CHAPTER 3

GOVERNMENT POLICY ON POPULATION –
MACRO POLICIES and MICRO RESPONSES

Overview

Population policy, though its connotation may differ from country to country, broadly refers to a set of policies that have an impact on the different components of demographic change, namely, migration, life expectancy, mortality and fertility. The ultimate goal of population policy has to be spelt out clearly by governments. Is achieving the desired population size an end in itself, in other words, is the government focused on such measures which deal with the active management of the overall size of the population, its age structure etc; or, is it a means to an end, which the government uses for the well being of the population? The latter scenario requires governments to focus on fostering/nurturing an enabling environment.

There are contradictory views as to whether countries need a population policy. It seems generally accepted that it is ethical for governments to monitor and have policies that influence life expectancy, mortality and migration; however, it is widely and hotly debated when it concerns fertility. The legitimacy of government intervention in monitoring and influencing fertility levels becomes the main issue to be resolved while considering whether to adopt a population policy. The growing international concern about the consequences of population change has caused governments to be ‘more inclined to view population as a legitimate area for government action’ [UN 2008, p.31]. In poorer countries, the presence of widespread and deep-rooted poverty justifies government action to contain demographic pressures that undermine the drive to economic development [Howse, 2007, p3].

The monitoring of national population policies by the UN at the international level began after the World Population Plan of Action was adopted at the World Population Conference held at Bucharest in 1974. In particular, the ICPD held at Cairo in 1994 recommended that actions be taken ‘to measure, assess, monitor and evaluate progress towards meeting the goals of its Programme of Action’ [UN, 2008, p 1].
The monitoring by UN encompasses three basic components:

(i) *Government views on population size and growth, population age structure and spatial distribution, and on the demographic components —fertility, mortality and migration—that affect them:* Two aspects of each variable are monitored. First, is the level or trend viewed as a significant policy issue and second, is the prevailing level or rate of change considered too high, too low, acceptable or satisfactory in relation to other social and economic conditions?

(ii) *Government objectives with respect to each variable:* Is the objective of the Government to raise, to lower the level of the variable, or to maintain its current level?

(iii) *Government policies concerning interventions to influence each variable:* Does the Government consider intervention to alter levels and trends as a legitimate exercise of its authority? Has the Government actively intervened to influence the variable? [UN, 2008, p 1].

According to the UN Report [*ibid*], governments’ views and policies concerning fertility have contributed to the fertility decline in developing countries. In the past, those governments that considered fertility levels too high did not necessarily adopt policies to influence fertility. For instance in 1976, 37 per cent of governments viewed their fertility level as too high and more than half of the governments did not intervene to modify the level of fertility. ‘By 2001, 91 per cent of Governments were providing support either directly or indirectly for contraceptive methods. The practice of limiting access to family planning methods has almost vanished’ [UN, 2003, p 28]. Consequently, the percentage of developing countries with policies to lower fertility rose from 34 per cent in 1976 to 56 per cent in 1996 but declined slightly to 51 per cent in 2007 [UN, 2008, p12], which could probably be because fertility levels had fallen below replacement levels. Thus, reproductive behaviour, while once viewed as a private matter outside the purview of Government action, became widely accepted as a major concern of Governments.

According to Merrick [1994, pp 86-87], concern about the negative impact of rapid population growth on efforts to raise living standards as well as the adverse effect of high fertility on the health and welfare of women and children has motivated governments in developing countries to subsidise family planning. As a result, fertility regulation has increased dramatically in developing countries. For instance, in
China, the population policy followed by Chinese government is a coercive one, wherein the state has enforced a common family size; the one-child policy has directly influenced China’s fertility rate [Howse, 2007, p 4].

However, advocates of government intervention are against any attempt to intervene coercively in individual choices about fertility and childbearing. In other words, it seems acceptable to use financial incentives (rewards) to boost fertility rates. Thus, much of the international condemnation of China’s one-child policy has been, not so much perhaps because of the ‘social compensation fee’ by which parents were required to pay for births above the stipulated number, but rather because of allegations of forced abortions and other coercive practices [Howse, 2007, p3]. Thus, Howse argues, if State intervention, in the low fertility case, is justified as a form of Pigovian subsidy designed to ensure that the production of children is increased to the socially optimum level, then a Pigovian tax, such as the social compensation fee introduced as part of China’s one-child policy, would also be justified in the high fertility case.

The promotion by government of a ‘climate of opinion’, which effectively stigmatises excessively large families as the product of anti-social behaviour, is also reflective of a coercive government policy [Howse, 2007, p3]. In India, the ‘climate of opinion’ assumes greater significance, because, coupled with the two-child norm, it has led to further entrenchment of the deep rooted social value system; for instance, the already prevalent social stigma attached to the female child, has, along with the extant population policy, led to an increase in female foeticide/infanticide.

There are two issues here. One, can a government influence fertility decisions, which are very private decisions of individuals? Secondly, do couples actually plan to have specific number of children keeping in view the government policies in this regard, or, do they follow their own agenda?

Whether couples follow government’s policy is dependent on the effectiveness of such government intervention. The first question stated above seems to find support when population growth rates are on either extreme. With high population growth rates, it was a widely held view that governments need to step up policies typically
aimed at reducing alarming population levels. Now, with countries facing low population growth rates owing to low (less than replacement) fertility levels, some governments are again resorting to measures to encourage couples to have more children in order to increase the population levels.

The impact of policy upon fertility has been the subject of many studies, such as those of Sleebos (2003), Grant et al (2004)\textsuperscript{32}, D’Addio et al (2005) and McDonald (2006). ‘These studies, while tending to support the view that policy can have a positive impact upon fertility, generally find, at best, only small effects for any one policy’ [McDonald, 2007, p 24].

