Appendix

NATIONAL POPULATION POLICY 2000

Evolution of the National Population Policy

It is well-recognized that India has the distinction of being the first country in the world to have a Government-sponsored family planning programme with the purpose of achieving population control. This was early as 1952. Even before that, the Bhore Committee had recommended in 1946 that birth control should be provided for the promotion of the health of mothers and children.

It was for the first time in 1976 a statement of the National Population Policy was declared by the then Congress Government. The revised version of the Policy Statement on Family Welfare (the new nomenclature adopted for family planning adopted by the Janta Government) was declared in 1977. The revised version excluded any reference to coercion in any form. Both these statements were laid on the Table in Parliament, but were never discussed or adopted. However, some of the measures suggested in the 1976 Policy Statement were acted upon. For instance, the minimum legal age at marriage for girls and boys was raised to 18 and 21 respectively and the representation in the Lok Sabha and the State Legislatures was frozen on the basis of the 1971 census till the year 2001.

The National Health Policy of 1983 emphasized the need for securing the small family norm through voluntary efforts and moving towards the goal of population stabilization. While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy. In 1991, the National Development Council appointed a Committee on Population under the chairmanship of Shri Karunakaran. The report of this committee submitted in 1993, proposed the formulation of a National Population Policy to take a long term holistic view of development population growth and environmental protection and to suggest policies and guidance for formulation of programmes, and a monitoring mechanism with short,
medium and long term perspectives and goals. It was recommended that a National Population Policy should be formulated and adopted by Parliament.

The expert Group, headed by Dr. M. S. Swaminathan, appointed for preparing a draft of a National Population Policy, submitted its report in 1994. It was circulated among members of Parliament and comments were invited from central and state agencies. In 1977, the Cabinet approved the draft National Population Policy, but the policy Document could not be placed in either House of Parliament as the respective houses stood adjourned, followed by the dissolution of the Lok Sabha. During 1998, another round of consultations was held and another National Population was finalized and placed before the cabinet in March 1999. The cabinet appointed a group of ministers headed by the Chairmanship of the Planning Commission to examine the draft policy. The issue of inclusion/exclusion of incentives and disincentives being crucial views were sought from several groups from the academia, public health professionals, demographers, social scientist and women’s representatives.

The draft Population Policy, as finalized by the group of Ministers, was placed before the Cabinet and was discussed on 19 November 1999. Several suggestions were made during the deliberations, on the basis of which a fresh draft was submitted to the cabinet.

The following sections contain the details of the National Population Policy 2000 as approved by the Cabinet in February 2000.

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The Policy Documents contains nine sections and four appendices. The details are as follows:

**A. INTRODUCTION**

The growth of India’s population and its current situation is described as follows:

On 11 May, 2000 India is projected to have 1 billion (100 crore) people i.e. 16 percent of the world’s population on 2.4 percent of the globe’s land area. If current trends
continue, India may overtake China in 2045, to become the most popular country in the world. While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crore) to 1 billion in the same period. India current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resources endowment and environment.

Stabilizing population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and effort for all, as of increasing the provisions and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications.

The National Population Policy 2000 (NPP 200) affirms the commitment of government towards voluntary and informing choice and consent of citizens while availing of reproductive health care services, and continuations of the target free approach in administering family planning services. The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels by 2010. it is based upon the need to simultaneously address issue of child survival, maternal health, and contraception, while increasing outreach and coverage of a comprehensives package of reproductive and child health services by government, industry and the voluntary non-government sector, working in partnership.

**B. OBJECTIVES**

The objectives of the National Population Policy (NPP) 2000 have been classified as Immediate Objectives, Medium Term Objectives and Long Term Objectives. The immediate objectives of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated services delivery for basic reproductive and child health care.
The medium term objective is to bring the TFR to replacement levels by 2010, through vigorous implementations of inter-sectoral operational strategies. The long term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated:

(1) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.

(2) Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.

