Chapter - VII

Population Policy in Andhra Pradesh
INTRODUCTION

A policy is formalised with a set of procedures designed to guide behaviour. Its purpose is either to maintain consistency in behaviour or to alter behaviour, in order to achieve a specified goal. Population policy represents a strategy for achieving a particular pattern of population change. The direct population policy is one aimed specifically at altering demographic behaviour. There are also indirect population policies, which are not necessarily designed to influence population change but wind up doing so any way.

The Adhoc Consultative Group of Experts on Population Policy, set up by Population Commission of the United Nations has included in population policy "Measures and programmes designed to contribute to the achievement of economic, social, demographic variables namely, the size and growth of population, its geographic distribution and its demographic characteristics." It has also been suggested that it should include measures and programmes that are likely to affect critical demographic variables as well as those specifically designed to do so, thus covering both direct and indirect.


3 Bernard Berelson, "Beyond Family Planning", Studies in Family Planning No.36, February 1969, pp 1-16
measures affecting these variables. Of particular importance, in the context of population policy, are the three components of population change - fertility, mortality and migration - because all demographic variables are influenced only through them. It is therefore, necessary to discuss population policy with respect to these three components of population change, with special reference to the direction of change expected to be brought about, while illustrating them from the population policy is not explicitly stated, and is unarticulated in the formal sense, yet it is implied in many of the programmes or legislative measures which the Government undertakes, the absence of quantitative goals need not be taken as an absence of a population policy.

While considering the population policy of India, it is necessary to concentrate on fertility as the single most important factor contributing to population change and the other two components of population change are mortality and migration. The migration does not warrant serious consideration in the context of the population policy of India.

1. National Population Policy

Population and sustainable development are the key issues that have determined the improvement in quality of life over the last five decades. There have been massive changes in demographic and health indices of the population. India is currently in the midst of demographic transition. The next two decades will witness an unprecedented increase in the number of...
persons in 15-59 age group, and there is a need to meet health and contraceptive needs of this population. The number of births may remain unaltered but there is an urgent need to reduce maternal and infant mortality so that there is a reduction in the desired level of fertility.

Taking all these into account, it is imperative that a National Population Policy is drawn up so that it provides a reliable and relevant policy framework not only for improving Family Welfare Services but also for measuring and monitoring the delivery of family welfare services and demographic impact in the new millennium.

The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society. In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirements of national economy". After 1952, sharp declines in death rates were however, not accompanied by a similar drop in birth rates. The National Health Policy, 1983 stated that Replacement Levels of Total Fertility (TFR) should be achieved by the year 2000.

On 11 May, 2000 India is projected to have 1 billion (100 crore) people i.e., 16 per cent of the world's population on 2.4 per cent of the globe's land area. If current trends continue, India may overtake China in 2045, to become the most populous 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 268 million (23 crores) to 1 billion in the same period. India's current annual increase in
population of 1.5 million is large enough to neutralize efforts to conserve the resource endowment and environment.

India's Demographic Achievement

Half a century after formulating the national family welfare programme, India has:

1. Reduced Crude Birth Rate (CBR) from 40.8 in 1961 to 26.4 by 2001.
3. Quadrupled the Couple Protection Rate (CPR) from 10.4 per cent in 1971 to 51 per cent by 2001.
4. Reduced Crude Death Rate (CDR) from 15 in 1951 to 8.0 by 2001.
5. Added 25 years to life expectancy from 37 years to 62 years.
6. Achieved nearly universal awareness of the need for and methods of family planning, and

Reduced Total Fertility Rate (TFR) from 6.0 in 1951 to 3.0 by 2001.

STATE POPULATION POLICY

One of the most crucial problems facing a state on par with nation is the high population growth rate. India is the first country in the world to embark upon a Population Control Programme as early as in 1961. However, five decades of planned development efforts have failed to yield the desired results in entraining the rapid increase in population. Population growth remains a formidable challenge even today demanding urgent, intensive, concerted and sustained action to address it and achieve the goal of population stabilization.
Need for Formulation of a State Population Policy

Although there will be commonalities of approach in the general contours of the approach in the general contours of the population policy for the country, specific policies and strategies are to be designed to suit the diverse demographic, socio-cultural, socio-biological and socio-economic factors prevailing in each state. An effective population stabilization programme must be State-specific, and within a state, it must be district, sub-district and gram panchayat specific, and within the gram panchayat, family-specific.

In the 1951 census, although Andhra Pradesh had almost the same population size (31 million) as Tamil Nadu (30 million), the difference in population size between the two states has increased to 11 million in the 1991 census. Andhra Pradesh with a population of 66.5 million and Tamil Nadu with a population of 55.8 million. Although Andhra Pradesh has achieved decline in fertility to some extent in recent times, notwithstanding low female literacy and high infant and child mortality, the State is not as favourably placed as its neighbouring States in terms of decline in fertility rates. In fact, Andhra Pradesh has experienced the most rapid population growth amongst the four Southern States during the decade 1981 to 1991.

It is clear then that the State's programmes and strategies require review, and that there is an imperative need for the development of new policy initiatives in this area of great human and social concern. Population policy, by definition, is a deliberate effort on the part of the Government to bring about a change in the size, structure and distribution of population to
a level that helps to improve the standard of living and quality of life of the people. The policy will specify in clear, measurable and attainable terms the demographic goals to be achieved in a specific period of time as well as the interventions and new initiatives proposed to attain the goals.

The Family Planning Programme, in a democratic State where coercive policies are not allowed, can help to bring down the birth rate to the level of desired family size, but to reduce the desired family size to two children or one child requires social change. As long as children are perceived as a source of income, a large family size will be perceived as desirable, as long as age at marriage for the female remains low, fertility behaviour will remain high; as long as half the population of the State is illiterate, social change is difficult. The population policy must necessarily take into account the overall social, cultural, economic and political environment, and specify policy initiatives and interventions in these related areas.

The 1994 International Conference on Population and Development articulated a call for a broader and more holistic population policy approach, linking demographic concerns, including fertility reduction, to a range of reproductive health concerns, particularly those affecting women. It also called for increased male responsibility for sexual and reproductive behaviour. India was a signatory to this call. The reproductive health approach must necessarily be integrated into the State's population policy initiatives.

Taking cognizance of these facts, it is considered essential that a population policy at State level be enunciated, which is in conformity with the
overall health and population policy of the country. Underlining the vital importance of this sector and the need to formulate a policy that works, Dr. M.S. Swaminathan has stated: "If our population policy goes wrong, nothing else will have the chance to go right."

Problem Statement

India's population, placed at 1 billion in the 2001 census, is expected to reach about one billion by the end of the current century. Andhra Pradesh, the fifth largest state in the country in population and area, constitutes 7.9% of the country's population, placed at 75.73 million in the 2001 census and projected to reach around 100 million by 2010 AD. Following the country's pattern, its population growth accelerated during the four decades, from 15.7 per 1000 population in 1951-61 to 13.86 in 1991-2001. At the current growth rate, approximately 18 million people are added to the country's population every year, of which 1.2 million is the contribution of Andhra Pradesh. The country's population, at this rate, is expected to double by the year 2056, by which time India will be the most populous nation in the world.

