Chapter IV

POPULATION AND FAMILY PLANNING POLICIES IN INDIA

India is the first country to develop family planning policies. Though it covers only 2.4 per cent of world land area, it has 16 per cent of world’s population. India’s population is growing in large. Without the implementation of stringent, effective population management policies, the country’s population will rise above 2 billion within the next 20 years. In the absence of control programs, India’s ever growing population will lead to increased incidents of famine, disease, environmental stress and result in a severe shortage of housing facilities. A drop in both the fertility and birth rates is essential. To achieve this goal, the 5-Year Planning Commission intends to follow the new population control program outlined by India's central government.¹

Population growth has long been a concern of the government, and India has a lengthy history of explicit population policy. In the 1950s, the government began, in a modest way, one of the earliest national, government-sponsored family planning efforts in the developing world. The annual population growth rate in the previous decade (1941 to 1951) had been below 1.3 per cent, and government planners optimistically believed that the population would continue to grow at roughly the same rate.

In the 1950s, existing hospitals and health care facilities made birth control information available, but there was no aggressive effort to encourage the use of contraceptives and limitation of family size.2

The Family Welfare Programme in India has experienced significant growth over the past half century since its inception in 1951. During this period, financial investments in the programme have substantially increased and service delivery points have significantly expanded. Services administered through the programme have been broadened to include immunisation, pregnancy, delivery and postpartum care, and preventive and curative health care.

The range of contraceptive products delivered through the programme has widened. Multiple stakeholders, including the private sector and non-governmental sector, have been engaged in providing contraceptive services. Of late, the programme has been integrated with the broader Reproductive and Child Health Programme.

However, there are certain issues hampering the achievements: a significant proportion of pregnancies continue to be unplanned; the contraceptive needs of millions of women remain unmet; several sub-population groups including adolescents and men continue to be neglected and under-served; and contraceptive choice remains conspicuous by its absence, as is quality of care within the programme.3

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2 Ibid.
Recognition of the changes worldwide and the challenges that are faced by the programme has led to the development of several new policy initiatives. Recently, the programme focus has shifted away from vertical family planning services towards the provision of comprehensive integrated reproductive health care at all levels of the health sector.\textsuperscript{4}

By the late 1960s, many policy makers strongly believed that the high rate of population growth was the greatest obstacle to economic development. The government began a massive program to lower the birth rate from forty-one per 1,000 to a target of twenty to twenty-five per 1,000 by the mid-1970s. The National Population Policy adopted in 1976 reflected the growing consensus among policy makers that family planning would enjoy only limited success unless it was part of an integrated program aimed at improving the general welfare of the population. Education about the population problem became part of school curriculum under the Fifth Five-Year Plan (FY 1974-78).\textsuperscript{5}

During the 1980s, an increased number of family planning programs were implemented through the state governments with financial assistance from the central government. In rural areas, the programs were further extended through a network of primary health centres and subcentres. By 1991, India had more than 150,000 public health facilities through which family planning programs were offered. Four special family planning projects were implemented under the Seventh Five-Year Plan (FY 1985-89). One was the All-India Hospitals Post-partum Programme at district- and sub-district level hospitals. Another program involved the reorganisation of primary health care

\textsuperscript{4} Ibid.
facilities in urban slum areas, while another project reserved a specified number of hospital beds for tubal ligation operations. The final program called for the renovation or remodelling of intrauterine device (IUD) rooms in rural family welfare centres attached to primary health care facilities.

Despite these developments in promoting family planning, the 1991 census results showed that India continued to have one of the most rapidly growing populations in the world. Between 1981 and 1991, the annual rate of population growth was estimated at about 2 per cent. The crude birth rate in 1992 was thirty per 1,000, only a small change over the 1981 level of thirty-four per 1,000. However, some demographers credit this slight lowering of the 1981-91 population growth rate to moderate successes of the family planning program.\(^6\)

In Financial Year 1986, the number of reproductive-age couples was 132.6 million, of whom only 37.5 per cent were estimated to be protected effectively by some form of contraception. A goal of the seventh plan was to achieve an effective couple protection rate of 42 per cent, requiring an annual increase of 2 per cent in effective use of contraceptives.

The heavy centralisation of India's family planning programs often prevents due consideration from being given to regional differences. Centralisation is encouraged to a large extent by reliance on central government funding. As a result, many of the goals and assumptions of national population control programs do not correspond exactly with local attitudes toward birth control. For example, in Jamkhed project at Maharashtra necessary changes were introduced. The successful use of women's clubs as a means of

\(^6\) Ibid.
involving women in community-wide family planning activities impressed the state
government to the degree that it set about organising such clubs in every village in the
state.\textsuperscript{7}

Another important family planning program is the Project for Community Action in
Family Planning. Located in Karnataka, the project operates in 154 project villages and
255 control villages. All project villages are of sufficient size to have a health subcentre,
although this advantage is offset by the fact that those villages are the most distant from
the area's primary health centres. As at Jamkhed, the project is much assisted by local
voluntary groups, such as the women's clubs. The local voluntary groups either provide
or secure sites suitable as distribution depots for condoms and birth control pills and also
make arrangements for the operation of sterilisation camps.\textsuperscript{8}

\textbf{Changing Policy and programme environment}

The Family Welfare Programme in India was launched with the objective of
reducing birth rates to the extent necessary to stabilise population at a level consistent
with the requirements of the national economy. The programme has since evolved
through a number of stages, and has changed direction, emphasis and strategies. During
the first decade of its existence, family planning was considered more a mechanism to
improve the health of mothers and children than a method of population control. Clinic-
centred family planning service delivery, along with health education activities were
promoted during this period.

