population growth will eventually stop or become negative, but that may not happen for a long time. The reasons have to do with age structure.

Many developed nations experienced baby booms following the Second World War that continued into the early 1960s. The first of the baby boomers began reaching childbearing age in the mid 1960s. The last of them reached childbearing age in the early 1980s. Not until about 2010 will the baby boomers complete their childbearing.

Because the number of prospective parents rose sharply during the period when baby boomers reached reproductive age while the fertility of individual couples declined, the number of births remained high. In the United States, for example, although fertility has been below "replacement" since 1972, births have in each year since that date exceeded deaths by about two million.

A Perpetual "Baby Boom" in Developing Countries

The developing countries have had a perpetual baby boom that only recently began to abate. Moreover, the levels of fertility in developing countries were much higher than fertility in developed nations even at the peak of their baby booms. For example, the peak fertility rate in the United States was 3.8 and that lasted only one year, although fertility remained at 3.5 or above for several years. Sustained fertility rates twice as high were not uncommon in developing countries a decade to two ago and are still found today in Africa and West Asia.

The age structure also affects the number of deaths and the crude death rates. Most deaths occur at the extremes of life, infancy and old age. Developing nations have relatively few older people, a situation that will change only gradually over the next century or more. Because there are so few older people, a large share of the deaths in developing countries occur to infants and young children. But as fertility declines, young children will represent a smaller and smaller proportion of the population. Lower fertility and better child spacing will combine with expanded health measures and hopefully better nutrition to reduce infant and child death rates.

The vast majority of the population of developed nations will be in the middle years of the age structure where few people die.

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Crude death rates in many developing countries could fall below five per thousand population. In fact, several countries already have death rates below five. The combined death rate for low fertility developing countries is already 6.6 compared to a death rate of 9.4 for low fertility developed countries.[18]

Because of these demographic factors, population growth will likely continue for 60 to 70 years before births and deaths come into balance, assuming, of course, that fertility remains below "replacement." During the transition, populations can double or even triple.

What Countries Can Do

Countries can do some things to reduce but not eliminate the consequences of their population growth.

By encouraging young people to postpone childbearing until they are in their late twenties or early thirties, several demographic phenomena come into play.

First, the inter-generational span will increase, slowing the rate of population growth. An example may serve to illustrate.

A population with a median age at childbearing of 25 years will have four generations each century. A population with a median age of 33 will have only three. If all other factors are equal, the second population will grow more slowly than the first.

If couples postpone fertility, they are likely to use family planning throughout their reproductive lifetimes.

The age structure for most developing countries is pyramidal. That is, the number of people at any given age is smaller than the number at any younger age. Consequently, raising the age of childbearing has the effect of reducing the number of prospective parents.

In Kenya, for example, where the growth rate has been between 3.0 and 4.0 percent over the past several decades, each five year age group contains about 20 percent fewer people than the preceding age group. Thus, raising the median age at childbearing by five years reduces the number of potential parents and potentially the number of births (assuming no change in fertility rates) by about one fifth. A ten-year increase will reduce the numbers by more than a third.

Raising the age at childbearing also effectively reduces the number of years women are at risk of pregnancy. Moreover, if couples take the necessary action to postpone fertility, they are likely to use family planning throughout their reproductive lifetimes.

Switching from a younger to an older fertility pattern will also produce a one time "savings" of births that do not happen during the transition period. Even if couples ultimately have the same number of children, these "lost" births will never be made up. Again, an example, albeit highly contrived, may serve to illustrate the point.

Assume a population in which all births occur to women age 25 and that no births occur to women at any other age. Now, assume that there is a universal decision to change the childbearing pattern such that all births occur to women age 33. During the eight-year transition, our contrived population will not have any births at all because women who had their babies under the old pattern will not have any more while women who reached age 25 after the decision to switch must wait until they are 33.

Strategies for Raising the Age at Childbirth

Countries have tried to increase the age at childbirth by raising the marriage age. That strategy can work up to a point, but there is a limit to how long healthy adults will forgo sexual relations. If the legal age at marriage is increased too much, couples may postpone formal marriage but not sexual relations. Many of these premarital relationships will result in

pregnancies, thereby increasing the number of out of wedlock births with all the social and economic consequences associated with them.

Encouraging Young People to Use Family Planning

Another approach is to encourage teenagers and young adults to use family planning. Programs designed to do that have often failed because young people are unreliable contraceptors. They forget to take the Pill or, in the moment of passion, fail to don a condom.

But Norplant has changed the way contraceptive decisions are made. A woman need only take a one time action to have the implants inserted to gain five years protection against pregnancy. After that, she must make a conscious decision to have a baby and take the positive action to cause it to happen -- namely, have the implants removed. Thus, the tables are reversed with respect to fertility decision.

The AIDs pandemic should also serve to reduce fertility. Young people particularly have a vital need to practice safe sex. If they use condoms with the care required to prevent the transmission of AIDs, they will necessarily prevent pregnancies as well.

Cultural changes may also be necessary. For example, some cultures expect women to produce a baby within a year or so after marriage to prove fecundity. Family planning programs often ignore newly married couples and concentrate on increasing the interval between the first and second births or on helping couples stop childbearing altogether after some prescribed number of children. While these programs are effective in reducing the number of births, they have the effect of *reducing* the inter-generational span.

Reduce Fertility Well Below Replacement for an Interim Period

Low fertility rates are not the consequence of government coercion; they are the cumulative effect of decisions by individual couples.

Countries may also need to achieve fertility rates of 1.0 to 1.5 for an interim period until population growth slows. Hong Kong's fertility rate is now 1.2. Italy and Spain have fertility rates of 1.3 and Austria 1.4. These low fertility rates are not the consequence of government coercion. They are the cumulative effect of fertility decisions by individual couples, each acting in what they believe to be their own self interest.

Fertility rates aggregate the fertility behavior of individual couples. They are averages. In all societies some women never marry and some that do never have children, either by choice or because they or their husbands are sterile. These zero birth women are included in the denominators used to derive the fertility rate but do not contribute to the numerators. Thus, women who do have children average more births than the fertility rate indicates.

More Effective Aid Agencies

National Public Radio observed that the United States military was able to get the relief programs for the Bangladesh cyclone better organized the first day than the Bangladesh government and the various aid organizations had done during the previous weeks. The American military is programmed for action. It is highly organized with a command structure dedicated to getting the job done and getting out.

Regrettably, the aid agencies, including AID, don't have the same drive for achievement. They are quite content to let problems fester and get worse, confident that the American taxpayers will continue to cough up the money for luxury housing and other perks members of the entrenched bureaucracy have come to expect.

There is an urgent need for an efficient and effective U.S. international population program.

There is an urgent need for an efficient and effective U.S. international population program, but the present program requires a major overhaul. New personnel, particularly at the top, is an essential first step. A new personnel system is needed, one that emphasizes accomplishment -- one that rewards people who get things done.

During the early 1970s, there was a proposal to establish an independent population organization outside the Department of State and AID. That proposal might be worth dusting off.

However the program is organized, it must be removed from politics. The politicians must stop listening to the extremists who oppose family planning. They must work to promote effectiveness and efficiency in population programs.

Politicians make a big to do about the human rights aspects of family planning. Those who make the most noise are usually family planning foes who allege that couples are coerced into conforming to government established birth quotas. They overlook the much more serious problem whereby couples are forced to have babies they do not want and cannot afford because they are denied access to safe and effective contraceptives.

Notes for Figures 1 and 2

Figure 1:

Period 1: Differences in numbers of births between 1960-64 and 1965-69.
Period 2: Differences in numbers of births between 1965-69 and 1970-74.
Period 3: Differences in numbers of births between 1970-74 and 1975-79.
Period 4: Differences in numbers of births between 1975-79 and 1980-84.
Period 5: Differences in numbers of births between 1980-85 and 1985-89.

Figure 2:

Period 1: Differences in total fertility rates for 1960-64 and 1965-69.
Period 2: Differences in total fertility rates for 1965-69 and 1970-74.
Period 3: Differences in total fertility rates for 1970-74 and 1975-79.
Period 4: Differences in total fertility rates for 1975-79 and 1980-84.
Period 5: Differences in total fertility rates for 1980-84 and circa 1990.

1. In addition to committee chairman General William H. Draper, Jr., the Committee members were Dillon Anderson, Joseph M. Dodge, General Alfred M. Gruenther, Marx Leva, John J. McCloy, George McGhee, General Joseph T. McNarney, Admiral Arthur W. Radford, and James E. Webb.

2. The Democrats did nominate Catholic John Kennedy, who was elected President in 1960.

3. After leaving office Eisenhower became honorary chairman of Planned Parenthood and made a number of public appearances supporting its activities.

4. For a detailed account of the work of the Draper Committee and the development of United States international population policies and programs up to about 1972, see Phyllis Tilson Piotrow, *World Population Crisis, The United States Response*, Praeger Publishers, 1973.

5. Prior to 1968 AID spent a total of about $10 million on a variety of population related activities, including a series of studies on the socio economic impact of family planning programs. These studies were instrumental in the decision of the United States Government to launch an international population program.

6. Budget data were derived from various published and unpublished AID reports, including the annual submissions to the Congress.

7. In 1997 the annual increment in world population may exceed 100 million compared with an annual increase of less than 20 million during the 1930s. Thus, world population will likely increase as much as in the single year 1997 as it did during the five years, 1930 to 1934.

8. World population is generally believed to have reached one billion at the beginning of the Nineteenth Century, possibly as early as 1800 but no later than 1830. It reached two billion around 1930. Thus, the doubling time from one to two billion was between 100 and 130 years. A person who died in 1930 would have had to be at least 100 years old to have lived during a period when world population doubled and probably 130 years old.

9. Demographic data used in this article came from a variety of sources, including the United Nations *Demographic Yearbook*, the United Nations Population Projections as Assessed in 1990, the Population Reference Bureau's *Population Data Sheet 1991* and reports from individual countries. Both the United Nations and the Population Reference Bureau publish data in magnetic format as well as in print.

10. For an account of the changing views of Soviet Marxist on population, see James W. Brackett, "The Evolution of Marxist Theories of Population: Marxism Recognizes the Population Problem." *Demography*, Vol. 5, No. 1, 1968.

11. According to classical Marxism, overpopulation is simply unemployment. All capitalist societies, by Marxist definition, have unemployment and are therefore overpopulated. Marxists maintained that unemployment was a necessary condition for the existence of capitalist systems since there was a need for a pool of unemployed workers from which capitalists could draw labor. Marxism would provide full employment. Thus, the solution to the population problem was Marxism.

This ideology predated the establishment of communist systems in China and Poland. Providing jobs to everyone in these countries proved difficult, even with very inefficient methods of utilizing labor. The population problems in developing countries posed other problems. Marxist theorists began talking about physical limits to the number of human beings a given quantity of land could sustain and about quality of life.

12. Some people on the ideological right took a different tact. They expressed concern about the "yellow peril," a term coined by Kaiser Wilhelm II, as well as the black and brown perils. Their view was that Europeans were under threat of being overrun by rapid increases in other races. Some advocated tying foreign aid to compulsory baby quotas. In order to receive Western aid, nations would be assigned rigid birth quotas not unlike those China assigns to its subregions. Fortunately, the U.S. Government, as well as other donor countries, rejected these ideas in favor of family planning programs based on self interest and voluntarism.

13. A good source of information on the diverse courses of action people advocated to reduce fertility can be found in the testimony before the Select Committee on Population on February 7, 8, and 9, 1978 published in *World Population: A Global Perspective. Hearings before the Select Committee on Population, Ninety-Fifth Congress, Second Session*, Washington 1978.

14. It is interesting to note the similarity between the Marxist view that the solution to the population problem was communism and Buckley's view that the solution was the free market. Both views were presented as magic wands of sorts that would cause people to have fewer children. Neither dealt with the practical issue of how the transition would come about. The type of political or economic system one lives under is unlikely to affect libido. Healthy adults are going to engage in sexual activity. Unless they have access to and use contraceptives, fertility rates will be high.Neither Buckley nor the Marxists concerned themselves with such mundane problems. A detailed account of the U.S. withdrawal from international population efforts can be found in *Gaining People, Losing Ground*, by Werner Fornos, President of the Population Institute, Science Press, 1990.

15. Japan offers another example of a country that first sharply reduced its fertility and then experienced rapid economic growth. Japan's fertility reduction was achieved while Japan was under military rule of the very conservative General Douglas MacArthur, who accomplished the fertility reduction by legalizing abortion.