However, while policies to reduce population (antinatalism), though without coercion, has been appreciated, governments have remained slow to take policy measures to support the having of children (pronatalism). The reasons for this are many according to McDonald [2007, p 23]. Firstly, in a crowded world facing environmental difficulties, it was argued that low fertility could be beneficial rather than detrimental. Secondly, State-sponsored pronatalism was portrayed as an invasion of the rights or the privacy of individuals to determine freely the number of children they want to have. (Although this argument is valid for antinatalist policies as well, it is seldom used). Again, as pronatalism involves public transfers (in whatever form) from those who do not have children to those who do, those opposed to family support policies on this ground argued that, because the decision to have a child is a private choice, those who make this decision should themselves bear the costs and consequences of their decisions.

According to McDonald [2007, p 23], the continuation of low rates of fertility over a longer period and recognition of the detrimental impacts of sustained low fertility upon future labour supply seem to have faded the objections to pronatalist policies. He supports his observation with the United Nations survey on population policy, in 2005, where ‘all 31 countries that had fertility rates lower than 1.5 births per woman reported that they considered their fertility rate to be too low and 35 countries

reported that they had policies in place that were intended to increase or sustain the national fertility rate’. At the intergovernmental level, the Commission of the European Communities’ Green Paper, *Confronting demographic change: a new solidarity between the generations*, also suggested that policies to increase fertility were a desirable direction.

Governments can choose to continue with current policies and deal with the results as they occur or can attempt to influence the future through changes to current policy. According to Sleebos [2003, p 5], while not all of the determinants or causal factors listed in the previous chapter are amenable to policy interventions, a range of measures *may* allow policy makers to influence fertility rates. He divides these policies in two groups:

- **Direct** policies that shape the financial incentives to childbearing, such as tax payments and subsidies.
- **Indirect** policies that, while targeted to other goals (such as increasing women’s employment, and diffusing dual-earner families), may also influence fertility, such as child-care, maternity and parental leave, the structure of tax and benefit system.

This aspect of secondary impact of policies is also corroborated by other studies, which state that fertility declines, and subsequent reverses, may be attributable more to the social and economic environment and less to policy changes. It is a belief that multiple types of policy intervention necessarily slow fertility declines.

However, the empirical testing of the impact of government policies on fertility seems difficult. D’addio et al [2005, p 57-58], while describing how a range of policies may affect the cost of children and analysing the relation between these policies and TFRs, observed that the empirical analysis of how policies influence childbearing is complex for various reasons. There being no universal definition of family policies; the difficulty in capturing the specific contribution of a policy change; some explanatory variables being endogenous; the difficulties in observing values of certain key variables (like direct costs of children, opportunity cost of a woman's time for women not in paid jobs) also complicate empirical estimation. Jackson [2001, pp 39-40] also states that ‘it can be recorded that the effects of explicit and/or direct pro-natal policies have typically been found to be nil or negligible’. Te extend the same
argument, the converse, namely, the effects of explicit and/or direct anti-natal policies, may also be nil or negligible.

McDonald [2006, p 506-507] justifies state intervention on moral, economic and sociological grounds and gives examples of four countries that have instituted major policy programmes to reverse the declining fertility trend, namely Austria, the Republic of Korea, Singapore and Japan. He opines that a stable environment will provide the necessary impetus for increasing fertility. ‘Fundamental to policy is institutional change that re-establishes a sense of confidence among young people that they will be able to embark on family formation with tolerable levels of economic loss and acceptable impacts upon individual aspirations’.

These studies focus on the need for an enabling environment, generally provided by the government, for fertility rates to increase. Conversely, the absence of such an environment will lead to a decline in fertility levels. However, in the Indian context, this argument does not seem tenable. Fertility rates have been higher in India, not because of ‘child friendly’ policies adopted by the government but because of other social, economic and cultural reasons, which is why the set of theories used to explain low fertility in western countries cannot be used in the case of India.

It is thus essential to understand the social, economic as well as political background and the mind-set of the government in order to comprehend the factors that influence the policymaking at the highest level. In India, though population was not so much the issue at that point of time, the family planning programme started from 1952. Since then the Government has had a major role in steering the focus of the nation on the problem of rising population. Whether the steering by government has brought down the fertility levels is discussed in this chapter.

**Fluctuating government policy in India - the background**

‘Population versus Development’ has been a matter of eternal debate. Few matters today provoke such intense discussion, dissent and discord as the population problem. Fluctuating ideologies have influenced population policies throughout the world. Relationship between population growth and economic development, rather their
interpretations, has led to different theories and conflicting government policies. The contours of the debate, as it has taken shape over the years, have played a role in moulding the population policy in India. The ‘population versus development’ debate that has occupied the world centre-stage for many decades is encapsulated in the following paragraphs.

The UN Report [2003, p 11-19], divides the evolution of population policies into five phases: (a) the 25-year period following the establishment of the United Nations (1945-1970); (b) the decade of the 1974 World Population Conference in Bucharest (1970-1980); (c) the decade of the 1984 International Conference on Population in Mexico City (1980-1990); (d) the decade of the 1994 International Conference on Population and Development (ICPD) in Cairo (1990-2000); and (e) the beginning of the 21st century.

During the first decades following the establishment of the United Nations, population and development were only beginning to emerge as concerns of the international community. Initially, the term development was connoting economic development and was measured only in terms of income. Myrdal [1987] redefined development as the upward movement of the whole social system involving levels of living, institutions, attitudes and policies besides production, distribution and modes of production. An advocate of economic planning, he argued that the only way to bring about rapid development in Southeast Asia is to control population, reform land tenure to enable the poor to own agricultural land, and expand basic services by investing in health and education. Thus, the stress was on human capital formation with the state making investments to build up human resources. Later, Todaro defined development as a multidimensional process involving major changes in social structure, popular attitudes and national institutions as well as acceleration of economic growth, the reduction of inequality and the reduction of absolute poverty. This was subsequently modified as ‘sustainable development’, a holistic term signifying development that meets the needs of the present generation without compromising those of the future. Since the 1990s, the concept of development is

more focused as human development. The United Nations [UNDP, 1990] in its Human Development Report (HDR) defines human development as the process of enlarging people’s choices, and thus the human being was brought to the centre stage of development.