\textsuperscript{7} Ibid.
\textsuperscript{8} Ibid.
With growing concerns about the rate of population growth and its adverse effect on the pace of social and economic development, the Third Five-year Plan period (1961–66) marked a subtle shift in the emphasis of the programme from the welfare of women and children to the macro objective of population stabilisation. At the same time, an extension education approach replaced the original clinic-centred approach, and the programme was integrated with health services. During 1965–75, the programme was further integrated with the maternal and child health programme. This period also witnessed the introduction of time-bound method-specific targets within the programme.9

The National Population Policy 1976 called for a “frontal attack on the problems of population” and inspired state governments to “pass suitable legislation to make family planning compulsory for citizens” and to stop childbearing after three children, if the “state so desires”. The Population Policy 1977 clearly underscored that “compulsion in the area of family welfare must be ruled out for all times to come,” and emphasised the need for an educational and motivational approach to make acceptance of family planning completely voluntary. However, in the 1980s, the time-bound, target-oriented approach was revived and efforts to encourage the use of reversible methods were initiated.10

In 1990s there were many changes in family welfare policies. The passing of the 72nd and 73rd Constitutional Amendments and the Panchayati Raj and Nagar Palika Acts in 1992 set in motion the process of democratic decentralisation, and brought the Family Welfare Programme, legally, in the domain of Panchayati Raj Institutions The

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10 Ibid.
International Conference on Population and Development in 1994 and the Beijing Women’s Conference in 1995 further catalysed the process of policy change.

In 1996, the government took the radical decision of abolishing method-specific contraceptive targets that had been used to guide, monitor and evaluate the programme for decades, replacing it with what was initially called the Target-free Approach, where health workers’ case loads would be determined by needs identified at the community level, rather than centrally-assigned.\textsuperscript{11}

In 1997, to avoid misconceptions and to direct the programme more towards addressing clients’ needs, the Target-free Approach was renamed as the Community Needs Assessment Approach, and decentralised participatory planning was initiated.

The government has provided broad guidelines for conducting community needs assessment and has given states the responsibility for working out the practical details of implementation. Thus lot of changes were initiated in the Family planning scenario over the decades and paved a way to face the challenges in reproductive health.\textsuperscript{12}

**Reproductive and Child Health Programme**

The Reproductive and Child Health Programme (RCH) was launched in 1997. Its aim is to integrate all the health services including safe and selective deliveries, prevention and management of reproductive tract infections and sexually transmitted infections. Underserved groups including adolescents, and economically and socially

\textsuperscript{11} Ibid.
\textsuperscript{12} Ibid.
disadvantaged groups, such as urban slum and tribal populations are also reached under this.

The Reproductive and Child Health Programme seeks to address gender issues impinging on women’s health by improving quality of care, including promoting better interaction between providers and clients; increasing the availability of female health care providers at the primary health care level; addressing neglected concerns of women such as reproductive tract infections; addressing the needs of neglected population sub-groups such as adolescents; organising gender sensitisation training for stakeholders; encouraging male involvement in reproductive health; and facilitating women’s and men’s participation in programme monitoring through client feedback.13

The National family planning policy adopted in February 2000 further legitimised the paradigm shift to client-based services. The National Population Commission was set up in May 2000. In March 2001, an Empowered Action Group was set up by the Government of India to facilitate focused efforts to promote the Reproductive and Child Health Programme in the states of Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Orissa, Chhattisgarh, Jharkhand and Uttaranchal which have been lagging behind in a number of socio-demographic indices. Several state governments have also framed state-specific population policies.14

The strong preference for sons is a deeply held cultural ideal based on economic roots. Sons not only assist with farm labour as they are growing up (as do daughters) but they provide labour in times of illness and unemployment and serve as their parents’ only security in old age. Surveys done by the New Delhi Operations Research Group in 1991

13 Ibid.
14 Ibid.
indicated that as many as 72 per cent of rural parents continue to have children until at least two sons are born; the preference for more than one son among urban parents was tabulated at 53 per cent. Once these goals have been achieved, birth control may be used or, especially in agricultural areas, it may not if additional child labour, later adult labour for the family is deemed desirable.

A significant result of this eagerness for sons is that the Indian population has a deficiency of females. Slightly higher female infant mortality rates (seventy-nine per 1,000 versus seventy-eight per 1,000 for males) can be attributed to poor health care, abortions of female fetuses, and female infanticide. Human rights activists have estimated that there are at least 10,000 cases of female infanticide annually throughout India.\(^\text{15}\)

The cost of theoretically illegal dowries and the loss of daughters to their in-laws' families are further disincentives for some parents to have daughters. Sons, of course continue to carry on the family line. The 1991 census revealed that the national sex ratio had declined from 934 females to 1,000 males in 1981 to 927 to 1,000 in 1991. In only one state - Kerala, a state with low fertility and mortality rates and the nation's highest literacy - did females exceed males. The census found, however, that female life expectancy at birth had for the first time exceeded that for males.

