Government Policy
CHAPTER-4

GOVERNMENT POLICY

(A) GOVERNMENT POLICY REGARDING POPULATION GROWTH

India, the second most populous country of the world, with more than a billion persons by May, 2000 (according to preliminary result of the 2001 census, India counted 1.027 billion people on 1 March, 2001) was the first to initiate a government policy of promoting a family planning programme in 1952.

At the beginning of the 21st Century, it is time to review our post record on population, the recently announced national population policy 2000 (NPP 2000), and the population policies announced by the three states of Andhra Pradesh, Madhya Pradesh and Rajasthan.

**Concept of Population Policy : (Before Independence)**

The size of population, its characteristics, spatial and rural urban distribution, rate of growth its determinants decide the quantum pattern and distribution of consumption and production. It is therefore, only natural for the state or the government to be concerned about population. Such concern is most essential for a complex democratic society seeking to eradicate poverty and ensure adequate standards of living for its people of course, even an authoritarian leader must
consider the actual or potential supply of workers, the requisite equipment and the consumption needs of people\textsuperscript{1}. Therefore, the three determinants of population change—birth rate, death rate and migration to or from a territorial unit.

A policy is defined as statement of important goals, accompanied by a specified set of means to achieve them. A well elaborated set of means constitutes a programme\textsuperscript{2}. A good policy has to be based on a sound theory linking the mean with the ends, although on social issues it is often likely to involve an element of judgment about the connection between inputs and outcomes or the process.

The choice between alternative policies has to be made not just in terms of their prospective contribution to the achievement of goal but also their legitimacy, cost potential popularity and, among other things, effect on other goals, there is a temptation to make it into a comprehensive development plan. Population policy could easily be drowned in an elaborate framework. However, a flexible, board framework is certainly imperative.

**Evolution of India's Population Policy**

In case of several other developing countries, the India concern

\textsuperscript{1} www.india-seminar.com/2002/511/511 Pravin Visaria.htm
\textsuperscript{2} Pravin Visaria and Leela Visaria 1999. 'India's Population : Its Growth and Key Characteristics'.

[87]
about the relatively high level of fertility or the number of children born Indian women rather than the rate of population growth, reflected a genuine desire to improve the living standard of the people. It was not imposed from abroad.

The Indian leadership had been exposed to the development in Western Countries and did not want India to lag behind. During the 1920's and 1930's, some pioneers had set up family planning clinics in Poona and Bangalore. In the 1940's the Bhore Committee on health survey and development (1946) an the subcommittee on population set up by the National Planning Committee (1940) favoured the involvement of the government in the promotion of family planning.

Not surprisingly therefore, the memorandum submitted by the family planning association of India, set up in 1949 under the presidency of lady Dhanvati Rama Rau, elicited a favourable response from the planning commission. The health panel chaired by health minister Rajkumari Amrit Kaur had appointed a sub-committee on population growth and family planning. R.A. Gopalswami, the census commissioner in charge of the first census of independent India, was its convener. There were differences of opinion.

The health minister insisted that no contraceptives should be

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3 Government of India, National Sample Survey Organization.
used. But prime minister Jawaharlal Nehru supported a more flexible approach and also the idea of state action to promote family planning. It was because of the report of this sub committee that in 1952 India became the first developing country in the world to adopt a policy of governmental effort to promote a reduction the number of children born to Indian couples.

The early concept of population policy covered both mortality and fertility and did not exclusively focus on fertility. There was also a recognition of the need to improve the quality of life of the people by lowering the burden of disease or morbidity, promoting universal primary education and eradicating illiteracy exploitation and poverty.

A separate department of family planning was setup in the ministry of health during the fourth five year plan period. Around the same time, a 'time-bound' target of reducing the crude birth rate from about 39 to 25 per 1000 population in 10 to 12 years was adopted.

In practice, it has been a moving target and was not, achieved even by 1999, the last year for which estimates of birth and death rates are available from the sample registration system setup in the 1960s. A working group on population policy, setup by the planning commission, recommended in 1980 an unrealistic goal before the

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5 The Report of the Commissioner for Family Planning.
country.

A net reproductive rate (NRR) of 1.0 by 1966 as a national average and by 2001 in all the states.

In the 1980s, prime minister Rajiv Gandhi initiated an effort to revise the strategy of the family welfare programme, but little came of it. In 1922, the Karunakaran Committee, setup by the National Development Council (NDC) partly in response to the 1991 census results, recommended the formulation of a national population policy. A draft prepared by an expert group under the chairmanship of M.S. Swaminathan in 1994 was circulated widely and its successive variants were considered by the cabinets of three different coalition governments. The draft underwent several revision until finally the NPP 2000 was announced by the present government in February after its approves by the cabinet. The policy is now expected to be discussed in parliament so that a board political consensus can be evolved on the subject.

In the meanwhile, the state government have began to follow the suggestion of the Swaminathan group to formulate state level population policies. Even before the expert group was setup to prepare a draft of the national population policy, the government of Tamil Nadu had formulated a 15-point programme for child welfare, to improve the
health and nutrition of women and children in the state.

The programme had incorporated in it the goals relating to infant and child mortality and the birth and death rates. Very recently, Uttar Pradesh also drafted a population policy. These state level population policies are expected to help the department of family welfare in the states to mobilize greater effort towards population and related programmes.

**A Brief History If India's Population Programme : 1947-1997**

The subcommittee on population, appointed by the national planning committee setup by the president of the Indian National Congress (Pandit Jawaharlal Nehru), considered family planning and a limitation of children essential for the interests of social economy, family happiness and national planning. The committee recommended the establishment of birth control clinics and other necessary measures such as raising the age at marriage and a eugenic sterilization programme.

The health survey and development committee (Bhore Committee) reported that the control of disease and famine and improvement of health would cause a serious problem of population growth. It considered deliberate limitation of births desirable.

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6 *Ino change India News & Feature Development News on Population in India.*

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In 1951 the draft outline of the first five year plan recognized 'population policy' as 'essential to planning' and 'family planning' as a step towards improvement in health of mother and children.

In 1952 the first five year plan, when India became independent, population growth was seen as a major impediment to the country's socio-economic development and population 'control' was seen as integral to the development process. Population growth was seen as an urgent problem related to economic development with limited resources. While an improved standard of living would eventually lead to a reduction in the birthrate, this would take, family planning would benefit both individual families as well as women's health (This tone continues even today The National Population Policy 2000 notes: "Stabilizing Population is an essential requirement for promoting sustainable development with more equitable distribution")

The final first five year plan document noted the 'urgency of the problems of family planning and population control' and advocated a reduction in the birth rate to stabilize population at a level consistent with the needs of the economy. In 1952, a sub-committee appointed by the planning commission asked the government to provide sterilization facilities and contraceptive advice theory existing health service, in

7 Government of India, NPP 2000.
order to limited family size and also institute studies on population.

While one committee member felt a government birth control programme should provide birth control appliances and literature free of charge at every health centre, the dominant view resisted efforts to promote birth control actively.

In 1956 the second five years plan proposed expansion of family planning clinics in both rural and urban areas and recommended a more or less autonomous central family planning board, with similar state level boards.

In 1961, the third five year plan envisaged the provision of sterilization facilities in district hospitals, sub divisional hospitals and primary health centres as a part of the family planning programme. Maharastra State organized 'sterilization camps' in rural areas.

In 1961 census, the population had grown from 361.09 million to 439.23 million in the decade since the previous census - a growth of 21.64% compared to earlier decennial changes between 11 and 14.22 percent8.

By this time, the Mysore population study looking at factor influencing family size preference, had identified some areas in which

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the programme was going wrong. Some of the findings: people had large families partly because they wanted sons.

In 1964, the reorganized family planning Programme recognized that people's decisions on reproduction are influenced by many social, educational health, economic, religious and cultural factors. It spoke of people's participation in formulating and implementing a policy the benefits of which go to them.

The director of family planning proposed a shift from the clinic approach to a community extension approach to be implemented by auxiliary nurse midwives (one per 10,000 population) located in PHCs. Other proposals included (a) a goal of lowering the birth rate from an estimated 40 to 25 by 1973 and (b) a cafeteria approach to the provision of contraceptive method, with an emphasis on free choice.

Unfortunately, these ideas remained on paper says Dr. Ravi Verma of the IIIPS. "The panic caused by the 1961 census findings, a new health minister who not only supported birth control but sterilization in particular, and a swing towards technological solution - all these resulted in a target oriented, technocratic programme with little interest in people's real needs. The 'population control' programme began in earnest."
The reorganized family planning programme ended up focusing programmes for IUD insertion and sterilization camps. Work was determined by abstract set by the ministry. In 1966, the health minister announced annual targets of 6 million IUD insertions (20/1,000 population in the urban areas and 10/1,000 in the rural areas) and 1.23 million sterilization or 2.5/1,000 population. Health workers were given incentives to meet targets and 'disincentives' or punishments if they failed.

This focus on sterilization and IUCDs has been at the cost of quality care and informal consent. Surveys have shown that one in four women who undergo sterilization suffer long-term complication in silence (Sterilization-mostly done through government services - accounts for the vast majority of contraception use in India. Sterilization accounts for more than 75 percent of total contraception in India, with female sterilizations. Eighty-two percent of sterilized women had never used any other method of contraception before being - sterilized).

A full fledge department of family planning was setup in the ministry of health. Condoms began to be distributed through the established channels of leading distributes of consumer goods.

In the fourth five year plan (1969-1974), a target of 14.9 million sterilization was expected to bring the CBR down from 39/1,000 to [95]
25/1,000 with in 10-12 years. In 1972 a liberal law permitting abortions on ground of health and humanitarian and eugenic consideration came into force.

Coercion, always a part of the family planning Programme at some level became formalized with the use incentives and later with harsher measure. At the 1974 international conference on population and development in Bucharest the Indian government coined the famous slogan: "Development is the best contraceptive", telling the world to give money for development. The government came home only to do exactly the opposite.

The Emergency, 1975-76 took coercion to new heights as slumdweller were rounded up and sterilized. In 1976-77 an all time high of 8.26 million sterilization were performed, mostly on men.

The statement on national population policy, made in the parliament by the minister for health and family planning assigned 'top national priority and commitment' to the population problem to bring about a sharp drop in fertility. The constitution was amended to freeze the representation of different states in the lower house of parliament according to the size of population in the 1971 census. The states were permitted to enact legislation providing for compulsory sterilization.

In 1976, the first national population policy talked of integrating family planning with general health care, of maternal and child health, the influence of female education, employment and age of marriage on family size, the effect of a high infant mortality rate and so on. 1977 saw the policy statement on the family welfare programme. Both statement were tabled in Parliament, but were not discussed on adopted. A revised population policy statement was tabled in parliament by a government formed by the former opposition parties. It emphasized the voluntary nature of the family planning programme. The term 'family welfare' replaced 'family planning'.

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'\(^\text{10}\).

The national health policy incorporated the targets included in the sixth five year plan document while adopting the health policy, the parliament emphasized the need for a separate national population policy.

In 1991, the report of the national development council committee on population proposed the formulation of a national population policy with a long term and holistic view of development population growth.

\(^{10}\) India, Registrar General, 1983.
and environmental protection. The policy was to suggest policies and guidelines for the formulation of programmes, with a monitoring mechanism.

In 1993, the Swaminathan committee, an expert group headed by Dr. M.S. Swaminathan presented a draft population policy. It called for a move away from the target approach and against incentives. In fact, in 1992-93 extra incentives were removed (only loss of wages was compensated). This draft foreshadowed many of the ideas expressed at the international conference on population and development at Cairo, Egypt, in 1994. A committee on population, set up by the national development council in 1991, in the wake of census results, proposed the formulation of a national population policy.