The classic explanation of European fertility declines arose in the period following World War I and came to be known as demographic transition theory. Malthus [1798] anticipated terrible disasters resulting from population growth and a consequent imbalance in the proportion between the natural increase of population and food. However, true to the Enlightenment tradition, Condorcet was confident that this problem would be solved by reasoned human action: through increases in productivity, through better conservation and prevention of waste, and through education (especially female education) which would contribute to reducing the birth rate. ‘The debate between Condorcet and Malthus in some ways marks the origin of the distinction between the “collaborative” (social development) and the “override” (population control) approaches, which still compete for attention’ [Sen, A, 1994, p 4].

Since the introduction of the national family planning programme over half a century ago, the pendulum has swung back and forth, from a policy of population control to a social development approach, depending on the world opinion on population and development. ‘Government’s efforts in promoting fertility control have changed from decade to decade’ [SAMA, 2005]. World over, growing population was viewed as a problem, and it was no different in India. At the time of independence, population growth was seen as a major impediment to India’s socio-economic development. Consequently, population ‘control’ became integral to economic development, given the limited resources. In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy" [MHFW, 2000, p 1].

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34 A more recent diagnosis of imminent calamity is by Garrett Hardin (1993): Living Within Limits: Ecology, Economics, and Population Taboos, Oxford University Press, New York,

35 Condorcet was the eighteenth-century French mathematician and social scientist from whom Malthus had actually derived the analysis of how population could outgrow the means of living.
India thus has the distinction of introducing the first family planning programme sponsored by a government. The basic strategy in the First Plan was to treat family planning as a part of the health programme and provide 100% funds for it as a centrally sponsored programme. The position continues to be almost the same even today. Increasing funds for family planning were allocated from one plan to the other. There was however very little contraceptive acceptance during this period. During the Second Five-Year Plan (1956-61), the focus was on further development of the family planning programme [Guilmoto et al, 2005b, p 2].

The United Nations organized the World Population Conference in Rome in September 1954. Unlike subsequent international population conferences, the Rome conference was a scientific exchange of information. Participants consisted of demographers and population specialists who did not represent governments. The Conference addressed the entire gamut of population issues and helped to establish the importance of demographic research for population policy. The inadequacy of statistics for much of the world’s population was highlighted, as were ideological differences, particularly between Western countries and representatives of the USSR, who contended that rapid population growth was only a problem for capitalistic societies. An important outcome of the Conference was its focus on the need to study all populations in the context of their particular economic, social and cultural conditions; it also provided a platform for wider concerns, indicating that the importance of global population trends was beginning to be acknowledged [UN, 2003, pp 11].

During the 1960s and 1970s, extreme views on the world population situation resurfaced. Alarmists spoke of ‘population explosion’ and held population growth responsible for the many afflictions of the developing world\textsuperscript{36}. One of the main fears expressed was Malthusian. Even though, in time, development may dependably work to stabilize population, there may not be, it was argued, enough time. Amartya Sen [1994, p 4] elaborates that ‘the override view can take many different forms and can

be of varying intensity (with the Chinese “one child policy” being something of an extreme case of a more general approach”).

Others took a more cautious approach, or, a collaborative view, and opined that rapid population growth led to detrimental consequences that warranted efforts to reduce fertility. This has been the primary rationale for family planning programmes [Menken, 1994, p 61]. This debate moved the UN to pass a resolution in the General Assembly in 1962, which called upon all those countries to accelerate their rate of economic development and take all appropriate measures to deal with their population problems.

Both these views found their voice in Indian population policies. The findings of the 1961 Census suggested that providing limited services was an inadequate strategy, as population had grown - a growth of 21.64 per cent compared to the earlier decennial growth rates ranging between 11 and 14.22 per cent. Ominous signals of impending crises induced a capitulation on the part of authorities to consider forceful measures for people to have fewer children and resulted in a target-oriented, top down family planning programme with little awareness of peoples’ real needs. The Government introduced financial incentives to acceptors of family planning. Health workers were given incentives to meet targets, and disincentives or punishments if they failed [Srinivasan].

It is evident that government wanted results in a hurry, as even before the family planning programme had been given a chance to work, by the Third Five-Year Plan (1961-66) period, ‘it was realised that fertility had not declined significantly and that population growth needed to be controlled through fertility regulation’. Despite government efforts, ‘only a negligible proportion of couples had accepted birth control. By the end of the Third Plan period, family planning services had become widely available through government outlets in both rural and urban areas’ [Guilmoto et al, 2005b, p2].

In 1974, the UN sponsored International Conference on Population and Development (ICPD) in Bucharest recognized that ‘Development is the best contraceptive’, but this dictum was not followed even by its most fervent supporters in the developing world [Menken, 1994, p 61]. ‘Despite India’s opposition to target oriented fertility control policy at the Bucharest Conference, the government resorted to what it described as a frontal attack on the problem of population’[SAMA, 2005, p 155]. Coercion, which was by now a part of the family planning programme, continued during the Fourth Five-Year Plan (1969-1974).

In 1976, the first explicit National Population Policy (NPP) of India was announced, which argued that it would be impracticable to wait for education and economic development to achieve demographic changes as stipulated during the Bucharest Conference. The demand for compulsory sterilisation was explicitly recognized and was soon followed by the inclusion of family planning in the programme of the youth wing of the political party that was then in power. There was a phenomenal rise in the acceptance of sterilisation, most of which were vasectomies. However, with strong pressure tactics the distinction between persuasion and coercion got blurred [Guilmoto et al, 2005b, pp 2-3].