India's high infant mortality and elevated mortality in early childhood remain significant stumbling blocks to population control. India's fertility rate is decreasing, however, and, at 3.4 in 1994, it is lower than those of its immediate neighbours (Bangladesh had a rate of 4.5 and Pakistan had 6.7). The rate is projected to decrease to

3.0 by 2000, 2.6 by 2010, and 2.3 by 2020. During the 1960s, 1970s, and 1980s, the growth rate had formed a sort of plateau. Some states, such as Kerala, Tamil Nadu, and, to a lesser extent, Punjab, Maharashtra and Karnataka had made progress in lowering their growth rates, but most did not. Under such conditions, India's population may not stabilise until 2060.\textsuperscript{16}

Projections of future population growth prepared by the Registrar General, assuming the highest level of fertility, show decreasing growth rates: 1.8 per cent by 2001, 1.3 per cent by 2011, and 0.9 per cent by 2021. These rates of growth, however, will put India's population above 1.0 billion in 2001, at 1.2 billion in 2011, and at 1.3 billion in 2021. ESCAP projections published in 1993 were close to those made by India: nearly 1.2 billion by 2010, still considerably less than the 2010 population projection for China of 1.4 billion. In 1992 the Washington-based Population Reference Bureau had a similar projection to ESCAP's for India's population in 2010 and projected nearly 1.4 billion by 2025 (nearly the same as projected for 2025 by the United Nations Department of International Economic and Social Affairs). According to other UN projections, India's population may stabilise at around 1.7 billion by 2060.

Such projections also show an increasingly aging population, with 76 million (8% of the population) age sixty and above in 2001, 102 million (9%) in 2011, and 137 million (11%) in 2021. These figures coincide closely with those estimated by the United States Bureau of the Census, which also projected that whereas the median age was

\textsuperscript{16} Ibid.
twenty-two in 1992, it was expected to increase to twenty-nine by 2020, placing the median age in India well above all of its South Asian neighbours except Sri Lanka.\footnote{India Country Studies website.}

**National Family Health Survey**

The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted in a representative sample of households throughout India. The NFHS is a collaborative project of the International Institute for Population Sciences (IIPS), Mumbai, India; ORC Macro, Calverton, Maryland, USA and the East-West Center, Honolulu, Hawaii, USA. The Ministry of Health and Family Welfare (MOHFW), Government of India, designated IIPS as the nodal agency, responsible for providing coordination and technical guidance for the NFHS. NFHS was funded by the United States Agency for International Development (USAID) with supplementary support from United Nations Children's Fund (UNICEF). IIPS collaborated with a number of Field Organisations (FO) for survey implementation. Each FO was responsible for conducting survey activities in one or more states covered by the NFHS. Technical assistance for the NFHS was provided by ORC Macro and the East-West Centre.\footnote{International Institute for Population sciences (2007). “National Family Health Survey Report”, pp.1-2.}

Three rounds of the survey have been conducted since the first survey in 1992-93. The survey provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services. Each successive round of the NFHS has had two specific goals: a) to provide essential data on health and family welfare needed by the Ministry of Health and Family Welfare and other
agencies for policy and programme purposes, and b) to provide information on important emerging health and family welfare issues.

The First National Family Health Survey (NFHS-1) was conducted in 1992-93. The survey collected extensive information on population, health, and nutrition, with an emphasis on women and young children. Eighteen Population Research Centres (PRCs), located in universities and institutes of national repute, assisted IIPS in all stages of conducting NFHS-1. All the state-level and national-level reports for the survey have already been published (48 reports in all). The Second National Family Health Survey (NFHS-2) was conducted in 1998-99 in all 26 states of India with added features on the quality of health and family planning services, domestic violence, reproductive health, anemia, the nutrition of women, and the status of women. The results of the survey are currently being published.\textsuperscript{19}

The Third National Family Health Survey (NFHS-3) was carried out in 2005-2006. Eighteen Research Organisations including five Population Research Centres carried out the survey in 29 states of India. The funding for NFHS-3 is provided by USAID, DFID, the Bill and Melinda Gates Foundation, UNICEF, UNFPA, and MOHFW, GOI. ORC Macro, USA, is providing technical assistance for NFHS-3, and the National AIDS Control Organization (NACO) and the National AIDS Research Institute (NARI) are providing technical assistance for the HIV component.

**Policies and Programmes since independence until 1995**

The population policies can conveniently be classified into six phases as follows:

\textsuperscript{19} Ibid.
1. Clinic Approach (1951-61)

2. Extension Education Approach low intensity HITTS model (1962-69)

3. High intensity HITTS Approach (1969-75)

4. Coercive approach (1976-77)

5. Recoil and recovery Phase (1977-94); and

6. Reproductive and Child Health Approach (since 1995) \(^{20}\)

### 1. Clinic Approach (During First Five Year Plan) : 1951-61

In April 1950, Government of India appointed a Population Policy Committee under the Chairmanship of Minister of Health and upon its recommendations; a Family Planning Cell was created in the office of the Director General of Health Services. The first Five Year Plan document presented to Parliament in December 1952, referred to a programme for Family Limitation and Population Control, terms, which may be considered objectionable on humanitarian grounds now. As an important component of its developmental strategy it sought to reduce the birth rates to the extent necessary to stabilise the population at a level consistent with the requirements of the national economy. A modest sum of Rs.6.5 million was allocated by the Central Government for the family planning programme, which included a plethora of activities such as motivation, education, research and clinical services. \(^{21}\)

### 2. Extension Education Approach : (Low intensity HITTS Approach - 1962-69)

However, the 1961 census showed a continued rise in the population growth rate and an increase in the fertility levels. As a reaction, for the first time in the country, a

\(^{20}\) Ibid.