The 1994 international conference on population and development in Cairo has been described as a historic meeting where pressure from international women's health organizations managed to shift the meeting agenda from population control to reproductive health. The programme of action in Cairo looked at population control as a by-product of a general people oriented health programme, not an end in itself. Though the Cairo document was silent about how to generate resource operationalise the programme and several other

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practical issues, it was unambiguous in its intentions and recommendations. Most important it was signed by all participating countries.

Other have argued that the 'reproductive health' of the 1994 ICPD is nothing more than the same population control programme: old wine in new bottles and the reproductive health. And child health programme, launched with much fanfare in India in 1997, has generally provided only contraceptive services\(^{12}\).

Secondly, 'top down' target (assigned to health workers, for the number of IUCD insertions or sterilizations each year) have been replaced by estimated levels of achievement (ELAs) the health worker's estimates of the community's unmet need for contraception - based on a survey of families in the area.

However, these may not represent people's own perception of their needs. Also, the pressure to achieve these new ELAs remains.

**The Reproductive and Child Health Programme**

The RCH Programme was launched in India on October 15, 1997 though it is yet to be implemented in all parts of the country. The earlier Programme was target oriented focused on women in the reproductive age group and catered only to their family planning and

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\(^{12}\) National Family Health Survey.
maternal and child health needs.

The RCH programme was meant to provide high quality, integrated, client centered services based on people's need and the local demand and at all stages of the life cycle. In fact RCH services are essentially the same as the earlier services; maternal and child health birth control and abortion. With the addition of treating reproductive infections and providing adolescent health services.

**Target Free Approach (TFA) and Reproductive and Child Health (RCH) as Population Policy**

The women's were able to actively agitate against population control policies at conference on environment held in Rio-de-Janeiro in 1992, at conference on human rights at Vienna 1993, and then they were able to get the POA (Programme of Action) of the conference on population and development (ICPD) held in Cairo in 1994 to clearly state that the population control will not be promoted through incentives or disincentives nor will any targets be given by the governments for achievements in distribution of contraceptives\(^\text{13}\). The discussions at the conference also pointed that women have problems regarding their reproductive health and these were not attended to. The 'culture of silence' surrounding issue related to sex and reproduction further prevented women from discussing their problems. It was stated

\(^{\text{13}}\) [www.popline.org/docs/281839](http://www.popline.org/docs/281839)

[100]
Fig. 5b: India - per capita income
at the ICPD that the states will take up programmes for empowerment of women, provide information and service on methods of regulating fertility and promote reproductive health.

With the policies of globalization and structural adjustment, accepted by the government, pressure from international agencies are influencing the functioning of several programmes in India. Since promotion of population control is the third world countries has gained considerable importance for several international agencies, reproduction has received attention from these groups. Lower status of women in the society has been exploited to promote vested interests. Through the government of India was a party to the decisions at the ICPD at Cairo, a review of the functioning of the family planning programme shows that the decisions such as 'no-targets' are on paper but women are being oppressed to accept family planning. Health of women continues to be neglected.

The UN organized international conference on population and development held in Cairo in September 1994, stressed the importance of reproductive rights and reproductive health for men and women and emphasized the need for equity is gender relations, responsible sexual behaviour, and the need to enhance access to appropriate information and services. Special efforts were also to be made to emphasis men's
shared responsibility and active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning, prenatal maternal and child health; prevention of sexually transmitted diseases, including HIV, prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition, and recognition and promotion of the equal value of the children of both sexes. Male responsibilities in family to be included in the education of children from the earliest ages, special emphasis to be placed on the prevention of violence against women and children.

Pachauri points out that "since 1997, a reproductive and child health programme is being implemented in India. These programmes are being redesigned to implement the new paradigm. The focus will shift from achieving demographic decisions regarding sexual behaviours, including use or non-use of contraceptive methods as well as practicing safer sex or risky behaviours, but also control resources and have control over women's time and mobility".14

Pauchauri points out that the issue of involving men in their programmes is expressed by the health community, because of its frustrations in addressing the emerging problem of HIV/AIDS and

14 Government of India, National Sample Survey Organization, Maternal and Child Health Care in India.
other sexually transmitted infections by targeting women alone. Secondly, the family planning programme is concerned about increasing contraceptive prevalence, by focusing efforts to generate a demand for male methods. But she expressed doubts about the success of the approach to achieve this through simplification of contraceptive methods such as vasectomy.

Which is already simple, safe and inexpensive. Thirdly, Pachauri points out the role of feminists in involving men in their programmes, having recognized that in Patriarchal society to improve the reproductive health of women, involvement of men is essential. While the above observation are important from the point of improving the programme, one must look at the suggestions in the light of the emphasis that the earlier programme had and how it functioned. This will also points to the mind set developed through the training and work experience of the staff that will be expected to operate approach to the programme.

Indian population policy, was guided by the demographic goals and has the reduction of the rate of growth of population as the main objective. Though at the Bucharest international population conference Indian health minister had said that "development is the best
contraceptive" back home the government had intensified its efforts to control population growth. For reducing the growth of population, fertility was targeted and the reduction of birth rate became the objective of the programme. The effort culminated in excesses in implementing the programme during 1975-77. This resulted in governments down fall in the general election.

Male sterilisation had proved politically volatile. Family planning programme was revamped as "Family welfare programme." And in the male-dominated hierarchical society women became targets of the programme." Tubectomy camps, laparoscopy techniques with incentive and disincentives for reaching the targets provided by the demographers, became one point programme. Most of the women sterilised were high parity, older women. Reduction in birth rate was not significant.

Interestingly, almost never was the predicted birth rate achieved, nor was the growth rate of the population anywhere near the desired goal. As early as 1962-63, a field survey, conducted by the Demographic Training and Research Centre (DTRC), had clearly showed that when questioned women said that their ideal size of family was 2 or 3 children. The survey, as well as other researches conducted at the time,

\[15 \text{ Government of India.}\]
had also showed that the couples desired small family, more significantly, the women wanted fewer children that their husbands desired. This finding should lead to the conclusion that women were not empowered to meet their own desires.

As a solution to reduce the gap between the desired family size and the actual, one time motivation method such as IUD (Intra Uterine Device) that could be fitted by the provides was introduced in the programme. With about 80% women having reproductive trace infections (RTIs) and other un-investigated causes, the women experienced several health problems and almost all the IUDs were pulled out by the women themselves. Research has since continued searching for female method that will have longer lasting effects in preventing pregnancy. There were hardly any efforts to know the reason for gap between desire for small family and actual fertility that was higher than the desire. Inspite of no information on the reason for the gap, the demographers continue calling it as an unmet need for contraception and use it for promotion of long acting hormonal methods that are provides controlled and for females. Demographers even argue that if this unmet need is met, the demographic goals could be achieved. In the 6th plan the objective of the programme, with the advise of the demographers, was changed to NRR-1, i.e. reducing then
women in the population so as to reduce the child-bearers and thereby reducing the births in the population. The seventh plan had achieved the target of 42% CPR (couple protection and yet birth rate) was higher than expected, showing that targeted CPR does not assure estimated decline in birth rate.

Demographers emphasis achieving demographic transition and which, by their definition means having birth rate close to the death rate. Registrar General reports birth rate of 28.7 (1993) and death rate of 9.3 (1993), indicating a growth rate of population of 19.4 or 1.94 percent. Lowering of the birth rate will certainly reduce growth rate of the population but will it assure improvement in the life of the people? Death rate measures numbers of persons dying but not who dies. Death rate of the developed countries is around 9 as is the core with India. Obviously the health of the two groups of people is not the same. In India most of these who die are infants, children and the young. In the developed countries those dying are nature adults and the old.

For lowering the fertility demographic goal is TFR of 2.1, i.e. an average of 2.1 children per woman, which is expected to assure stabilization of the population. National Family Health Survey (NFHS), which represent 99% of the Indian population, shows that TFR (Total Fertility Rate) for India is 3.39 whereas even up to age 5 the number of
children surviving is 2.5. And Registrar General (RG) reports 3.4% of the total deaths are of children under age 15 years\textsuperscript{16}. Thus TFR does not assure that the children born will survive. It also needs to be noted that the TFR in India has come down from 5.2 in 1971 to 3.39 in 1992-93 without making much change in early child bearing and without much improvement in the quality of life. It is known that the birth weight and health condition of the children under age 5 are indicator of the quality of future population. India has one of the highest proportion of low birth weight (LBW) babies and about 53 percent of the children under age 5 are stunted, wasted and malnourished. This has happened because in the anxiety of reducing the birth rate the population programme instead of improving the conditions of women and empowering them to take decisions about their sexuality and structure which is achieving the fertility reduction by promoting sterilization of young women thereby only damaging their health but strengthening patriarchy and oppression of women.

NFHS shows that median age of women at sterilization has come down to 26.3 year and in Andhra Pradesh it is as low as 24.5 years. Current contraceptives are damaging the health of women is shown by NFHS. About 24% of the sterilized women and about 20% of the IUD as

\textsuperscript{16} Indian Registrar General
well as pill users are developing health problem. And which means that the women will have to live with pain and suffering from young ages. The unmet need of contraception should not be used promote harmful, long-acting contraceptives but to look for ways and means of addressing gender equality and for that empowering women.

Demographic transition which assure low growth rate of the population cannot by itself meet the objective of the welfare of the people. There is a clear evidence that the fertility of the populations of the now developing counties was not only high but it was much higher than the one seen in today's developing countries. The developed countries never had policies to control fertility.

As the living condition, including nutrition and sanitation improved, chances of survival improved and status of women improvement, the birth rate come down. Many of these countries now have below replacement fertility without ever having had population control programme.

Demography as a science prospered under the patroage of developed countries, and especially of the united states of America, major contribution of the science is in the population control field. Large amounts of money have gone in propagating the belief that population size is at the root of the problem faced by developing
countries and population control is the solution to all the problems and there is an urgent need to propagate population control in all these countries.

Economist have assured that not the population growth but wrong planning and management of the resources which promote unequal distribution of wealth and that is at the root of sections of populations remaining poor, world development report of the world bank for the year 1990, which had poverty as its theme, says population growth is not the cause of poverty but poverty lead to rise in population growth\textsuperscript{17}.

Similarly there is adequate evidence that neglect of health and well being of women had resulted in poor health of people including high infant, field and maternal mortality. Women of poor health give birth to children with poor health irrespective of their birth order. Women who have poor health and receive is adequate attention during their growing years, during their pregnancies and deliveries, experience high maternal morbidity and mortality even at first or second pregnancies. Their children also have poor health. so family planning by itself is no solution to the population problems.

Evidence from many poor countries demonstrated that human

\textsuperscript{17} Population in India's Development.
development indicators are not necessarily correlated with economic prosperity. Quality primary health care, maternal and child survival programmes, good sanitation and primary education can turn the tide. When infant mortality decreases, people feel assured about the survival of their children, family size begins to decline. Globally, the efforts to develop human development indicators and ranking countries according to quality of life, forced demographers and population control walls to rethink the environment question, carrying capacity of the planet also pointed towards consumption patterns among the rich and the poor across the world and within countries. All these effectively diffused the 'population bomb'.