(3) Reduce infant mortality rate to below 30 per 1000 live births.

(4) Reduce maternal mortality ratio to below 100 per 1,00,000 live births.

(5) Achieve universal immunization of children against all vaccine preventable diseases.

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

(7) Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.

(8) Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.

(9) Achieve 100 percent registration of births, deaths, marriage and pregnancy.

(10) Contains the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organization.

(11) Prevent and control communicable diseases.

(12) Promote vigorously the small family norm to achieve replacement levels of TFR.
(13) Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people centered programme.

It is imperative that the reproductive age group adopts without further delay or exception the “small family norm” for the reason that about 45 percent of population increase is contributed by births above two children per family. Higher fertility due to unmet need for contraception. Urgent steps are required to make contraception more widely available, accessible, and affordable. High wanted fertility due to the high infant mortality rate. Over 50 percent of girls many below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of “too early, too frequent, too many”. Around 33 percent births occur at intervals of less than 24 months, which also results in high IMR.

C. STRATEGIC THEMES

Twelve strategic themes which must be simultaneously pursued in “stand alone” or inter sectoral programme in order to achieve the national socio-demographic goals for 2010 have been identified. These are presented below:

(i) Decentralized Planning and Programme Implementation
Since 33 percent of elected panchayat seats are reserved for women, representative committees of the panchyats should be formed to promote a gender sensitive, multi-sectoral agenda for population stabilization, which will “think, plan and act locally, and support nationally”. Panchayats demonstrating exemplary performance in the compulsory registration of births, deaths, marriages, and pregnancies, universalizing the small family norm, increasing safe deliveries, bringing about reductions in infant and maternal mortality, and promoting compulsory education up to age 14, will be nationally recognize and honored.

(ii) Convergence of Service Delivery at Village Levels
Efforts at population stabilization will be effective only if we direct an integrated package of essential services at village and household levels. Absence of supportive supervision, lack of training in inter-personal communication, and lack
of motivation to work in rural areas, together impede citizen’s access to reproductive and child health services, and contribute to poor quality of service and an apparent insensitiveness to client’s needs. We need to promote a more flexible approach, by extending basic reproductive and child health care through mobile clinics and counseling services.

(iii) Empowering Women for Improved Health and Nutrition
The complex socio-cultural determinants of women’s health and nutrition have cumulative effects over a lifetime. Discriminatory childcare leads to malnutrition and impaired physical development of the girl child. Under nutrition and micronutrient deficiency in early adolescence goes beyond mere food entitlements to those nutrition related capabilities that become crucial to a women’s well-being, and through her to the well-being of children. The positive effect of good health and nutrition on the labour productivity of the poor is well documents. To the extent that women are over represented among the poor, interventions for improving women’s health and nutrition are critical for poverty reduction.

(iv) Child Health and Survival
Infant mortality is a sensitive indicator of human development. High mortality and morbidity among infants and children below 5 years occurs on account of inadequate care, asphyxia during birth, premature birth, low birth weight, acute respiratory infections, diarrhea, vaccine preventable diseases, malnutrition, and deficiencies of nutrients, including Vitamin A. Infant mortality rates have not significantly declined in recent years. Child survival i.e. universal immunization, control of childhood diarrhoeas with oral dehydration therapies, management of acute respiratory infections, and massive doses of Vitamin A and food supplements have all helped to reduce infant and child mortality and morbidity. Significant improvements need to be made in the quality and coverage of the routine immunization programme.

(v) Meeting the Unmet Needs for Family Welfare Services
In both rural and urban areas there continue to be unmet needs for contraceptives, supplies and equipment for integrated service delivery, mobility of health providers
and patients, and comprehensive information. It is important to strengthen, energies and make accountable the cutting edge of health infrastructure at the village, sub centre and primary health centre levels to improve facilities for referral transportation, to encourage and strengthen local initiatives for ambulance services at village and block levels, to increase innovative social marketing schemes for affordable products and services, and to improve advocacy in locality relevant and acceptable dialects.