During the decade 1991-2001, the exponential growth rate in the State (1.30%) has been higher than that in the country (1.23%), a reversal of the trend in the earlier decades, when Andhra Pradesh consistently showed a lower growth rate than the country's. One of the explanations adduced for this trend is migration, though this view can be confirmed only when detailed migration tables become available from the 1991 census. Another explanation is that it is essentially the result of a sharp decline in mortality juxtaposed
against a much slower decline in fertility, the state has recorded more or less stable birth rates during the first 6 years of the 81-91 decade and fertility transition has started in a perceptible way only during the latter half of the decade, whereas the death rate has shown a consistent decline during this period from 11.1 to 9.7, and this factor, along with the age structure, (the percentage of women in the reproductive age group 15 to 49 increased from 48% in 1981 to 50.5% by 1991) explains the higher population growth during this decade. A combination of these factors - migration, sharp decline in mortality and a slower decline in fertility - perhaps accounts for this trend.

The performance of urban Andhra Pradesh in fertility and natural growth is also unsatisfactory. As per the Sample Registration System for the year 2001, Andhra Pradesh is having a lower birth rate (20.4) than India (26.9).

Density of population in the State has increased almost fourfold, from 69 per sq km at the beginning of the century, to 275 per sq. km in 2001.

Of all the figures in the 2001 census, the most distressing is with regard to the sex ratio in the State, which has decreased from 988 females to 1000 males in 1951 to 978 females in 2001. This follows the all-India pattern, the only exception being Kerala which records 1058 females per 1000 males. The consistent decline of females in the sex ratio of the State is a clear indicator of the lower status of women in society, which in turn contributes to lower female literacy rate, low age at marriage for girls, higher fertility and higher mortality levels during the reproductive ages.
India's population, as also the State's, is characterized by a large proportion of young people 34.1% below the age of 15, causing a high dependency on adult population. Because of the persistence of high fertility levels, there has been very little change in this proportion since the beginning of this century. On the other hand, with declining mortality rates, the proportion of 60+ population has continued to rise over the years. The dependency ratio in A.P. (children below 15 and adults 60+ to the population aged 15 to 59), has been estimated at 70.4% in 1991.

Many studies have indicated that high infant and child mortality rates (IMR & CMR) are directly related to higher fertility rates. About 100 million children in the country, and 7.2 million children in the State, are in the 0-4 age group. The CMR (0-4 age group) for the State at 22.4 is lower than the country's (39.4). Similarly, the IMR (0-4 age group) for the state at 68 per 1000 is also lower than the country's (72 per 1000), but much higher than Kerala's which stands at the creditable 13 per 1000. Infant mortality in Andhra Pradesh has declined in the post-natal care component, and it is neonatal causes that account for a substantial part of infant mortality in the State. A study on the burden of disease in Andhra Pradesh reveals that perinatal causes form a significant component of burden of disease. Interventions relating to ante-natal and intra-natal care are obviously inadequate.

Life expectancy at birth, which indicates the general health status of a nation, is 60.6 for males and 61.7 for females in India and 61.4 and 84.4 respectively in Andhra Pradesh. However, compared to Kerala, where life expectancy for males is 67.2 and for females 72.4 Andhra Pradesh has a long way to go.

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Total fertility performance of a woman is linked to three major factors—the age at marriage, the length of marital union and the use of contraception. Several studies have proved that there is an inverse relationship between the age at marriage and the number of children born to a woman; the lower the age at marriage, the higher the number of children. The median age at marriage for females in Andhra Pradesh is 15.1 years, close to Bihar (14.7) and Uttar Pradesh (15.1) and a far cry from Tamil Nadu (18.1 years) and Kerala (19.8 years). Low age at marriage also influences mortality and morbidity levels of mothers and children. In Andhra Pradesh, as per the National Family Health Survey 1992, the IMR for children born to mothers < 20 years is 88 as compared to 58 for children born to mothers aged 20-29.

Fertility and contraceptive prevalence are greatly influenced by the literacy levels of women. In Bihar, the female literacy rate is 22.9%; the Crude Birth Rate (CBR) is 32.2, and the Couple Protection Rate (CPR) is 24.1%. In Andhra Pradesh, the female literacy rate is 32.7%; the CBR is 24.0, and the CPR is 48.8%; the CBR is 17.7 and the CPR is 51%. Not only is contraceptive prevalence higher among educated couples, but the use of spacing methods is also higher among them. In Kerala, 11.2% of contraceptive prevalence is accounted for by spacing methods compared to Andhra Pradesh's 4% among the couples using any modern method of contraception.

Rapid growth of population has serious implications for socio-economic development and the preservation of the environment. The implications are:

(a) Production of food may not keep pace with the growing population. Though the per capita per day availability of food grains has increased from 394 grams in 1951 to 474 grams in 1990, the per capita availability of pulses has declined during this period from 61 grams in
1951 to 36.5 grams in 1990. The country's ability to meet the nutritional requirements of its people is put to serious doubt, given the phenomenal increase in the population. It is estimated that at present 50% of children, 60% of women and 40% of men are anaemic in India. 51% of female children and 47% of male children in Andhra Pradesh are nutritionally disadvantaged, of whom one third are severely undernourished.

(b) Pressure on land and other facilities will increase further, resulting in social tension and violence. Average operational holding size has come down from 1.72 ha to 1.56 ha in Andhra Pradesh during the period 1986 to 1991.

(c) Housing in both rural and urban areas will become a serious problem. Over the period 1981-2001, it is estimated that there is a backlog requirement of 23.3 million dwelling units and a new requirement of 63.8 million units in the country. The estimated figure for new dwelling units in Andhra Pradesh during the same period is around 4.7 million units in urban areas alone. Rapid urbanization, a concomitant of rapid population growth, demands large resources for urban infrastructure investment.

(d) Of the total population, 41.3 million in rural areas and 6.4 million in urban areas of Andhra Pradesh do not have access to sanitation facilities in 1991. If this trend continues, 44.3 million in rural areas and 7.3 million in urban areas will not have sanitation facilities by 2001.
(e) Safe drinking water is one of the essential requirements to reduce water-borne diseases. A total population of 9.1 million in rural areas and 1.8 million in urban areas of Andhra Pradesh do not have access to safe drinking water in 1991. If this proportion is kept constant, the number of persons without safe drinking water in 2001 will be 13 million.

(f) By the end of the 2001 India is having 500 million illiterates, more than half of all the illiterates in the world, to which the contribution of Andhra Pradesh at current literacy rates is estimated at 40 million.

(g) There will be increase in unemployment. It has been projected that between the period 1991 to 2001, the labor force in the country will increase by 63.1 million, all of them to be provided employment. The projection of Andhra Pradesh is 6 million.