After considerable pressure from the non-government organization (NGOs) especially those from the south and the women's organizations, discussion at the international conference on human rights held in 1993 in Vienna, it was agreed that population control programmes were oppressing women and especially the poor from the developing countries and this was happening in spite of the fact that growth of population was not the main cause of environmental problems and consumerist lifestyle among the rich rather than the fertility of poor women was deteriorating the environment. It was also pointed out that human rights programmes neglected the rights of
women and violence against women was increasing. Finally at the
international conference on population and development (ICPD) held in
1994 at Cairo it was decided that population control programme be
replaced by a new approach that was based on gender equity and
empowerment of women. The Cairo conference was the turning point.
The entire debate centered around woman's control over own body, her
right to say 'no' and 'enough' abortion invasive contraceptive
technologies, male responsibility; the right to be treated with respect
and dignity; rights of people with in unconventional relationship;
family reunification rights, forced migration-all these issue turned Cairo
into a women's conference.18

In spite of India being a party to the decision at ICPD, currently all
efforts surrounding issues of mortality, morbidity child health and
survival etc. are linked to the goal of fertility reduction. Basic mind-set
of planner, policy makers, service providers and a large section of
decision makers, is still influenced by the old thinking favoring
promotion of population control as an urgent need. This mind-set is
also affecting the implementing the programme as target free approach
(TFA) to family planning. Health watch an informal network of NGOs
organized regional meetings to find out the functioning of TFA and

come to the conclusion that the providers of the service—ANMs, MPWs and PHC doctors etc. who have been trained almost for four decades to work for targets cannot make a quick transition without intensive training. Major obstacle to an effective training is the mind-set which has been decades built all arguments to promote demographic approach for dealing with human issues. It was pointed out that the reproductive health of women was poor and its improvement needed several social and medical interventions. Yet population lobby is using this to target women in reproductive ages. Reproductive and child health (RCA) approach of the current population is targeting sexually active women is reproductive ages and those who have not accepted family planning methods. Thus completely ignoring the young, the old and the women who are not child bearing. Also ignoring the fact that reproductive health cannot be achieved in the absence of comprehensive health care.

Political will plays an important role in bringing about a social change. Unfortunately the political parties in India have never taken serious interest in the population policy and still used the high growth rate of population as an excuse for their failure on all fronts. It is perhaps for the first time that the election manifestos of political parties have mentioned their views on the population issues, all the parties
were guided by the demographers and stabilization of population is said as the main objective of their population policy. This can have serious implication for the future of the programme.

The draft national population policy, first seen by the cabinet in October 1997, headed by prime minister I.K. Gujral. A number of revision based on the comments of a cross-section of academics, public health specialist, demographers, social scientists and women's representatives before being placed before the cabinet in the year 2000.

Another draft of National Population Policy, placed before the cabinet, was remitted to a group of minister (GOM) headed by the deputy chairman of the planning commission to examine the scope for the inclusion of incentives and disincentives for its implementation.

The GOM consulted various academic expert and women's representation and finalized a draft, which was discussed by the cabinet on 19 Nov., 1999 and which was revised further for re-submission.

The National Population Policy, 2000

❖ The NPP 2000’s stated goal is to achieve net replacement level by 2010, by meeting people's reproductive and child health needs. The government plan to work with the private sector and voluntary organization to establish a health infrastructure and provide a
package of contraception, maternal and child health services\textsuperscript{19}. This approach is to result in population stabilization (Total fertility rate of 2.1) by the year 2045 - a population 'consistent with sustainable development'.

- The NPP affirm commitment of the government towards voluntary and informed choice and consent of citizen while availing of reproductive health care services, and continuation of the target-free approach in administering family planning services'.

- It aims at developing an infrastructure for the RCH package, providing and ensuring education till age 14, reducing infant mortality to below 30/1000 live birth deaths, marriage and pregnancy, tackling communicable diseases, integrated Indian system of medicine in these services, reaching out to household, promoting the small family norm, and linking family planning to other social sector programmes.

- A national commission on population to guide all efforts is to be presided over by the prime minister, with the chief minister of all states and united states and central minister of the department of family welfare as well as other concerned department (such as

women and child development, education, social justice and empowerment, rural development, environment and forests) as well as demographers, public health professionals and non-governmental organizations.

❖ Funding will be a priority: "All efforts at population stabilization, will be adequately funded in view of their critical importance to national development".

❖ A number of promotional and motivational measures are described: rewarding panchayats for exemplary performance in achieving 'small family nouns', low IMRs high schooling..... cash incentives with the birth of girls (the first two children) for women who have their first child after the age of 19, for couples getting sterilized after two children. States with high birth rates are penalized by freezing the number of representatives to the central legislative assembly, on the basis of population at 1971 census level, until 2026.

❖ Following the publication of the national population policy, a number of state have come out or coming out - with their own population policies.

Goals of National Policy

The National Population Policy (NPP) 2000 has distinguished between immediate, medium term and long term policy objectives. The [115]
Immediate objective is to address:

(a) The unmet needs for contraception.

(b) Health care infrastructure and health personnel.

(c) To provide integrated service delivery for basic reproductive and child health care.

The specification of the fertility reduction goal in terms of the replacement level of fertility or a total fertility rate of 2.1, to be achieved by 2010, is better than the earlier goal of a Net Reproduction Rate (NRR) of 1.0, noted in the national health policy of 1983 and the sixth five year plan. The NRR is a function of both fertility and mortality. The medium term objectives is to bring the TFR to replacement level by 2010, through vigorous implementation of intersectoral operational strategies. The long term objectives is to a stable population by 2045, at a level consistent with the requirement of sustainable economic growth, social development and environmental protection.

Objectives
In pursuance of these objectives, the following national socio-demographic goal 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 dropouts at primary and secondary school level to below 20 percent for both boys and girls.

(3) Reduce infant mortality rate to below 30 per 100,000 live births.

(4) Universal immunization of children against all vaccine preventable diseases.

(5) Promotion of delayed marriage among girls together age 18, and preferably after 20 years of age.

(6) Raising the institutional deliveries to 80% and these by trained person to 100%.

(7) 100% registration of births, deaths, marriage and pregnancies.

(8) Containments of AIDS and treatment of RTIs and STIs.

(9) Prevention and control of communicable diseases.

(10) Reduce material mortality ratio to below 100 live births.

(11) Achieve universal immunization of children against vaccine preventable disease.

(12) Achieve universal access to information counseling and service for fertility regulation and contraception with a wide basket of choices.
(13) Contain the spread of acquired immunodeficiency syndrome.

(14) Achieve 100 percent registration of births, death marriage and pregnancy.

(15) Prevent and control communicable diseases.

(16) Integrated Indian System of Medicine (ISM) and the National AIDS control organization.

(17) Promote vigorously the small family norm to achieve replacement level of TFR.

(18) Bring about coveragence in implementation of related social sector programme so that family welfare becomes a people centered programme.

It may be quest for the so called holistic approach to population containment which is reflected in the list of 14 goals in the new policy or it can be the plain realization that it is an agenda of human development which is focused on women and children, which constitutes the most practical manifestation of population policy. Of the 14 goals specified in the policy 2000, one relates to the long-neglected imperative of free and compulsory school education along with that of reducing the school dropout ratio.

Few other relate the area of health in particular to the need to reduce the Infant Mortality Rate (IMR) and the maternal mortality ratio
besides the universalization of immunization of children against all vaccine-preventable diseases.

The NPP 2000 refers to five schemes that involve incentive payments for individuals, these include:

(1) **Balika Samridhi Yojana**: Run by the department of women and child development to promote survival and care of the girl child, with a cash incentive of Rs. 500 given at the time of birth of a girl child of birth order 1 or 2.

(2) **The Maternal Benefit Scheme**: Run by the department of rural development awards an incentive of Rs. 500 for the birth of the first child after 19 years of age and is limited to the first and second births only. The cash award is now to be linked to antenatal check up, institutional delivery by a trained birth attendant, registration of birth and BCG immunization.

(3) **A Family Welfare-Linked Health Insurance Plan**: Is to be established to offer health insurance (for hospitalization, not exceeding Rs. 5000) to couples and their children below the poverty line, if their couple undergo sterilization with no more than two living children.

(4) **Couples Below the Poverty Line**: Who many after the legal age
at 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, are to be rewarded.

(5) **A Fifth Scheme**: Provide for group incentives that will reward Panchayats and Zila Parishads for exemplary performance in universalizing the small family norm, achieving reductions in infant mortality and birth rates and promoting literacy with completion of primary schooling, while it would be a mistake to judge these schemes from the point of view of small sums of money to provide for, the real costs of providing one's eligibility and actually receiving the awards for exceed what is recognized in our metropolitan centres.

**Disincentives**

The question of disincentives for a large family has after been discussed.

- During the past few years, Haryana and Rajasthan have passed laws that prospectively debar persons, who do not adopt the two-child norm from contesting election for Panchayats, Zila Parishads and Nagarpalika. In Rajasthan, the high court have upheld the rationale of the laws. The population policy document of Rajasthan, proposes
to consider an extension of the law making candidates with two or more children ineligible to contest elections to 'other elected bodies like cooperative institutions, it may also be made a 'service condition' for state government employees.

- The population policy of Madhya Pradesh also states that, "Persons having more than two children after 26 January, 2001 would not be eligible for contesting elections for Panchayats, local bodies, cooperatives in the state. In case they get elected, and in the meantime they have the third child, they would be disqualified for the post."

- The policy for Rajasthan proposes 'legal registration of marriage', compulsory observance of minimum age at marriage for availing of 'government facilities and services'.

- The policy for Rajasthan proposes 'legal registration of marriage', compulsory observance of minimum age at marriage for availing of 'government facilities and services' and 'stiffer penal provisions for violation of the legal age at marriage'.

Madhya Pradesh also lays down that, "from 26 January, 2001, persons marrying before legal age at marriage will not be eligible to

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seek government employment”.

**Population Commission**

Following the announcement of NPP 2000, a large population commission was constituted on 11 May. The department of family welfare serves as the secretariat to the commission, which is expected to ‘oversee and review’ the implementation of NPP 2000. Similar commission are envisaged at the state and union territory level.

It has after been cynically argued, without convincing reasons, that the department of family welfare/planning should be abolished and its functions partly transferred to the directorate general of health services (DGHS) and partly to other departments of the government.

The important task is to ensure that the population commission is properly briefed to make the best use of the talent and advice it seeks to mobilize.

**State Level Population Policies**

The preceding discussion has noted the formulation of state level population policies in Andhra Pradesh, Rajasthan and Madhya Pradesh over the past three years. In come sense, the pioneer in this respect was Tamil Nadu, even though it did not release a separate document called state population policy. However, all the states have been ambitious in their targets with respect to decline in fertility and mortality.
A joint endeavour of USAID Govt. of India, Govt. of U.P. to improve quality and accessibility of family planning services through innovation, partnership, social health, SIFPSA. State innovations in family planning services project agency. If the current fertility trends continue, the population of U.P. will be 216 million in 2011, 325 million, 2031 and 441 million in 2051. In five decades, the population will increase by 270 million. The density of population will increase from the current 578 person per sq.km. to 1,498 persons in 2051 - almost a three-fold increase. About 10 districts in U.P. would have more than 10 million people and another 18 districts will have more than 6 million. This huge increase in population will exert enormous pressure on natural resources and has the potential to frustrate all attempts to improve the quality of life of the people and to achieve sustainable development. Therefore, there is an urgent need to develop people-friendly policies and strategies, to mobilize all possible resources in all sectors, and to energize the system to reach replacement level fertility by 2016 and to attain population stabilization as soon as possible thereafter.

The population policy looks at the issue related to population

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[123]
stabilization in a holistic, open and transparent manner. Population stabilization cannot be achieved without addressing the health issues related to women and children. The status of women and children, the status of women, gender equity literacy, reduction of infant and maternal mortality, improved health and nutrition status of mother and children have long been recognized as key determinants of fertility behaviour and are the central issues of population policy.

To achieve replacement-level fertility, all developments have to work in cohesion, and the synergy generated will not only help population stabilization efforts but also the objectives of various departments working to improve the quality of life of the people of U.P. recognizes and addresses there regional variations.

**Andhra Pradesh**

Andhra Pradesh, which has attracted considerable attention over the past few years because of its rapid fertility decline from 4.7 during 1970-72 to 2.5 during 1995-97, seeks to lower its TFR to 2.1 in 2000 and 1.5 by 2010.

The chief minister's foreword describes the policy document as a statement of resolve by the state government to 'bring about a change in the size, structure and distribution of the population' to improve 'the standard of living and quality of life of the people in general' and to
extent the benefits of such change and development to 'the most
vulnerable and disadvantaged'. 'Fertility reduction' is said to be 'at the
heart of the development of the state'.