16. An average of 2.3 lifetime births per woman was used as the level of "replacement" fertility. The levels for individual countries may be higher or lower, depending on the demographic situation. To attain "replacement" fertility, women must ON AVERAGE give birth to just enough girl babies to ensure that one will survive to adulthood. The fertility rate required for "replacement" depends on two factors: 1) the level of mortality, particularly among infants and children, and 2) the sex ration at birth. Women in countries with high mortality must necessarily have more births to achieve "replacement:" fertility than women in low mortality countries.

Among people of European and Asian ancestry, about 106 boys are born for every 100 girls. Among people of African ancestry, the ratio is about 103 boys to 100 girls. Thus, the fertility rate required for "replacement" will be lower for people of Africa ancestry than for European and Asian populations, assuming the same level of mortality.

17. A more detailed account of the situation in Romania can be found in "Romania Experiment Holds Lesson for World," *Atlanta Constitution*, by Werner Fornos, April 15, 1990.

18. The death rate for developed countries with fertility rates between 2.4 and 3.0 is 5.8 deaths per 1000 population. Albania accounts for 97 percent of this category. Albania's death rate is 5.7. Although it is included among the developed countries, Albania is a very primitive country which experienced a dramatic drop in fertility in recent years. Its age structure is like those of developing countries.

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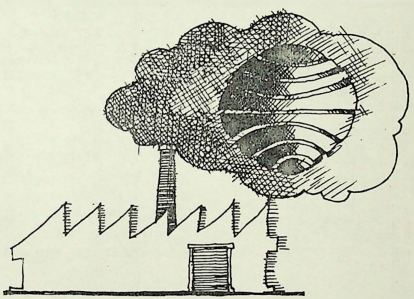
People And Ecosystems
A Complex Relationship

Dr. Vandana Shiva

Industrial and socio-economic paradigm simultaneously transforms people and resources and the relationship between them. People, especially poor people, become "population." Resources are transformed from self renewing systems into industrial raw material. The relationship between people and resources defined through the "commons" is also disrupted. "Commons" are living ecosystems nurtured by social communities which are bounded by ecological, ethical, cultural, political and economic limits. When resources are transformed into raw material, commons must be enclosed, and people must be displaced.



Three processes are unleashed simultaneously:

a. People are rendered dispensable and turned into surplus 'population'

b. Resources are privatised

c. Resources are exploited at rates and in quantities determined by distant markets, not by local demand or by ecological demands.

The result of these simultaneously unleashed processes are:

a. the population crisis

b. the poverty and deprivation crisis

c. the ecological crisis.

However, instead of seeing these three processes as being simultaneous consequences of the same root cause, (a) is falsely turned into a cause for (b) and (c).

Population and the environment at UNCED

Population growth in the Third World is being increasingly and falsely identified as a primary cause of environmental destruction. This tendency was also articulated in the UNCED Documents A Conf. 151/PC 45 and 46, which focussed heavily on 'demographic pressures.'

Even documents not related to population issues erroneously identify population growth as a cause for environmental destruction. Thus even the production of toxic chemicals which has grown exponentially in the industrialised world and has been transferred to the Third World, is related to population growth — for example, Document PC 42 Add. 5 on biotechnology states.

The expanding world population is generating, and will continue to generate, more wastes resulting from the use of more chemicals, more energy and more agricultural and industrial products.

The report fails to recognise that the sparsely populated rural areas of the US use far more chemicals than the heavily populated regions of the Third World and that the increase in the use of toxic chemicals is more directly a result of the pushing of chemicals by the industry. Neglecting the pressure from production interests in the North, and the heavier dependence of the North on toxic chemicals, the document falsely identifies population growth as a cause for the production and use of millions of tons of toxic chemicals.

There are four main reasons why population growth cannot be identified as the primary cause of environmental destruction.

Firstly, the large number of poor people in the Third World, whose population is growing, do not participate in the use of most products that are causing environmental destruction because these are not within their purchasing power. They do not use Chlorofluoro Carbons (CFCs) for refrigeration and hence cannot be identified as agents of ozone destruction.

Secondly, the large numbers of poor people use *insignificant fractions* of the resources used by the North and the elites of the South. Thus, an average US citizen uses 250 times as much energy as an average Nigerian. Northern lifestyles, therefore, contribute disproportionately to the pressures on resources, including the resources of the South.

Thirdly, production processes that have emerged from the Northern industrialised countries are inherently destructive of the environment and this destruction capacity is independent of population growth. As has been stated, environmental destruction is a function of the resource destroying capacity of technologies of production (the technology factor) and the goods produced or consumed per capita. In other words:

Total pollution=pollution per unit of economic goods produced X goods consumed per capita X population.

The first two factors are contributed disproportionately by the North, both in terms of transfer of resource-intensive technologies and in terms of high consumption of resource-intensive products.

Finally, population growth is not a cause of the environmental crisis but an aspect of it; both are related to the alienation of resources and destruction of livelihoods, first by colonialism and then by Northern imposed models of mal- development.

Population growth arises from the same causes that lead to poverty, on the one hand, and environmental degradation and resource alienation, on the other. This should be apparent from Indian data, which shows that population control programmes have systematically failed because people in destitution make a rational choice to have more children.

The focus on population as the case of environmental destruction is erroneous at two levels. Firstly, it blames the victims. Secondly, by failing to address economic insecurity and by denying the rights to survival that underline population growth, current policy prescriptions avoid the real problem. False perceptions of the problem lead to false solutions. As a result, environmental degradation, poverty creation, and population growth continue unabated, in spite of the billions of dollars spent on population control programmes.

Giving people rights and access to resources to generate sustainable livelihoods is the only solution to arrest environmental destruction and the simultaneous process of population growth.

The elusive search

However, it is fashionable these days to treat the population problem as the number one environmental problem. An example of this is Maurice King's thesis that sustainability of the planet demands that children in poor countries be allowed to die.

The expanding world population is generating, and will continue to generate, more wastes resulting from the use of more chemicals, more energy and more agricultural and industrial products.

Much of the theorising is based on a one to one correspondence and causal connection between rising populations and deteriorating ecosystems.

Maurice King's analysis of the "Demographic Trap" is an example of such theorising. He assumes that local population pressure is the only environmental pressure on ecosystems, that there is a straight- forward carrying capacity calculus for human societies as there is for non-human communities.

However, most ecosystems in the Third World do not merely "carry" local populations. They also "carry" the demand for industrial raw material and consumption in the North. The Northern demand on Third World resources implies that the threshold for support of local populations is lowered. In other words, what would be a "sustainable" population size on the basis of the local production, consumption and lifestyle patterns is rendered non-sustainable due to non-local use.

The theoretical and conceptual challenge is to find the tools of non-sustainable use, not just in visible local demand but also in the invisible, non-local demand for resources. Otherwise the search for "sustainable populations" will become an ideological war declared against the victims of environmental degradation in the Third World, especially poor women, without removing the real pressures on the environment that come from global economic systems.

Double burden

The "carrying capacity" in the case of human societies is not merely a biological function of local population size and local biological support systems. It is a more complex relationship that relates populations in the North to populations and ecosystems in the South. The ecosystems of the South (E) therefore carry a double burden — that of supplying commodities and raw materials to global market (G), and that of supporting the survival of local communities (L).

Reducing L, and ignoring G, cannot protect E. Moreover, most analysis of the relationship of population and the environment ignores the non-local demand for resources. This is also true of Garett Hardin's seminal essay, "Tragedy of the Commons." What Hardin failed to notice about the degradation of the commons is that such degradation is accelerated when the commons are "enclosed" — i.e., they stop being commons and are privatised.

The "enclosure of the commons" introduces a separation between people and resources. As commons are enclosed, people are displaced and resources are exploited for private profit. In England, the enclosure of the commons forced peasants off land and turned it into pasture land for sheep. "Enclosures make fat beasts and lean people," "sheep eat men" were some of the characterisations of the consequences of the enclosure of the commons. "Carrying Capacity" had been problematised by the enclosure of the commons, because the land no longer supported people but sheep for raw material. Disenfranchised people were turned into a resource, worth only the

➢ *Continued on page 35*

Continued from page 14 ➢

labour power they could sell on the market. Displacement from land make a necessity of growth in numbers.

Colonisation and development projects have had the same consequence in the Third World as the enclosure of commons in England. Population growth is not a cause of the environmental crisis but one aspect of it, and both are related to resource alienation and to destruction of livelihoods, first by colonialism and then by Northern imposed models of maldevelopment. In 1600, the population of India was between 100 million and 125 million. In 1800, the population remained stable. Then the rise began — 130 million in 1845, 175 million in 1855, 194 million in 1867, 255 million in 1871. The beginning of the "population explosion" dovetailed neatly with the expansion of Bristish rule in India, when resources and rights and livelihoods were taken away from people. As Mahmood Mamdam has put it "high birth rates are not the cause of present impoverishment; they are the response of an impoverished peasantry." When people lose all other kinds of security, children are the only economic security.

After many decades of failed "population control" it might well be more fruitful to directly address the roots of the problem — economic insecurity. Giving people rights and access to resources so that they can generate sustainable livelihoods is the only solution to environmental destruction and the population growth which accompanies it.

Maurice King's analysis of the demographic trap fails to take these complex ecological relationships into account and hence settles for a naive and somewhat cruel prescription for sustainability.

(This paper is based on the author's interventions in UNCED and on her response to Maurice King in a debate on the Demographic Trap in Oslo University in December 1991)

Dr. Vandana Shiva is Director of the Research Foundation of Science, Technology and Natural Resource Policy, Dehradun. She has been actively involved in citizens' action against ecological destruction, and has written extensively on women, ecology and the philosophy of science.

Female Condom Ready for Sale

In spite of questions about its effectiveness in preventing pregnancy and protecting against sexually transmitted diseases, the first female condom has been approved for marketing by the Food and Drug Administration, USA.

In its approval, the agency required the company to include labelling that emphasised that male latex condoms appeared to be a better safe-guard against pregnancy and disease.

The female condom, sometimes called a vaginal pouch, is essentially a polyurethane sheath that lines the vagina. The device, which is about six and half inches long, is held in place by two flexible plastic rings, one at the cervix and one outside the body.

(Warren E. Leary, The New York Times, appeared Deccan Herald, June 6, '93).

Extracted from VOICES, Vol. 1 No. 2, journal of Madhyam Communications

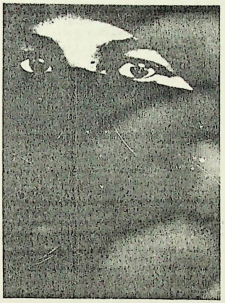
Women's Experiences with Family Planning

Manisha Gupte

Women bear the major brunt of the population policy all over the world, be it to increase or to reduce fertility. In India, rural women are made targets in a family planning campaign, because they lack visibility, articulation and political power. Women's lack of choice and low access to resources need to be documented in their own words and, keeping this in mind, we have attempted to articulate some feelings that rural women in Maharashtra have tried to express. While the reality of women's lives is neatly ignored, unsafe contraceptives that take away choice are peddled to them 'for their own good,' as it were. Ironically, women's real need for safe contraception stays unfulfilled, either because they recoil from government pressure or because real choices are not yet available to them. I hope that the following article will be able to bring out these nuances, as far as possible through women's own experiences, which I have documented and presented here.

The price of death

In our socio-economic study of women's work, fertility and access to health care in two villages, we accidentally stumbled upon the direct relationship that one's children's death has with one's fertility. Besides the agony, guilt and sense of helplessness that a woman undergoes after a child's death, she also immediately pays a high personal price by bearing more children to replace the dead one. In both the villages, we found that for every dead child a woman had to produce two more children, on an average. Abortions, miscarriages and still births are not included in this figure. We can only dare imagine the extent to which a woman stretches and exerts herself to create a counteracting buffer by undergoing an enormous number of conceptions. The desired family size of three children (two sons and a daughter), and the social consequences of children dying (including exorcism, desertion and mental illness) set up a trap from which few rural women can dare to escape. "God gives, God takes," as women say, is the only temporary escape from insanity.



Can we lift the veil of superstition and secrecy which shrouds women's awareness about their bodies . . .

When children die, other childless women suffer too. They are the first suspects of having performed voodoo or witchcraft.

When children die, other childless women suffer, too. They are the first suspects of having performed voodoo or witchcraft. Deserted women, widows, menstruating women — all come next in the line of suspicion. In one village, a one day old child suddenly started to turn blue. In my presence a woman exorcist was summoned and she said that the grandmother who had gone to wash the baby's clothes at the pool had perhaps not noticed that some menstruating wanton had defiled the water at the same time. She then advised that some exorcised and "charged" materials be placed in the backyard of another childless woman who wished the baby ill. The social and political factors affecting illness and death thus go unquestioned and a web of super-stition takes its place, making one victim fight the other.