(vi) **Under-Served Population Groups**
Nearly 100 million people live in the urban slums, with little or no access to potable water, sanitation facilities, and health care services. This contributes to high infant and child mortality, which in turn perpetuate high TFR and maternal mortality. Basic and primary health care, including reproductive and child health care needs to be provided.

In the past, population programmes have tended to exclude men folk. Gender inequalities in patriarchal societies ensure that men play a critical role in determining the education and employment of family members, age at marriage, besides access to and utilization of health, nutrition, and family welfare services for women and children. The active involvement of men is called for in planning families, supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoiding delays in seeking care, helping after the baby is born, and finally being, responsible fathers. The special needs of men include re-popularizing vasectomies, in particular no-scalpel vasectomy as a safe and simple procedure, and focusing on men in the information campaigns to promote the small family norm.

(vii) **Diverse Health Care Providers**
Given the large unmet need for reproductive and child health services, and inadequacies in health care infrastructure, it is imperative that we increase the numbers and diversify the categories of health care providers. Ways of doing this include accrediting private medical practitioners and assigning them to defined beneficiary groups to provide these services; and revival of the system of licensed
medical practitioner who, after appropriate certification from the Indian Medical Association, could provide specified clinical services.

(viii) **Collaboration with and Commitments from the Non-Government Organization and the Private Sector**

A national effort to reach out to household cannot be sustainable by government alone. We need to put in place a partnership of non-government voluntary organizations, the private corporate sector, government, and the community. Triggered by rising incomes and institutional finance, private health care has grown significantly skills, and currently accounts for nearly 75 percent of health care expenditures. However, despite their obvious potential, mobilizing the private sector to serve public health goals raises governance issues of contracting, accreditation, regulation, referral, besides the appropriate division of labour between the public and private health providers, all of which need to be addressed carefully.

(ix) **Mainstreaming Indian System of Medicine and Homeopathy**

India’s community supported ancient but living traditions of indigenous system of medicine has sustained the population for centuries, with effective curse and remedies for numerous conditions, including those relating to women and children, with minimal side effects. Utilization of ISMH in basic reproductive and child health care will expand the pool of effective health care providers, optimize utilization of locally based, remedies and cures, and promote low cost health care. Guidelines need to be evolved to regulate and ensure the standardization, efficiency and safety of ISMH drugs, for wider entry into national markets.

(x) **Contraceptive Technology and Research on Reproductive and Child Health**

Government must constantly advance, encourage, and support medical, social science, demographic and behavioural science research on maternal, child and reproductive health care issues. This will improve medical techniques relevant to the country’s needs, and strengthen programme and project design and implementation. Consultation and frequent dialogue by Government with the exiting network of academic and research institutions in allopathy and ISHM, and
with other relevant public and private research institutions engaged in social science, demography and behavioral research must continue. The International Institute of Population Sciences, and the population research centres which have been set up to pursue applied research in population related matters need to be revitalized and strengthened.

(xii) Providing for the Older Population

Improved life expectancy is leading to an increase in the absolute number and proportion of persons aged 60 years and above, and is anticipated to nearly double during 1996-2016, from 62.3 million to 112.9 million. When viewed in the context of significant weakening of traditional support system, the elderly are increasingly vulnerable, needing protection and care. Promoting old age health care and support will, over time, also serve to reduce the incentives to have large families.

(xii) Information, Education, and Communication

Information, education and communication of family welfare message must be clear, focused and disseminated everywhere, including to the remote corners of the country, and in local dialects. This will ensure that the messages are effectively conveyed. These need to be strengthened and their outreach widened, with locally relevant and locally comprehensible media and message. On the modal of the total literacy campaigns which have successfully mobilized local populations, there is need to undertake a massive national campaign on population related issues, via artist, popular film stars, doctors, vaidayas, hakims, nurses, local midwives, women’s organizations, and youth organizations.