Interestingly, the minister for medical health and family welfare
affirms that the state must 'accept ownership for the programme, which
is a crucial factors for its successful implementation. The state's
ownership of the programme is reflected in the commitment that while
the programme is entirely found by the central government, the 'state
will contribute additional amounts, as required from its own resources
for this vital programme'. The policy is inspired by the faster progress
in Tamil Nadu and Kerala with respect to various demographic
indicators.

An interesting feature of the policy is its emphasis on 'marketing
the population stabilization programme' at the 'state level' through
contracted 'professional services' for 'information, education and
communication or IEC activities. Emphasis is laid on improving the
quality of services to 'the cutting edge level' and making 'primary health
service a special category service, with provision of better
salaries/perks and service penalties like dismissal for absence from
duty'.

[125]
Rajasthan and Madhya Pradesh

The policy documents of both Rajasthan and Madhya Pradesh have been prepared with the futures group international and the population resource centres setup in the two states.

Rajasthan proposes to lower its TFR from 4.1 in 1997 to 3.1 in 2007 and 2.1 in 2016. Madhya Pradesh aims to lower its TFR from the current level of 4.0 to 3.0 by 2005 and 2.1 by 2011. Rapid declines are also planned in the level of infant, child and maternal mortality in both states. The need for rapid progress is stressed by reference to what has already been achieved in states such as Kerala or even Gujarat, and the inter-regional diversity within two states. The minister in charge of family welfare in Rajasthan describe the policy as 'practical as well as ethically sound and culturally appropriate holistic approach', with 'an emphasis' on ending gender discrimination' and 'ensuring popular support' for its objectives. The document for Rajasthan also stresses the fact that the state has 'less than one percent of available water resource in the country' and that tremendous pressure of population on natural resources leads to environment degradation.

The policy document for both the states carry endorsements by their chief ministers and emphasis the need for interdepartmental coordination as well the expected contribution of each department.
Rajasthan has constituted a state population council and proposes to setup district family welfare coordination and monitoring committees. Madhya Pradesh proposes to call its apex body the state population and development council, to be supported by the state population policy-implementation committee and district population and development coordination committees. The institutional structure proposed to be setup follow the recommendations of the expert group chaired by M.S. Swaminathan. However questions persist as to whether and how for these policies represent careful assessments of what is feasible, backed by a resolve to make the necessary effort.

Both policy documents highlight the potential role of the non governmental organizations but they also recognize the small number of NGOs and their concentration in a few district of the state. Two-thirds of the 360 voluntary organizations active in various department fields in Rajasthan are located in only seven districts (Ajmer).

Bharatpur, Bikaner, Jodhpur, Sawai Madhopur, Udaipur and Jaipur. Madhya Pradesh has more than 650 NGOs, but many of them are likely to be concentrated in the developed districts. In any case, these organizations must help to ensure that these documents do not remain, as so often happens, a statement of the desirable goals whose fulfilment is allowed to recede in time along with the movement of the key factor and decision-makers.

[127]
Experience of Tamil Nadu

The prospects for these states may be illustrated by some aspects of the policy adopted by Tamil Nadu, which had prepared an ambitious early statement of its goals about fertility and mortality. Tamil Nadu has done extremely well in lowering its TFR to the below-replacement level during 1996-97, with an IMR of 53 per 1000 live births (40 in urban areas and 60 in rural areas), it has already achieved an NRR of 1.0. There is still substantial scope for a further decline in the level of infant and child mortality as well as adult mortality.

The life expectancy at birth in Tamil Nadu during 1991-95 was 63.3 years, 3 years above the national average of 60 years but more than 9 years below the high of 72.9 years achieved by Kerala.

The 15-point programme for child welfare, adopted by the government of Tamil Nadu in the early 1990s, had aimed to reduce the IMR to less than 30 per 1000 live-births rate to 15 by the year 2000. The goals for 2010 are an IMR of 20 and a birth rate of 10. The population was expected to reach a stationary level of around 65 million by 2010. These ambitious goals overlooked the momentum of growth built into the age distribution.

As for the birth rate, in 1991 Tamil Nadu had almost 31% of its population in the age group of 0-14 years (the corresponding figures for [128]}
Kerala and India as a whole were 30% and 36% respectively). Again, the TFR would have to drop to 1.8 by 1998, 1.7 by 2003 and 1.6 by 2008. Once again, such changes are not impossible, as has been illustrated by Kerala's low TFR of 1.7 in 1992 and even lower TFR seen in several European countries. Some couples would need to adopt a one-child family. With such a sharp decline in fertility, the crude birth rate would be around 15 in 2003 and 13 in 2008; but Tamil Nadu would not have attained a stationary population by 2010. Positive population growth would continue for several more decades, at the pace decided mainly by the level of fertility. Given the associated ageing of population, it is a main point whether and how for the government of Tamil Nadu should try to lower the level of wanted fertility below the replacement level.

These issues need dispassionate discussion on the basis of intensive studies on the preference and priorities of the people, their goals and aspirations and the desired and desirable means to achieve them. Unfortunately, there has hardly been any research in Tamil Nadu on the implications of alternative trends in the rate of population growth. In fact, we do not know the extent to which the decline in fertility in Tamil Nadu so far is a result of the rise in the age at marriage, abortion and contraception.

The national family health survey has reported a contraceptive
prevalence rate of 58% in Tamil Nadu. The mean age at marriage among women in Tamil Nadu in 1991 was probably already around 21.5 years and thus the target of raising it to 21 has indeed been achieved. Some 15% of women aged 15-19 years were married, but there may not be many violations of the law relating to minimum age at marriage. In any case, the implementation of such policies needs people's participation and confidence in the leadership. Credibility of the leadership probably plays a critical role in such bold experiments in social engineering. The state need to encourage monitoring and evaluation by genuinely autonomous scholars and institutions with the necessary analytical skills to provide an imaginative portrayal of the shape of things to come under alternative scenarios.

Indian Census Data for 2001

- The Indian census is a massive, countrywide operation which takes place every 10 years. Information gathered in the census and other regular data collection programmes is meant to guide the governments policies. The 2001 census has just been completed this March. We have some statistics.

- As of March 2001, the total population of India was a little over 1 billion - 1,027,051,247 to be exact (531,277,078; female : 495,739,169) of this number 157,863,145 are children upto the age of six years (81,911,041 males and 75,952,104 females).
A little over 65 percent of the population is literate 75.85 percent of males, and 54.16 percent of females. Demographer, or student of population, have various indicators with which to measure a population's charge and to make predictions of population change.

Some of these figures for India are given below:

Crude Birth Rate (Annual No. of Births per 1000 total Population) 27.00
Crude Death Rate (Annual No. of Deaths per 1000 total Population) 9.00
Infant Mortality Rate Seventy out of every 1000 babies born die before their first birthday.

Seven percent of (72/1000), newborn infants perish within a year of birth, because of low birth weight, prematurity, malnutrition, diarrhoeal diseases, acute respiratory infections and malnutrition. Compare this to the IMRs in Sri Lanka (18/1000) and China (41/1000) moreover in India. There are more female deaths (rural or urban areas) in the age group of 0-14 than elsewhere. Although the IMR has decreased from 146 per 1000 births in 1951 to 72 per 1000 births (1997) and sex differential are narrowing, there are wide inter-state differences.

Life Expectancy: The average person can expect to live up to the age of 62.

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India Registrar General, 2001, Census of India.
[131]
Rate of Natural Increases: Birth rate minus death rate, expressed as a percentage 1.80.

Total Fertility Rate: Average number of children born to a woman during her lifetime 3.30 only nine states or union territories in the country have a TFR less than or equal to the desired 2.1: Eleven have a total fertility rate of more than 2.1 but less than 3.0. At least 12 have a total fertility rate of 3.0 or even.

Eighteen percent of Births: are to teenage women aged between 15 and 19.

Forty-Nine percent of Woman: give birth for the first time by age 20.

Forty-Three percent: of married or informal union is 20.

Females in secondary school/100 males: 65

**ALTERNATIVE SUGGESTIONS FROM THE NPP**

Measure to 'motivate' poor couples to marry late have children late and get sterilised after the second child. National health insurance for children whose mother or father was sterilised after the birth of the second child. Linking the provision to facilities to urban slum dweller with their observance to the small family norm.

**Suggestion from State Policies**
- People married before the legal age at marriage are barred from government jobs.
• Health worker will be assessed according to their performance in the reproductive and child health programme.

• Local governments allocation will be linked to their family planning performance.

• Third children will not have access to public subsidies or education.

This punishes women who after to have control over the number of children they have, and children for their parent's actions.

Writes public health specialist Mohan Rao, "The fact that structural adjustment polices have led to the collapse of weak and underfunded public health care system, and that these same policies have also led to an increase of infant mortality rate in 10 of the 15 major states of the country do not seem to concern our policy makers. So single minded are they in their short sighted policies that they do not realise the appealing fact that it is the fearsome pursuit of family planning programme that has led to the distrust of the health system among the poor." 23

The key objective of the policy 2000 is to bring the fertility rate to "replacement" level by 2010 and the long term goal will be to achieve a stable population by the year 2045. The Union Cabinet endorsed the policy and accepted a system of incentives for couples adopting the small family norm opting to do, away with disincentives.

23 Mohan Rao.
It remain to be seen if this exercise will achieve the desired results because given the illiteracy, unless the people see the disincentives for large family, they may not be inclined to stop with two children. The core of the population problem in the country centres on the higher fertility rate among the poorer sections and the explosion taking place in the less developed states. There is no use for a population policy that cannot be easily or effectively implemented.

The Central and State Government must together adopt a cafeteria approach to cater to various needs and segments of the population. It must be left to the health worker and the primary health centre to follow up on couples. Delaying the first child, spacing the second and stopping the third must remain the objectives.

Table-4.1. Key Population Statistic of India, 1901-200123.

<table>
<thead>
<tr>
<th>Census year</th>
<th>Total Population (million)</th>
<th>Average Annual growth rate (%)</th>
<th>Density (Person Per. sq km.)</th>
<th>Sex ratio (Male per 100 female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>238.3</td>
<td>0.3</td>
<td>77</td>
<td>1029</td>
</tr>
<tr>
<td>1911</td>
<td>252.0</td>
<td>0.6</td>
<td>82</td>
<td>1038</td>
</tr>
<tr>
<td>1921</td>
<td>251.2</td>
<td>N</td>
<td>81</td>
<td>1047</td>
</tr>
<tr>
<td>1931</td>
<td>278.9</td>
<td>1.1</td>
<td>90</td>
<td>1953</td>
</tr>
<tr>
<td>1941</td>
<td>318.5</td>
<td>1.3</td>
<td>103</td>
<td>1058</td>
</tr>
<tr>
<td>1951</td>
<td>361.0</td>
<td>1.3</td>
<td>117</td>
<td>1057</td>
</tr>
<tr>
<td>1961</td>
<td>439.1</td>
<td>2.0</td>
<td>141</td>
<td>1063</td>
</tr>
<tr>
<td>1971</td>
<td>548.2</td>
<td>2.2b</td>
<td>178</td>
<td>1075</td>
</tr>
<tr>
<td>1981</td>
<td>683.3</td>
<td>2.2b</td>
<td>221</td>
<td>1071</td>
</tr>
<tr>
<td>1991</td>
<td>846.6</td>
<td>2.1</td>
<td>267</td>
<td>1076</td>
</tr>
<tr>
<td>2001</td>
<td>1027.0</td>
<td>1.9</td>
<td>324</td>
<td>1072</td>
</tr>
</tbody>
</table>

A population policy is generally conceived at the national level. However, in a large country like India with conspicuous spatial variations, a case has after been made for region or state specific policies and some state governments have recently announced population policies. But there are other dimensions of diversity, especially ethnicity, religion and caste. On account of social, cultural and historical factors, the aspirations of groups and hence immediate objectives, may differ, if not the ultimate goals. Besides, strategies appropriate for one group may not be so for another, even when the objectives are the same.