(h) The absolute number of people below the poverty line will still be large. At present, 29.2% of the population in the country is estimated to be below the poverty line. In Andhra Pradesh, the number is currently 25 million, projected to be 21 million by 2000 A.D.;

(i) There will be serious pressure on the country's natural resources causing deforestation, desertification, and consequently more frequent natural calamities such as droughts and floods, air and water pollution and a degraded environment;
Population Stabilization Goals

(1) National demographic goals & current status:

In spite of five decades of effort, backed by extensive infrastructure and a fair outlay of resources from the Government of India, the Family Welfare Programme in the State has not succeeded in lowering the fertility rate to the desired extent. Although a large number of births are estimated to have been averted 191 million from 1956 to 1996, and about 49% of eligible couples are currently protected by the programme, the CBR is still unacceptably high at 20.4 compared to Kerala’s 17.8 and Tamilnadu’s 19.2 Andhra Pradesh emerges as a low performing state.

The following table indicates the current levels of achievement of Andhra Pradesh in comparison with two other Southern states and the country with reference to the long-term demographic goals laid down in the National Health Policy adopted by the Parliament in 1983.

<table>
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<tr>
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<th>Targets for 2000 A.D.</th>
<th>Current level of achievement as per SRS 1996</th>
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<tr>
<td></td>
<td>India A.P. Tamil Nadu</td>
<td>Kerala</td>
</tr>
<tr>
<td>a. Natural Growth Rate (%)</td>
<td>1.2</td>
<td>1.85 1.44</td>
</tr>
<tr>
<td>b. Crude Birth Rate</td>
<td>21.0</td>
<td>27.4 22.7</td>
</tr>
<tr>
<td>c. Crude Death Rate</td>
<td>9.0</td>
<td>8.9 8.3</td>
</tr>
<tr>
<td>d. Infant Mortality Rate</td>
<td>66.0</td>
<td>72.0 66.0</td>
</tr>
<tr>
<td>e. Maternal Mortahty Rate</td>
<td>2.0</td>
<td>4.2' 3.8'</td>
</tr>
<tr>
<td>f. Couple Protection Rate (%)</td>
<td>60.0</td>
<td>46.4' 46.8'</td>
</tr>
<tr>
<td>g. Total Fertility Rate</td>
<td>2.3</td>
<td>3.5 2.7</td>
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</table>

Source: Govt. of India Bulletins.
(2) **The demographic goals for the state are set as under:**

<table>
<thead>
<tr>
<th></th>
<th>1996†</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
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<tbody>
<tr>
<td>a Natural Growth Rate (%)</td>
<td>1.44</td>
<td>1.15</td>
<td>0.80</td>
<td>0.70</td>
</tr>
<tr>
<td>b Crude Birth Rate</td>
<td>22.7</td>
<td>19.0</td>
<td>15.0</td>
<td>13.0</td>
</tr>
<tr>
<td>c Crude Death Rate</td>
<td>8.3</td>
<td>7.5</td>
<td>7.0</td>
<td>6.0</td>
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<tr>
<td>d Infant Mortality Rate</td>
<td>66.0</td>
<td>45.0</td>
<td>30.0</td>
<td>15.0</td>
</tr>
<tr>
<td>e Maternal Mortality Rate</td>
<td>3.8**</td>
<td>2.0</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>f Couple Protection Rate (%)</td>
<td>48.8**</td>
<td>60.0</td>
<td>70.0</td>
<td>75.0</td>
</tr>
<tr>
<td>g Total Fertility Rate</td>
<td>2.7</td>
<td>2.1</td>
<td>1.6</td>
<td>1.5</td>
</tr>
</tbody>
</table>

* Sample Registration System
** GOI Bulletins

**Population Stabilization - Objectives**

The following are the objectives of the population stabilization in Andhra Pradesh state. The family welfare programmes cuts across various sectors demanding policy interventions and strategies to bring about changes in the social, cultural, economic and political environment. Therefore, the objectives of the Family Welfare Department, and other departments, who are major players in the field, will form part of the policy statement:
Objectives of the Family Welfare Department

(i) Reduction in the fertility rate through:
   a. Promotion of use of spacing methods: minimum spacing of 2 years before first birth and 3-5 years between 1st and 2nd births;
   b. Promotion of use of terminal methods with concentration on couples with 2 children and above;

(c) Increasing the use of male contraceptive methods;
(d) Increasing accessibility to reproductive health services;
(e) Improving the quality of family planning services;

(ii) Reduction in MMR through
(a) Increase in coverage of pregnant women with tsetanus toxoid, IIbA tables and other ante-natal care from the current level of 88% to 100% by 2000 A.D.,
(b) Increase in institutional deliveries (current level 32.9%) and domiciliary deliveries by medical and para medical personnel and trained traditional birth attendants (current level 27.3%) to 100% by 2000 A.D.,
(c) Improved referral systems for emergency obstetric care;
(d) Increase in accessibility to quality services for medical termination of pregnancies and for treatment of reproductive tract infections.
(iii) Reduction in IMR/CMR through

(a) Eradication of polio cases and deaths by 1988,

(b) Elimination of neo-natal tetanus by 1993,

(c) Elimination of measles deaths by 1998,

(d) Sustained universal immunization of children.

(e) Reduction in the incidence of diarrhoeal deaths by 75% and in cases by 60% by 2000 AD

(f) Reduction in acute respiratory infection deaths by 75% by 2000 AD

(g) Reduction in the incidence of low birth weight babies from the present level of 38% to 20% by 2000 AD

(iv) Objectives related to other Departments

(a) Increase in the female literacy level from the current 88%.

(b) Increase in the median age at marriage of females from the current 18.1 years.

(c) Reduction in severe and moderate malnutrition among women and children.

(d) Reduction in child labour among children up to 14 years.

(e) Social, economic and political empowerment of women.

Structures and Processes for Implementation

(1) Creation of Institutions at State Level

The Family Welfare Programme has so far remained a programme of the Family Welfare Department, with little involvement from political leadership, community leadership, and other departments. The result has been that it has achieved only a limited degree of success. If the programme
has to become a "people’s movement", as it must, demanding as it does, social change, then it has to be accorded the necessary status and authority.

A State Council for Population Stabilization will be set up, under the Chairmanship of the Chief Minister and with the Minister for Health and Family Welfare as Vice-Chairman. This council will have as its members the Ministers for Finance, Education, Women Development and Child Welfare, Panchayat Raj and Rural Development, Urban Development, Revenue, Social Welfare, Minority Welfare, Sports and GMEY, Information and Public Relations, Vice Chairman of Planning Board the Chief Secretary, related Department Secretaries and experts in population policy and management. Since population issues should be de-linked for party/political/denominational affiliations and consideration, leaders of all political parties and prominent religious leaders will be the special invitees to this Council. The youth, women and labour wings of all political parties can play an active and crucial role in supporting the governments’ population control programmes and representatives from these wings will also be invitees to the Council. The Cantele will formulate state policy, issue policy directives, guide and review performance, and mobilize support for the programme from all sections both within and outside the Government.