The Emergency rule declared in 1975-76, took coercion to new heights as slum dwellers were rounded up and sterilised. In 1976-77 an all-time high of 8.26 million sterilisations were performed, mostly on men [Srinivasan37]. Thus, population was viewed as a leviathan that had to be cut to size. The Tenth Five Year Plan (2002-07) document [PC, 2002, p 174] acknowledges that ‘this (methodology) did not have any perceptible impact on the birth rate, as the cases were not appropriately chosen. There was a steep fall in acceptance in the very next year’.

After the Emergency excesses in 1975-76, a modified NPP was announced in 1977, which viewed the policy as an integral part of education, health, maternal and child health etc. and stressed the voluntary nature of the family planning programme38. The Policy Statement on the Family Welfare Programme came out in 1977. However, both statements were tabled in Parliament, but were not discussed or

38 Taken from http://populationcommission.nic.in/hp.htm
adopted [MHFW, 2000, p32]. During this time, the name of the programme also changed from Family Planning to Family Welfare, which is retained until date. The Government appointed a Working Group on Population Policy in 1977. Its report advocated a Net Reproduction Rate of one (NRR=1) by the year 2000, which meant a Birth rate of 21 and a Death Rate of 9 per thousand. This implied a population growth rate of 1.2 per cent per year. This was considered as the threshold level for population stabilization. The recommendation of the Working Group still remains the guiding number for our population programme.

However, a paradigm shift in government policy was noticed in the post Emergency period, namely the onus of having a small family was transferred fully to women through the increasing use of doctor-friendly medicine and the shift from non-invasive to invasive means of birth control techniques aimed at controlling women’s reproductive ability. Even today, this policy continues as female sterilization accounts for two-thirds of total contraceptive use [IIPS, 2007, p 120]. Many women undergo tubectomy because of the subtle pressures of health workers and the absence of knowledge and access to other services [Das, 2005].

In 1983, the Government announced a National Health Policy (NHP), which adopted the recommendations of the Working Group on Population Policy as the long-term demographic goal of the country. The NHP also reaffirmed that ‘not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation’ [MHFW, 1983].

Meanwhile on the other side of the globe, Julian Simon contested the view that rapid population growth had deleterious effects and instead stated that it was a significant and effective long-term stimulus to economic development, by increasing the tempo of innovation. Simon’s views profoundly influenced the US Government’s stance at the 1984 United Nations International Conference on Population in Mexico City [Menken, 1994, p 61]. Subsequently, the 1994 International Conference on Population and Development (ICPD) in Cairo has been

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described as a historic meeting where it had the perspective of development with emphasis on empowerment of women as the key to population control and holding men more responsible for family planning. ‘The impetus provided by the women’s movement and the forceful voicing of concerns regarding women’s health at ICPD 1994 led to a paradigm shift in India’s Family Planning Programme, moving from existing numerical, method-specific target approach towards an approach of reproductive health concerns and women’s rights and empowerment. The concept based itself on the belief that it moves birth control out from the umbrella of family planning and planned parenthood, with their patriarchal connotations, into the realm of individual rights to sexual and reproductive health’ [SAMA, 2005, p 156] This paradigm shift advocated major development investments and reproductive health concerns for attaining population stabilisation. ‘Following the ICPD in Cairo in 1994, India’s Family Planning Policy underwent a paradigm shift from the existing method specific target oriented approach to an approach towards reproductive health through women’s rights and empowerment [Duggal et al, 2005a, p 14].

The ‘collaborative view’ seems to have held sway over the world opinion leaders for little over a decade. The Indian Government’s focus on population control however continued. The injectable contraceptive Depo-Provera was approved for marketing in India in 1993 without the mandatory Phase 3 trials [Sarojini et al, 2005]. ‘The government’s obsession with population stabilisation is evident with its persistence to introduce injectables like Net En (Norethisterone Evanthane) and Cyclofem (a monthly combined injectable) through the Public Health System’ [SAMA, 2008-09].

Contemporaneously, an Expert Group on Population Policy headed by Dr M S Swaminathan submitted its report in 1994. ‘The issues addressed were fairly similar and, like the ICPD, the Swaminathan Committee report also reflected the new thinking on population. A small family norm was advocated, yet the choice was left to the couple. Population policy was to be driven by the perceived needs of people rather than imposed from the top’ [Guilmoto et al, 2005b, p3]. The Government of India abolished the method specific approach in 1996, where targets for all activities were

40 The Expert Group on Population Policy was known as the Swaminathan Committee.
fixed at national level. However, states adopted their own strategies. For instance, Maharashtra adopted a ‘self determined strategy, where expected levels of contraceptive use for each district were estimated using criteria based on birth rates and death rates, and targets were drawn by the district level officers’ [Duggal et al, 2005b, p 23].

However, just as it is argued that ‘the reproductive health of the 1994 ICPD is nothing more than the same population control programme: as an old wine in a new bottle’ [Srinivasan41], the same seems to hold water with respect to the Reproductive and Child Health Programme, launched in 1997, which generally again provided only contraceptive services. Again, the top-down targets were replaced by estimated levels of achievement (ELAs), which were the health worker's estimates of the community's unmet need for contraception based on a survey of families in the area. So the pressure to achieve these new ELAs continued.

In February 2000, the Government of India announced the NPP, 2000. This has some elements of the policies recommended by the Swaminathan Committee and the ICPD but it cannot be considered to be primarily based either on the Swaminathan Committee Report or on the ICPD Plan of Action [Guilmoto et al, 2005b, p3]. The immediate objective of the NPP 2000 was to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection [MHFW, 2000, p 4]. Thus, population stabilisation through increasing use of contraceptives remains the cornerstone of India’s population policy.