D. LEGISLATION

As a motivational measure, in order to enable state governments to fearlessly and effectively pursue the agenda for population stabilization contained in the National Population Policy, 2000, one legislation is considered necessary. It is recommended that the 42\(^{nd}\) Constitutional Amendment that freezes till 2001, the number of seats to the Lok Sabha and the Rajya Sabha based on the 1971 Census, be extended up to 2026.

E. PUBLIC SUPPORT
Demonstration of strong support to the small family norm, as well as personal example by political, community, business, professional, and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout society. Government will actively enlist their support in concrete ways.

**F. NEW STRUCTURE**

The NPP 2000 is to be largely implemented and managed at panchyat and nagarpalika levels, in coordination with the concerned State/Union Territory administrations. Accordingly the specific situation in each state/UT must be kept in mind. This will require comprehensive and multisectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes or education, nutrition, women and child development safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection, and urban development. Accordingly the following structures are recommended:

(i) **National Commission on Population**

A National Commission on Population presides over by the Prime Minister, will have the Chief Ministers of all states and UT’s and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministers and Departments, for example, Department of women and child development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, and reputed demographers, public health professionals, and NGO’s as members. This Commission will oversee and review implementation of policy. The Commission Secretariat will be provided by the Department of Family Welfare.

(ii) **State/UT Commission on Population**

Each state and UT may consider having a State/UT Commission on Population, presides over by the Chief Minister, on the analogy of the
National Commission, to likewise oversee and review implementation of the NPP 2000 in the state/UT.

(iii) **Coordination cell in the Planning Commission**
The Planning Commission will have a Coordination Cell for inter-sectoral coordination between Ministers for enhancing performance, particularly in States/UT’s needing special attention on account of adverse demographic and human development indicators.

(iv) **Technology Mission in the Department of Family Welfare**
To enhance performance, particularly in States with currently below average socio demographic indices that need focused attention, a Technology Mission in the Department of Family Welfare will be establishment to provide technology support in respect of design and monitoring of projects and programmes for reproductive and child health, as well as for IEC campaigns.

**G. FUNDING**
The programmes, projects and schemes premised on the goals and objectives of the NPP 2000, and indeed all efforts at population stabilization, will be adequately funded in view of their critical importance to national development. Preventive and promotive services such as ante-natal and post-natal care for women, immunization for children and contraception will continue to be subsidized. Even though the annual budget for Population stabilization activities assigned to the Department of Family Welfare has increased over the years, at least 50 percent of budgetary outlay is deployed towards non-plan activities. The Department of Family Welfare has been unable to revise norms of operational costs of health infrastructure, which in turn has impacted directly the quality of care and outreach of services provided.

**H. PROMOTIONAL AND MOTIVATIONAL MEASURES FOR ADOPTION OF THE SMALL FAMILY NORM**
The following promotional and motivational measures will be undertaken:

(i) Panchayat and Zilla Parishad will be rewarded and honoured for exemplary performance in universalisation the small family norm, achieving reductions
in infant mortality and birth rates, and promoting literacy with completion of primary schooling.

(ii) The Balika Samiridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs 500 is awarded at the birth of the girl child of birth order 1 or 2.

(iii) Maternity Benefit Schemes run by the Department of Rural Development will continue. A cash incentive of Rs. 500 is awarded to mothers who have their first child after 19 years of age, for birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth, and BCG immunization.

(iv) A Family Welfare linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible for health insurance not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilisation.

(v) 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, will be rewarded.

(vi) A revolving fund will be set up for income-generating activities by village-level self help groups, who provide community level health care services.

(vii) Crèches and child care centres will be opened in rural areas and urban slums. This will facilities and promote participation of women in paid employment.

(viii) A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent.

(ix) Facilities for safe abortion will be strengthened and expanded.
(x) Products and services will be made affordable, through innovative social marketing schemes.