\(^{21}\) Ibid.
demographic goal was set in 1962, to reach a crude birth of 25 by 1972. Since then reduction in fertility levels was the sole objective of the Indian population policy until the early eighties. Incentives were offered to vasectomy acceptors and to women who were accepting IUD insertions, and the clinic approach was replaced by extension approach in which the family planning workers were asked to make house to house visits to motivate couples to accept family planning methods; targets on the number of contraceptive acceptors to be recruited were fixed to the workers.\textsuperscript{22}

In the centre, a separate department of family planning was set up and the departments of health in the states were renamed, over time as Departments of Health and Family Planning. Family planning programme was fully funded from the central funds with staffing patterns and methods of functioning formulated by them. With the setting up of demographic goals, state-by-state, district-by-district, for the programme, achievement of these goals was made the responsibility of the health departments through recruitment of a targeted number of contraceptive acceptors. The programme became entrenched in a HITTS model: i.e., Health department operated, Incentive based, Target-oriented, Time-bound and Sterilisation-focused programme. Vasectomy came to be regarded as the main fulcrum for fertility regulation. However the demographic goals set in 1962, being extremely unrealistic, had to be revised time and again at the end of each Five Year Plan.\textsuperscript{23}

\textsuperscript{22} Ibid. \textsuperscript{23} Ibid.
3. HITTS Approach: High Intensity (1969-76)

The HITTS approach initiated in 1962 was not as successful as it was expected to be. Sample surveys done in the late ‘sixties in different parts of the country revealed that the birth rate was not declining but on the other hand was even rising in some areas. High population growth was considered as one of the key factors responsible for retarding the economic development of the country in spite of increased investments in the five-year plans. Hence, vasectomy camps were organised, first as mini camps (where not more than 30 vasectomies were done in one day) and then as large camps such as the Ernakulam camp in Kerala in 1970 where over 60,000 vasectomies were done over a week. Government officials from many other departments, other than health, were involved in the organisation of these camps and incentives both in cash and kind, were offered in addition to those officially sanctioned by the Government of India.\(^{24}\)

The involvement of officials from revenue and police departments added a touch of coercion and even compulsion in the programme.

4. Coercive Approach: For the first time, a National Population Policy was formulated and adopted by the Parliament (April 76) which called for a ‘frontal attack on the problems of population’ and which inspired the state governments to ‘pass suitable legislation to make family planning compulsory for citizens’ and to stop child bearing after three children, if the ‘state so desires’. Many other measures were introduced such as stipulations to government officials in the health and revenue departments to recruit

\(^{24}\)Ibid.
given numbers of vasectomies from their areas of operation, failing which punishments were to be met out to them.\textsuperscript{25}

The incentive payments to acceptors was substantially increased and related on a sliding scale to the number of living children a couple had at the time of accepting sterilisation. Innovative political and fiscal incentives were offered by centre to the state governments to implement the family planning programme very seriously. Laws, which made it compulsory for couples to stop reproduction after two or three children, were beginning to be drafted and placed before state legislatures in Maharashtra and other states for enactment.

Vasectomies were conducted in railway stations and in quickly arranged camp sites, and it is alleged that in the northern states of Uttar Pradesh and Bihar men were forcefully subjected to sterilisation under some reason or the other.\textsuperscript{26}

The strategy during this period can be termed as ‘Coercion’. The number of sterilisations done in India during April 1976 to March 1977 was 8.26 million, more than the total number done in the previous five years and more than the number done in any other country in the world until that time.

5. Recoil and Recovery Phase: Post-Emergency period (1977-94)

There was a strong political reaction to the policy of April 1976 in the post emergency government that assumed power in March 1977. There was a tremendous backlash on the family planning programme, especially its insistence on targets for vasectomy. The new government changed the name of ‘family planning’ to ‘family

\textsuperscript{25} Ibid., pp.4-5.
\textsuperscript{26} Ibid.
welfare’, reduced the targets on sterilisation and chose to achieve demographic change through a programme of education and motivation. A judicial commission was appointed to enquire into the wrong doings during the emergency period including forced sterilisations.\(^{27}\)

A revised Population Policy adopted in 1977 was totally against compulsory sterilisation and legislation of any kind towards that end and stated that compulsion in the area of family welfare must be ruled out for all times to come and “Our approach is educational and wholly voluntary”. The new government enacted into law the proposal by the earlier government, the policy of raising the minimum age at marriage of 18 for girls and 21 for boys which came into operation in October 1978. The period after 1977 can be considered to be a *Recoil and Recovery* phase for the family planning programme.