In recent years, visions of impending doom have been increasingly aired, often presenting the population problem as a ‘bomb’ that has been planted and is about to

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‘go off’. The growth in the world's unemployed poor is forecast to be a major destabilizing force, what population expert Werner Fornos calls the ‘Aspiration Bomb’ [Daleiden, 1999]. In fact, according to Daleiden, the population bomb has exploded, and he attributes the loss of the Amazon rain forests and African wildlife, the increased pollution, destruction of ozone layer, soil erosion, and increasing crime and poverty, directly to population growth. These catastrophic images have encouraged a tendency to search for emergency solutions, which treat the people involved not as reasonable beings, allies facing a common problem, but as impulsive and uncontrolled sources of great social harm, in need of strong discipline. Sen also acknowledges population being a problem as he states that ‘the fact that Malthus was mistaken in his diagnosis as well as his prognosis two hundred years ago does not, however, indicate that contemporary fears about population growth must be similarly erroneous’ [Sen, A, 1994, p 1]. Renewed concern about so-called population explosion has tilted the balance in favour of energetic family planning programmes- adoption of the Chinese style if needed of advocating single child norm [ibid, p 4].

The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies for the next decade in order to meet the reproductive and child health needs of the people of India and to achieve net replacement levels by 2010. Since the NPP, 2000 presumes that the ‘problem of population growth’ arises only from the rural, uneducated masses, it focuses on policies that are mainly directed at the rural poor and other ‘underserved population groups’, namely, urban slums, tribal communities, hill area populations and displaced and migrant populations.

According to NPP [MHFW, 2000, p6], population growth in India continues to be high because of the following reasons:

1. The large size of the population in the reproductive age group (estimated contribution to population growth is 58 percent).
2. Higher fertility due to unmet need for contraception (estimated contribution 20 percent). India has 168 million eligible couples, of which just 44 percent are currently effectively protected.
3. High wanted fertility due to the high infant mortality rate (IMR) (estimated contribution about 20 percent). Repeated childbirths are seen as an insurance against
multiple infant (and child) deaths and accordingly, high infant mortality stymies all efforts at reducing TFR.

4. Over 50 percent of girls marry below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of ‘too early, too frequent, too many’. Around 33 percent births occur at intervals of less than 24 months, which also results in high IMR (presumably, the balance contribution of this segment would be 2 per cent).

India’s family planning programme has thus undergone a number of changes in policy, approach, and implementation. NFHS 3 [IIPS, 2007, p 5] has succinctly summed it up. ‘In the last five decades, the programme has embraced six major approaches. In chronological sequence, these are the clinic approach (1951-61), extension and education approach - low intensity HITTS (Health department operated, Incentive based, Target-oriented, Time-bound, and Sterilization-focused programme) approach (1962-69), high intensity HITTS approach (1969-75), coercive approach (1976-77), recoil and recovery phase (1977-94), and reproductive and child health approach (since 1995)’.

Different states also introduced policies to promote the ‘two-child’ norm in line with the central policy. Rajasthan introduced it in 1992, which barred people with more than two children from contesting elections for Panchayats, Zilla Parishads and Nagarpalikas. The policy of 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”. Rajasthan’s example was soon followed by other states such as Haryana, Orissa, Andhra Pradesh, Madhya Pradesh, Maharashtra and Gujarat. Surprisingly, these disincentives were considered to be in national interest, and legal approval was given to them. Rao [2005, 119] terms this a ‘punitive approach that violates the principle of natural justice, creating two sets of citizenship rights on the basis of

42 Taken from http://populationcommission.nic.in/hp.htm
43 In July 2003, a 3-judge Bench of the Supreme Court of India upheld the Haryana government law prohibiting a person from contesting or holding the post of sarpanch or panch in the PRIs of the state if she/he had more than two children [Rao, 2005, pp 117-118].
fertility. Such policies represent going back to the days before universal suffrage when property rights decided citizenship claims’.

‘It is unfortunate that India has persisted in the control approach, as is evident from the Common Minimum Programme of the current government, which lays out the agenda for its governance. The section on women and children states, a *sharply targeted population control* (italics mine) programme will be launched in the 150-odd high fertility districts. The very notion of population control and the way the family planning programme is being implemented in India raises serious ethical issues’ [Das, 2005]. Nevertheless, Drèze et al [2001, p 34] argue that the Indian experience does not warrant the disenchantment with the social development approach. ‘India is not a model of social development by any means, but many Indian states are making reasonable progress with fertility decline through non authoritarian methods’.

Indian policy on population has thus, swung like a pendulum-with the changing paradigms of development. The TIMELINE of India’s Population Policy is given at Annexure 3.1. The common thread running across through the population policy is cutting population size and thus the main thrust of government, at both the Centre and the state level, was and continues to be the ‘two-child’ norm in order to achieve the desired population size. The government’s population policy was, and continues to be therefore, target oriented.

**Impact of population policies - *macro policies versus micro responses* and the resultant ‘negative externalities’**

It is difficult to isolate the impact of population policy and conclude that the policies of the Government on population control have led to the decline in the TFR. More so considering that, ‘the programme moved from the extension approach to the intrauterine contraceptive device (IUCD) approach to the vasectomy approach to placing reliance on female sterilisation’ [Rao, 2005, p117]. Since some States have responded better than other States owing to their socio-economic environment, the same policy is erroneously being continued with renewed vigour in order to bring the ‘non-conformist’ states in line. To achieve population stabilisation, a 2.1 per cent growth rate of population and NRR of 1 (that is, mother should be replaced by one
daughter only) are envisaged. These targets have an inherent sexist bias because it desires birth of 1 daughter and 1.1 sons [Patel, 2003 (a)]

Moreover, the reductions in fertility rates are being achieved at a cost may be because of the varied micro responses to the macro policies, which were not anticipated while formulating the policies. The negative fallouts of pursuing a population policy that largely focuses on birth control measures as adumbrated in the earlier sub-sections, relate to the declining CSR and to the increasing use of questionable contraceptives for women to achieve the targets. The latter aspect is considered here while analysing the target-oriented top down approach of the government, while the issue of declining CSR is discussed in detail in Chapter 5.