(xi) Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.

(xii) Increased vocational training schemes for girls, leading to self-employment will be encouraged.


(xiv) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994.

(xv) Soft loans to ensure mobility of the ANMs will be increased.

I. CONCLUSION

In the new millennium, nations are judged by the well-being of their peoples; by levels of health, nutrition and education; by the civil and political liberties enjoyed by their citizens; by the protection guaranteed to children; and by provisions made for the vulnerable and the disadvantaged.

The vast numbers of the people of India can be its greatest asset if they are provided with means to lead healthy and economically productive lives. Population stabilization is a multi-sectoral endeavor requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a steady, equitable improvement in family incomes, will facilitate early achievements of the socio-demographic goals. Success will be achieved if the Action Plan contained in the NPP 2000 is pursued as a national movement.
REFERENCE
Appendix

NATIONAL POPULATION POLICY 2000

Evolution of the National Population Policy

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In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated:

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3. Reduce infant mortality rate to below 30 per 1000 live births.
4. Reduce maternal mortality ratio to below 100 per 1,00,000 live births.
5. Achieve universal immunization of children against all vaccine preventable diseases.
6. Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
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India’s community supported ancient but living traditions of indigenous system of medicine has sustained the population for centuries, with effective curse and remedies for numerous conditions, including those relating to women and children, with minimal side effects. Utilization of ISMH in basic reproductive and child health care will expand the pool of effective health care providers, optimize utilization of locally based, remedies and cures, and promote low cost health care. Guidelines need to be evolved to regulate and ensure the standardization, efficiency and safety of ISMH drugs, for wider entry into national markets.

(x)**Contraceptive Technology and Research on Reproductive and Child Health**

Government must constantly advance, encourage, and support medical, social science, demographic and behavioural science research on maternal, child and reproductive health care issues. This will improve medical techniques relevant to the country’s needs, and strengthen programme and project design and implementation. Consultation and frequent dialogue by Government with the exiting network of academic and research institutions in allopathy and ISHM, and
with other relevant public and private research institutions engaged in social science, demography and behavioral research must continue. The International Institute of Population Sciences, and the population research centres which have been set up to pursue applied research in population related matters need to be revitalized and strengthened.

(xi) **Providing for the Older Population**
Improved life expectancy is leading to an increase in the absolute number and proportion of persons aged 60 years and above, and is anticipated to nearly double during 1996-2016, from 62.3 million to 112.9 million. When viewed in the context of significant weakening of traditional support system, the elderly are increasingly vulnerable, needing protection and care. Promoting old age health care and support will, over time, also serve to reduce the incentives to have large families.

(xii) **Information, Education, and Communication**
Information, education and communication of family welfare message must be clear, focused and disseminated everywhere, including to the remote corners of the country, and in local dialects. This will ensure that the messages are effectively conveyed. These need to be strengthened and their outreach widened, with locally relevant and locally comprehensible media and message. On the modal of the total literacy campaigns which have successfully mobilized local populations, there is need to undertake a massive national campaign on population related issues, via artist, popular film stars, doctors, vaidayas, hakims, nurses, local midwives, women’s organizations, and youth organizations.

**D. LEGISLATION**
As a motivational measure, in order to enable state governments to fearlessly and effectively pursue the agenda for population stabilization contained in the National Population Policy, 2000, one legislation is considered necessary. It is recommended that the 42\(^{nd}\) Constitutional Amendment that freezes till 2001, the number of seats to the Lok Sabha and the Rajya Sabha based on the 1971 Census, be extended up to 2026.

**E. PUBLIC SUPPORT**
Demonstration of strong support to the small family norm, as well as personal example by political, community, business, professional, and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout society. Government will actively enlist their support in concrete ways.