The Swaminathan Committee suggested the ‘Concept of unity in population goal and diversity in implementation strategies’ (expert group on population policy, 1994) when interests of various sections differ, it is possible that a policy might give precedence to the concerns of dominant groups at the cost of dis-advantaged the minority groups.

It is imperative that the national goal and objectives incorporate aspiration and needs of various groups, including smaller and weaker section of society strategies be designed to meet these and further that national policies and strategies do not adversely affect the interests of various groups intentionally or otherwise. Formulation of policies separately for social group may not be feasible since such groups do not
form units or levels of governance. However, it is essential that the perspectives of special population groups—ethnic, religious and caste—are taken into account in the formulation of national or state policies.

In principle a national policy ought to be designed toward achieving collective national goals. But when there is stratification on the basis of rise, ethnicity, religion or caste, group interests could possibly differ and conflict with national interests. In the sphere of population, though lowering the population growth rate may be a desirable national goal, may groups would like to ensure that their share does not fall during the process of demographic transition since share in power depend on share in population. This is an issue well recognized in the context of religious diversity in India. Clearly, regions form special groups that could legitimately have concerns about the size and share of their population.

Moreover, the scheduled castes, which suffered due to oppression and denial of opportunities for generations and the scheduled tribes that were secluded and excluded from the process of development for a long time, constitute special groups.

This paper focuses on the perspectives of religion and caste group in India in matter of population policy, specifically. How do religious minorities the schedules caste and scheduled tribes fare in
population and related aspects? Do some special groups need policy interventions? The demographic profile and changes in it could give some idea of the needs of special population group. In particular an assessment of differentials in growth rates and changes in population share is useful.

This calls for an examination of differentials in the components of population changes, namely, fertility, mortality and migration. Further, population policies in recent years have given greater attention to aspect of reproductive and child health. Do the special groups receive appropriate services in these? Finally, does the National Population Policy 2000 of India address the needs of special groups?

Moreover, though the NPP 2000 explicitly recognises that some tribes are dwindling in number, it is not clear what specific efforts are contemplated, to support these tribes. In the matter of low fertility caused by infertility, specific reproductive health programmes can help. But population policy may not be the appropriate instrument to overcome the problem of low growth caused by late marriage and voluntary low fertility, observed in some sections, since international experience shows that pro-natalist policies have rarely been successful.

The available data also indicate that certain issue are relevant in some states and not necessarily in others. The NPP 2000, designed to

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25 Roger Jeffrey and Patrica Jeffery, 2000, Religion and Fertility in India. [137]
operate at the national level, may not be an ideal instrument to address these. State policies are normally designed to achieve state level goal and plan strategies appropriate to condition in the state. Given the large inter-state variations, this is a desirable approach. But in doing so, it is essential that the policies for individual state give adequate attention to the need of special group with in these.

The core issue is whether population policies in India have addressed the needs of special groups. The thrust of the National population policy 1976, the first explicit population policy in India, was ion intensifying the programme and there was little mention of special groups. But in the context of compulsory sterilization it was stated that, if brought about by states, it may be made 'uniformly applicable to all Indian citizens resident in the state without distinction of caste creed or community'. This was apparently designed to emphasize uniformity.

The policy statement of 1977, primarily rejecting the emolument of compulsion in family planning made no mention of special groups (for reviews of the policies, see, Mitra, 1978; Srinivasan, 1982; Raina, 1988; Visaria and Chari, 1988). At the international level, the international conference on population and development (ICPD) 1994, recognized that indigenous population have a distinct and important perspective on population and development relationship (U.N., 1994). One of the objective stated by the ICPD was to insure that indigenous
people receive population and development related services that they
deem socially and culturally appropriate.

recognizes the special needs of tribal communities and hill area
populations. The policy statement notes the problem of low literacy,
poor nutrition and high childhood mortality among these sections of
population (India, Department of Family Welfare, 2000; para 25). The
policy acknowledges that these groups are under served on account of
poor access and suggest strategies to overcome the problem.
Significantly, the NPP 2000 also makes the points that ‘many tribal
communities are dwindling in number and may not need fertility
regulation. Instead they may need information and counseling in
respect of infertility.

Thus, there is recognition of the fact that a population policy need
not always be reduced to one of fertility control. Health issues receive
Primary attention for these special population. It must be stated that
though the earlier population policies did not note the special needs of
tribal populations, health programme have always done so and
prescribed better than average health centre to population ratio for
tribal and hilly areas.

The NPP 2000 does not take note of the special needs of the
scheduled castes. The data show that the scheduled castes are not well
served in delivery care. Poverty is undoubtedly a factor operating in this matter. But are public services also loaded against the scheduled castes? A point to be noted is that in antenatal care the scheduled castes are as well served as other groups. This is a task performed by the female health worker (in some states called an auxiliary nurse midwife or public health nurse).

To their credit, these workers have been doing a good job of reaching all section of the society and providing services to pregnant women. But delivery care falls in a different class. Accessing a health facility or a health professional at the time of need is not easy for women from the weaker sections and the existing programs have not been able to overcome this handicap.

Religion as a factor does not find place in the NPP 2000 document. Recognition of religious differentials in a policy document is presumably considered politically incorrect. In fact, as noted earlier, the 1976 policy stressed that there should be no distinction by community. Yet certain needs do vary by religion. The low or negative growth of some religions does not attract much public attention perhaps because population of these are quite small and upper class. It is probably felt that they are capable of addressing these issues themselves and not in need of policy support. The relatively high fertility among Muslims has been a touchy issue for some time. While it is true that demand for
contraception is lower than average among Muslim, sweeping statement such as Muslim are against birth control are not supported by evidence. The NFHS-2 revealed that 37% of Muslims couples used some contraception and 20% were sterilised.26

These figures are not insignificant and in fact, contraceptive prevalence among Muslim in India as a whole is higher than the level for general population of these are quite small and upper class. It is probably felt that they are capable of addressing these issues themselves and not in need of policy support.

But an important issue that emerged out of the data presented is the high unmet need for contraception among Muslims. Possibly, here are reservations about specific methods, particularly sterilization; the prevalence of reversible method is not lower among Muslims compared to the general population. If the cafeteria approach were seriously pursued allowing couples greater choice in reversible methods, the contraceptive need of Muslims could also be met to a larger extent.

Finally, the comparative view of the special group discussed in the paper, namely religious minorities and the scheduled castes and tribes reveals that the principal differences are in areas of health. The schedule castes and especially the scheduled tribes are poorly served in

maternal and child health care. This calls for strategies to cater to the needs of these weaker sections. The NPP 2000 has recognised these issue for the scheduled tribes, but special strategies could also be developed to cater to the needs of the scheduled castes.

The NPP 2000 proposes special schemes for urban slums, this would take care of needs of some weaker sections. However, a majority of the scheduled castes live in rural areas and programmes needs to be developed for this large population27. In contraceptive practice, the large unmet need among Muslim is a matter of concern.

(B) UNCONCERNED REGARDING THE RISE OF POPULATION

United Nations, is an International Organization of Countries, Created to Promote World Peace and Cooperation. The United Nation was formed after World War-II ended in 1945. It's mission to maintain world peace, develop good relation between countries. Promote cooperation in solving the world problem and encourage respect for human rights. The international conference on population and development convened by the United Nations at Cairo, Egypt in 1994, was the first of the decennial population conferences to link population to sustainable development around the world28.

According to paper published by the United States Census Bureau, the world population hit 6.5 billion (6,500,000000) on Feb. 25, 2006. It is estimated that by 2012 the earth will be home to 7 billion. The United Nations population fund designated October 12, 1999 as the approximate day on which world population reached 6 billion. This was about 12 years after world population reached 5 billion in 1987.

In 2007 the United Nation population division projected that the world's population will most likely surpass 9 billion in 2050. The last 50 years have shown rapid increase in productivity, particularly in the period 1960 to 1995 made by the green revolution.

A disturbing report came out from the United Nations recently. It predicts that in the next 45 years, the world's population will increase by more than two and a half billion people, to top nine billion. At the end of this year, the world will have 76 million more people than it did when the year began. At that rate, there will be about 2.6 billion more people by 2050. That growth by itself is more than the total population of the world in 1950, and according to the U.N. figures, the projected picture represents a definite split between the rich and poor nations. In the hungry developing countries, the population is exploding, while in the rich, predominantly northern ones growth has showed to in some cases, level below which the population can sustain itself without
immigration. The earth now had about six and a half billion people, of which the industrial countries account for around 1.2 billion. The people at the U.N. population division, who study these things, don't expect that figure to change significantly, since countries in Europe and Japan experienced dramatic reduction in their birth rates in the past 20 years or 50. The main exception among the wealthy nations is the United States, which takes in a relatively large number of immigrants, who tend to have more children in the first generation.

Among the developing nations, the U.N. predicts that population will triple in Afghanistan, Burkina Faso, Burundi, Chad, Congo, Democratic Republic of the Congo (which for many years called itself Zaire), Timor-Leste, and Uganda overwhelmingly African.

Particularly in South Africa, AIDS has cut into the population so drastically that life expectancy has dropped from 62 years between 1990 and 1995 to 48 in 2000 - 2005. The U.N. adds that it could go as low as 43 years in the next decade before a slow recovery takes hold. The agency also reports that AIDS and poor health care is also dragging down life expectancy in eastern Europe, particularly in Russia and Ukraine.

The two giants in world population - India and China - will continue to duke it out for the first place. India, where women have an average of three children, will surpass China in population²⁹. There,

because of a stringent birth-control policy, women have an average of 1.7 children. By 2050, both Asian giants will have about half the world's population. Right now, most of the word's people live in only a few countries. Four out of ten people live in either India or China, while eight of ten inhabitants are found in the United States, Indonesia, Brazil, Pakistan, Russia, Bangladesh, Nigeria and Japan. All these additional people will want a higher standard of living than the preceding generation and this puts enormous pressure on the world itself. During the past century and particularly in the last 40 years — people have caused enormous changes in the environment. For example, we have cleared about half of the world's original forest cover, and have degraded or fragmented another 30 percent. By burning ever increasing quantities of wood, coal, oil and natural gas, we pour spiraling quantities of gases such as carbon dioxide into the atmosphere, creating what's now known as the greenhouse effect. Because the carbon dioxide traps the heat in the atmosphere, the earth is warming up much faster than it has in its entire history except for periods of unusual geological activity.

Perhaps the most dramatic indication of humanity's deleterious effect on the world, we call home is found in the oceans. Three quarters of the world's fish stock are being exploited at, or above levels which

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are sustainable. The U.N. people estimate that in the past half century, the growing industrial fishing fleets have taken perhaps 90 percent of the large ocean predators at the top of the food chain - species like tuna, marlin, sword fish and sharks. Anyone familiar with mathematics will understand the exponential nature of population growth$^{31}$. You don't need a great deal of growth down at the individual level, but as the overall number increases, the growth spurs out in directions. That makes the problem increasingly harder to control, but it's still not impossible. It means that every country has to address population issues in a calm, rational manner, and then take the firm, drastic measures needed to grasp control of this runaway beast.

In doing so, it is well for us to bear in mind the musings of Thomas Malthus, an English political economist of the late 18th century: "Population, when unchecked, increase in a geometrical ratio. Subsistence increase only in an arithmetical ratio"$^{32}$.

The Indian population of 1.12 billion and rising, is too much for a nation that has problem in providing basic welfare to a majority of its people. Some argue that it is the lack of basic amenities and rights for many that leads to the 'population problem'. For years, policymakers have been tinkering with this chicken-and-egg problem. Responding to

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the Government of India's petition to replace one maternity scheme with another that removes the two child, 19 years olds and above cap for eligibility, the court observed that such a scheme could not be indefinitely funded.