A State Population Stabilization Cell under the chairmanship of the Chief Secretary, with concerned Department Secretaries will also be set up to provide administrative support to the State Council, to ensure implementation of policy directives, to oversee formulation of integrated, intersectoral plans of action, and to regularly monitor and review performance.
Information, education, communication and publicity efforts for the programme must be greatly enhanced and strengthened for enhancing people's participation in the programme. At the State level, an institutional mechanism to direct and guide IEC efforts in the State will be put in place. A State IEC Bureau for Population Stabilization will be constituted merging the State Health Education Bureau in the Directorate of Health and the State Mass Education & Media Wing in the Commission of Family Welfare with professional/experts taken on contractual consultancy basis as representatives from the F & FR Department. This Bureau will be authorized to contract professional services for marketing the population stabilization programme at the State level. The Bureau will also make sustained efforts to promote and enhance counseling services through NGOs and community-based groups. It will utilize the services of all media of communication and enlist the support of various cadre unions and social groups to create a social environment for population stabilization. The Bureau will organize professional services for district-level IEC efforts, if required. The State IEC Bureau will be headed by a Civil Service Officer with experience in IEC.

Creation of Institutions at District and Mandal Level

A review of the Family Welfare Programme will show gross differentials in terms of demographic indicators. There are region-wise differentials - the Telangana Region shows the lowest demographic performance indices a CBR of 28 as compared to 33 of the Coastal belt, and a CPR of 41.1% as compared to the Coastal Region’s 56.5% District-wise differentials are similarly high. For example, the CBR ranges from 91.1 in Mahbubnagar district to 24.9 in Anantapur district to 20.4 in East Godavari.
district, and the CPR from 29.6% in Range Reddy district to 42% in Anantapur District to 63% in East Godavari District. This only underlines the need for a differential approach in the planning and implementation of the Family Welfare Programme. Even within a district, demographic, socio-cultural, administrative, infra-structural and geographical differentials obtain in given areas. Area-specific planning, implementation and monitoring should form the base and basis of the population stabilization programme.

Such an approach calls for delegation of authority and responsibility and administrative and financial flexibility and administrative and financial flexibility at the district level to allow for effective adaptation of the programme to localized needs. Accordingly, a District Society for Population Stabilization with be constituted. The Governing Body of the Society, under the chairmanship of the Chairman, District Development Review Committee, and with the District Collector as Vice-chairman, will have as its members the Chairman, Zilla Parishad, all M L As and M P.s, 10% of Mandal Praja Parishad Presidents, all Nagarpalika Chairmen, five representative Sarpanches, five representative DWCRA group leaders five representative youth leaders and the DM&HO. All concerned departmental officials, Municipal Commissioners, two NGOs, two social scientists/experts working in the health and family welfare sectors and representatives for fusional bodies shall be special invitees to the meetings of the District society.

The executive Body of the District Society, under the Chairmanship of the District Collector, will have the DM & HO as the ex-officio chief executive, and shall have as its members two M L A.s, one M.P., two ZPTC members, two Presidents of Mandal Praja Parishads, one Chairperson of
Nagarpalikas, Superintendent of the district hospital and Superintendent of one referral hospital, Project Officer, ICDS, Project Officer, DRDA, District Educational Officer, District Development Officer, District Co-operative Officer, District Public Relations Officer and NSS/Youth Co-ordinator. Two representative NGOs, and two eminent social scientists in the health/population fields shall be special invitees.

The District Society will be authorized to constitute a District IEC Cell for Population Stabilization to plan, implement and monitor IEC efforts at district and mandal level. The District Health Educator of the Directorate of Health and the District Education and Media Officer of the Commissionerate of Family Welfare will work together in this cell for co-ordinated IEC efforts. The District Society will be authorized to engage professional services on part-time/contractual basis to market population control programmes. Audience-Specific and need-specific scripts will be developed by the IEC cell, in particular to address resistant communities such as fishermen, certain B.C. Communities, parents-in-law and so on. This Cell will function under the control and direction of the Executive Body of the District Society at the district level and under the State IEC Bureau at the State level.

The District Society will function under the administrative control of the Directorate of Family Welfare, which will have the powers of appointment of the chief executive as also conduct of audit of the accounts of the Society through appropriate mechanisms.

For micro-level planning, implementation and monitoring, the District Society will be authorized to constitute Mandal/Nagarpalika Committees.
under the Chairmanship of the Mandal Praya Parishad President/Nagarpanika Chairman with suitable official, non-official and community representatives as members. The Mandal/Nagarpanika Committees will constitute suitable Gram Panchayat / Ward Level Committees.

At present, the Family Welfare Programme is entirely funded by the Government of India. The State will contribute additional amounts, as required, from its own resources for this vital programme.

In order to enable the District Society to effectively plan, implement and monitor area-specific schemes and programmes, it should be given adequate flexibility in the administration of the programme and in the utilization of funds. Each society will have a District Population Stabilization Funds consisting of:

(a) Plan funds, excluding salaries,
(b) Government grants,
(c) Funds earmarked for the purpose from assigned taxes/grants/devolution made to local bodies,
(d) Grants from donor institutions;
(e) Resources mobilized from the corporate/Cooperative sector;
(f) Voluntary contributions from philanthropists, both within and outside the country.

Except for plan funds and funds earmarked for specific purposes/schemes, the Society will have flexibility in the utilization of funds. The
detailed annual budget of the Population Stabilization Fund based on the District Action Plan will be approved by the Governing Body

**Delivery Mechanisms at District Level**

At the district level, the administrative leadership for the programme will vest with the District Collector. The emphasis will be on implementation of a District Action Plan for Population Stabilization, through area-specific interventions, schemes and programmes, and through improving the delivery system and the quality of services. This will be achieved through

(a) A scientific district planning and monitoring exercise, based on a sound database;

(b) A regular system of inspections up to village level by designated officers to ensure availability and accessibility of quality services,

(c) Ensuring availability of medical and paramedical manpower wherever required in the district,

(d) Area-specific project planning and monitoring, with special plans for remote/tribal areas/urban slums/low-performing areas,

(e) Upgrading technical, management, communication and counselling skills of personnel involved in the programme through regular in-service training programmes,

(f) Ensuring adequate accommodation, supplies of drugs, equipment and other essential material in order to empower personnel to deliver quality service,

(g) Ensuring inter-sectoral co-ordination to facilitate convergence of services at the grass-root level;
(h) Increasing outreach and community participation through involvement of elected and social leadership groups, particularly panchayats, nagarpalika, NGOs, women and youth organisations,

(i) Launching an IEC campaign for population stabilization on the lines of the Total Literacy Campaign and the Pulse Polio Immunization Campaign

Mechanisms to facilitate the effective implementation of the District Action Plan, delivery of quality services and to promote an enabling environment are as listed below.

The family will be the focus for population stabilization measures. Joint responsibility of the couple in reproductive and child health issues, particularly family planning, will be promoted, mainly through elected and community leadership and inter-personal counselling services. Male sterilization currently accounts for only 6% of total sterilization. The male health worker and youth associations will be drawn into the programme to motivate men to undertake vasectomy/adopt the condom method where family limitation is desired. Public opinion will be moulded to support this stand through text books, media, elected and community leadership.