Alarmist reaction led to the formulation of the ‘two-child’ norm, which is the basis of the Indian Family Planning programme. Simultaneously, a reduction in CSR is reported and therefore an argument supporting the existence of a nexus between the government-sponsored ‘two-child’ norm and increase in female foeticide has emerged. ‘Commenting on the serious decline in the 0-6 SR in India, Ashish Bose states that the government’s policies on the ‘two-child’ norm has got mixed up with female foeticide’ [Gurung, 2004]. Data from NFHS 1 and 2 provides evidence that SRB has deteriorated in many states between the two surveys. Surprisingly it has improved in Rajasthan, Uttar Pradesh, Madhya Pradesh and Orissa. Rajasthan Government introduced specific policies to promote the ‘two-child’ norm; this was followed by other states like, Madhya Pradesh, Haryana, Orissa, Andhra Pradesh, Maharashtra and Gujarat. Prima facie, reports of an improving CSR despite the ‘two-child’ norm, does not support the above nexus theory. The Maharashtra Population Policy (MPP), restricts the eligibility for contesting to get elected or being appointed/nominated to Zilla Parishads, Panchayat Samitis, civic bodies from Municipal Corporations downwards, Government-owned corporations, co-operative societies, district co-operative banks, milk producers’ unions, etc., to those who have not more

44 This article is an expanded version of a paper presented by Dr Vibhuti Patel at the "National Workshop on PNDT Act" organised by Baailancho Saad and Centre for Women's Development Studies, Delhi held at Panaji, Goa in April, 2003.

45 A report in Tribune News Service, April 9, 2007, states that in a recent survey undertaken by the district administration of Bhiwani, it was found that the child sex ratio had skewed against boys in many villages of this district of Haryana. In 2001 Census, the CSR of Bhiwani was 841.
than two children [GoM, 2001]. Since this policy was adopted in 2001, the impact of this on further affecting the CSR in Maharashtra is yet to be seen, though the CSR in Maharashtra is declining. The revised Tamil Nadu Population Policy (TNPP) of 2007 (at Annexure 3.2) has set a TFR target of 1.4 to be achieved by 2012. Although it has also set a target for improving the CSR to 950 by 2012, it also aims to ‘encourage couples to go in for tubectomy with two children or even one child’ [GoTN, 2007, p19]. The targets will work at cross-purposes and will only serve to expose the unborn girl child to more risk, as the CSR is already declining. Further, the TNPP continues to put the onus of birth control on women.

There are studies\(^{46}\) highlighting that coercive population policies and the ‘two-child’ norm have inflicted misery on people in many States. However, the results of improvement in CSR reported in some states need further research. Overall, there are studies that show that the indirect consequence of the Government’s preoccupation with numbers has been a decline in SR of the child population (0-6 years) and intensification of gender discrimination.

An analysis of the causal relationship between TFR and CSR in the districts of Tamil Nadu and Maharashtra has been carried out in Chapter 5. The analysis has not yielded any conclusive results. What is, however, observed is that in both Tamil Nadu and Maharashtra, despite higher per capita incomes and higher literacy levels across districts as compared to the all India average, the CSRs are declining. Both governments, do follow the targeted population policy. Despite the Pre-Natal Diagnostic Techniques (PNDT) Act, the NFHS 3 [IIPS, 2007, p 205-206] reports that at the all-India level, sex determination tests are being done in 24 per cent of pregnancies, with the percentage of sex determination tests done increasing with education. While only about 9 per cent of women with no education accessed ultrasound tests, a mammoth 65 per cent of women who have completed 12 or more years of education had undergone sex determination tests.

\(^{46}\) People's Tribunal on Coercive Population Policies and Two Child Norm held in Delhi on October 9 and 10, 2004. Organised by the Human Rights Law Network, the Jan Swasthya Abhiyan (People's Health Movement), Healthwatch (of Uttar Pradesh and Bihar), Sama (a women's organisation working on health rights) and The Hunger Project (an international movement, which works in as many as 14 Indian States), the tribunal looked critically at various State population policies and the experiences of people in those States, and eventually came to the conclusion that coercive population policies had no place in a democracy like India.
The deficit of females in India has, over the years, aroused and captured the attention of social scientists, demographers and activists, who have tried to unravel the reasons and understand the factors leading to the unique situation. Numerous studies have been conducted and articles written on this issue that ring alarm bells that something must be done, and soon, to correct the aggravating situation. However, though the various policies of the Government acknowledge the existence of the pressing issue, it has never been flagged to receive focused attention and policy intervention.

There is just a passing mention in the Appendix of NPP on the glaring issue of declining female SR. ‘The (female to male) sex ratio has been steadily declining. From 1901 to 1991, the sex ratio has declined from 972 to 927. This is largely attributed to the son preference, discrimination against the girl child leading to lower female literacy, female feticide, higher fertility and higher mortality levels for females, in all age groups up to 45’ [MHFW, 2000, p 37]. However, the NPP has no specific agenda on this. The NPP aims at ‘promoting vigorously the small family norm to achieve replacement levels of TFR’. One of the promotional/motivational measures to achieve the goal is strict enforcement of the PNDT Act, 1994.

The implications of policy are not perceived at the conception stage. Studies have also revealed the preponderance of an adverse FMR in the better-off families in both rural and urban areas. However, the policies framed do not take cognizance of this important fact. For instance, there are policies to promote the girl child, like free education for the girl child, which again deal with the problem at the superficial level only, as despite this CSRs are declining in Tamil Nadu and Maharashtra. As indicated earlier, policies seem to have framed with the presumption that the malaise affects only the poor and disadvantaged groups, as is the case of the MPP that advocated the Savitribai Phule Kanya Yojana for couples below poverty line only [GoM, 2002, p 15].
The Millennium Development Goals (MDGs)\(^{47}\) included time-bound targets relating to key achievements in human development. These targets are to be achieved by 2015 by all the member countries from their levels in 1990 (UN, 2001).