The new scheme applies to women from below poverty line (BPL) families and provides Rs. 500 to expecting mothers 12 weeks before delivery. Does the state indefinitely keep throwing taxpayers' money at pregnant women? Or does it provide nutritional care to women who cannot afford the most basic maternal care? There methods are scampering up the wrong tree. Linking incentives and disincentives with the use of contraception is pointless. Such an approach fails, making needy individuals with more than two children ineligible for schemes.

The real way is a bundle of policy initiatives like the education of girls, provision of better health services and social security, empowering women to take reproductive decisions and providing peer group information on contraception. The correlation between these initiatives and reducing fertility rates is proven. Will the state, socialistic in its rhetoric down the decades stop taking the easy way out and proceed to build a solid welfare net that can take care of our needy

33 World Population Prospect: The 2004 Revision, United Nation.
millions who, today, have nothing to gain in the long-term by having smaller families.

**United Nations Population Fund (UNFPA)**

UNFPA, the main international source of population funding, began operations in 1969. It is funded by voluntary contributions from member countries. It helps countries in finding solutions to their population problems. It is the main international source of economic assistance to developing countries. The fund supports programs to improve pre and postnatal mother's health, to provide access to voluntary family programs and contraception, to support education on sexually transmitted diseases and HIV, and to formulate population policies that support sustainable development and poverty eradication. The fund helps to reduce unwanted pregnancies and deaths and injuries for millions of mothers around the world.

UNFPA is assisting India in supporting the strategy endorsed by the 1994 international conference on population and development (ICPD), which emphasized the inseparability of population and development and focused on meeting individuals' needs rather than demographic targets. The key to this new approach is empowering women and expanding access to education, health services and employment opportunities.

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UNFPA Country Program - V (1997-2001) of US $100 million for India is the largest UNFPA Programme of assistance worldwide\textsuperscript{36}. The Country program-V has been divided into 3 sub programs:

- Population and development
- Reproductive health
- Advocacy and IEC

All the activities are undertaken in accordance with the principles and objectives of the ICPD Program of Action, endorsed by the U.N. General Assembly. The sub-program seek to institutionalize as many activities as possible with in the existing government and non governmental structure to ensure, longevity and sustainability. UNFPA supported integrated population and development (IPD) projects in approximately 40 districts in 6 states in India (Maharastra, Gujrat, Madhya Pradesh, Kerala, Rajasthan and Orrisa) will address the needs of individuals and couples to achieve their personal reproductive intentions, will help in eliminating discrimination against girls, and will help in providing quality reproductive health services.

UNFPA Country Program - V supports the Government of India in the following key areas:

- Integrating population issues within a wider development context.

\textsuperscript{36} U.N. News Centre.
• Implementing the draft national policy for the empowerment of women.

• Developing special programmes to improve women's status and address gender disparities.

• Strengthening the logistics system for distribution of contraceptives and broading the choice of available contraceptive methods; and

• Enhancing advocacy efforts to promote the concept of reproductive health and gender equality.

U.N. Conference on Population (Cairo 1994)

The United Nations has for over forty years been coordinating efforts to bring global population under control. At the U.N. Conference on population in Cairo in 1994, 179 nations endorsed a new "Programme of Action" that called on governments to provide universal access to reproductive health care by 2015 as a global human rights imperative. Instead of focusing just on controlling population growth. This program tries to identify and deal with the many interrelated social problems that contribute to population growth and poverty. The conference recognized that meeting individual reproductive health needs would enable couples to choose the number and spacing of their children, and that this would lead to smaller families and stabilization.

of the human population. The goal of the Cairo agreement is to stabilize human population at 7.8 billion by 2050. There are five basic components:

- Provide universal access to family planning and reproductive health programs and to information and education regarding these programs. As estimated 125 million women desire family planning services but do not have access to them.\textsuperscript{38}

- Recognize that environmental protection and economic development are not necessarily antagonistic, but that economic development is essential for environmental protection. Promote free trade, private investment and development assistance.

- Make women equal participants in all aspects of society — by increasing women's health, education and employment.

- Increase access to education. Inadequate education is an undeniable determinant of high birth rates and prevents individuals from reaching their full potential. The goal is universal primary education by 2015. Provide information and services for adolescents to prevent unwanted pregnancies, unsafe abortion and the spread of AIDS and sexually transmitted diseases.\textsuperscript{39}

\textsuperscript{38} October 30, 2007. Hindustan Times.

\textsuperscript{39} June 17, 2005. UNFPA.
• Ensure that men fulfill their responsibility to ensure healthy pregnancies, proper child-care, promotion of women's worth and dignity. Prevention of unwanted pregnancies and prevention of the spread of AIDS and sexually transmitted diseases.

• The world could possibly reduce consumption down to a very basic level, but if population keeps growing eventually that will not be enough. Even today many are living on a sub-sustainable level, due in part to an uneven distribution of resources, but also because, in many regions, population has outgrown resources for that region.

When people feel threatened by a hand-to-mouth existence, they are more likely to look towards less-than democratic way to reduce population, especially if they have the foresight to realize that population growth is like a runaway train, very difficult to slow and stop.

However, more and more evidences are showing that the methods that work the best towards reducing population growth, are the methods established by the principles of the Cairo conference in 1994 (United Nations International Conference on Population and Development (ICPD) September 1994, Cairo, Egypt), which include:

• Empowering women and girls in the economic, political and social arenas.

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- Removing gender disparities in education.
- Integrating family planning with related effort to improve maternal and child health.
- Removal of target family sizes.

**Fertility Rates Drop**

Some 180 nations agree with economist Amartyasen; Author of "Development as freedom" receipt of the noble memorial prize in economics science in 1998 at the united nations international conference on population and development in Cairo in 1994; that Coercion has no place in any population programme, whether it be a one-child policy, sterilization, forced marriage, forced child bearing or forced sex. Perhaps the most immediate adversity caused by a high rate of population growth lies in the loss of freedom that women suffer when they are shackled by persistent bearing and rearing of children.

Female illiteracy, lack of female employment opportunity and economic independence contributed substantially to the muffling women's voice in society and within the family. Not knowing about family planning or available family planning facilities is also an important source of helplessness. Cultural and religious factors often force young women to accept a subservient position and burden of constantly bearing and rearing children which husband or parents - in -
law have placed on them. On the other hand, women's empowerment, through employment, education, property rights, etc. can lead to the reduction of the fertility rate. The Indian states of Kerala, Tamil Nadu or Himanchal Pradesh have experienced speedy fertility declines which can be linked to the rapid enhancement of female education, employment opportunity and other empowerment of young women\(^{41}\). The states of Uttar Pradesh, Bihar and Rajasthan on the other hand give few economic and educational opportunities to young women and experience high fertility rates.

It is notable that China where coercive one-child policies were adopted. Fertility rates fell from 2.8 to 2.0 between 1979 and 1991. Where in Kerala, where fertility decline was freely chosen. Fertility rates fell much faster from 3 to 1.8 in the same period. In Kerala the rate of expansion of female literacy has also been faster than China and consequently Kerala's infant mortality rate has continued to fall fast while it has not in China.

**The Cairo Program of Action**

Acknowledges the complex personal and social contexts within which decision about child bearing are made. It separates the problem of unwanted fertility, which can be addressed by access to family

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\(^{41}\) The Nation. No. 4, Vol. 27.
planning services, from other causes of population growth, including the desire for large families. Calls for other social investments — such as the education of girls and the reduction of infant mortality — to help make small families the norm, endorses a reproductive health approach to family planning. Recognizes the central role of gender relations, with a link between high fertility and the low status of women and offers strategies to empower women through access to educational resources and opportunity. Addresses the harmful effects of northern consumption pattern, drawing the connection between consumption, population growth and environmental degradation.

The document asks governments to address unsafe abortion as a major public health concern. It also asks governments to ensure that abortion services are safe when they are not against the law to provide reliable and compassionate counseling for all women who have unwanted pregnancies and to provide human care for all women who suffer the consequences of unsafe abortion.

Stand on solid ethical ground, coercion of all is rejected. The means it proposes to slow population growth for all desirable ends in themselves. It offers strategies to narrow the gaps between rich and
poor, and between men and women. When we talk about the ICPD programme of Action, we are not discussing ideas and programs that might work. We are talking about ideas and programs that have already been proven to work in a cost-effective manner and in a short period of time. These are programs that, if funded properly, could improve the lives of billions of people and also stabilize the population of the world during the middle of the next century.

The United Nation Commission on population and development estimates that in 2000 world's population was around 6 billion. In 2050, it will be 9 billion. India is the world's second most populated country with over 1.1 billion people, not far behind China which has 1.3 billion. But China's population is expected to level off in the coming decades because of the government one-child per family policy. India's population will keep on rising and the united nation expects it to reach around 1.6 billion by 2050 by which time it will have overtaken China to become the world's most populated country.

The United Nation population fund announced that the world population crossed the six billion mark today, with India all set to touch the one billion mark by May next year, accounting for almost one Sixth of it. Almost 78 million people are being added globally every year and the growth is concentrated in some of the poorest countries, the

organization's India representative 'Michael Vlassoff' said at a press conference hence today being observed world wide as the "day of the six billion"\[44\].

The goodwill ambassador of UNFPA Shabana Azmi said — to stabilize the growing population, the government should come out with a strong population policy and appropriate health care measures. She said — a coercive method of population planning have failed in the past, the new policy should make men and women equal partners in decisions regarding reproductive health issue, without violating the reproductive rights of people. Azmi said — All the states should learn from Tamil Nadu and Kerala which have successfully implemented India's reproductive and child health (RCH) policy that started in 1997\[45\].

Infant mortality rate has been reduced to 57 per 1000 from 155 per 1000 in 1950. Increase in urban population is three times faster than the increase in rural population world wide and there would be megacities in the world by 2015, 18 of which would be in Asia, UNFPA said.

In 1994, 179 nations agreed to confront population related challenges at the international conference on population and development (ICPD) at Cairo. A five-year review has shown that


(ICPD) approach has met with some success and member countries are firmly committed to it. According to UNFPA population growth has slowed due to lower fertility, increased life expectancy and decreased infant mortality rates.

The Indian Association of Parliamentarians on Population and Development (IAPPD) in collaboration with UNFPA, is getting a pledge card signed by senior leaders and state minister that would be presented to the U.N. Secretary General Kofi Annan. Shabana Azmi said — 70 percent of maternal death in the country were preventible and more women die of pregnancy related disorder in India in a week than those in Europe annually. Azmi pointed out — most women in rural India suffer from reproductive tract infections due to poor hygiene. Population stabilization measures world wide require $17 billion annually which equals what the world spends on weapons in a week, she said.

UNFPA will organize various campaign starting today to review the debate on population and development issues. Population foundation of India would organize a national symposium on population and development in February next year. About 80 million people are annually added to the world population and about 56 million people die every year\(^{46}\). Population declines due to lower birthrates. Japan, Bulgaria, Italy Estonia and the Russian Federation are

among the countries that have achieved negative population growth. Population explosions tend to occur in regions already struggling with hunger. Africa is expected to undergo the most rapid growth, increasing from 784 million people in 2000 to nearly 1.8 billion in 2050. Eight countries — India, Pakistan, Nigeria, The United States, China, Bangladesh, Ethiopia and the Democratic Republic of Congo — are expected to account for half of the world’s population increase during the next fifty years. India may overtake China as the most populous country, rising from just over one billion to more than 1.5 billion between 2000 and 2050.

**United Nations Projections**

At the beginning of the twenty-first century, the world population is still growing at a rate of 1.2 percent annually. This is the same as adding 77 million people to the world each year. A world population projection published by the United Nations in 2002 estimates that the world’s human population will reach 8.9 billion by 2050.

The population is not expected to occur evenly across the globe. The population of some nations is shrinking while those of other nation's is swelling. During the past few decades, reproduction rate have decreased in countries where the standard of living has improved;

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47 Ashford Lori
these improved living standards are generally associated with higher education level across a population and access to birth control.