Fear of the unknown

Health services, as well as the 'family planning' services, are based on an incomplete knowledge of people's perceptions of body, anatomy, illness and cure. On the other hand, people are also kept in the dark about the interventions that are going to be performed on their bodies, especially through contraception. Numerous justifications may be offered for these lapses, but that does not help to improve the situation. Women, who bear the major brunt of the population control measures, feel unnerved and ill at ease with contraceptives. They attribute all kinds of side effects to birth control methods, and their suspicions are further strengthened when the doctor refuses to entertain even the most genuine symptoms and sequalae.

Through all our group meetings, women say that 'camps' create more side-effects than individually performed tubectomies. Some women narrate their horrific experiences of the Emergency

period of 1975-77. One woman described how she had been picked up from the jowar fields and tubectomised. Another recalled how she had literally been forced into a waiting vehicle and taken away to the tehsil hospital. She was sterilised at midnight in very unhygienic conditions. "There were more than fifty women like me at the hospital, all scared. We were treated like animals and were literally thrown out after the sterilisation." When asked whether this experience had had long term repercussions, she countered: "Just think of yourself in my place. What would have happened to you?"

Not surprisingly, then, women who undergo sterilisations against their wishes, or who have not been mentally prepared to accept the interventions about to be performed, suffer more. Menstrual chaos and lower backache feature as the most common complaints after tubectomy, and often these sequalae last long enough to justify other complicated interventions on their bodies. The government health services turn a deaf ear to any problems related to contraception, either because they disbelieve the women, or because they do not want to give the programme a bad name, and so the women are left to fend for themselves.

The private doctors, who are not interested in contraceptives because they are not lucrative, suddenly come to the forefront, and suggest hysterectomy (surgical removal of the uterus) as the solution to the women's problem. We have met many women who have undergone hysterectomies after years of suffering, post tubectomy. "If you have one operation, the other is bound to follow. They are like sisters." Whereas all the tubectomies had been performed in the public health services, all hysterectomies are invariably performed in private clinics. Each hysterectomy costs Rs. 4-5000, while the daily wage earned by the women is never more than Rs. 15 per day.

Little choice

Within the limited choice that the people exert within the target- oriented FP programme, tubectomy is the most 'preferred' method. Condoms pose a disposal problem in the villages, where there is no garbage removal system. The low bio-degradability of condoms also puts a damper on its usage. Copper-T or *tambi* is also not a very popular method. Often health workers register false cases of barrier methods and of Copper-T. We have heaps of condoms and Copper-Ts, which were found in various parts of the village, and have witnessed large-scale incinerations of pills and condoms in the Public Health Centre (PHC) premises. A clever guess is that these devices feature as completed targets. Once, I asked a local nurse how she fulfilled the Copper-T targets.

She told me: "I call the women for a cup of tea, give them the incentive money and enter their names on the 'protected couple' list." When I asked her what would happen if a surprise check was conducted, she replied: "We tell the women to say that the *tambi* fell off. Even the doctor knows that we are filling up false records. He doesn't care, as long as our targets are completed. If we honestly report a high rejection rate of *tambis* inserted, we get a shouting. So we learn to report low failure figures." This nurse considered me a good friend as I had let her use my name as a *tambi* acceptor whenever she ran short of her target goal.

Pressure to meet FP targets

Reeling under the pressure of targets for population control, the village based health workers are in an unenviable position. In March 1987, Manda Padwal, an Auxiliary Nurse-Midwife (ANM) in rural Maharashtra, committed suicide after a reprimand from the medical officer to complete her target of sterilising 20 tribals within the next seven days, at the close of the financial year. When we investigated, we found that she had been the sole earner in the family, with a disabled younger brother. The doctor said that the suicide was a result of sexual frustration, because Manda was unmarried and she was anyway prone to exhibit bizarre behavior due to this condition.

In numerous instances, both during our visits to PHCs all over Maharashtra and in our area of work, we have seen the humiliation that health workers undergo during the monthly staff meetings. The doctor, just having received a scolding from the district authorities, comes down relentlessly on his own staff. Since all health workers do not want to go Manda Padwal's way, they are left with no choice except to harass people (read women) in turn.

ANMs and village women thus play an unending game of love and hate, each party trying to outsmart the other whenever possible. The fact that the ANM is herself a frightened young woman, living alone in a strange village, is forgotten, because only her hard, determined quality is seen by the local women. "How can we be friends with her? She taunts us when we get pregnant; she tells lies about the side effects of *tambi*. I can't trust her." On the other hand, an ANM said: "You expect me to help the women? I am beaten by my own husband. He comes every month to take my salary away and batters me, saying that I am having affairs with the doctor, the Multi-Purpose Workers (MPWs) and the men in the village. He has another wife, but he won't let me leave because of my steady income. If my pay is withheld for family planning reasons (incomplete targets) he says that I am giving the money to a lover."

Often we were caught in the cross fire between these warring women. The nurses reprimanded us for telling women about the expected side effects of contraceptives, and the women thought we were the nurses' agents. For over a year, during our stay in the villages, we were seen as family planning officers because, in the villages, health services are synonymous with population control. It was only after we stayed there for some years without any 'case' to our credit, that women started to confide in us about their actual need for birth control and asking us how to exercise choice within the limited available options.

Benefits, rights: unheard of

Today, the pregnancy centre that we manage regularly registers women's demands for birth control, and women insist that our workers (all of who are local women) accompany anyone who goes to the PHC for a tubectomy. "Of course I don't want too many children. But I feel so suspicious of the nurses. I don't feel safe and relaxed." This individual sentiment expresses the mass paranoia that the mindless, target-oriented population control programme has generated among the women while, at the same time, leaving their legitimate need for safe and reliable contraception unmet.

Though a 1983 state government circular clearly grants maternity benefits of a partial kind to all women workers on the state-sponsored Employment Guarantee Scheme (EGS) sites, we have not come across a single case in our cluster of villages so far where any woman has availed of the same. In fact, women said: "If we deliver in the afternoon, we get paid only for the morning's work that we put in ." Most women work until the last week of their pregnancy and return within a month or two of the delivery if the drought continues. "Is there a choice? The fields are not irrigated and so our lives are spent carrying and dumping stones." Women were even surprised to hear that some maternity and post-tubectomy benefits had been granted to them by the state.

In one instance, we witnessed a woman who had recently delivered being motivated for sterilisation. Everyone except her participated in the conversation. The woman in question sat behind the curtain, with the infant in her lap, and listened to what the family members had to say. The MPW wanted to complete his targets immediately, whereas the girl's parents were waiting to hear from her husband. The girl's father-in law wanted to give the case to the health worker in their village, and so he was not ready for the operation in the girl's natal village. The local MPW threatened to sever all his relations with the girl's parents and said, "If ever there is any health problem in your family hereafter, do not bother to call me. I have no time for ungrateful people."

It has been our constant observation that, though sterilisations are mostly performed on women, they have the least say in the matter. This alienation from their bodies could partially explain the trauma that accompanies the surgery and makes them vulnerable to future invasive interventions as well.

The suspicion that women harbour about health workers is also not entirely unfounded. In one instance, a male health worker was motivating a woman in my presence. He looked at me with a flourish and said to the woman: "Now you don't have to worry. Here is a lady doctor from Bombay who has decided to live in our village. She will perform all the 'operations' henceforth." I countered him saying that this information was not true. Later on, still sulking, he questioned me about why I had been so 'indiscreet' in front of the woman and made him lose face. In turn I asked him how he expected the woman to believe him. Would she not find out the truth once she came to the PHC? "That's my business," he said, "Once she is inside the operation theatre, she can hardly run away. Now you have lost me a perfectly good case."

False promises

Women have also complained about the false promises given at the time of sterilisation. "Our children were promised free medicines until the age of twelve years. Later on we realised that they didn't even have enough 'triple' (immunisation) doses. We have never received the medicines or the free health check-ups they promised."

It is a common sight to see health workers discuss a woman's eventual sterilisation, over her head, during the ante-natal care (ANC) check-up. A certain nurse will croon over a pregnant woman or taunt her, saying. "After all this care, don't have your operation at your mother's village, after your delivery. Don't betray me." Noticing my presence, the nurses would also hurriedly add something like "There is no difference between girls and boys, you know. They are equal, so don't postpone your operation just because it's a daughter !" It probably doesn't matter that the mother is not asked her opinion at any point or that nurse has never questioned her own no-win position. Girls and boys are certainly equal.

This individual sentiment expresses the mass paranoia that the mindless, target-oriented population control programme has generated among the women while, at the same time, leaving their legitimate need for safe and reliable contraception unmet.

Once I saw a nurse in tears and I was surprised, because the usual day for nurses to cry is the day of the monthly staff meeting. She bitterly complained about how her male colleague had slyly taken away her case. "I had 'cultivated' this case all through the pregnancy. How dare she agree to go with the MPW ? Just let her come to me for the child's immunisation. I'll give her a good dose of her own medicine."

Stealing a case

A community health guide from a neighbouring village reported how it was very difficult to motivate a woman to insert a Copper-T and how he had, instead, taken a few women to the taluka place (hospital) for tubectomies. All of them were 'stolen' by the local MPW; on one occasion, he managed to motivate a man for vasectomy. The same evening, the Block Development Officer's (BDO) car came along and took his case away. Asked why he allowed such snatching, he said: "They are all big officers. I cannot do anything, except complain to the medical officer when he questions me about my incomplete target figures."

Another motivated Community Health Guide (CHG) from a nearby village said that it was no longer very difficult to motivate young couples to stop after two or three births. Women were mostly sent in for sterilisation, and the few men who agreed to undergo vasectomies preferred to wait until the end of the financial year, when the incentives are the highest. The major problems as narrated by him was "The MPWs and the ANMs snatch away our cases. They justify it by saying that, as CHGs, we don't have to complete targets officially. Once the 'case' is taken to the health centre, they tear off the forms filled in by us and fill in new ones with their own names as motivators."

Who is bigamous?

To understand the true extent of the "minorities" threat — which suggests that members of minority communities are primarily responsible for the population explosion through their customary large family size and the practice of bigamy — we decided to conduct a census of our own village. Our findings were unexpected, to say the least. Among the 182 households (with a total head count of 859 individuals) we found that every tenth Hindu household was 'officially' bigamous, with more than one woman openly using the same

➢ *Continued on page 26*

Continued from page 17 ➢

man's name and that the entire community accepted these marriages as rightful and unstigmatised in any way. Ironically, whereas 10 per cent of Hindu men, spread over all age groups, educational levels and castes, were openly bigamous, none of the 21 Muslim households in the village are officially bigamous.

The average household size of Hindu families is 5.0, whereas that of their Muslim counterparts is 5.4, indicating that there is no considerable difference, especially since we found that small households (kitchen units) in the village are not merely a representation of reduced fertility, but also of opportunities (or lack of opportunities) for migration to the cities for better prospects. The study was conducted in 1992 by the author.

Myths and biases are excellent breeding grounds for planned coercion and so we find, even in well-meaning circles, the agreement that the growth of 'certain populations' needs to be curtailed. Coercion on women, the minorities, the working class, villagers and the illiterate are thus justified. A cursory glance at reality may help to dispel some of the eugenic biases we unnecessarily gather.

Unsafe contraceptives, no-choice situations

About three years ago, a young adolescent girl came to the PHC for her first delivery. Her old grandmother stayed the night with her. This old woman confided in the nurse about her own vaginal discharge. The internal check-up revealed a foul, frothing, black discharge. Then the grandmother told the nurse that she had never got her IUD (probably a Dalkon shield) removed. She had got it inserted when her youngest son, the father of the girl in labour, was born, 40 years earlier.

This woman certainly does not represent the typical picture regarding invasive contraceptives, but surely there are a few more like her, somewhere on the Indian sub-continent. The agony is compounded by the fact that women's access to general health services is also very low, it being further reduced by the constant nagging for family planning. In this context, it is both undesirable and unconceivable to consider introducing long-acting hormonal contraceptives, such as injectables and implants in the Indian Family Planning Programme. The absence of choices, low access to all resources, including health services, low self-perception of women and the anti-people stance of population policies, would only compound the miseries of the common woman. ■

Manisha Gupte is involved in a rural health education project of the Foundation for Research in Community Health, Bombay, in the drought-prone and semi-accessible Purander tehsil of Pune district.