Panchayat/Nagarpalika and Mandal

The Mandal Population Stabilization Committee will encourage each gram panchayat/nagarpalika to prepare a Panchayat/Nagarpalika population Stabilisation Action Plan, which will specify the demographic goals and the
expected levels of achievement annually and a charter of social actions for achieving population stabilization, arrived at after consensus within the community. The action Plan will specify the actions to be taken to achieve the goals within a definite time frame. The charter will list out the actions proposed by the community to address the issues of early marriage, girl child education, skill formation/income generation for adolescent girls, female literacy, female infanticide, elimination of the practice of dowry and so on. The Mandal Action Plan will be formulated based on gram panchayat/nagarpalika plans and will include specific interventions for improving the quality of services. The technical and financial support required for implementation of the Action Plans will be made available through the District Population Stabilisation Society.

District

The District Population Stabilisation Society, through its Executive Body, will formulate the District Action Plan, specifying the district demographic goals to be achieved and the expected levels of achievement annually, indicators for improving the quality of service delivery and a charter specifying the social actions for population stabilisation to be implemented within a definite time-frame. It will ensure that the District Action Plan takes into account area-specific demographic, health, socio-economic and socio-cultural indicators, with special strategies to tackle low-performing areas. There will be appropriate and corresponding linkages between the panchayat/nagarpalikas, Mandal and District Action Plans and monitoring of their implementation will be through the District Population Stabilization MIS. The Society will institute community incentives/prizes for
good performance, based on simple measurable parameters. The Society will ensure the convergence of services at the cutting edge level. It will evoke the wholehearted participation of the people for the programme through communication management, marketing skills and leadership motivation. The technical and financial support for implementation of the District Action Plan will be made available through the District Society.

**Improving Quality of Services**

The essential ingredients for quality in service delivery are as follows:

(a) Availability of medical and para-medical personnel in the required places at the required times.

(b) Adequate technical and management skills and a degree of commitment and anew amongst personnel delivering family welfare services.

(c) An enabling environment for quality services in terms of adequate infrastructure, essential equipment and sufficient supplies of drugs, dressings and other materials.

(d) Community participation in the programme.

One of the major problems plaguing the effective implementation and quality of the Family Welfare Program is the non-availability of Medical Officer, MPHAs and staff at their places of posting and a lack of access to services. Several solutions to this problem have been advanced in a piecemeal manner from time to time, but the problem still begs a solution. The suggested solution range as under
(a) Providing rent-free accommodation at all PHCs and Sub-Centres,
(b) Providing a female helper to the Multipurpose Health Assistant (MPHA),
(c) Allowing for posting of MPHA’s at their native places,
(d) Separating recruitment for Primary Health Service from secondary and tertiary health services and enacting legislation to make primary health service a special category service, with provision of better salaries/perks and service penalties like dismissal for absence from duty,
(e) Handing over the administration and management of the primary health care system to local bodies which will facilitate local recruitment and local control,
(f) Handing over management of Primary Health Centres in remote areas to NGOs;
(g) Restricting appointment of PHC Medical Officers to MBBS degree holders only;
(h) Instituting a separate course of three years recognized by the Medical Council of India for primary health care and practice,
(i) Prescribing a minimum rural PHC service of six months during internship,
(j) Allowing for contract service in rural and tribal PHCs, which service will count for preference in appointment to government service and in admissions for higher studies.
The solution to this problem will have an immensely positive impact on the delivery and quality of the population control and health care programmes in the State. An Expert Committee will be constituted to recommend the solution to the problem and implementation will be within a specific time-frame. In the meantime, the District Society will be authorized to provide the services of specialists, doctors and paramedical staff on contract basis or through NGOs/Women's groups, wherever required, provided that such persons have the qualifications prescribed for such posts. The District Societies will also be permitted to implement pilot projects, for making MPHAs/village nurse midwives services available in remote villages/habitations through NGOs/Women's groups on a self-employment basis, i.e., through charging user's fees as decided by the community.

Any programme is only as good as the personnel managing it. Technical skills, management skills, communication and counselling skills and attitudinal changes are essential for programme managers, field functionaries and staff involved in the delivery of population control programmes. Simultaneously, the skills of NGOs, elected representatives, community leadership groups and opinion-makers are also to be developed to ensure effective community participation in the programme. Financial allocations will be made for this purpose.
Kerala and Tamil Nadu have already achieved most of the goals set for 2000 A.D. The fall in birth rate in Kerala is mainly due to

(a) Female literacy,
(b) Access to health and family welfare services,
(c) Storing political and community commitment,

Similarly in Tamil Nadu, the fall in birth rate is ascribed to

(a) Sustained political commitment,
(b) Improved access to maternal and child health services,
(c) Improvement in women’s status through education and employment

To all intents and purposes, Andhra Pradesh seems set to achieve the goals set for 2000 A.D. However, given the implications of a slow fertility decline and the fact that neighbouring Kerala and Tamil Nadu have already achieved most of the goals set for 2000 A.D., it is well that we set our goal higher and attempt to reach the targets set for the country before 2000 A.D.

In the short-term, the State will aim at reaching the All-India demographic goals set for 2000 A.D., and in the long-term, it will aim for a Kerala-like situation where the third stage of demographic transition has been reached—low population growth rate with low fertility and mortality.

There are 175 Community Health Centres (CHC), 1837 Primary Health Centres (PHC) and 10,568 Sub-Centres (SC) in the State. Consolidation and operationalization of this extensive network is a priority for delivery of quality services. This can be achieved through.
(a) Completion of buildings for the centres and staff quarters,
(b) Provision of essential equipment,
(c) Ensuring supply of essential drugs, dressings, and other materials,
(d) Ensuring mobility for PHC medical officers and MPHAs,

The required financial allocations will be made

Specific Operational Strategies

i. Promotion of Terminal and Spacing Methods

The proportion of terminal methods users in Andhra Pradesh is one of the highest in the country (8 per 1000 as compared to Tamilnadu’s 6 Kerala’s 4 per 1000). Terminal methods remain the preferred method of contraception the NFHS reveals that a large majority (91%) of women in the State who intend to use a method in the future prefer sterilisation. Despite the high use of terminal methods, the birth rate in the State continues to be high. One of the reasons is that over 60% of terminal method users are couples with parity 3 and above, and the Family Planning Programmes, in pursuit of targets, has not emphasized a parity-based approach. The NFHS also reveals that male contraceptive users account for only 15.7% of current contraceptive use. 14 2% of couples underwent vasectomy and 15% use condoms. In view of the lower risk and complications associated with vasectomy as compared to tubectomy, and the need for greater male involvement in responsible reproductive behaviour, the programme must emphasize male sterilisation also. The strategy, therefore, in respect of terminal methods will be to:
(a) Increase focus on couples with parity 2;
(b) Ensure reduction of births occurring to women with parity 3 and above,
(c) Promote vasectomies to account for a minimum of 30% of total sterilisations by 2000 AD,
(d) Enhance the role of private medical practitioners in promoting terminal methods,
(e) Launch an intensive clinical skills training programme for government doctors and PMPs in the "Double-puncture" laparoscopy and "no-scalpel" vasectomy techniques,
(f) Target those couples who are likely to have more children in an attempt to have sons with the introduction of the gnu child scheme 
the only daughter or one of two children of a couple adopting sterilisation will get a series of monetary benefits until she is 20 years old and will get a lump sum amount when she is 20 years old, provided she remains unmarried until 18 years