In the Tenth Five Year Plan, the Planning Commission [PC, 2002c] has outlined India’s Human Development Goals (HDGs) and targets for the next five to 10 years as shown in Box 3.1 below. Most of these are related to and are more ambitious than the Millennium Development Goals. The issue of the declining CSR does not figure either in the MDGs or in the HDGs.

**B 3.1 : India: Human Development Goals (HDGs)**

- reduction of poverty ratio by 5 percentage points by 2007 and 15 percentage points by 2012
- providing gainful employment to the additional labour force
- all children in school by 2003 and compulsory five years schooling by 2007
- at least 50 per cent gender gaps reduction in literacy and wage rates by 2007
- reducing decadal growth rate (2001-2011) of population to 16.2 per cent
- increasing the overall literacy rate of the nation to 75 per cent by the end of Tenth Plan Period
- Reducing IMR to 45 per 1000 live births by 2007 and further to 28 by 2012
- Reducing MMR to 2 per 1000 live births by 2007 and further to one by 2012
- Increase forest and tree cover to 25 by per cent 2007 and 33 per cent by 2012
- providing potable drinking water to all villages within the Plan period
- cleaning all major polluted rivers by 2007
- achieving zero level increase of HIV/AIDS prevalence by 2007
- reducing the prevalence of malarial fever by fixing certain targets : Annual Blood Examination Rate over 10 %, Annual Parasite Incidence 1.3 or less and 50% reduction of morbidity due to malaria by 2010.


It is to be recognised and highlighted that this scenario appears to be changing. The Eleventh Five Year Plan (2012-17) document shows that policy makers have grasped the link between declining fertility and declining CSRs. Although the Eleventh Five Year Plan has fixed a target to achieve a reduction of TFR to 2.1 by 2012 and state-wise targets are also fixed, a change in approach is evident, namely, that of recognising the need to involve people. ‘The Plan will ensure that all issues of demographic change, the population policies, and programmes to achieve population stabilization are addressed without violating the peoples’ rights of decision making

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\(^{47}\) The MDGs were as follows: i. halving income - poverty and hunger; ii. achieving universal primary education; iii. attaining gender equality; iv. reducing infant and child mortality by two-thirds; v. reducing maternal mortality by three quarters; vi. reversing the spread of HIV / AIDs and other communicable diseases; vii. ensuring environmental sustainability and halving the proportion of people without access to safe water; viii. developing global partnership for an overall development. Accessed from [http://www.undp.org.in](http://www.undp.org.in).
and choices. Most importantly, this should be done without adversely affecting the
sex ratio’ [PC, 2008, p 94]. For the first time, targets have been set for reversing the
child sex ratio as shown in the Box 3.2 below. The TNPP [GoTN, 2007] has also
flagged the issue of declining CSR and has accordingly set targets to increase the
same.

**Box 3.2: Monitorable Targets set by Eleventh Five Year Plan**

The Eleventh Plan lays down six monitorable targets:

- Raise the sex ratio for age group 0–6 from 927 in 2001 to 935 by 2011–12 and to 950 by
  2016–17.
- Ensure that at least 33% of the direct and indirect beneficiaries of all government schemes
  are women and girl children.
- Reduce IMR from 57 to 28 and MMR from 3.01 to one per 1000 live births.
- Reduce malnutrition among children of age group 0–3 to half its present level.
- Reduce anaemia among women and girls by 50% by the end of the Eleventh Plan.
- Reduce dropout rate for primary and secondary schooling by 10% for both girls as well as
  boys.

*Source: Eleventh Five Year Plan, Planning Commission, Government of India, 2008, p 185*

As per the NFHS 3 [IIPS, 2008 (a) & (b)] reports, the median age at first
marriage has been exhibiting a gradual rise from the oldest to the youngest cohorts
in both the states under review. For instance, 11.1 per cent of the 45-49 cohort of
women were married by age 15, whereas for the 15-19 cohorts it is 1.0 per cent.
Despite the decline over the years, in Tamil Nadu, among young women age 15-19,
8 percent have already begun childbearing, which is half of the national average of
16 percent; while in Maharashtra, it is higher at 14%. Young women in rural areas
of both Tamil Nadu and Maharashtra are almost twice as likely to have begun
childbearing (10 per cent and 18 per cent respectively) as compared to young
women in urban areas (5 per cent and 9 per cent respectively). It is significant that
teenage pregnancies is least in the lowest wealth quintile with the highest quintile
following next, and the middle quintiles accounting for a higher percentage of
teenage pregnancies in Tamil Nadu, while it reduces with increase in incomes in the
case of Maharashtra.

A related issue of teenage pregnancy is abortion as a method of contraception. In
her study of select villages in Tamil Nadu, Anandhi [2007, p 1056] found that despite
the influence of the state’s logic of abortion as a method of family limitation, women
have consciously sought abortion for various other reasons. ‘Women’s decision to
Abort seems to be linked to a vector of factors like childcare as their exclusive responsibility, marital conflicts, son preference and belief in astrology and local religion. Since women do not have control over these social conditions, their “choice” of abortion is basically to deal with these situations’. She gives another instance of how work and working conditions in the informal sector shape and constrain young unmarried women’s decisions to abort. Being unmarried, their decisions discloses how reasons other than family limitation force abortion.

An estimate of induced abortions in Tamil Nadu puts the figure at 447,000 for 1991 (assuming 25 abortions per 73 live births, of which 60 per cent are induced). During the early 1990s, the reported number of medical termination(s) of pregnancy (MTPs) performed in Tamil Nadu was around 45,000 per year. Allowing for some under-reporting of MTPs and overestimation of induced abortions, the data still suggest that a sizeable proportion of abortions go unrecorded and that safe abortion services remain inaccessible to a sizeable proportion of those who need them. Rural women are particularly vulnerable [GoTN, 2003, p 44].