The observations made in this article were recorded over a period of five years — during her involvement in a study undertaken for the National Commission on Self Employed Women and Women in the Unorganised Sector, during the author's extensive travel in rural Maharashtra to visit various PHCs and NGOs engaged in rural community health care and, of course, during their project work.

Extracted from VOICES, Vol. 1 No. 2, journal of Madhyam Communications

Reproductive Rights & Population

DAWN INFORMS 1/93

Development Alternatives with Women for a New Era

ICPD: COMPLEX ISSUES & UNRESOLVED CONFLICTS

As women's health advocates worldwide move to ensure that women's voices are heard at the 1994 United Nations International Conference on Population and Development [ICPD] in Cairo, the need to understand the complexity of the issues and the many unresolved conflicts within the women's movement becomes paramount.

Intense political debates at the First International Population Conference (Bucharest, 1974) ensured social and economic concerns took precedence over quantitative demographic targets. Various paragraphs relating to women's status were included in the key document of the conference (World Plan for Population Action) and the United Nations system itself was motivated to increase its Women and Development efforts, resulting in the Decade of Women (1975-1985).

Within the Decade, women worldwide had more space and more resources to explore the issues affecting them. Hence by the time of the Second International Population Conference (Mexico City, 1984), although feminist activists and experts were in attendance, a critical mass of women's health activists of the world were at the same time participating in the First Global Women's Health and Reproductive Rights Meeting in Amsterdam.

In Mexico City, a major contradiction arose. On the one hand the United States, which promoted population growth as a 'neutral phenomenon' within the context of 'development as economic growth fueled by free markets and privatization' [Freedman and Isaacs, 1992], withdrew funding support for organisations working in the field of reproduction, such as UNFPA - a shift seen by many as related to increased influence on the US government by fundamentalist anti-abortion forces.

In contrast, the conference convenors re-emphasized the need to raise the status of women and approved the principle that 'governments should make family planning services widely available' [Population, CIDA, 1992], going far beyond the Bucharest position that 'couples and individuals have basic rights to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so'.

The Amsterdam meeting, meanwhile, promoted the belief that 'women should be seen as subjects and not objects of population policies'. The concepts, issues and strategies raised in Amsterdam have since been spread widely, resulting in an upsurge of differing positions within the international women's health movement. As feminist perspectives of reproductive rights have undergone refinement and diversification, so too have some of the major actors in the population establishment been reconsidering their traditional frameworks. In doing so, they have taken into consideration those aspects of the feminist analysis they find digestible.

And so, as ICPD-3 approaches, there's a real danger that legitimate concerns will be used by those with negative attitudes towards contraception to make their case. It's been tried before. In Nairobi in 1985 at the World Conference which marked the end of the UN Decade for Women, such elements tried to co-opt Third World women to support their anti-contraception position. At that time prompt action by experienced women's health advocates prevented what might have been a major setback for women's reproductive rights. However, the conflict is far from resolved.

Most recently, the 1992 UN Conference on Environment and Development in Rio de Janeiro, Brazil, exposed the complexities and unresolved conflicts inherent in the population issue. The old debate on the relationship between population growth and the environment resurfaced, effectively distracting attention from some of the most important causes of environmental degradation, as well as confusing the population issue.

The Vatican won approval from many who would normally be opposed to its position on women's status and reproductive rights, when it rejected the argument that 'population is the problem', affirmed the importance of ethics, and recognised the need for a less materialistic approach to development. On the other hand, UNFPA's emphasis on the narrow view of population as "the means of avoiding world demographic disaster" [Dr Nafis Sadik, Executive Director, UNFPA] was deeply troubling to women's health advocates.

cont'd on pg. 9

COMPLEX ISSUES *(cont'd from page 1)*

The argument that social (including population) and economic policies were influenced by racism also resurfaced in the wake of public protests against the prevalence of sterilization in Brazil. The issue is carried strongly by the Brazilian black movement, but has far broader implications since, in the absence of an adequate reproductive health programme in the country, many women seek out and pay for sterilization services. In the population debates, in which a large number of Brazilian women took part, allegations of genocide against black people created a climate of suspicion between women of different races and countries making it difficult to identify common ground and mutual concerns.

Another crucial debate centered on reproductive technologies. Within the international women's movement there's now a significant trend, particularly among European feminists, that expresses outright rejection of all new reproductive technologies. Third World ecofeminists have extended the critique to include concerns about the role of Northern science and technology in the marginalisation of indigenous knowledge systems.

Legitimate criticisms of the [illegible]side effects of contraceptives, drug experimentation and 'drug dumping' on South women; coercive practices and genocide, are also used by right-to-life advocates to carry forward their objective to end family planning and abortion services all together. What often gets lost are such vital realities as services, female and male sexual needs and vulnerabilities, and gender power relations. Instead the most conservative positions do not concede the legitimacy of any population policy or any kind of intervention.

But without any kind of reproductive health policy, and lacking access to the means of fertility regulation, women are left vulnerable and open to unwanted pregnancies, children they cannot support and a host of preventable health problems.

Broad definitions of reproductive health should include violence against women along with the more traditional issues such as maternal health, contraception and abortion, sexually transmitted diseases (STDs) and reproductive tract infections (RTIs). An integrated approach such as fertility regulation programmes which include education and counselling, screening and treatment; or STD and AIDs clinics which recognize the link between STDs, RTIs and HIV, would rationalize services and result in more efficient and effective use of limited resources. Such an approach would also address the issue of women's time, whereby multiple roles as mothers, healthcare providers and bread-winners result in stress that can damage health. In addition, women are not socialized to take care of themselves which means they often neglect their own health, visiting clinics for the health needs of children and elders rather than themselves. Clinics focussing on women's overall health and well-being beyond the narrow confines of contraception would greatly reduce the incidence of 'drop outs' and contraceptive failure.

The complexity of the issues involved and the dangerous consequences which would result from reinforced population-control oriented policies, together present a special challenge to the women's movement in the preparatory stages of ICPD. The event itself is shaping up to be a major area of struggle for women worldwide come June 1994. In this context, it becomes critical that women of the South participate fully in the process of developing an agenda of consensus. What can women's reproductive rights advocates do in this regard? Some suggestions:

- ✓ Encourage women (individuals, groups, organisations) to lobby their governments with the aim of influencing final platform positions and having their spokespersons included in conference delegations.
- ✓ Make an input to the Declaration on Women's Reproductive Health and Justice produced by the International Alliance for Women's Reproductive Health and Justice, an initiative of the International Women's Health Coalition (see centre spread).
- ✓ Contribute to DAWN's analysis (see page 3)

Service providers and advocates concerned about women's rights and health should be natural allies for fertility regulation programmes; they understand the importance of reproductive health and are committed to promoting women's health through the provision of better services as well as by encouraging women to take better care of themselves.

This partnership, however, depends on the level of commitment and openness both service providers and advocates have towards exploring avenues for collaboration. The need for this kind of collaboration has never been clearer.

[Sources: DAWN's Preliminary Platform Document on Population and Reproductive Rights by Sonia Correa; Presentation by Peggy Antrobus, DAWN General Coordinator, to IPPF Regional Council Meeting; Terra Viva Number 12, June 12, 1992]

APPENDIX: TABLE I TO XII

TABLE I. ASIA IN THE WORLD PERSPECTIVE, 1900-2000

Year	Population (millions)	Per cent of world population
1900	925	56.1
1950	1355	54.9
1960	1645	55.3
1970	2056	56.6
1980	2581	57.8
1990	3177	58.2
2000	3778	58.0

Source : Economic Commission for Asia and the Far East: The Demographic Situation in the ECAFE Region (POP/APC/2/BP/1).

TABLE II. INCREASE IN POPULATION 1900-2000

Year	World (millions)	Asia (millions)	Share of Asia (per cent)
1900-1950	836	430	51.4
1950-1960	496	290	59.5
1960-1970	654	410	62.7
1970-1980	832	525	63.1
1980-1990	989	596	60.3
1990-2000	1056	601	56.9
1950-2000	4029	2423	60.1

Source : As for Table I.

TABLE III. PERCENTAGE INCREASE IN POPULATION, 1900-2000

Year	World	Asia
1900-1950	50.6	46.5
1950-1960	20.0	21.4
1960-1970	21.9	24.9
1970-1980	22.9	25.6
1980-1990	22.1	23.1
1990-2000	19.4	18.9
1950-2000	162.1	178.7

Source : As for Table I.

TABLE IV, PROJECTED POPULATION OF SELECTED ASIAN COUNTRIES, 2000

Country	Assumption A (millions)	Assumption B
1. China	1178	954
2. India	1081	834
3. Indonesia	262	186
4. Bangladesh	161	103
5. Pakistan	141	91
6. Japan	133	128
7. Philippines	93	67
8. Thailand	80	60
9. Iran	62	50
10. Republic of Korea	59	45
11. Burma	53	50

Source : As for Table I.

TABLE V. RURAL POPULATION AS A PERCENTAGE OF TOTAL POPULATION, PROJECTIONS FOR 1980-2000

Country	1980	1990	2000
Afghanistan	89.2	87.0	81.0
Bangladesh	90.0	86.0	81.0
Bhutan	78.0	72.0	66.0
Brunei	36.0	28.5	20.0
Burma	80.2	74.0	65.0
China	71.8	65.2	58.5
Hong Kong	6.2	3.9	2.0
India	75.8	68.0	57.0
Indonesia	77.3	68.4	60.0
Iran	52.8	45.0	37.0
Japan	19.4	14.0	10.0
Khmer Republic	84.7	80.5	75.0
Korea, Demo. People's Republic of	52.6	43.0	34.5
Korea, Republic of	52.9	43.1	34.5
Laos	82.2	78.5	75.0
Malaysia	45.0	36.5	32.0
Mongolia	44.1	39.4	35.0
Nepal	93.3	89.3	84.8
Pakistan	68.0	62.0	55.0
Philippines	62.6	55.0	46.6
Singapore	—	—	—
Sri Lanka	73.0	64.0	50.0
Thailand	82.4	78.2	73.0
Viet Nam, Democratic Republic of	77.1	72.0	68.0
Viet Nam, Republic of	70.0	64.5	58.2
ASIA	70.6	64.3	56.5

Source : As for Table I.

TABLE VI. LEVEL OF URBANISATION IN ASIAN COUNTRIES, 1970

Country	Estimated total population in 1970 (millions)	Estimated urban population in 1970 (millions)	Per cent of urban to total
Afghanistan	17.0	1.6	9.7
Bangladesh	73.2	5.1	7.0
Bhutan	0.84	0.13	16.0
Brunei	0.12	0.07	56.0
Burma	27.7	5.0	18.0
China	773.7	186.9	24.2
Hong Kong	4.2	3.8	92.0
India	554.6	110.4	19.9
Indonesia	121.2	21.6	17.8
Iran	28.4	11.5	40.6
Japan	103.5	74.7	72.2
Khmer Republic	7.1	0.9	12.8
Korea,Democratic People's Republic of	13.9	5.6	40.0
Korea, Republic of	32.1	12.8	40.0
Laos	3.0	0.5	15.1
Malaysia	10.8	4.9	45.0
Mongolia	1.3	0.66	51.6
Nepal	11.3	0.52	4.6
Pakistan	63.7	17.2	27.0
Philippines	38.1	12.1	31.8
Singapore	2.1	2.1	100.0
Sri Lanka	12.6	2.8	22.3
Thailand	36.2	5.4	14.8
Viet Nam, Democratic Republic of	21.2	3.9	18.2
Viet Nam, Republic of	18.0	4.3	24.1
Total Asian ECAFE Region	1975.5	494.5	25.0

Source : As for Table I.