The proportion of spacing method users in Andhra Pradesh is one of the lowest in the country. 4% of total contraceptive use. While knowledge about sterilisation is widespread in the State (97% of currently married women), knowledge of the officially sponsored spacing methods, the IUD, the pill and the condom is far less widespread: 44%, 54% and 42% respectively. For promoting spacing methods, the strategy will be to:
(a) Launch an information campaign on spacing methods,

(b) Ensure proper screening procedures before IUD insertion and monitor retention levels building in checks in the MIS and through women's groups,

(c) Enhance the role of PMPs in promoting spacing methods,

(d) Associate ISM practitioners in promoting spacing methods;

(e) Increase access to condoms and oral pills through social marketing, the public distribution system and community-based distribution systems,

(f) Target newly weds with a gift of condoms on their wedding day with a letter from the District Collector congratulating them and explaining the need for spacing children,

(g) Enhance inter-personal communication and counselling service through NGOs and community leadership groups.

Targets for both terminal and spacing methods have so far been fixed by the State and communicated to the district for implementation. This top-down system has not only resulted in inflated reporting, particularly in respect of spacing methods, but has also affected quality of services. Targets will, in future, be fixed from the Panchayat/Nagarpalika upwards, in consultation with the grass-root level worker and the community. The targets so fixed will form the basis for the Mandal and District Action Plans.

ii. Safe Delivery

In Andhra Pradesh 33% of deliveries are institutional and 66% are home deliveries. In Kerala 86.7% and in Tamilnadu 48.7% of deliveries are institutional. The level of institutional deliveries has a direct bearing on
MMR & IMR and an inverse relationship with the birth rate. The State's goal by 2000 AD will be to increase the percentage of institutional deliveries and by trained personnel of 100% through

(a) Converting 450 Primary Health Centres as Primary Health cum Women Health Centres where 24 hour delivery service will be available by positioning one gynecologist and two staff - nurses in each centre through regular posting/contract appointments,

(b) Ensuring that there is a minimum of one trained birth attendant in every village,

(c) Improving back-up referral services for emergency obstetric care;

(d) Conducting mother and child health clinics in each village on a fixed-day basis,

(e) Instituting a fund in remote/hard-to-reach villages on a declining matching basis with the community to be used for transporting women in emergency situation, for group insurance for high risk cases and for health kits for monthly mother and child health clinics;

(f) Conducting a health clinic for pregnant women, mothers and children in every village once a month with the female health worker, anginoid worker and community leaders;

(g) Increasing participation of private medicar institutions in promoting institutional deliveries,

iii. Safe Abortion (Medical Termination of Pregnancy)

The 1971 Medical Termination of Pregnancy (MTP) Act was a landmark piece of social legislation. But it has so far failed to translate itself
into a reality for most women, especially in rural areas, as MTP services are thinly spread at district hospitals and a few Community Health Centres. It is estimated that there are ten times as many illegal abortions as legal abortions in a year. Unsafe abortions are estimated to account for 15% of maternal mortality. Unmarried adolescents constitute a sizeable proportion of abortion seekers and most of them often delay their abortion dangerously, because of ignorance of fear of social stigma. Safe management of unwanted pregnancies supplements family planning efforts as most women who undergo MTP accept one of the contraceptive methods. Widespread MTP services are clearly desirable because of their favourable demographic and reproductive health impacts. The state will attempt to improve services relating to the prevention and management of unwanted pregnancies through:

(a) Launching of an intensive MTP training programme for government doctors and private medical practitioners;

(b) Expansion of MTP services through the primary health care system by equipping Community Health Centres and 450 selected PHCs with the required infrastructure, equipment and supplies;

(c) Expansion of MTP services through notified private medical practitioners;

(d) Instituting counselling services at the Primary Health Centre through training of staff nurses/lady health visitors to inform and support adolescents and women who seek this service;

(e) Enhancing the role of NGOs and community leaders in IEC and counselling services for safe abortions through training and supporting NGO and community efforts in this area.
iv. RTI/STD Prevention and Management

IUDs have only recently made a foray into the State’s population programme. Insertion of a IUD when RTI or STD is present, substantially increases the risk of ectopic pregnancy, infertility, a serious aggravation of the condition and so on. RTIs and STDs can also adversely affect child survival by causing pre-term delivery of low-birth weight babies, or by causing infections during delivery. The need to provide for RTI/STD screening/treatment is essential in this context. The state will seek to provide this service through

(a) Making available the services of female gynecologists at the 450 primary health centres designated as Primary Health cum Women Health Centres thorough regular posting, or through contract appointments,

(b) Improving back-up referral services in the secondary health sector;

(c) Enhancing the role of NGOs, women’s groups and youth groups in reproductive health education for preventing and recognizing RTIs/STDs, with a special focus on adolescents,

(d) Including reproductive health and population issues as a subject at secondary school level.

v. Age at Marriage

The median age at marriage of female in Andhra Pradesh is 16.1 years. In Tamilnadu it is 18.1 and in Kerala it is 19.8 years. More than three-fourths of rural women aged 20-24 have married below the legal age of 18.
years Perhaps the most striking feature of current fertility in the State is the substantial contribution of women aged 15-19 to the total fertility rate 28%. Concerted efforts to educate and motivate people are necessary, not only to reduce current fertility rates, but to reduce the risk associated with early child bearing.

Amongst other things, male attitudes have a great bearing on age at marriage in Kerala, the male demands that his prospective bride has passed intermediate, if not graduation. Increase in age at marriage is possible only through a change in value systems. The State will seek to bring about such social change through:

(a) Effective use of media, particularly Doordarshan, cable TV and AIR for intensive publicity on adverse effects of early marriage and pregnancy,

(b) Introduction of the girl child scheme to delay the age at marriage,

(c) Involvement of political leadership, women's groups/non-governmental organisations and community leadership groups to promote attitudinal change, particularly among male youth, parents and elders,

(d) Promotion of girl-child education through state awards and community incentives for panchayats/nagarpalikas/districts which achieve full enrolment, retention and completion of school education by girl children;

(e) Promotion of self-employment and skill development programmes for adolescent girls,
(f) Intensive promotion of female literacy programmes through the Total Literacy and Post Literacy Campaign;