The change of government again in January 1980 marked a turning point and helped to restore the family planning programme garbed as family welfare programme. The emphasis on sterilisations continued though on a voluntary nature. During the revised sixth Five Year Plan, 1980-85, a Working Group of Population Policy was set up by the Planning Commission to formulate long-term policy goals and programme targets for family welfare programmes.\(^{28}\)

The long-term demographic goals were revised in terms of achieving Net Reproduction Rate (NRR-1) by the year 1996 for the country as a whole on an average, and by the year 2001 in all the states. These goals are yet to be realised.

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\(^{27}\) *Ibid.*  
\(^{28}\) *Ibid.*
These goals were translated into achieving a crude birth rate of 21, a crude death rate of nine, infant mortality rate of 60, expectancy of life at birth of 64 years and contraceptive prevalence rate 60 per cent among eligible couples by modern methods of family planning to be achieved in all the states by the year 2000. The health-based, time-bound target-oriented family planning programme was revived with reduced emphasis on sterilisation and greater emphasis on spacing methods and on child survival programmes. These were to be implemented through all the sub-centres and Primary Health Centres in the rural areas, without any aggressive campaigns or mass camps for sterilisation as were adopted in earlier years. With greater assistance from the international organisations, especially the UNICEF and the WHO, Universal Immunisation Programmes (UIP) and Expanded program of Immunisations (EIP) were launched in a systematic manner covering all the districts of the country in a phased manner.29

**Changing Social and Economic Context:** A major change in the political scenario of the country was introduced in 1992 with the passing of constitutional amendments 72 and 73 and enactments of Panchayat Raj and Nagar Palika Acts setting in motion the process of democratic decentralisation. These acts ushered in a three-tier system of political governance in the country, central government, state government and the *panchayats* in the rural areas and the *Nagar palikas* in the urban areas up to the district level, by which constitutionally, the powers, responsibilities and resources are to be shared by these three-tiers of elected bodies.

The primary health care including family planning, primary education and provision of certain basic amenities to the people such as drinking water and roads became the

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responsibility of the panchayats. Another notable feature of this Act is the reservation of one third of the seats in panchayats for women members.\textsuperscript{30}

All family planning programmes have been ultimately targeting women through propagation of female methods of family planning, in the context of a target-oriented and incentive based system. The preponderance of female sterilisations as the dominant method of family planning in the country, it was argued, was because of the pressure brought on women by the officials in the health department who were keen to fulfil their quotas of family planning.

The third major change that took place since the late ‘eighties and pursued vigorously in the ‘nineties was the economic liberalisation policies of the government and the slow but steady linking of the Indian economy with the global economy. The launching of National Family Health Survey-I in 1991-92 for which preparations were started in 1989.

Until 1988 data from the censuses and large-scale surveys in the country were not supposed to leave the country, and taking original data even on placid demographic variables out of the country was considered a crime. Now data from a number of large-scale surveys in the country such as the NFHS and RCH series are in the public domain through websites for access to anyone in the world. This liberalisation of the Indian economy and the society has also had its impact on population policies and programmes in the country.\textsuperscript{31}

\textsuperscript{30} Ibid.
\textsuperscript{31} Ibid.
Swaminathan Committee Report

The Government of India appointed in July 1993 an Expert Group for drafting a national population policy for consideration of the government and adoption by parliament. The Expert Group chaired by Dr. M.S. Swaminathan, an eminent agricultural scientist, submitted its report in May 1994. It has also a number of popular clichés such as it is "pro-nature, pro-poor and pro-women“ in its direction and thrust that the population program should move from negative to positive goals: that population growth is depleting non-renewable natural resources, especially the underground water at an exponential pace and if not checked in time, can lead to serious deficiencies of water in the country.\(^{32}\)

Only broad goals were set for achieving reductions in selected demographic parameters by the year 2010, such as in the TFR (Total Fertility Rate) values from the existing level to 2.1, IMR (Infant mortality rate) to less than 30, MMR (maternal mortality rate) to less than 100 per 100,000 live births, negligible incidence of marriage below age 18 for girls, and rapid improvements on a number of other social indicators such as female education, abolition of child labour, and accessible quality primary health care.

The Committee recommended some new structures such as setting up a Population and Social Development Commission at the centre with the Prime Minister as Chairman and also similar commissions at the state level; integration of the Department of Family Welfare at the central level with the Department of Health Services and a Population and

\(^{32}\) *Ibid.*
Social development Fund to direct the flow of funds for population and related programmes.\textsuperscript{33}

\textbf{International Conference on Population and Development at Cairo, 1994}

The International Conference on Population and Development (ICPD), organised by the United Nations at Cairo in 1994, was in its deliberations, by and large, dominated by women’s groups. The Programme of Action formulated at the end of the Conference and for which India is a signatory, postulated that population policies should be viewed as an integral part of programmes for women’s development, women’s rights, women’s reproductive health, poverty alleviation and sustainable development.

\textbf{CURRENT POLICIES: RCH APPROACH SINCE 1995}

At present, three policies seem to be in operation in the country that have direct impact on population issues and availability of family planning services. These are the National Population Policy 2000 (NPP 2000), the National Health Policy (NHP 2002) and the recently launched National Rural Health Mission (NRHM 2005).\textsuperscript{34}


The goal for IMR stipulated in all the three policies: reach IMR of 30 by 2010 in NPP 2000 and NHP 2002 and by 2012 in NRHM 2005. Similarly the goal for MMR has been set as to reach 100 maternal deaths per 100,000 live births by the year 2010 in both NPP and NHP. The data from NFHS 1 and 2 done during the years 1992-93 and 1998-99

indicate that there is practically no decline in the MMR values during this period and the level hovered around 450 for the past decade.