TABLE VII. PROJECTED GROWTH RATES OF URBAN AND RURAL POPULATION 1970-2000

Country		1970-75	1975-80	1980-85	1985-90	1990-2000
Afghanistan	Urban	3.4	4.0	4.3	4.6	6.1
	Rural	2.5	2.5	2.3	2.2	1.4
Bangladesh	Urban	6.2	8.0	7.0	5.5	5.1
	Rural	3.2	2.8	2.7	1.8	1.3
Bhutan	Urban	4.6	6.4	4.8	4.5	4.0
	Rural	1.7	1.2	1.4	1.4	1.1
Brunei	Urban	4.7	4.8	3.7	3.8	3.5
	Rural	1.5	1.1	0.7	0.0	—1.0
Burma	Urban	3.3	3.3	4.0	6.1	5.0
	Rural	2.2	2.1	2.1	1.0	0.6
China	Urban	3.3	3.4	3.7	3.5	3.3
	Rural	1.2	1.0	0.7	0.2	0.1
Hong Kong	Urban	2.7	2.6	2.6	1.3	1.2
	Rural	0.0	—0.4	—1.1	—4.7	—5.5
India	Urban	3.8	5.5	5.4	4.9	4.9
	Rural	2.4	1.7	1.4	1.0	0.2
Indonesia	Urban	4.9	6.0	6.1	6.1	4.7
	Rural	2.6	2.0	1.5	1.3	0.9
Iran	Urban	4.4	5.1	4.9	3.7	3.4
	Rural	2.3	1.6	1.3	0.8	0.0
Japan	Urban	2.3	2.1	1.6	1.3	1.1
	Rural	—1.9	-2.2	—2.6	—3.0	—2.7
Khmer Rep.	Urban	4.4	5.7	5.8	5.3	4.9
	Rural	3.0	2.8	2.6	2.2	1.6
Korea, Demos.	Urban	4.6	4.4	4.7	3.8	3.2
People's Rep.	Rural	1.5	1.3	0.6	0.1	-0.4
Korea, Rep. of	Urban	4.2	4.1	4.5	3.6	3.1
	Rural	1.2	1.1	0.4	—0.3	—0.6
Laos	Urban	3.9	5.0	4.0	4.8	3.5
	Rural	2.5	2.3	2.4	1.6	1.4
Malaysia	Urban	4.9	5.1	4.6	3.4	2.6
	Rural	1.2	0.5	0.4	0.3	0.6
Mongolia	Urban	4.0	3.8	3.7	3.6	3.1
	Rural	2.2	2.0	1.7	1.6	1.1
Nepal	Urban	6.0	6.4	5.9	8.3	5.6
	Rural	2.1	2.1	2.0	1.6	1.4
Pakistan	Urban	5.0	5.5	5.1	3.9	3.6
	Rural	3.0	2.5	2.3	1.2	0.7
Philippines	Urban	5.0	5.5	5.4	4.7	4.1
	Rural	2.8	2.5	2.2	1.4	0.7
Singapore	Urban	2.3	2.3	2.3	1.1	1.0
	Rural	—	—	—	—	—
Sri Lanka	Urban	3.9	4.8	5.0	4.7	4.8
	Rural	2.0	1.5	1.0	0.1	1.0
Thailand	Urban	4.8	5.3	5.1	4.7	4.3
	Rural	3.0	2.8	2.5	1.8	1.4
Viet Nam Dem.Rep.	Urban	4.4	4.3	4.3	3.8	3.2
	Rural	1.8	1.2	1.1	1.4	1.2
Viet Nam Rep. of	Urban	3.9	3.9	3.9	4.1	3.5
	Rural	1.5	1.2	1.0	1.0	0.8
Total Asian EAFE Region	Urban	3.7	4.1	4.2	3.9	3.6
	Rural	1.9	1.5	1.2	0.8	0.3

TABLE VIII. THE INCREASING IMPORTANCE OF MILLION-CITIES URBANISATION PROCESS, 1950-1985

	Average annual rate of growth, 1950-1985 (per cent per year, compound rate)				
	Total Population	Urban Population	Population of million cities existing in 1950	Population of old and new million cities combined[1]	towns and cities smaller than a million at any given time[2]
World total	2.0	3.3	2.6	4.5	2.8
More dev. region[3]	1.1	2.2	1.8	2.9	1.8
Less dev. regions[3]	2.4	4.6	4.1	6.7	3.8
East Asia	1.7	4.7	3.6	5.4	4.3
South Asia	2.6	4.0	4.1	7.1	3.0
Europe	0.8	1.6	1.2	1.8	1.5
Soviet Union	1.3	2.9	1.5	5.4	2.4
Africa	2.6	4.9	4.2	9.3	4.2
North America	1.5	2.2	1.7	3.0	1.6
Latin America	2.9	4.3	4.2	6.1	3.5
Oceania	2.2	2.6	2.7	3.5	1.8

[1] the combination of million-cities existing at any given date.

[2] the urban population excluding million-cities existing at any given date.

[3] The more developed regions comprise Japan, Europe, the Soviet Union, North America, temperate South America, and Australia and New Zealand, the less developed regions comprise the rest of the world.

Source : United Nations, population Division, Department of Economic and Social Affairs: The World's Million-Cities, 1950-1985) (ESA/P/WP/45.)

TABLE IX NUMBER OF MILLION-CITIES, 1950-85

Year	World	More developed regions	Less developed regions	East Asia	South Asia
1950	75	51	24	13	8
1955	90	56	34	17	13
1960	109	64	45	23	16
1965	136	75	61	28	23
1970	162	83	79	36	27
1975	191	90	101	45	34
1980	229	108	121	50	40
1985	273	126	147	54	53

Source : As for Table VIII.

TABLE X. PERCENTAGE OF WORLD'S MILLION-CITY POPULATION CONTAINED IN DIFFERENT REGIONS, 1950-85

Year	World	More developed regions	Less developed regions	East Asia	South Asia
1950	100.0	72.6	27.4	18.1	8.6
1955	100.0	68.0	32.0	19.7	11.1
1960	100.0	63.6	36.4	22.0	11.8
1965	100.0	59.0	41.0	22.5	14.0
1970	100.0	53.7	46.3	24.2	15.2
1975	100.0	48.6	51.4	25.4	17.1
1980	100.0	45.6	54.4	25.0	18.5
1985	100.0	42.3	57.7	24.2	20.6

Source : As for Table VIII.

WH 17.3

WWF World Wide Fund
For Nature

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WWF: Consumption and Population

The following is information on consumption and population issues as viewed by WWF, including reference to the UNCED process.

Background

The population issue is complex and can be examined in a number of ways, among them reproductive rights, maternal and child health care, freedom of choice and quality of life issues, demographic trends, and family planning policies. WWF is concerned about the relationship between population and degradation of the environment, particularly in light of the dependence of people on the natural environment for basic human needs. WWF looks at consumption and population as relates to our three mission areas: preserving genetic, species and ecosystem biodiversity; sustainable use of renewable natural resources; and pollution and wasteful exploitation and consumption of resources and energy.

The WWF focus is on people and their actions which place pressure on the natural environment and resource base. Thus concentration is in two categories: excessive consumption and waste, and population growth.

The Problem

Population-related characteristics as associated with the environment manifest themselves differently around the world.

In developed countries, the pressure is due to the excessive levels of per capita natural resource and energy consumption and waste. There are far fewer people there, but consumption levels are much higher. A disproportionate 25% of the world population (found in industrialized countries) is consuming 80% of its energy and producing 75% of its pollutants. In their lifetime a North American consumes 500 times more energy than a Malian does.

In developing countries, pressure on the environment comes from the lack of choices imposed by poverty and inequitable benefits from the development process, and secondly, the sheer numbers of people depending on scarce or relatively inaccessible natural resources. Developing countries have the highest population growth rates in the world, and are expected to make up 80% of the world population within decades.

The Caring for the Earth (CFE) document, published jointly by WWF, IUCN (World Conservation Union), and UNEP (United Nations Environment Programme) addresses consumption and population with

WH 1723

WOMEN POVERTY AND POPULATION DRAFT: DEVAKI JAIN (Sr Xpr. 15/9/94
(Jan.2, 1993)

PREAMBLE

The evidence for this draft chapter or paper has been drawn from many sources; e.g. from those concerned with women, from women perspectives as also from Many papers & processes as also from Papers by Dr Ramalingaswamy, A.K. Sen, Malcolm Adhisheshiah, Ashish Bose. The responses received by Prof Gupta, NIHFW analysed by his team and the ideas and practices that have been included in population discourse both nationally and internationally.

We have prepared a growing list of literature that has come to us starting with the preparation of the Chapter for the Country paper, moving to the international official and academic meetings to the documents given by the expert group. This list is, of course, too long but I have marked those that I have especially used.

I am very concerned that sections of the chapters for the official paper for Cairo that have been circulated by Dr. Pathak contain recommendations and elements of Population Policy which are really astounding and unacceptable to many of us, and I hope to most of the expert group.

e.g. a Constitutional amendment which links benefits to size of family. We cannot have any inconsistency between what we are drafting as a population policy for India and the country presentation at Cairo that does something else.

Hence I suggest that the country paper be seen again.

Also laws are being considered so that the centre and the States could link development benefits to performance in population growth. Thes idea is to legislate conditionality, e.g. maternity benefit is being linked to number of children and so on.

This would also go against the grain of what is being recommended here, namely a non coercive , or voluntary family planning programme, as the most effective, efficient and sustainable policy to reduce the numbers while enhancing well being.

I hope the members of the Committee will ensure consistency.

Xpert Group. DJ 3rd Jan. 1994

WOMEN POPULATION AND POVERTY

draft Devaki Jain

I propose a chapter which is broken down to sections as given below. I have not achieved it . but am sending this rough edged , rather too long paper for the first round.

Proposed breakdown into sections

Summary of argument
Main Pillars
Review of experience
Proposed detailed strategy

What that entails in terms of change from present strategy

What goals it can achieve in terms of population growth.
Cost - how to finance such a strategy re-allocation of resources and different methods of utilisation of resources..

SECTION 1

Introduction and argument:

The main pillars of an effective and sustainable population policy has to rest on an understanding of poverty and within it poor women, the characteristics of their life situation, their deprivations and capabilities.

The policy also has to shed many 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.

The policy has to acknowledge and believe that the poor and within them women want to have the power to determine the number of children they have. They are no more seeped in ignorance. They are aware of the fact that there are methods by which conception can be avoided - and even more aware of the fact that foetuses can be killed or removed through abortion of many kinds. Most govt documents mention the cruel phenomena of ill-serviced abortions (by quacks, unsanitary methods etc that cause deaths among women).

There is also enough survey research to show that even in the most remote areas of India and even amongst the most hidden popoulations such as the tribal people living in forests the consciousness of modern methods is there, however hated, disdained or feared. In fact the electoral results after 1975 show

that it was in the backward, so called ignorant areas, that this message caused political rejection - not as we would like to believe because the poor were ignorant of the knife and its value, not because of superstition that loss of fertility is loss of life, but because in fact operations turned out to be killers and also because there was enforcement associated with loss of ones rights or put the other way with terror.

Further social research is revealing a less comfortable but similar evidence/results, namely, that these "less visible, less exposed people "are losing their own traditional customs as well as methods of restraining the size of their families, traditional forms of birth control not only herbal medicine but associated with custom and ritual and most of all equality in decision making power between men and women which is the hallmark of tribal and other small communities in India. (MASSF-B.R Hills.)

Once this postulate is changed- namely the analysis moved from one of dealing with ignorant, backward superstitious people to one of dealing with people who are dealing with their life situation as rationally as they can in their circumstances, the approach would change. [A.K. Sen]

And this has to be the first demystification of population policy.

The second is that single prong interventions can transform fertility patterns - namely moving statistical analysis into homes, (or what can be called family decisions or couple decisions).

For example: (1) that literacy inputs into women will bring lower fertility outputs - because we find that female education moves with fertility. It is now being shown (Tim Dyson) that inversely male education influences fertility even more! and of course that female & male literacy move together hence it only makes the point that general educational upward movement influences fertility. Hence one cannot stretch too much statistical relationships or translate them too simplistically into policy.

Eg. (ii) that income generating projects for women will "empower" women i.e change gender relations., again a too simple connection. Income generating projects can often even add to the burdens of a woman,without strengthening either her control over resources or her decision making powers. On the other hand access to own income, along with organisation to strengthen collective strength and self esteem does give women some power - but not necessarily an improvement in status.

In other words, one cannot take the success of Kerala, or any other complex outcome and draw one line inferences from its success.

On the other hand Kerala and some districts and sub districts in India where there have been community based health programmes have revealed the importance of what can be called a broad package approach which cannot and should not be summarised

as: Development is the best contraceptive.

The difference is that it is not development nor growth by itself, but it is the content and the method- also content in the sense of investment in basic social amenities, institutuions which means both the organisation and the politicial culture which gives access to these facilities. [DJ Kerala from Jap Paper]

When political will is postulated as a necessary condition, it is translated to mean either that politicians should also harangue people to limit their families, or that membership to legislative councils should be given as a reward to those politicians who have few or no childtren and so on.

Political will or attention to population should be translated as a will to redress the deprivation of the poor, to provide them with social and economic security as basic services, and then build their capability to avail of these entitlements.

It can then be suggested that for the poor to fulfill their own desire to achieve a sense of well being, in which for women few child births is a strong desire, there has to be a situation where they are offered social entitlements to basic health services, which of course includes food, may be even livelihood, and then their capacity built to avail of these ent itlements, namely through education, information - but not only that but through providiing the institutional mechanism that share power, which offer space for groups like women to participate in decision making, thus to excercise power.