F. NEW STRUCTURE

The NPP 2000 is to be largely implemented and managed at panchyat and nagarpalika levels, in coordination with the concerned State/Union Territory administrations. Accordingly the specific situation in each state/UT must be kept in mind. This will require comprehensive and multisectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes or education, nutrition, women and child development safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection, and urban development. Accordingly the following structures are recommended:

(i) National Commission on Population

A National Commission on Population presides over by the Prime Minister, will have the Chief Ministers of all states and UT’s and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministers and Departments, for example, Department of women and child development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, and reputed demographers, public health professionals, and NGO’s as members. This Commission will oversee and review implementation of policy. The Commission Secretariat will be provided by the Department of Family Welfare.

(ii) State/UT Commission on Population

Each state and UT may consider having a State/UT Commission on Population, presides over by the Chief Minister, on the analogy of the
National Commission, to likewise oversee and review implementation of the NPP 2000 in the state/UT.

(iii) **Coordination cell in the Planning Commission**
The Planning Commission will have a Coordination Cell for inter-sectoral coordination between Ministers for enhancing performance, particularly in States/UT’s needing special attention on account of adverse demographic and human development indicators.

(iv) **Technology Mission in the Department of Family Welfare**
To enhance performance, particularly in States with currently below average socio demographic indices that need focused attention, a Technology Mission in the Department of Family Welfare will be establishment to provide technology support in respect of design and monitoring of projects and programmes for reproductive and child health, as well as for IEC campaigns.

**G. FUNDING**
The programmes, projects and schemes premised on the goals and objectives of the NPP 2000, and indeed all efforts at population stabilization, will be adequately funded in view of their critical importance to national development. Preventive and promotive services such as ante-natal and post-natal care for women, immunization for children and contraception will continue to be subsidized. Even though the annual budget for Population stabilization activities assigned to the Department of Family Welfare has increased over the years, at least 50 percent of budgetary outlay is deployed towards non-plan activities. The Department of Family Welfare has been unable to revise norms of operational costs of health infrastructure, which in turn has impacted directly the quality of care and outreach of services provided.

**H. PROMOTIONAL AND MOTIVATIONAL MEASURES FOR ADOPTION OF THE SMALL FAMILY NORM**
The following promotional and motivational measures will be undertaken:

(i) Panchayat and Zilla Parishad will be rewarded and honoured for exemplary performance in universalisation the small family norm, achieving reductions
in infant mortality and birth rates, and promoting literacy with completion of primary schooling.

(ii) The Balika Samiridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs 500 is awarded at the birth of the girl child of birth order 1 or 2.

(iii) Maternity Benefit Schemes run by the Department of Rural Development will continue. A cash incentive of Rs. 500 is awarded to mothers who have their first child after 19 years of age, for birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth, and BCG immunization.

(iv) A Family Welfare linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible for health insurance not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilisation.

(v) 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, will be rewarded.

(vi) A revolving fund will be set up for income-generating activities by village-level self help groups, who provide community level health care services.

(vii) Crèches and child care centres will be opened in rural areas and urban slums. This will facilities and promote participation of women in paid employment.

(viii) A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent.

(ix) Facilities for safe abortion will be strengthened and expanded.
(x) Products and services will be made affordable, through innovative social marketing schemes.

(xi) Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.

(xii) Increased vocational training schemes for girls, leading to self-employment will be encouraged.


(xiv) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994.

(xv) Soft loans to ensure mobility of the ANMs will be increased.

I. CONCLUSION

In the new millennium, nations are judged by the well-being of their peoples; by levels of health, nutrition and education; by the civil and political liberties enjoyed by their citizens: by the protection guaranteed to children; and by provisions made for the vulnerable and the disadvantaged.

The vast numbers of the people of India can be its greatest asset if they are provided with means to lead healthy and economically productive lives. Population stabilization is a multi sectoral endeavor requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a steady, equitable improvement in family incomes, will facilitate early achievements of the socio-demographic goals. Success will be achieved if the Action Plan contained in the NPP 2000 is pursued as a national movement.
REFERENCE