Similarly, the NHP has stated that mortality rates due to TB, Malaria, other vector and water borne diseases should be reduced by 50 per cent by 2010 and achieve a zero level of growth in HIV/AIDS.

**National Rural Health Mission 2005**

The National Rural Health Mission 2005 (NRHM) recently launched by the Hon’ble Prime Minister is a departure from the earlier policy and plan documents in two aspects.35

The Mission adopts a synergistic approach by relating health to determinants of good health viz., segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organisational structures, optimisation of health manpower, decentralisation and district level management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalising community health centres into functional hospitals meeting Indian Public Health Standards in each Block of the Country.36

The National Population Policy affirms the government’s commitment to the provision of quality services, information and counselling, and expanding contraceptive

method choices in order to enable people to make voluntary and informed choices. Disincentives have not been included in the Policy, though several promotional and motivational measures are to be implemented at the community and individual level. Unlike in the past, these incentives are not just for sterilisation but have been linked to poverty, delayed marriage, antenatal and delivery care, birth registration, birth of a girl child and immunisation.

These include, to list a few, rewarding and honouring Panchayats and Zilla Parishads for exemplary performance in universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling; providing cash incentives to mothers who have their first child after 19 years of age; and rewarding couples below the poverty line who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child.37

In their urgency to reduce population numbers, some states, including Andhra Pradesh, Madhya Pradesh, Maharashtra and Rajasthan, have articulated several open or “veiled” disincentives. The population policy of Madhya Pradesh, for example, advocates debarring individuals marrying before the legal age at marriage from seeking jobs, getting admission in educational institutions and applying for loans.

The policy also calls for debarring individuals with more than two children from contesting local body elections (Government of Madhya Pradesh, 2000). These policies

will negatively affect women who hardly play a role in deciding the age at which they are married or the number of children they bear.\textsuperscript{38}

The Goal of the National Rural Health Mission is to “improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.”

With regard to inputs into the programme the emphasis of the NHRM is different from the NPP and NHP. Unlike the latter two documents that talk about percentage of GDP or per cent of total government budget to be spent on public health, the NHRM talks about actual money to be spent, Rs.6,500 crores during 2005-06 and, if needed to be raised by 30 per cent every year. Similarly, under inputs it talks of committees to be formed at each level, village, district, state and national levels, and the activities including training and monitoring programmes to be initiated.

There will be a community liaison person in every village at the rate of 1 for 1000 population called ASHA an acronym for “Accredited Social Health Activist” similar to the \textit{Anganwadi} Worker but functioning under the control and guidance of the health department. ASHA will be selected from the young ever-married women of a village with at least middle school education and an interest in the community. She will be given needed training in primary health care services focusing on maternal and childcare, will be paid a monthly honorarium and monetary incentives to take care of the pregnant women, for arranging for and caring during institutional delivery.\textsuperscript{39}

\textsuperscript{38} \textit{Ibid.}
Impact of post 1994 policies on reproductive and child health

GLOBAL DEBATE ON POPULATION-DEVELOPMENT NEXUS: CHANGING PERSPECTIVES

Many of the population research centres were started as Family Planning Communication Action Research Centres and demographic research and trainings were funded by the family planning department of the central government.

New journals were started as an outlet for these research outputs. Family Planning Fact Books, published by the Population Council, New York brings out annually the progress in the family planning front across the globe.

Activism for women’s rights and reproductive rights

An undercurrent at Cairo declaration was that family planning programmes were becoming instruments of demographic imperialism used by the rich nations to control the behaviour of women in the developing world as a means of stemming population growth.

CURRENT SITUATION IN INDIA: WIDENING INTERSTATE DIFFERENTIAL AND DISPARITIES

According to NFHS-2, the proportion of births attended to by health professional at the time of delivery was only 42.5 per cent in the country as a whole ranging from 95 per cent in Kerala to less than 30 per cent in the states of Madhya Pradesh, Uttar Pradesh and Bihar. The per cent of ever married women with any anaemia is as high as 52 per cent in the country as a whole, ranging from a low of 23 per cent in Kerala to over 60 per

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Ibid.

In 2001, the HDI (Human Development Index) value for the country as a whole was 0.472, ranging from 0.638 in Kerala to 0.367 in Bihar. Globally India ranks 127 among the 175 countries assessed on HDI values in 2001 (UNDP, 2003). There is no evidence that the age at marriage for girls is increasing as expected even with the Minimum Age at Marriage Act enacted in 1977, specifying age at marriage as 18 for girls and 20 for boys.\footnote{Ibid.}

During the period of emergency the parliament enacted a constitutional amendment freezing the seats in parliament and state legislations on the basis of 1971 census until the year 2000, making it politically unattractive to the states to have a higher rate of population growth. This freeze has been extended again by the parliament based on NPP 2000 recommendations until 2021.