Thus a base for a population policy has to be the provision of a floor - which gives access to income, - it could be a form of employment guarantee, it could be a strentgthening of existing labour use pockets but with the exploitation removed (SEWA) This floor is not to be limited to the economic zone alone, but must include health and education, translated to univerasal primary education, and universal primary health care. It should also include basic civic amenities like water, energy, sanitaton - a blend of economic and social services.

However, the management of the provision of this floor has to be through local self government - as then both the diversity of India, the participation of local communities, especially the voices of the unheard in decision making, the accountability required for monitoring and redressal is assured.

Jean Dreze puts it very well when he says that the State should provide the services of economic and social security to the poor but for it to reach the poor this service has to be accomapanied by social dynamism . - namely the commitment and participation of civic society, namely political parties, voluntary organisations, the elected bodies and professional institutions. Because to provide a service to the poor is one thing, but for it to reach them is quite another.

The usual queston that will emerge when such a big commitment is put on the national exchequer is lack of resources. In

fact the Expert Group should know that in the ICPD (Cairo, UNFPA) document, the G7 countries have objected to the use of the term "poverty eradication" (they prefer "poverty alleviation") because they say "eradication" is too costly. Remove the poor by population control - we have no money to remove poverty, is the message from the North - as Malthus stalks the chapters and the propaganda.

But is this the case? Can India not afford such a policy?Basically Political will means political choices - and the question is not one of raising resources but of allocation of resources and also of methods through which the resources can be used.

The Argument 2

The argument for reducing the growth of population at the rate at which it is now growing in India is presented usually

1) as being unsustainable in terms of natural resources particularly food. This argument has been countered from many points of view but the most convincing and unrefutable case is in a recent lecture by Amartya Kumar Sen (Nov 93) who shows that the rate of growth of food production globally has outstripped the growth of population that prices of food grains have not gone up, in fact are the lowest among tradable commodities, and third that food production is best and growing where population is largest and growing namely Asia.

He does refer to the diferent picture presented by sub saharan Africa but argues that there it is lack of democracy, seen as a system which encourages open information flows that has made for the bottlenecks.

2)as being caused by the situation of the poor - their high rates of mortality especially amongst infants, makes them insure against death by having many children, their low income makes them want to have many hands to bring in small incomes, their need for fuel and fodder as free collections degraded land and therefore adds to the imbalance between natural resources and numbers.

Such arguments lend a sense not only of panic but hysteria in the poor and heavily populated countries, - that it is the numbers that have to be brought down, numbers that are standing in the way of reaching more widespread and higher levels of well being.

The natural logic then is to address a programme of birth control to the poor directly, targetted and strengthened by incentives and disincentives .

This in our view is exactly the reverse of what needs to be done; the diagnosis too is exactly the reverse of the reality.

It is not the number of poor that have to be reduced but it is their poverty that has to be removed. It is not numbers that is causing poverty but the unequal distribution of resources

and resource use, the unequal distribution of all the basic amenitiies social and economic of a civilised life.

Inequality and poverty are, of course, distinct concepts but there is a close causal relationship between the two. Given the level of development and the level of per capita income/consumption expenditure, a less unequal distribution would result in lower incidence of poverty.

Poor women are the first to want to reduce the number of child births that they have. But they are constrained not only because of poor quality and limited variety of contraceptive services but because of their lives and livelihood situation.

The unmet need is not for contraceptives. Their unmet need is for the economic and social security, which in turn would enable them to exercise informed choice on their reproductive path.

A.K Sen's next point is that coercion is neither necessary nor efficient. He cites Kerala and contrasts with China and argues that given information, given" incentives" for small family. (Note in his case incentives does not mean cash or jobs, but reduction in infant mortality, access to education and most of all a perspective which quests for an equitable society), people will voluntarily make a rational choice to limit numbers. Further it is efficient in his terms becasue it does not kill off females as is done in China which like India has a strong son preference culture. I quote from Sen

EXTRACT from Top Paper
by Devaki Jain ISS/1993

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 the poor, living in very inadequate habitats - with no water or sanitation and 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, or to take the pure "fertility control" approach.

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 for labour, the need for a son, the self image of the male partner whose virility is substantiated by the women's pregnancy and son.

2. Their understanding of the dangers of some of the new invasive contraceptives especially when implemented 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' - additionally 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 of society.

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.

There is urgency not only because population especially its control has come up high on the Agenda of the State but also because the view point that the factors which are most influential in reducing fertility lie outside direct intervention especially into the women's womb is gaining momentum. We need to develop a minimal 5 point policy approach which can be Asian and the World's.

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".

Two, 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)(1).

Three, that due to these concerns that population somehow must be controlled and reduced, technologies which have developed are being brought and with subsidies, with political and commercial pressure being put to use especially on women in developing countries.

Their 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)by over consumption of natural resources, both in the production and consumption styles of what is called modern industry & affluent society. 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 in this area , namely in reproductive choice leading to reproductive rights has to be strengthened.

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

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 the money spent on what is called the propaganda, if it is transferred to provide better public health services, both in quantity & quality, no further resources are required.

Therefore, they appeal that the UNFPA should have more emphasis on Public Health, 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 merely 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.

Fourth, they have shown how disincentives like not getting land, housing, electoral positions, jobs in organised sector because of family size tend not to be disincentive 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 unequal society.

Targets have not worked in India nor any where because targets 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.(Amal Ray) One must understand that in very poor societies with acute unemployment, providers, grassroot functionaries and the men and women 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 being both designed at the community level to integrate itself with other care and with local needs, accountability being proximate to the people who receive the health care so that the redressal mechanisms are immediate and accessible has been brought up in the Indian debate.

India will be going into a form of decentralised political management through the 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 three states some 60,000 women have already been elected to 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, and facilitate women and men to goal their own objectives in terms of population, its size and its quality.

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 pushed through the state machineries are rejected.

In a paper called the Economics of life and death, A.K.Sen gives comparative data on survival rates by sex and religion and also life expectancy in different countries. He shows how survival rates for example for women are higher in Kerala, India than in Black Harlem or Black U.S. He also shows how death rates in the U.S. vary dramatically according to race. Establishing the point that even in advanced countries subordinate social categories can live in an Island of "backwardness". He also shows that public investment, the State, must intervene in such a situation.

Analysis which shifts responsibility from the wasters and polluters to the poor.

The contraceptive approach namely the fertility approach.

The coercive approach.

& SUPPORT

The health approach.

Public health services, public investment in public health.

Women's Participation in designing health .

Local self-government, redressal mechanisms, accountability.

Basic needs/livelihoods/food security/ support structures.

WOMEN OF THE SOUTH

(HEALTH)

DJ/JAP

Greater investment in health care

Merging of general health with maternal health.

Minimal basic service of health, literacy and decision making spaces.

CULTURAL PERCEPTIONS AND CATEGORIZATION OF MALE SEXUAL HEALTH PROBLEMS BY PRACTITIONERS AND MEN IN A MUMBAI SLUM POPULATION

BY

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INTRODUCTION

This paper presents data comparing practitioners' and community male's cultural perceptions and categorizing of sexual health problems in a Mumbai slum population. Structured qualitative data from Free listing, pile sorting and ratings are frequently used to obtain a systematic picture of the vocabulary of terminology, ways of classifying, and other information in a specific topical domain such as "illnesses", "types of healers/practitioners", "foods" and so on[1].

Until recently, the entire area of reproductive health was very poorly understood, particularly with reference to South Asian populations. However, during the 1990s a number of studies of women's gynaecological health issues have been reported from several areas of India and Bangladesh (Gittelshon et al 1994; Bang and Bang 1989; Bhatia and Cleland 1995; Ross et al in press). Several of these studies have used structured qualitative methods, in order to get culturally specific *emic* data and other information about women's perceived health problems and treatment seeking behaviours. On the other hand male sexual reproductive health, including their vocabularies and perceptions of sexually transmitted problems, have been much less studied.

The growing public and governmental awareness of the spread of the AIDS epidemic has shifted attention to the importance of male sexual health problems in part because of the role of sexually transmitted infections (STIs) in increased risk of HIV infection. In India and elsewhere, programmes aimed at reducing the spread of HIV include STD clinics, counseling programmes, and other interventions that try to reach men who are involved in risky sexual behaviours. The detailed information is, therefore needed concerning all aspects of male sexual behaviours and particularly sexual health problems.

There are a number of interrelated questions that we have dealt with in this study. In addition to the vocabulary of sexual health problems, we have explored the contrasts and similarities between the perceptions of practitioners who treat sexual health problems and the cultural views of the men in communities served by these practitioners. In this study we are using the label, "sexual health problems" rather than sexually transmitted diseases (STDs). This is because the concept of STDs as a category is medical language, and may not correspond to the ways in which people in the Mumbai slum community categorize illnesses and symptoms. Published and unpublished data from the studies of gynaecological health problems of women and unpublished data from some recent studies of males, indicate that the vocabularies of sexual health problems are complex, and the emerging picture suggests that both males and females recognize the concept of sexual transmission, but the same health problems that may be transmitted sexually are also thought to be caused by other factors, especially those associated with

Garmi. For example, in a study in a tribal area of Gujarat, the SARATHI researchers reported that people recognize sexual transmission as one of the causes of their illnesses, but they also believe that other factors can also be important as agents causation (Grenon, and Tazeem, 1996).

GUPT ROG: SECRET ILLNESSES

The cultural domain of the sexual health problems in Mumabi slum can be understood by the general cover term which is used to describe them. "*Gupt Rog*" (Secret Illnesses)" is the most common term to describe sexual health problems in the Hindi speaking part of India. The term Gupt Rog implies that the illness belongs to the secret parts of the human body. It also suggests that the illnesses have be associated with something shameful that are better kept secret. It is however important to remember that many of the sexual health problems are not necessarily thought to be transmitted through interpersonal contacts. For example, excessive masturbation, thinning of semen and wet dreams or penile abnormalities are clearly not transmitted through personal contacts. In that sense they are not "*Rog*"(illness) but problems which have very different etiology than what is expected bio-medically. During the field work we often found both doctors and men using the term *Kamjori* (Weakness) to refer to all kinds of sexual health problems. In this sense the cultural domain of sexual problems for the community in Mumbai slums is beyond the concept of *Rog*. We shall discuss "kamjori" in greater detail in the following section. Pelto (1996) has used the term contact and non-contact illnesses to describe this concept.

Contact" and "non-contact" sexual health problems: Several studies have shown that male sexual concerns center around two quite different sectors:

Non-contact concerns about semen-loss including concerns about masturbation, nocturnal emission, and other forms. These semen-loss concerns that are very pervasive among young men in South Asia, are also related to fears of impotence (Pelto et al.1996; SARATHI, 1996).

A. Contact or infectious problems that may indicate STDs, there are some problems: Burning urination might not be due to infection, for example. Similarly itching and some sours, pimples or other conditions, in the genital areas may be fungal infection rather than sexually transmitted infection. In some areas of India filariasis and hydrocil occur quite frequently, and are often reported as sexual health problems by many people (Bang and Bang; 1997, Orissa study in progress)

In view of the above, the present paper describes the cultural perception and categorization of sexual health problems by the practitioners and men in a Mumbai slum community.

STUDY AREA AND METHODOLOGY

The data presented here, are a part of a study that is in progress in a slum community located in the North-east part of Mumbai[2]. It is a large slum consisting of about 70,000 population and is primarily inhabited by the people who were relocated from the central part of the Mumabi in the late Seventies. Over a period of about two decades the slum population has grown enormously, with a large number of illegal and unauthorized structures mainly of migrants coming from various parts of the country. A large proportion of the population is Muslim from the Konkan area of Maharashtra, Kerala and the eastern Uttar Pradesh. It is a typical overcrowded Mumbai slum with many lanes, ad-hoc structures and lots of "joints"—such as tea and Paan shops for informal gatherings. A large number of health practitioners are found in the lanes of this slum. Transecting the entire area, we counted 53 practitioners, some of whom had formal training in allopathy[3]. However, a large number of them did not possess any recognized degree or diploma and yet prescribed all kinds of health care tratment.

Initial contacts were made with practitioners who were willing to help in the study. Due to unavailability of suitable male field researchers, the initial contacts were established by a senior level female researcher and the Principal Investigator of the study. Since the practitioners contacted were Muslim, the language used for gathering information was Hindi. The first several rounds of discussions with the practitioners were informal discussions about the kind of patients who visit them. These discussions also provided insight into the sexual behaviours of the community males as these practitioners claimed to be treating a variety of male sexual problems.