(g) Introducing legislation for compulsory registration of marriages

vi. **Female Literacy**

There is a wide disparity between male literacy rate (55.1) and female literacy rate (33.7) in Andhra Pradesh. Fertility and contraceptive prevalence are greatly influenced by the literacy levels of women. The TFR for illiterate women in Andhra Pradesh is 2.9 as compared to a TFR of 2.1 for literate women. The infant mortality rate in the state declines sharply with increasing education of women from a high of 80 per 1000 live births for illiterate women to a low of 36 per 1000 live births for illiterate women to a low of 36 per 1000 live births for illiterate women to a low of 36 per 1000 live births for women with high school education. Increasing education levels of girls and women will not only reduce fertility but infant mortality as well. In these circumstances, the following options will be considered to increase female literacy rate

(a) Legislation on compulsory primary and secondary education,

(b) When a body is admitted to school, obtaining a certificate from the parents that there is no girl child of the school-going age in the family not enrolled,

(c) Establishment of exclusive schools for girls wherever required,

(d) Establishment of creche centres/Balwadis near primary schools to free girl children of the "child care" chore;
(a) Allowing for flexibility in the system to adapt to local needs for example, flexibility in timings (a shift system) to enable girl children to attend school,

(f) Ensuring parental involvement through effective functioning of the Parent Teacher Associations and the School Committees,

(g) Ensuring a more intensive focus on women in the Total Literacy and Post Literacy Campaign,

(h) Formulating District Action Plans for girl child education and female literacy specifying annual targets and strategies, with the District Collector in Charge of implementation,

(i) Instituting State awards and community incentives for panchayats/ nagarpalikas/ districts which achieve girl-child education/ female literacy targets.

vii. Survival of the Child

Population policy must necessarily emphasize programmes and activities directed towards the survival and development of the child. One in every 14 children dies within the first year of life and one in every 11 children dies before reaching age five in the State.

Infant and child survival and health strategies which will be given greater focus are

(a) Promotion of institutional deliveries and safe delivery practices through trained birth attendants,

(b) Increasing average minimum birth weight of children to 3 kg by improving nutritional status of the mothers;
(c) Elimination of poliomyelitis, neonatal tetanus and measles deaths through 100% immunization coverage,

(d) Ensuring 100% knowledge and increased use of oral rehydration salts and safe drinking water in the management of diarrhoea through specific campaigns and interventions,

(e) Ensuring that all parents have knowledge in the control and management of Acute Respiratory Infections through regular IEC and special campaigns;

(f) Eliminating micro-nutrient deficiencies vitamin A deficiency, iodine deficiency and iron deficiency through 100% coverage of children with Vitamin A, coverage of all anaemic children with IFA and universal use of iodised salts;

(g) Reducing severe and moderate energy-protein malnutrition among children by enhancing knowledge on correct infant feeding practices and improving coverage under nutrition support and supplementation programmes,

(h) Making all hospitals and maternity centres "baby-friendly";

(i) Instituting effective mechanisms for reduction of child labour

Strategies for child survival and development require a co-ordinated and convergent programme of action involving various sectors, in particular, health and nutrition. The ICDS nutrition and family welfare programmes will be implemented with increased and more effective co-ordination for improved service delivery.
Other sectors involved in child survival and development are education, water supply, sanitation and social welfare. A State Programme of Action for the Child, specifying the targets to be achieved by 2000 A.D. has been prepared. This will form an integral part of the population stabilization programme for the state. At the district level, a similar programme of action will be formulated by the District Society for integration into the District Population Stabilization Programme.

Reproductive behaviour stems to a great extent from deep-seated social, religious and cultural values and attitudes. The population stabilization programme which seeks to bring about a change in attitudes and behaviour has to become a social movement. It has to be perceived as a programme that benefits the people and not a government programme. NGOs can play a vital role in this social movement, as they are geographically and culturally close to the community they serve. The state will endeavor to enhance the participation of NGOs in the population stabilization programme through the following initiatives:

(a) Creating an Apex Society to encourage, organize, train and fund voluntary action for population stabilization;

(b) Preparing a basket of schemes for population stabilization for NGOs and disseminating the schemes widely through the print and the electronic media,
(c) Organizing training programmes for NGOs in project formulation, programme management, monitoring and sustainability and for officials in supporting voluntary efforts for better integration of government and NGO activities,

(d) Improving systems for sanctioning, monitoring and evaluation of NGO projects,

(e) Instituting a scheme through the District Society to fund local bodies which desire to hand over management of PHCs/Subcentres to NGOs in remote/tribal areas which are inadequately served,

(f) Encouraging NGOs working in other sectors to include population stabilisation as part of their activities

ix. Information Education Communication

The NFHS reveals that while 97% of eligible couples are knowledgeable about family planning in Andhra Pradesh, only 47% practice contraception. This gap between knowledge and practice can be bridged through Information, Education and Communication. IEC efforts will have to be given a new thrust and direction in order to have the necessary impact on the targeted audience.

AIR, Doordarshan and other TV channels will be used much more effectively, and population programmes put on these networks at specific times for targeted audience segments, as is being done currently for agriculture. Messages on population control and related social messages will be aired at prime time, and if required, legislation to ensure such slots will be considered.
Since cinema remains an effective means of communication, population stabilization programmes will be marketed through this medium creatively and effectively.

The emphasis and focus in IEC will be on the family and equally on men and women, to promote responsible reproductive behaviour amongst both.

Curricula at various levels of the education system, formal and non-formal, will include population and reproductive health issues.

The identification of family planning with sterilizations has resulted in a negative image for the programme. IEC efforts will emphasize and market issues such as higher age at marriage, delaying first birth, increasing birth spacing, increasing female literacy, increasing male responsibility in reproductive behaviour and the desirability of having a planned family.

x. Social Marketing

The social marketing programme which was originally launched for Nirodh has shown the important and significant role that giant consumer goods/pharmaceutical industries and oil companies can play towards achieving family planning objectives. The corporate sector has a huge untapped capacity for involvement in this area of vital social concern. It will be the State’s endeavor to motivate as many industries as possible to extend their expertise, their organisation, management and marketing capabilities for social marketing, publicity and programme management.

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In recent times, marketing agencies for the exclusive marketing of contraceptives and ORS have come into being in the northern States. These agencies have their own brand, superior packaging, differential pricing, distribution network and promotional strategies which are proving to be successful. The State will endeavor to encourage and motivate private enterprise along this route, including marketing of condoms through condom-vending machines.

The State is already attempting the marketing of condoms through the Public Distribution System in a few selected districts. This attempt will be intensified to include marketing through local kirana shops, pan shops, barber shops and so on, particularly in backward areas with low population density, where low volume of sales will deter social marketing agencies. Community-based distribution systems in difficult, hard-to-reach areas will also be attempted.

Community & individual incentives will be instituted to enhance awareness and to motivate participation in the programme.

a. **Community Incentives**

   The following community incentives are proposed:

1. Incentives at Gram Panchayat level in each district for such Gram Panchayats which exceed protection of couples under Family Welfare Programme beyond a fixed percentage, say 60%, will be instituted. Such incentives will be provided in the shape of additional works,
school buildings, etc, and by setting apart a portion from the overall funds available under schemes such as JRY, EAS, RWS, etc, for this purpose will be considered.