**World Population Fast Growing**

The world population of 6.4 billion is expected to be over 8.9 billion by 2050. In 1950 the total world population was 2.5 billion. Human growth has slowed since it peaked in 1980's at around 82 million, the average children family has declined from 6 in 1960 to three today as family planning became more accessible. Projection suggest that population will start to level off by the middle of the century due to fertility drops to replacement level. In the poorest countries where access to family planning is limited, the transition to smaller families is just beginning. Six developing countries, India, China, Pakistan, Nigeria, Indonesia and Bangladesh account for half of the annual increments of the world population, with India making up 21%.

**Investing in Slowing Population Growth**

United Nation agreed on a plan to achieve economic development and slow population growth in 20 years by investing in reproductive health care and education. In 1994, the world's population of 5.6 billion was growing at 93 million per year, but today it is 77 million, 17% slower. Challenges remain to be overcome.

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• Population will increase by one-third in the next 50 years.
• Meeting reproductive health needs is faltering.
• There is inadequate funding for education.

Nations should make good on their pledge to invest $365 billion in family planning and reproductive healthcare before 2015, but investment is 70% behind schedule. Half the world is under 25 and they deserve the services and information to make decisions about childbearing. The more educated a woman is the more she improves her family's health and income delays her age of marriage and lowers the number of children. Research indicates a link between falling birth rates and economic growth. A variety of programs need to be expanded to reach more people and requires partnerships between government and society. Commitment will be demonstrated when government show their leadership by embracing program that work.

**Effective Tools for Empowering, Educating Women**

We have just entered the 10th anniversary year of the historic international conference on population and development, held under United Nations auspices leadership in Cairo in 1994. For the U.N. to succeed in its endeavors, partnership with civil society is a necessity. The conference in 1995 forged a consensus to ensure that reproductive

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49 U.S. Census Bureau's World Population Profile, 1996.
health is recognized as a human right and reached agreement on actions
to achieve gender equality, economic and social justice. It also paved the
way for the Millennium Development Goals — adopted by all the
world’s countries as a blue print for building better lives for people
every where in the 21st Century51. Every one of us can and should
respond; one of the most effective ways is through the education and
empowerment of girls and women.

Reproductive Health of Young Adults in India: The Road to Public
Health

In 1999, with the support of the Bill and Melinda Gates
Foundation and unrestricted seed money by the pathfinder board of
directors, pathfinder international launched the first phase of the
reproductive health of young adults in India (RHEYA) project, a seven­
year pilot project to change the attitude of adolescents and young adults
related to reproduction, overcoming the idea that ill health is an act of
God or a result of one’s fate. RHEYA project has improved the overall
utilization of reproductive health and family planning services
primarily by changing popular beliefs and knowledge about early
marriage and child bearing and the importance of spacing children to
improve their chances of surviving and thriving.

In selected areas of the states of Tamil Nadu, New Delhi, Rajasthan and Madhya Pradesh, Pathfinder Partnered with four local non governmental organization to develop effective interventions that reached nearly 22,000 young people from underprivileged communities with adolescent sexual and reproductive health (ASRH) information.

The project's goal was to reach parents, in laws, and community and religious leader, as well as the young people themselves — all at the same time. More than 81% of the people of India live on less than $2 per day; despite amazing economic progress, much of the country remains crushingly poor. India is a home to 30% of the world's young people between the age of 10 and 24.3 — reaching their reproductive years. Indian women bear an average of 3.0 children, which means the country's population will double in 41 years. Indian women "like those in many developing countries" bear their children at very young age. The median age of marriage of girls is 16.75, well below the legal age of 18. Given little knowledge of or access to contraception, their child bearing is telescoped into adolescence and early adulthood. Only 5% of married women between the ages of 15 - 19 and 21% between 20 - 24, use modern method of contraception. In fact, according to a study from NFHS 2 (National Fertility Health Survey) 1998 - 1999, at least 25.6% of women between the ages of 15 - 19 and 18.4% do so. For over 30 years the government of India aggressively addressed the problem of
population, with a dominant focus on promoting small families and the use of sterilization after two or three children.

"A small family is a happy family" was the slogan, which led people to believe that the government's goal was to limit the population. They saw contraception as a government need, rather than as something that is to their personal advantage. India has a tragically high maternal mortality rate and adolescent girls are twice as likely to die in childbirth as women in their twenties. For those between the ages of 10 - 14 years, the risk is five times higher, due to emotional and physical immaturity. Adolescents are also the age group most vulnerable to sexually transmitted infections (STIs) and HIV/AIDS.

In India, and in much of the developing world, the key to reducing maternal and child mortality, the prevention and treatment of HIV/AIDS, empowering women, improving their health, ensuring family well being and reducing population growth rates, is an urgent focus on adolescents52.

UNFPA Proposed Projects and Programmes in India

The United Nations Population Fund (UNFPA) proposes to support a population programme over the five-year period 1997-2001 to assist the government of India achieve its population and development

objectives. UNFPA proposes to fund the programme in the amount of $100 million, of which $80 million would be programmed from UNFPA's regular resources to the extent such resources are available. UNFPA would seek to provide the balance of $20 million from multilateral and/or other, including regular, resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources. This will be UNFPA's fifth programme of assistance to India.

The proposed programme was developed with the participation and in cooperation with the government of India, national experts and non-governmental organizations (NGOs) following a programme review and strategy development (PRSD) mission that visited India in August 1996. The new programme has been designed to coincide with the governments ninth five-year plan (1997-2001) and with UNDP's fifth programme cycle.

The main purpose of the proposed programme would be to complement the government's efforts to operationalize the reproductive health approach to replace the target-oriented family welfare programme of the past. The programme would assist the government in meeting its national goal of improving the reproductive health of India's

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women, men and adolescents and of achieving an early stabilization of the country's population. The proposed programme would operate within the framework of the government's policies of decentralizing authority to local governments.

The proposed programme will operate at two levels. In order to help the country meet the needs of its citizens for quality reproductive health services, the programme will assist in the provision of such services in 40 districts in six states. Some of these districts were chosen because they have particularly unfavourable reproductive health indicators and/or lack a full range of essential services while other were selected because they are relatively better endowed with services and can easily serve to develop programmes for replication elsewhere\(^5^4\). These interventions are intended to have an immediate impact on the districts where they will be implemented as well as to serve as models for other states and districts. At the national level, the programme will assist the government in promoting the integration of population issues within a wider developmental context; implementing the national policy for the empowerment of women and special programme to improve women's status and address gender disparities; and strengthening the logistics system for distribution of contraceptives as


[166]
well as increase the contraceptive method choice. The programme also aims to help the government strengthen advocacy efforts in favour of reproductive health to incorporate the concepts and approaches of the international conference on population and development (ICPD).

All activities under the proposed programme, as in all UNFPA-assisted activities, would be undertaken in accordance with the principles and objectives of the ICPD programme of action, which was endorsed by the general assembly through its resolution.

India's population in 1996 was over 950 million and, at an annual growth rate of about 1.8%, it will cross the billion mark before the end of the millennium. Despite the fact that birthrates and fertility level have fallen everywhere in India, there are wide regional variations, ranging from total fertility rate of 4.8 in Uttar Pradesh to 1.9 in Goa and Kerala. The pace of fertility decline has accelerated in recent years, due mostly to the increased use of modern contraception. However, due to large population base and a relatively young population profile, India's population would continue to grow for another 40 years even if replacement fertility were reached immediately. Economic growth has been robust in the last two years, but poverty remains very high and continues to be the most important development challenge. Though India still remain a rural nation, it is experiencing rapid urbanization. By the year 2021 about 50 percent of the population is projected to be
living in cities and towns. This rapid growth has important implications for health services in urban areas, particularly for slum dweller's and other vulnerable groups. India is classified as a category "A" country in terms of UNFPA's new approach for resource allocation

Women in India lack power with regard to many of the decision that affect their lives, including those of healthy and fertility. Preferences for sons continues, resulting in discrimination and neglect of the girl child and in some cases, to female infanticide. Our serious concern is the overall female-to-male sex ratio of the population, which has been declining consistently over the decades to a level of 927 women over 1,000 men, according to the 1991 census. Educational inequalities between females and males are pronounced, with male literacy at about 64 percent while female literacy is only around 35 percent. Employment of women continues to be very low, and most their work remain home-based.

India has been a leader in developing national population and health policies and in many respects has achieved significant success. In the past 40 years, life expectancy at birth has doubled; infant mortality dropped from an average of 150 per 1,000 live births to 82 per 1,000 live births maternal mortality was reduced from 800 per 100,000 live births to 460 per 100,000.

55 U.S. Census Bureau's World Population Profile 1996.
Fertility levels declined from over 6 children per woman to an average of 3.4, while the contraceptive prevalence rate increased from less than 10 percent to 43 percent. However, female sterilization currently accounts for over 80% of modern contraceptive practice, which suggests a strong need for increasing the use of temporary methods. The current use of kills and intrauterine devices (IUDs) are less than 1.2 and 1.9 percent, respectively, of the total use of contraceptives. India manufactures and distributes its own contraceptives — including pills, IUDs and condoms — UNFPA has played a significant role in bringing about this self-sufficiency; however, there is a very low use of contraceptive among the age groups in which fertility is highest, 15 - 19 and 19 - 24, who have been neglected by both the health and the family welfare programmes. As a consequence there is a notably higher risk of maternal mortality and morbidity in these age groups.

(a) Previous UNFP Assistance

UNFPA assistance has contributed significantly to India's advances in the areas of population and reproductive health. Support for maternal and child health and family planning (MCH/FP) programmes has helped to improve family planning services in backward districts in three states by providing intensive support under
the area development project scheme. The fund has also helped India to achieve self-sufficiency in local production of IUDs and oral pills. In assessing, UNFPA's past assistance, the PRSD mission found that UNFPA's limited resources had been placed in key areas and that UNFPA had successfully supported the government's shifts from a targeted family planning approach to one based on maximizing reproductive health.

One of the many successful activities cited was support for a state population information, education and communication (IEC) bureau in Rajasthan, which helped integrate IEC components into family welfare programmes throughout the state. This is now being replicate in other states. In addition, the PRSD found that UNFPA played a critical role in building consensus on population and women's issues among NGOs.

The country programme evaluation highlighted a number of constraints that need to be addressed in the development of future activities. First, the absence of baseline surveys made it difficult to assess the impact of the programme. Also, since a significant proportion of UNFPA funds were invested in building infrastructure, fewer funds were available for human development, systems improvements and operational research. Disbursement and utilization of committed funds were delayed in a number of projects due to procedural bottleneck.
resulting from the government's approval and implementation process. And it was felt that the program had insufficient focus on the specific needs of adolescents and youth on male involvement in family planning, on the challenges facing women's empowerment, and on the problems of the urban poor.

In considering UNFPA's future role, the PRSD recommended that the fund continue to support a comprehensive population programme focused on operationalizing India's new target-free approach as well as increasing the accessibility of quality reproductive health services and undertaking operations research to demonstrate the cost-effectiveness of a variety of approaches. The PRSD supported enhancing the role of NGOs, their capacities and their participation in the proposed programme. It additionally recommended promoting policy support and intersectoral linkages between reproductive health and other sectors, as well as empowerment initiatives addressing gender disparities. Since 25 percent of India's population is made up of adolescents, the mission emphasized that UNFPA assistance should give adolescent reproductive health issues, especially those of girls, priority attention.