The practitioners introduced us to some key informants in the community, who also happened to be their clients. At this stage of the field work, concerted efforts were made to appoint male field researchers and train them in collecting sensitive information. Three male researchers, carried out the main data collection.

The techniques used to collect information on sexual problems included free-listing, pile sorting and rating, which were used as part of in-depth interviews. An opportunistic sample of forty four practitioners and fifty six community men were contacted in the initial qualitative phase of data collection (see appendix I for the characteristics of the practitioners interviewed). Two to three sittings were required with each respondent. In the present paper we are presenting the findings based on the free-listing of the sexual health problems and severity ratings

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[2] The study is part of a Ford-Foundation funded capacity building project in the area of reproductive health.

[3] A formally trained graduate in India is conferred with MBBS (Bachelor in Medicine and Bachelor in Surgery) degree.

Free-List of Sexual Health Problems:

According to the Weller and Romney (1988), the first step in a study of cultural perceptions is to obtain a clear understanding of the definition and boundaries of what the domain being studied. Free-listing is a technique used to define the contents of a cultural domain. It is particularly useful to get the culturally relevant items (vocabulary) and to delineate the boundaries of a semantic or cultural domain. The free-listing can also be used to make inferences about the informant's cognitive structure from the order of recall and the frequency of recall. The free-list helps to collect the local vocabulary used for the study items. Responses are tabulated by counting the number of respondents who mentioned each item and then items are ordered in terms of frequency of response. Frequencies or percentages can then be used as estimates of how salient or important each item is to the sample of informants.

In the present study, each respondent was asked " what are all sexual health problems faced by men in this community?" The answer to this question generated a large number of sexual health problems by both the men and the practitioners. A variety of synonyms were used to in the case of some of the problem. We therefore edited the list by grouping obvious synonyms under a common heading. The examples of the problems which were grouped are as follows:

Masturbation: Hasthmaithun, muth marna, paani nikalana, hand practice.

1. Bent penis problems: Tedhapan, ling ka mud jaana, Dahine ya baayi or muda ling.
2. Sours on the penis: Jhakham, Phori, Phunsi, Foda.
3. White discharge: Dhat girna, Apne ap dhatu girna, money ka girna, safeda.
4. Loss of sexual desire: sambhog ki Eichha na hona, Sambhog na kar pana.

Data were analyzed and tabulated using ANTHROPAC and discrepancies in spellings were corrected before data entry.

Table 1 presents the frequency, response percentage, average rank and salience of the various types of sexual health problems listed by men in community. *Kamjori* (Sexual weakness), *Khujali* (Itching around genital areas), *Peshab me Jalan* (burning sensation during urination), *Jaldi Girna* (Early ejaculation), *Jhakham/Phori* (Wounds on the genitals), and *Dhat Girna* (White discharge)) are among the most frequently mentioned sexual problems.

Table 1: Free listing of male sexual problems by men in the community (N=56)

No.	Sexual problems and local terms	Freq.	Resp.Pct.	Avg. Rank	Salience
1	Kamjori (Weakness)	35	63	3.914	0.285
2	Khujli (Itching)	31	55	3.484	0.271
3	Peshab Main Jalan (Burning urine)	30	54	3.467	0.294
4	Jaldi Girna (Early Ejaculation)	28	50	4.464	0.212
5	Jakham Hona/Fori /Foda (Wounds)	28	50	3.786	0.251
6	Dhat Girna (White discharge)	27	48	3.370	0.312
7	Echcha Na Hona (Lack of Desire)	17	30	4.765	0.155
8	Tedhapan (Bent penis)	17	30	4.706	0.135
9	Khada Na Hona (Lack of erection)	15	27	4.867	0.111
10	Hasthmaithun (Masturbation)	15	27	3.800	0.149
11	Dane Nikalna (Boils, sours)	14	25	4.071	0.113
12	Dhat Patla Hona (Thinning of semen)	13	23	5.308	0.084
13	Ling Main Dard/Sujan/Sujak (Pain)	11	20	4.636	0.085
14	Swapnadosh (Wet dream)	11	20	4.455	0.108
15	Garmi (Heat)	10	18	2.700	0.120
16	AIDS	9	16	3.778	0.094
17	Pus Nikalna (Pus discharge)	9	16	3.778	0.094
18	Ling Se Khoon/Chamdi (Bleeding)	8	14	5.875	0.058
19	Hydrocil	7	13	5.714	0.041
20	Syphilis	5	9	2.800	0.039
21	Gonorrhoea	2	4	1.000	0.036
22	Chancroids	1	2	3.000	0.011
23	Herpes	1	2	4.000	0.007

It is interesting to note that although *Kamjori* and *Khujali* were the most frequently mentioned items, *dhat girna* (Involuntary loss of semen) is upper most in the minds of men as revealed by the measure of salience[4].

Table 2 presents the frequency, response percentage, average rank and salience of the sexual health problems listed by practitioners in the study area. *Tedhapan* ("bent" penis), *Jaldi Girna* (Early ejaculation), *Kamjori* (Sexual weakness), *Dhat Girna* (Involuntary loss of semen), *Peshab me Jalan* (burning sensation during urination), *Gonorrhea*, *Khada na Hona* (lack of erection), *Pus Nikalana* (pus discharge), *Syphilis*, *Jhakham/Phori* (Sours on the genitals), were the most common sexual problems faced by men in the community according to the practitioners. It is important to note that although mentioned by 68 percent of the practitioners, *Tedhapan* (bent penis) is assigned a very low rank and therefore is low on the salience. Most salient sexual health problems were the Jaldi Girna (early ejaculation), Kamjori (sexual weakness), Dhat Girna(White discharge) and Gonorrhea.

[4] Salience is calculated from the average rank and the frequency of a particular item.

Table 2: Free listing of male sexual problems by Practitioners (N=44)

No.	Sexual problems and local terms	Freq.	Resp.pct.	Avg. Rank	Salience
1	Tedhapan (Bent Penis)	30	68	6.467	0.208
2	Jaldi Girna (early Ejaculation)	27	61	4.333	0.367
3	Kamjori (Weakness)	25	57	4.160	0.351
4	Dhat Girna (White discharge)	23	52	3.522	0.341
5	Peshab Main Jalan (Burning)	23	52	4.783	0.285
6	Gonorrhoea	23	52	4.174	0.309
7	Khada Na Hona (Lack of erection)	21	48	4.714	0.257
8	Pus Nikalna (Pus discharge)	20	45	4.500	0.279
9	Syphilis	20	45	4.400	0.243
10	Jakham /Fori /Foda (Sours/uicers)	19	43	5.842	0.167
11	Hasthmaithun (Masturbation)	17	39	5.294	0.182
12	Swapnadosh (Wet Dream)	15	34	5.267	0.175
13	Khujli (Itching)	15	34	6.467	0.094
14	Ling se Khoon/Chamdi (Bleding)	14	32	6.714	0.107
15	Ling Main Dard/Sujak (Pain)	12	27	4.333	0.135
16	Sambhog Na Karpana (Lack of desire)	11	25	5.273	0.133
17	Dane Nikalna (Boil. sours)	9	20	4.667	0.111
18	Dhat Patla Hona (Thinning of Semen)	9	20	4.778	0.099
19	AIDS	7	16	6.429	0.041
20	Hydrocil	6	14	6.333	0.048
21	Garmi (Heat)	4	9	3.500	0.050
22	Dhat Ka Abhav (Lack of semen)	2	5	4.000	0.033
23	Herpes	2	5	7.000	0.000
24	Warts	2	5	5.500	0.027
25	Chancroids	2	5	3.500	0.027

The basic contents of the two lists are same. In fact, both practitioners and the men are talking about the same domain and put a lot of emphasis on non-contact sexual health problems. Both show anxieties related to the sexual weaknesses, semen loss, penile size and impotence. There are a number of differences also. For example, doctors give higher priority to Syphilis, Gonorrhea and Pus discharge. That is, they are more concerned with the sexually transmitted infections. Men, on the other hand give high priority to anxieties related to semen loss issues, Garmi, and itching problems and place less emphasis on the several infectious or contact sexual problems. The big difference is observed in case of Swapnadosh (wet dream) and Garmi (heat). In case of Swapnadosh, the difference is that of 14 points with doctors giving it higher priority than the community men. In case of Garmi, the difference is of 9 points with men giving it a higher priority.

Listing of illnesses is one way of looking at the cultural perceptions. But the list does not tell us the categorization of the sexual health problems. For this purpose we used the methods of pile sorting and rating.

Groupings of Sexual Health Problems:

From the list of the sexual problems we chose 23 of the more salient items for pile sorting. The items were written on a set of cards (each item on aseparate card) and 49 males and 41 practitioners were asked to group the sexual problems according to their similarity, without reference to any specific criteria. The collected information was analysed by using the ANTHROPAC software. The combined results of the pile sorting were analysed using the multidimensional scaling programme (MDS).

Figure 1, shows the results of the MDS analysis for the practitioners. It is found that *swapnadosh* (wet dream), *dhatgirna* (white discharge), *dhat patla* (thining of semen), *hasthmaithun* (masturbation), *jaldi girna* (early ejaculation) and *echacha na hona* (no desire for sex) are clustered together in the left side of the spatial distribution (Group 1) while pus nikalna, syphilis pus discharge), gonorrhoea, chancroids and herpes are clustered in the right side (Group 2). AIDS remained separate from the rest of the problems. The above clusters clearly indicate some of the major domains of problems. Practitioners have grouped the sexual problems that are non-infectious (Group 1) as quite separate from those that are sexually transmitted infections (STIs).

In the case of men (Figure 2), it is found that Group 1 and Group 2 problems are somewhat distinct, but the pattern is more scattered. In this figure also AIDS is emerged as a separate one and some extent syphilis also did not group with any other illnesses. It is clear from the above results that practioners, tend to group sexual problems in broad domains and perhaps have tretment strategy in their mind while categorizing. They of course place due emphasis on the semen related issues. Men, on the other hand, group the problems in a number of different categories. Among both the types of respondents *peshab main jalan* (burning urination) appears somewhere in between infection oriented and non infection oriented problems.

Further, the groupings of sexual problems by both practitioners and men, were further analysed using cluster analysis technique. (Figure 3 and Figure 4). The clusters tend to support the observations obtained on the basis of multi-dimensional scaling.

Severity of Problems:

We also asked the respondents to rate the severity of these problems. We asked them to rate the severity on a four point scale ranging from "not at all severe" to "very severe", with "somewhat severe" and "severe" in between.

Table 4. Severity Rating of Male Sexual Problems (Males=49)

Sr.No	Item	Mean	Std. Dev.
1	Bent Penis	1.86	0.83
2	Early ejaculation	2.02	0.80
3	Weakness	2.10	0.61
4	Burning urination	2.29	0.73
5	Gonorrhoea	3.24	0.74
6	White discharge	2.27	0.75
7	Lack of erection	2.27	0.80
8	Pus disvcharge	2.78	0.74
9	Syphilis	3.35	0.66
10	Boils/sours	2.37	0.72
11	Masturbation	1.55	0.83
12	Wet dream	1.37	0.63
13	Itching	2.14	0.86
14	Swelling	2.31	0.61
15	Lack of desire	1.98	0.80
16	Boils	2.24	0.80
17	Thinning semen	2.43	0.81
18	AIDS	3.94	0.42
19	Hydrocil	2.02	0.59
20	Skin sours	2.39	0.60
21	Heat	2.33	0.96

Findings are presented in Table(s) 4 and 5. AIDS was uniformally rated as very severe, followed by syphilis and gonorrhoea. Pus discharge was also seen as severe. Most of the non-contact problems tended to be rated as less severe by both the practitioners and the community males. It is interesting to note that the practitioners on the whole rated most conditions as less severe than did their clients.

Table 5. Severity Rating of Male Sexual Problems (Practitioners=41)

Sr.No	Item	Mean	Std. Dev.
1	Bent Penis	1.73	0.80
2	Early ejaculation	1.73	0.80
3	Weakness	1.68	0.60
4	Burning urination	2.10	0.76
5	Gonorrhoea	3.00	0.86
6	White discharge	1.71	0.86
7	Lack of erection	1.85	0.75
8	Pus discharge	2.85	0.84
9	Syphilis	3.15	0.72
10	Wound	2.34	0.90
11	Masturbation	1.71	0.80
12	Wet dream	1.54	0.74
13	Itching	1.78	0.78
14	Swelling	2.39	0.66
15	Lack of desire	1.90	0.85
16	Boils	2.27	0.86
17	Semen thinning	1.85	0.84
18	AIDS	3.98	0.15
19	Hydrocil	1.71	0.71
20	Skin sour	2.34	0.84
21	Heat	2.24	0.96
22	Herpes	3.27	0.80
23	Chancroid	3.32	0.68

Perceived Causes of the Sexual Health Problems as reported by the Practitioners:

During the in-depth interviews, we asked the practitioners about the causes for several of these sexual health problems and also the possible treatments.