Because of the rigidity in the organisational pattern for maternal, child health and family planning programmes through out the country and the strong implicit insistence of the government at all levels (Centre, State and the District) on achieving the targets on sterilisation, the delivery of maternal and child health services have suffered over the years. This has to be corrected and Janai Suraksha Yojana of the national Rural Health Mission offers some hope in this regard since it is emphasising on processes rather than outcomes.\footnote{Ibid., p.21.}
STATED OBJECTIVES OF THE RECENT POPULATION AND HEALTH POLICIES

National Population Policy 2000

1. To address the unmet needs for contraception, health care infrastructure, and health personnel, and to integrate service delivery for basic reproductive and child health care.

2. To bring the TFR to replacement levels of 2.1 by 2010.

3. To achieve a stable population by 2045.

National Health Policy 2002

1. To achieve an acceptable standard of good health among the general population of the country.

2. To increase the aggregate public health investment through a substantially increased contribution by the central Govt.

3. To ensure the increased access to tried and tested systems of traditional medicine.

National rural Health Mission 2005

1. To provide effective healthcare to rural population throughout the country with special focus on 18 backward states.

2. To raise public spending on health from 0.9 per cent to 2-3 per cent of GDP in five years.\(^4^4\)

3. To undertake architectural correction of the health system to enable it to effectively handle increased allocations.

4. To revitalise local health traditions and mainstream AYUSH into public health system.

\(^4^4\) Ibid.
5. Aim at effective integration of health concerns with determinants of health like sanitation and hygiene, nutrition and safe drinking water.

6. To address the inter-state and inter-district disparities including unmet needs for public health infrastructure.

**Stated goals to be achieved in recent Population and Health Policies:**

**National Population Policy 2000**

1. Address the unmet needs for basic RCH services, supplies and infrastructures.

2. Make school education upto 14 free and compulsory and reduce dropouts at primary and secondary levels.

3. Reduce IMR to 30 per 1000 live births.

4. Reduce MMR to 100 per 100,000 live births.\(^{45}\)

**National Health Policy 2002**


6. Reduce mortality by 50 per cent on account of TB, Malaria and other Vector and Water Borne diseases by 2010.

**National Rural Health Mission 2005**

1. Reduce IMR to 30 per 1000 live births.

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2. Reduce MMR to 100 per 100,000 live births.

3. Universal access to public health services such as women’s health, child health, water, sanitation and hygiene, immunisation and nutrition.

4. Prevention and control of communicable and non-communicable diseases including locally endemic diseases.\textsuperscript{46}


6. Promote delayed marriage for girls, not earlier than age 18 and preferably after age 20.

6.1. Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons.

6.2. Achieve universal access to information/counselling.

6.3. Achieve 100 per cent registration of births, deaths, marriage and pregnancy.

6.4. Contain the spread of AIDS, and promote greater integration between the management of RTI, STI and NACO.

6.5 Prevent and control communicable diseases.

6.6 Integrate Indian System of Medicine in the provision of RCH services and in reaching out to households.

6.7 Promote vigorously the small family norm to achieve replacement levels of TFR.

6.8 Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centered programme.

7. Reduce prevalence of blindness to 0.5 per cent by 2010.

8. Reduce IMR to 30 per 1000 and MMR to 100 per 100,000 live births by 2010.

9. Increase utilisation of public health facilities from current level of $<20$ per cent to $>75$ per cent by 2010.

10. Establish an integrated system of surveillance, National Health Accounts and Health Statistics by 2005.

\textsuperscript{46} Ibid.
11. Increase health expenditure by Govt. as a per cent of GDP from the existing 0.9 per cent to 2.0 per cent by 2010.

12. Increase share of central grant to constitute at least 25 per cent of total health spending by 2010.

13. Increasing state sector health spending from 5.5 per cent to 7.0 per cent of the budget by 2005 and further increase to 8.0 per cent by 2010.\textsuperscript{47}

**Population Research Centres**

There are 18 Population research centres in the country to carry out research on various topics related to Population stabilisation, Demography, socio-demographic surveys and communication aspects of Population and Family welfare programs. These centres prepare research studies/papers.

**Budget outlay in Five-Year Plans**

The approved Outlay of the Department of Family Welfare for the Ninth Five Year Plan (1997-2002) was Rs.15,120.00 crores. Against this, the total funds available were Rs.14102.35 crores, and the expenditure incurred was Rs.13,968.72 crores.

The Department of Family Welfare proposed an outlay of Rs.43,996.58 crores for the Tenth Plan (2002-07), against which the approved outlay is Rs.27,125.00 crores. For the year 2002-03, against the proposed outlay of Rs.7,590.56 crore, the approved outlay was Rs.4,930.00 crores, which was reduced at the RE stage to Rs.4,150 crores.