Every village which achieves the performance level as described above will also be selected for full coverage under schemes under schemes such as TRYSEM, Low Cost Sanitation Scheme and Weaker Section Housing Scheme. For this purpose, a portion of sanctions under the Weaker Section Housing Scheme in each district will be earmarked to be sanctioned by the District Collector as per the above preferential norms.

Preference in funding of DWCRA groups will be given on the basis of 100% ante-natal coverage of women members and 100% immunization of their children and on the percentage of eligible couple-members who are protected under the Family Welfare Programme. Similar preference in funding will be considered for other social groups based on their participation in the Family Welfare Programme.

At the State Level a Rolling Shield will be instituted to be given to the best performing district each year under the Family Welfare Programme. Similarly, at the district level rolling shields will be instituted to be given to the best performing Primary Health Centre and at Mandal Level for the best-performing Gram Panchayat

b. Individual Incentives

Special incentives to generate awareness amongst resistant/focus groups regarding the Family Welfare Programme will be instituted
An award of Rs 10,000/- each to 3 couples per district in each of the following categories to be selected by lucky dip will be given on World Population Day in the capital city of Hyderabad

(a) Three couples per district with 2 girl children adopting permanent method of family planning,
(b) Three couples per district with one child adopting permanent method,
(c) Three couples per district with 2 or less children adopting vasectomy,

Similar special prizes to acceptors of permanent methods with two girl children, or one child, or under vasectomy method will be given at district level and mandal level with local contribution.

Since there is insecurity regarding child survival in the minds of parents, which in turn, contributes to parents having more children, Government will examine the possibility of introducing a scheme to give Health Insurance Coverage to the children of acceptors of permanent methods of sterilization (white card holders only) with one or two children.

In the sanction of individual schemes, all eligibility criteria being fulfilled, preference will be given to acceptors of sterilization with two or less than two children, in schemes such as assignment of land, allotment of surplus agricultural land, assignment of house sites, and houses, IRDP, SC Action Plan, BC Action Plan, TRYSEM, PMRY CMYEP and other similar schemes, in the following order of priority.

(a) Acceptor with two girl children;
(b) Acceptor with one child adopting vasectomy;
(c) Acceptor with one child;
(d) Acceptor with two children adopting vasectomy;
(e) Acceptor with two children
c. **Incentives for service providers**

A Chief Minister's Gold Medal for the best service providers in the following categories to be awarded on World Population Day will be instituted

(a) District Medical & Health Officer;
(b) Medical Officer,
(c) Mass Media Functionary,
(d) Female Health Supervisor,
(e) Female Health Worker;
(f) Male Health Worker,
(g) NGO for innovative strategies

Similar awards will be initiated at district and mandal level which will be presented on World Population Day

In order to motivate team work amongst primary health staff, incentives in the shape of cash awards will be given each year to a team of service providers who have achieved a performance level which is above a prescribed minimum standard.

Government expects that its employees should serve as role models and that they must give the lead in adopting the two-child norm. Government will accordingly examine the desirability of limiting incentives such as LTC and educational concession for the first two children only. Govt. will also examine the desirability of restricting family planning incentives to all acceptors of sterilisation, including Govt. employees, to an equal, one-time benefit. Government will explore the possibility of modifying the service rules and promotion policies such that the adoption of the two-child norm is encouraged.
xii. Monitoring and Evaluation

A sound data base is essential for scientific planning, implementation and monitoring, both at macro and micro level. An effective District Population Stabilization MIS will be built into the District Health and Family Welfare Information System, supported by concurrent evaluation and sample survey systems. The District MIS will be effectively linked to the State level network for timely monitoring and action. The District MIS and the link-up will be made operational within a definite time-frame.

A part from quantitative indicators, qualitative indicators on quality and outreach of care will also be developed and implemented within a specific time-frame. Concurrent evaluation on quality of care will be regularly undertaken.

State-level institutions and Medical Colleges will be entrusted with the responsibility of concurrent evaluation of family welfare programmes and monitoring of side-effects and contraceptive failure.

Regular sample surveys, will be undertaken through the State Statistical and Family Welfare Departments, and independent agencies using a uniform format and a proper manual, for updating/validation of demographic data.
Research will be an ongoing component of the programme. Socio-demographic and operations research will provide the programme much-needed support in terms of newer interventions, better management and improved service delivery. Testing and validation of commonly held hypotheses like the relationship between IMR and the fertility rate, between CBR and CPR must be undertaken to support planning efforts.

Currently, there is no institutional mechanism at state level to direct and co-ordinate research efforts in this field. The state will constitute a Research Cell in the Indian Institute of Health and Family Welfare with representatives of Health and Family Welfare Institutes dealing with training and research, Population Research Centres and Population Development Study Centres attached to Universities, as also well-known national and state experts in the fields of demography, epidemiology, health/population management and communication as members. The Director of the Indian Institute of Health and Family Welfare will be the Chief Co-ordinator of the Cell. Funds earmarked for research in various externally-aided projects in the Health and Family Welfare Department will be pooled and placed with the Research Cell. Such an arrangement will eliminate duplication of research efforts and facilitate co-ordinated and focussed action in this area.
xiv. Role of leadership in the Population Stabilization Movement

While the Government bears the primary responsibility for promotion of population stabilization programmes, any endeavor that requires social change is dependent upon the support of political, religious and community leadership. It will be the state's endeavor to motivate and mobilize support for the programme through

(a) The people's elected representatives who will be involved at all levels in policy formulation, implementation and monitoring

(b) Other leadership groups, i.e., Associations of Professionals, Trade and Industry, Journalism and NGOs,

c. Medical professional bodies: the Indian Medical Association, the National Academy of Science, the Indian Academy of Paediatrics, Federation of Obstetricians and Gynaecologists, Indian Association of Preventive and Social Medicine to name a few

d. Practitioners of Indian Systems of Medicine;

(e) Cadre of teachers;

(f) The organized sector: the management, the labour and the trade unions

g. Chambers of commerce and industry,

(h) Co-operatives
1) Youth: NSS, NCC, Nehru Yuva K Kendra, Youth Clubs and Assenting youth wings of political parties.

2) Women: DWCRA groups, Mahila Mandal, Women's Associations, women wings of political parties.

3) Civil besides guild.

For each of these groups, meetings seminars/workshop, and in some cases, training programmes will be organised, and their role in the programme clearly defined. In order to underline the importance Government attaches to the programme and to enlist the full co-operation and support of these leadership groups, members of the State Council for Population Stabilisation will participate in the sessions with each of the groups.

CONCLUSIONS

The success of the programme is ultimately in the hands of the people, in their determination to create a better present for themselves and to forge a better future for their children. It will be the State's endeavor to provide the requisite leadership through political will, to ensure effective delivery of the programme through an efficient administration, and by these efforts to generate the necessary community commitment and momentum that will transform the population stabilisation programme into a people's movement.