KAMJORI: Sexual weakness Kamjori is a general concept that appears to be very salient for both practitioners and lay persons. Kamjori refers to a wide range of symptoms, including impotence inadequate quantity and quality of semen, and infertility among men (Table 6). According to one doctor, kamjori begins with the practice of masturbation at a very young age. "Children start *hand practice* at a very young age and gradually begin losing large quantities of semen. As a result, they feel weak and over a period of time, become impotent or *kamjor*". The quantity and quality of semen appears to be at the root of the kamjori. Most doctors clearly stated that with frequent masturbation, the quantity of semen reduces and semen becomes thin. Thinning of semen was also attributed to food habits. For example, according to one doctor, "hot foods, which include spices, onions, liquor and even English medicines, produce excessive heat (sexual) in body and result in involuntary loss and thinning of semen".

Table 6: Male sexual Problems, their local terms and the perceived causes as reported by doctors in a slum of Mumbai

Male Sexual Problems	Local Terms	Perceived causes
1. Boils, Sores, Pus or blood in the urine, ulcers around genital areas.	Garmi, Sujak, Foda/Phunsi.	Intercourse without Condoms; Use of public toilets; Anal sex/homosex/oral sex; Sex with "cheap" women.. Excessive sexual desire;
2. White Discharge	Dhat Girna, Loss of money, Beej girna	Excessive masturbation; Watching Blue films; Sexual excitement; Stomach problem (Gastric).
1. Thinning of semen/ reduction in semen quantity	Dhat patla hona, Dhat ka abhav	Swapnadosh; Excessive masturbation; Eating 'hot foods'/liqour; Garmi inside body.
1. Masturbation	Muth marna, Hand practice, Hasthmaithun	Wrong company; Exposure to sex magazines and films: Suppression of sexual desire; It is a illness to satisfy one's own sexual desire.
1. Wet dream	Swapna dosh	Excessive masturbation: Exposure to sex magazines and films: Unsatisfied sexual desire.
1. Early ejaculation	Jaldi Girna, Money girna	Ignorance about the sex; Excessive masturbation; Mental problem; Thinning of semen:
7. Lack of erection	Ling ka khada na hona: Ling ka kamjor hona.	Thinning of semen: Excessive masturbation: Excessive swapnadosh: Weak Muscles of penis; Excessive sexual intercourse.

Early ejaculation and lack of erection was attributed to the excessive masturbation (once or twice a day) and poor quality of semen. The high and sacrosanct value which is attached to semen can be gauged from the fact that semen or Veerya was often referred to as *money*. One doctor summed up the importance of semen by drawing similarities between a poor man who has no money and a sexually weak person who has no semen. "One hundred drops of blood produce one drop of semen" was the common statement of doctors, who believed that masturbation and excessive sexual heat (garmi) lead to their loss. Doctors treated men for the thinning of semen with the help of a variety of Ayurvedic and Unani medications.

Some of the important sexual problems, their local terms and their perceived causes as reported by practitioners are summarized in Table 6. It appears that masturbation is clearly singled out as one of the problematic behaviours that leads to various forms of sexual problems associated with *Kamjori*.

Masturbation or "excessive masturbation", was thought to be caused by wrong company, "exposure to sex magazines and films (even Hindi films) and suppression of sexual desires; Practitioners clearly thought that the masturbation is a kind of illness and is a cause of several other problems.

GARMI: heat Garmi is yet another problem which indicates the prevalence of STDs among men. Sores and various forms of pus discharges and appearance of boils and pimples are thought to be representing Garmi. They however think of its etiology very differently than it is conceptualized bio-medically. As mentioned above, excessive sexual desire results in the involuntary loss of semen and may also be manifested in the forms of boils, sores or ulcers around the penis and genital area. Use of public toilets, sex without condoms, oral and anal sex and sex with "cheap" women are also considered as important reasons for *garmi* Garmi is generally considered a serious illness.

Treatment of Sexual Problems:

In keeping with the perception of the basic causes, the sexual problems, are treated by the practitioners using a variety of concoctions, aphordiasics and even standard antibiotics. Table 7 presents treatments suggested by the practitioners for various sexual problems. The Problems considered here are those which appeared salient from the earlier analysis. The treatments include a large number of concotions including a number of modern medicines. Persons are treated even for masturbation and early ejaculation. The extent of anxiety related to semen quantity and quality can be guaged from the fact that a large number of aphordiasic preparations are provided by the practitioners.

Conclusions:

According to Indian tradition (writings in 'Upanishids') the term 'Virya' stands for both 'Vigour' and 'Semen' (Nag, 1996). It is considered the source of physical and spiritual strength. The loss of Virya through any sexual acts or imagery (including Masturbation, swapnadosh, etc.) is considered harmful both physically and spiritually. According to metaphysical physiology, food is converted into semen and there are many beliefs and practices prescribed to preserve and enhance the quality and quantity of semen. Given this background it is not surprising that semen loss in some form seems to be a major health concern among the men in Mumbai slum area.

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Table 7: Treatments offered by Practioners for a group of Sexual problems.

Problems	Local Term	Treatment[5]
Boils, Sores, Pus or blood in the urine, ulcers around genital areas.	Garmi, sujak, Parma. Gagkran, Phodi. Miyad Ana, Pesab me jalan	Norfloxin, Doxycycline, Penicillin, Candid ointment, Incidat tab. Concoction prepared out of: Suvarn Makardhawaj*, Chandraprabha vati*, M. Saline, Alkasoal*, Moos*. Satawar*, Vidharikand*, Moosli*, Samelata*.
White Discharge	Dhat girna, Mani Jana. Beej girna	Kursjiryan tab*. Shilajeet cap*. Chandraprabha vati.
Thinning of semen	Dhat ka abhav. Beer kam niklana, Mani Patla hona, Beer patla hona.	Shilajeet tab. Spemanfort, Kursjiryan tab. Majon Mogleenamani. Suparipak, Majoon ardkurma, Lavive kabur jelly, Maullaham Khas, habekhas.
Masturbation/penile abnormalities	Moottmarna, Motthi. Hathbhatti, Hathchlana	Sioton, Suvern bhasm, Heerabhasm, Chandibhasm, Tila : Ointment veergoti,parateen.junjunastr.regmare,for massage. Herbal (Concoction prepared out of: safadmoosli, sataver,vahmanshastra,safadvidharikand,laj vanti.duknugokru.ka ras,trifala
Swapnadosh	Chaddigeela hona, Jhaldi girna, Chaddi kharabhona. Malgirna	Brahmnivati tab/syrup, Shilageet cap.
Early ejaculation	Jaldi girna. Kamnakarpana, Manijaldi girna.	Shilajeet tab. Spemanfort. Kursjiryan tab. Suparipak, Chandraprabha vati.
Lack of erection	Ling ka khada na ho pana. Sambhog na kar pana. Sambhog me safal na ho pana.	Aphoradiasic Suvarnmakardhwaj,siyotone,brahmnivati.norflox,chandraprabhavati.majon suparipak.majon Mogleenamani,Jatifaladivati,tentexfort,himcolin cream,speman coat,Tilaysurkhay,rogan perateen,majon ardhkurma
Kamjori		Majon awar-a-kurma,Majon Sharab-a-awar,General tonic,Vitamin B complex.
Gonorrhoea, Syphilis		Norploxin, Doxycycline, Concoction prepared out of: Moos, Satawar, Vidharikand, Moosli, Samelata.

[5] The treatments mentioned by the doctors include a wide range of ayurvedic medicines as well as other non-allopathic materials. We have not made inquiries into the active ingredients in those preparations.

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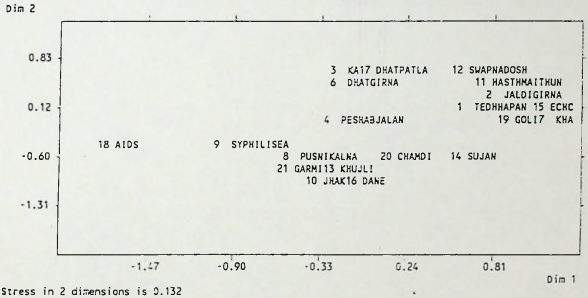
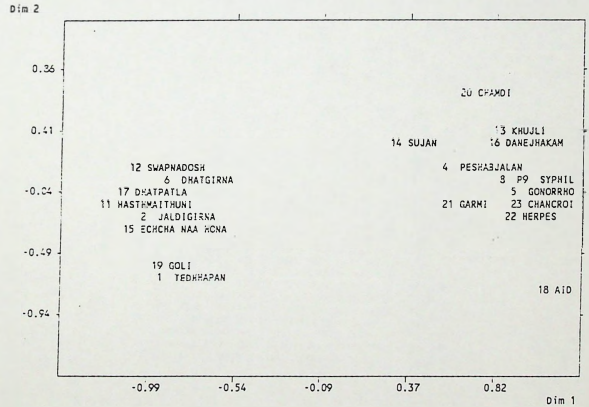
Figure 1, Cognitive Map of Male Sexual Problems (Males=49)



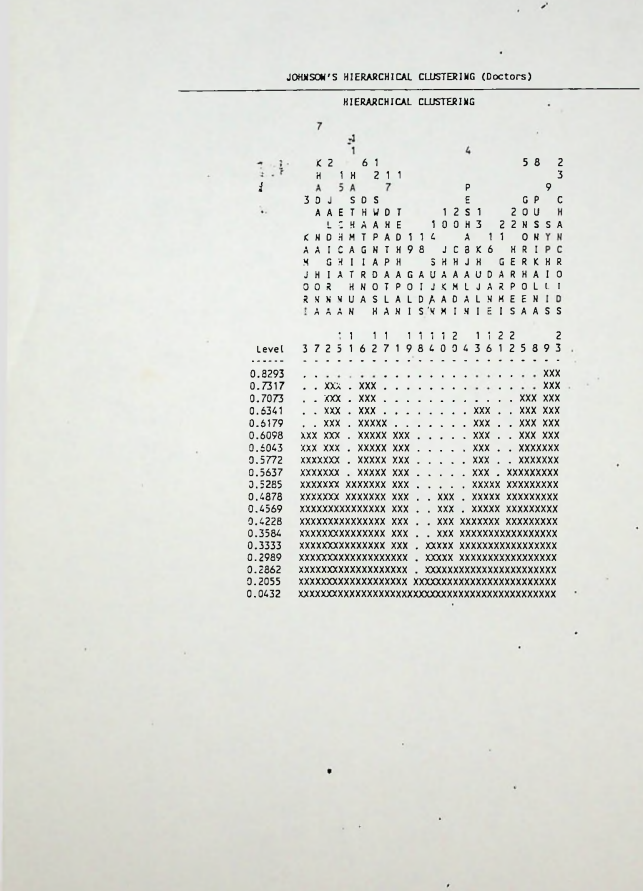
Stress in 2 dimensions is 0.132

Figure 2, Cognitive Map of Male Sexual Problems (Practitioners=41)

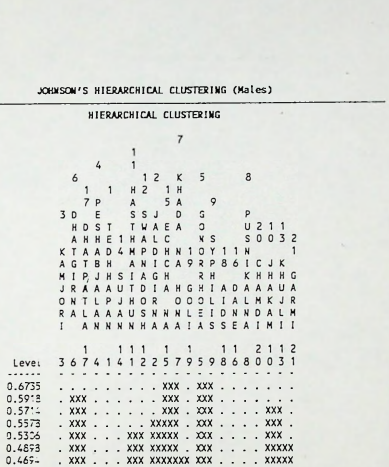


Stress in 2 dimensions is 0.081

JOHNSON'S HIERARCHICAL CLUSTERING (Doctors)



JOHNSON'S HIERARCHICAL CLUSTERING (Males)



CONSENSUS ANALYSIS

Males				
FACTOR	VALUE	PERCENT	CUM %	RATIO
1	23.504	90.0	90.0	16.708
2	1.407	5.4	95.3	1.155
3	1.218	4.7	100.0	
	26.129	100.0		
Practitioners				
FACTOR	VALUE	PERCENT	CUM %	RATIO
1	20.906	84.1	84.1	8.323
2	2.512	10.1	94.2	1.727
3	1.455	5.8	100.0	
	24.873	100.0		