\textsuperscript{47} Ibid., p.8.
Plan-wise Outlays under the Family Welfare Programme in Five Year Plans (Rs. in crores)

<table>
<thead>
<tr>
<th>Period</th>
<th>Years</th>
<th>Outlay (Rs.in crores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Plan</td>
<td>1951-56</td>
<td>0.65</td>
</tr>
<tr>
<td>Second Plan</td>
<td>1956-61</td>
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<tr>
<td>Third Plan</td>
<td>1961-66</td>
<td>27.00</td>
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<tr>
<td>Annual Plans</td>
<td>1966-69</td>
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</tr>
<tr>
<td>Fourth Plan</td>
<td>1969-74</td>
<td>285.80</td>
</tr>
<tr>
<td>Fifth Plan</td>
<td>1974-78</td>
<td>285.60</td>
</tr>
<tr>
<td>Annual Plans</td>
<td>1978-80</td>
<td>228.00</td>
</tr>
<tr>
<td>Sixth Plan</td>
<td>1980-85</td>
<td>1309.00</td>
</tr>
<tr>
<td>Seventh Plan</td>
<td>1985-90</td>
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<td>Annual Plans</td>
<td>1990-92</td>
<td>1424.00</td>
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<tr>
<td>Eighth Plan</td>
<td>1992-97</td>
<td>6195.00</td>
</tr>
<tr>
<td>Ninth Plan</td>
<td>1997-2002</td>
<td>14170.00</td>
</tr>
<tr>
<td>Tenth Plan</td>
<td>2002-07</td>
<td>27125.00</td>
</tr>
</tbody>
</table>

@ As per Five Year Plan allocation.

The *Jansankhya Sthirata Kosh (JSK)* has been registered under the Societies Registration Act XXI of 1860 in June 2003. The objective of JSK is to facilitate the attainment of the goals of National Population Policy 2000. The Fund will support project, schemes, imitative and innovative ideas, designed to help population stabilisation both in the Government and Voluntary sectors. A contribution of Rs. hundred crores has been made out of plan budget of Department of Family Welfare and Planning Commission.

Rashtriya Janani Suraksha Yojana (RJSY), a 100 per cent Centrally Sponsored Scheme for giving cash assistance to mothers belonging to Below Poverty Line (BPL) family was also launched on the 11th of April 2003 by the Hon’ble Minister of Health and Family Welfare. Under the scheme, cash assistance will be paid @ Rs.500/- for the birth of a male child and Rs.1000/- will be paid on the birth of a female child, if the delivery takes place in an institution. In addition, village level workers like ANM and Dias have
been involved in the identification of beneficiaries. The new scheme awaits approvals at various levels, for which, action has been initiated. The ‘Janani Suraksha Diwas’ was launched on the birth anniversary of Kasturba Gandhi, the 11th of April 2003 in order to focus the attention of the general public and policy matters on the need for reducing maternal mortality.48

National population policy also recognises NGOs’ role. Mother NGO concept is followed in promoting reproductive health. Regional resource centres work on capacity building of NGOs to mobilise communities towards better health. Public Private Partnership with for profit sector is being utilised for social marketing of contraceptives, provisioning of services through adoption of primary health centres, IEC campaign through CII and FICCI and involvement of private medical practitioners in the delivery of family welfare services.

**Introduction of new contraceptive methods:** Emergency Contraceptive Pills were introduced in the year 2002 in the national reproductive and Child Health Programme. The Emergency Contraceptive Pills help to prevent an unwanted pregnancy from an unprotected sexual intercourse if taken within the prescribed time period. An unwanted pregnancy, often leads to unsafe abortions and consequent maternal deaths. Thus the introduction of the Emergency Contraceptive Pills is another step towards achieving the National Population Policy goals of decreased maternal mortality and reduced fertility. In order to provide a longer, durable and safe IUCD, the Government introduced Copper-T 380A in 2002 under the National Family Welfare Programme that provides safety for about 10 years.

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48 mohfw.nic.in
THE CONSTITUTION (SEVENTY-NINTH AMENDMENT) BILL, 1992

The Constitution (Seventy-Ninth Amendment) Bill, 1992 was introduced in the Rajya Sabha in December 1992. This proposes that a person would be disqualified for being chosen as, and for being a Member of either House of Legislature of a State, if he has more than two children.

THE PRE-NATAL DIAGNOSTIC TECHNIQUES (REGULATION AND PREVENTION OF MISUSE) ACT, 1994

With a view to contain the declining sex ratio (number of females per thousand males) and for curbing the menace of female foeticide, the Government brought into force the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (PNDT Act) with effect from 1.1.1996. The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 has since been amended with effect from 14.2.2003 to make it more effective.49

The Medical Termination of Pregnancy Act, 1971

According to this act, medical termination of pregnancies have to be made only by Government Registered Medical Practitioners.

Social Marketing Scheme

In view of better access to Family planning services, Condoms, Oral pills etc are provided by Government at a subsidised cost with the help of some not for profit NGOs like Hindustan Latex and Family planning promotion Trust. An innovative female condom is also under trials by this NGO.

49 Ibid.
STERILISATION AND IUD INSERTION (COMPENSATION SCHEME)

The Government of India provides funding for loss of wages to acceptors of sterilisation/IUD insertion under the National Family Welfare Programme. Under the existing 'Sterilisation and IUD Insertion Scheme the Central Government pays to the States/UTs a sum of Rs.300/250/20 for Tubectomy/Vasectomy/IUD Insertion respectively.

Role of Private Sector

Public Private Partnership with for profit sector is being utilised for social marketing of contraceptives, provisioning of services through adoption of primary health centres, IEC campaign and involvement of private medical practitioners in the delivery of family welfare services. Incentives are paid to private medical practitioners for encouraging family planning methods.