Other External Assistance

In addition to UNFPA, other major development partners in the population field include the world Bank, UNICEF, the world health
organization (WHO), and the government of Denmark, Sweden, Norway, the United Kingdom and the United States. The world bank is expected to provide $300 million as an international development assistance (IDA) loan to strengthen the department of family welfare in support of the government's reproductive and child health programme. UNICEF provides $40 - 60 million annually to support efforts to improve the status of children including child survival and safe motherhood activities, targeting areas with the lowest health status, particularly in the northern states. A number of donors, including UNDP, UNICEF and UNFPA, are making resources available in an effort to expand the educational opportunities for the girls child and enhance the empowerment of women through income - generating activities. The German Kreditanstalt fur wiederaufbau (KFW) has recently signed an agreement to support an international NGO, population services international in a social marketing programme. The international planned parent hood federation (IPPF) provide assistance to its affiliate, the family planning association of India.

Donors assistance to other population and development sectors is less prominent, and UNFPA remains the only donor supporting a comprehensive population programme. UNFPA's comparative

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advantage is based on the government's recognition of its long experience in the country and belief that UNFPA should provide guidance for major aspects of national level policy change as well as in operationalizing the reproductive health approach at the state and district levels. Under the proposed programme UNFPA's concentration of reproductive health activities in certain districts will complement the interventions of other donors active in other parts of the country.

**Proposed Programme**

Given the existing inequalities faced by women in all spheres of life in India, the UNFPA programme will have a strong focus on women's empowerment issues. The programme will support the implementation of the national policy for the empowerment of women and assist the government in its strong advocacy and awareness-building activities designed to influence Indian attitudes regarding gender issues. Adolescents will also be given special attention in all programme components and initiatives through information and counseling and the provision of reproductive health services. Resources will be used for a few selected urban locations to integrate reproductive health services in ongoing government schemes addressing the improvement of the lives of women and adolescents among the urban poor.

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59 March 11, 2005. UN News Centre.
UNFPA will operationalize the integrated reproductive health approach in 40 selected districts in six states — Gujrat, Kerala, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh. Fifty percent of programme funds will be used to support the introduction of quality reproductive health service and associated activities integrated with other development programmes in these selected districts. In order to increase the participation of NGOs in programme implementation, 10 percent of country programme funds will be set aside exclusively for activities to be undertaken by NGOs and for strengthening NGO capabilities. This will enhance implementation of innovative initiative and provide service to communities that are remote or have little access to other programmes. UNFPA will also continue to work with women's advocacy group to improve awareness of access to and the quality and range of reproductive health services. In view of the large number of expertise India has developed over the years in the area of population and development, UNFPA will facilitate exchange of knowledge with other countries in the region.

Reproductive Health

The proposed programme would support the government's goal of reducing maternal and infant mortality, increasing the contraceptive prevalence rate and achieving a net reproduction rate of 1 by the year
2006. Nationally the programme will fund research for the development of effective IEC interventions regarding safe practices, family planning, violence against women, safe motherhood, and sexually transmitted disease (STDs) inducing HIV/AIDS.

The programme also proposes to help create demand, and be more responsive to needs for reproductive health services among the general public, one method for achieving this will be to enable health care provider to respond to client needs through effective interpersonal communication. The programme will also assist in developing quality IEC materials that reflect post ICPD concepts and approaches. Training will be provided to improve population education in schools.

The proposed programme also seeks to ensure availability of a wider range of quality contraceptive methods emphasizing non-permanent methods, in that currently 80 percent of contraception is achieved by female sterilization and there is a need to reach younger couples and men. To help improve performance of the national reproductive and child health programme. UNFPA will help develop and introduce procedures, guideline, standards and assessment indicators of unmet needs for contraception and other services. Support will also be provided for upgrading the logistics management system so

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that it can accommodate the needs of comprehensive reproductive health services. The fund will also provide assistance for operations research and for epidemiological surveys to determine the prevalence and patterns of maternal mortality and morbidity, reproductive health morbidities and infertility.

UNFPA will assist the government in implementing "target free" reproductive health programmes in 40 districts in six states with local community involvement in design and implementation. The service will include family planning, sexual health, maternal health, management of the consequences of unsafe abortions and the prevention and screening of reproductive tract infections and STDs. The fund will also support IEC activities in the 40 districts directed towards specific communities and to specific target groups, including women, men, young people and traditional birth attendants. INFPA will support baseline surveys of health services in the selected districts in order to establish a project evaluation mechanism, giving special focus to women adolescents. Based on the findings of these surveys, the fund will provide training and technical support to enhance the capacities of district health staff in terms of planning and management.

**Population and Development Strategies**

Coordination of population and development activities will be
pursued through the strengthening of the capacities of the local governments in the 40 districts selected for UNFPA assistance. The programme proposes to provide selective support for key policy-oriented research, the outcomes of which will be used for advocacy and for guiding programme activities. In addition, it will assist the government to improve the data entry and analysis processes for the census to be conducted in 2001. Special focus will be on producing gender disaggregated data and data that will include comprehensive reproductive health indicators. Drawing on lessons learned from past experience with women's income-generating activities and empowerment projects, the programme will support interventions with other donors that enable girls and women to have equal access to social and economic assets and to improve their health and status in society61.

In this context, UNFPA will also support components of a primary education programme for girls as part of a United Nations system initiative for India.

**Advocacy**

UNFPA proposes to undertake efforts to assist the government in increasing the awareness of public representatives, policy makers, programme planners and service provider on key reproductive health

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61 U.N. Statistical Division. Women's Indicators and Statistic Database, Version 3 (CD-ROM), 1994. Which is based on data compiled by UNESCO.
issues, including women's empowerment, the special needs of adolescents, male participation in reproductive health programmes and the integrated nature of population and development issues. Lesson learned from UNFPA's previous programmes suggest that India's advocacy programme have not adequately addressed cultural, ethnic and linguistic diversity in developing messages.

The need for effective interpersonal communication has not been given adequate attention in the past. Although India has a long history of population education programmes, which were started in 1969, the focus needs to be reoriented to post-ICPD concepts. The challenges will be addressed under the proposed programme. To carry out more effective advocacy in support of the government's reproductive and child health programmes, UNFPA will support IEC Bureau in selected states and some NGOs and academic institutions to enable them to carry out state or district level programmes.

**Implementation, Monitoring Evaluation and Coordination**

As in the past, the programme will be largely carried out through national modalities, drawing on the large pool of human and institutional resources available in India. This will include central ministries, state and local governments and national research institutions and NGOs. Certain specific technical inputs will be carried
out through United Nations agencies and international NGOs. The modalities for implementing districts programmes will vary depending on the administrative set-up of the states but will include departments, voluntary societies under the district collector or the district council, and NGOs. UNFPA will work in the six states in a phased manner starting in 1997 with the districts in Rajasthan, where it has a substantial niche in terms of physical presence, past experiences and working relationship with the state mechanism. To expedite the processing of NGO proposals, UNFPA will establish a regular system of view meeting with concerned government departments.

In order to provide stronger technical and managerial support at the district, state and national levels, UNFPA proposes to create a unit in each of the targeted state and a technical services group based in New Delhi. In addition, the UNFPA country support team based in Kathmandu Nepal, will provide technical expertise as required. For a more continuous and efficient flow of funds from the centre to the states and individual projects, UNFPA will work with the government to identify multiple channels like government treasuries at the central and state levels and direct transfer from the concerned department of the central government to the implementing agency at the state or district level.
The UNFPA country programme will be reviewed annually by a National Committee chaired by the union secretary for family welfare and will include the membership of other relevant sectors, ministries. It will assess the programme in terms of its contribution towards achieving national population and development programme objectives and also to address population and development priorities for the coming year. Similar review mechanism will be established for large projects at the state level. A mid-term review of the programme will be conducted in 1999.

**Recommendation**

The Executive Director recommends that Executive Board approve the proposed programme of assistance for India, as outlined above, in the amount of $100 million over the five-year period 1997-2001, $80 million of which would be programmed from UNFPA's regular resources, to the extent such resources are available, and the balance of $20 million would be sought from multi-bilateral resources and/or other, including regular resources to the extent possible, consistent with executive board decision 96/15 on the allocation of UNFPA resources.

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62 Second Regular Session 1997, 10-14 March 1997, New York, Item of the Provisional Agenda UNFPA.
Conclusion

United Nations is an international organization of countries. Its aim is to maintain world peace, and to promote cooperation in solving the world problem. In 1994 international conference on population and development (ICPD) in Cairo focused the world's attention on the challenges facing all nations as they seek to integrate population and development policies and programmes. United Nation's report says that in the next 45 years the world population will increase by more than two and half billion people. At that rate, there will be about 2.6 billion more people's by 2050. The two giants in world population - Indian and China will continue to duke it out for the first place India will surpass China in population. UNFPA is the main international source of population funding. It helps countries in finding solution to their population problem. The 179 countries committed to the ICPD programme of action for the next 20 years. Promising to shift goals away from demographic targets, fertility reduction, and population control focused on comprehensive health and well being, women's empowerment and reproductive rights. UNFPA will support the population Census organization of developing countries to ensure women's concerned are addressed. UNFPA will continue to work on policy and advocacy for the millennium development goals.

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UNFPA is assisting India in supporting the strategy endorsed by the 1994 conference. UNFPA supported IPD project in approximately 40 districts in 6 states in India. UNFPA proposes to support a population programme over the five year period 1997 - 2001 to assist the government of India. UNFPA proposes to fund the programme in the amount of $100 million. The UNFPA programme will support the implementation of the national policy for the empowerment of women. UNFPA will assist the government in implementing "target free" reproductive health programme in 40 districts in six states.

We have just entered the 10th anniversary year of the historic international conference on population and development held under the auspices United Nation in Cairo in 1994.

For the U.N. to succeed in its endeavors, partnership with civil society is a necessity. The conference in 1994 forged a consensus to ensure that reproductive health is recognized as a human right and reached agreement on action to achieve gender equality, economics and social justice.
CONCLUSION

We are aware of the problems created by rapid growth of population. To solve these problems and to attain national welfare, a population policy is essential.

The need for population policy are -

❖ To improve the economy of a country
❖ To maintain population suitable to the economy
❖ To attain economic and social progress
❖ To improve the standard of living
❖ To improve education and health
❖ To solve unemployment problem.

In 1952 India became the first developing country in the world to adopt a policy of governmental efforts to promote a reduction in the number of children born to Indian couples. Many schemes were also implemented for family planning and family welfare.

Though the actual policy was first formulated only in 1976, the subject was discussed in various reports on the health services and taken up in the first five year plan in 1952 when India became independent, population growth was seen as a major impediment to the
country's socio-economic development and population "Control" was seen as integral to the development process.

In 1976, the first National Population Policy talked of integrating family planning with general health care, of maternal and child health, the influence of female education, employment and age at marriage on family size, the effect of a high infant mortality rate and so on.

The NPP 2000's states goal is to achieve not replacement level by 2010, by meeting people's reproductive and child health needs. The government plan to work with the private sector and voluntary organizations to establish a health infrastructure and provide a package of contraception, maternal and child health services. This approach is to result in population 'stabilization (total fertility rate of 2.1) by the year 2045 - a population' consistent with sustainable development.

The NPP 2000 notes that only 44 percent of India's 168 million couple's in the reproductive age group use effective contraception. Reproductive health and basic health infrastructure and service often do not reach the villages.

"India is in a state of rapid fertility transition with the pace of decline having accelerated in recent years". The use of 'incentives' disincentives and other forms of coercion is one of the most
controversial aspect of India's population programme. The National Population Policy 2000 (NPP 2000) explicitly recognizes the special needs of tribal communities and hill area populations. The policy statement noted the problem of low literacy, poor nutrition and childhood mortality among these sections of population (India, Department of Family Welfare, 2000: Para 25).

The Policy acknowledges that these groups are underserved on account of poor access and suggests strategies to overcome the problem.

The pressing need of the day is to create ideal condition for acceptance of the need for stabilizing the population and how it is an essential element of human welfare and development.

The solution this lies in spreading of education and enlightenment, and in the empowerment of women. There is no use of a population policy that cannot be easily or effectively implemented. The central and state government must together adopt a cafeteria approach to cater various needs and segments of the population.