‘The logic of family limitation through abortion as promoted by the state population policy might be influencing women’s consciousness on abortion. But how women arrive at the decision to abort is not based on the received notions of family planning or birth control, but on the basis of local, social and cultural conditions and relations that define their lives’ [Anandhi, 2007, p 1056]. Thus, this highlights both the ineffectiveness of population policy and the need to combine macro-level data, which often gives us family limitation as the predominant reason for abortion, with micro-level details of the actual processes of women’s decision-making.

The need for a conducive and consistent holistic policy is seen, as in the case of Maharashtra where the government’s efforts at curbing population growth have been negated not only by the prevailing social norms but also by some variations in sexual behaviour. For example, tackling the issue of teenage fertility is dependent on the enforcement of laws pertaining to the minimum age of marriage; however, a rise in pregnancies outside marriage has also led to an increase in teenage fertility. Although official statistics like that of the NFHS data do not report any pregnancies outside
marriage, there are studies\textsuperscript{48} that show that the issue of unwed teenage mothers merits serious concern in Maharashtra. As a corollary to this, ‘socio-cultural factors, such as the stigma attached to unwed motherhood and, therefore the prevalence of abortion, only serves to increase the incidence of maternal mortality’ among adolescent girls [UNFPA, 2000, p14]. Such events brings to the fore, that target oriented, top down approaches are bound to be limited in their impact, and that greater sensitivity to local issues at the time of formulation and an inclusive policy that takes into account the multiple correlation among variables are needed.

Another negative fall out of the government’s preoccupation with population stabilisation and its birth control policy relates to its ethicality. The ethical issues around Family Planning programme implementation can be seen at two levels – at the level of choice of contraceptive and in the provision of actual contraceptive services. As regards choice, the most commonly used method of contraception in India is female sterilization. ‘Recent figures reveal that of the total sterilisation operations, tubectomy/laparoscopic sterilisations account for more than 98 per cent, while less than 2 per cent men undergo vasectomy operations though they are less complicated and less risky’ [Patel, 2003b, p 436]. The methods by which the contraceptive services are actually being delivered are highly questionable\textsuperscript{49}. Doctors often justify the shoddy treatment of women at sterilisation camps by referring to the pressure of targets that they have to fulfil or the lack of time [Das, 2005]. The ethical angle can be extended to contraceptive researches and to trials on humans who are used as guinea pigs in the process. The long-acting hormonal contraceptives such as injectables (Net En and Depo Provera) and sub-dermal implants (Norplant) are likely to cause irreversible damage to the women’s own and their progeny’s health\textsuperscript{50} [Sarojini et al, 2005].

\textsuperscript{48} ‘Despite the difficulty in obtaining data on abortions, including illegal abortions, from studies such as those in Solapur hospital (where 30 per cent of abortion seekers were under 15) and KEM Hospital, one can infer that the incidence of adolescent abortion is quite high [UNFPA, 2000, p 13].

\textsuperscript{49} The ethical issues involved in the way female sterilisation services are being delivered in Uttar Pradesh have been described by Abhijit Das in an article, Ensuring quality of care in sterilisation services. Indian Journal of Medical Ethics. 2004. 12 (3): 79-80.

\textsuperscript{50} There are numerous studies showing the negative effects of such injectable contraceptives on women’s health - Siddhivinayak Hirve (2005): “Injectables as a choice - evidence-based lessons”. Indian Journal of Medical Ethics: 13 (1); C Sathyamala (2000): “An epidemiological review of the injectable contraceptive Depo-Provera”. Medico Friend Circle, Forum for Women’s Health, Mumbai.
The Indian Council of Medical Research (ICMR) has completed Phase III trials, and without a public debate on a matter that has widespread implications, the government has approved the initiation of Phase IV trials to be conducted. There has also been a proposed initiation of these trials for Net En and Cyclofem through the PHS, despite the opinion of the Technical Committee of Drugs Technical Advisory Board that the key constituent of Cyclofem should not be allowed for mass use in Family Planning programme [SAMA, 2008-09]. The injectable contraceptives and particularly their introduction in the public health system thus raise several ethical issues.

The process of regulating contraceptive technologies (like artificial insemination, in vitro fertilisation and surrogacy) commonly known as of Assisted Reproductive Technologies (ARTs) is the other side of the same coin. A major concern is the unregulated practice of these technologies and the increasing commercialisation and commodification of women’s reproductive tissues. The draft ART (Regulation) Bill and Rules, 2008, has been recently presented by ICMR. Although this is a positive step towards regulation of this industry, activists and researchers opine that it is inadequate inter alia, in protecting and safeguarding the rights and health of women who undergo these procedures [Sarojini et al, 2009].

What comes out clearly is that, contrary to what is stated, India’s population policy is singularly focused on extending family planning measures, mainly contraceptives for women, to leave the women with no reproductive choice or autonomy.

**Population policy – a straitjacket approach will not work**

The dictionary definition of the term ‘population’ is, the total number of persons inhabiting a country, city, or any district or area. It is therefore, a statistic. Hence, by inference, population policy per se aims at controlling this statistic. It also follows, therefore, that a population policy cannot stand alone and since it relates to people it forms part of the larger canvas, namely the socio-economic-environmental scenario, that affect the life of the inhabitants. The isolationist approach of population policy, therefore, will not be effective.
Population policy in India has generally attempted to arrive at an optimal growth rate of population that would lead to sustainable development. ‘The NPP 2000 made a departure from previous attempts at family planning by widening the whole concept of population stabilization programme to link the same with various social sector programmes concerned with the improvement in the quality of life of the people’

Unfortunately, a simplistic approach cannot work owing to the interplay of different, and at times even conflicting, issues.

The oft-expressed fear that rapid population growth will accompany deteriorations in living standards has not been borne out by experience so far; at least, not when judged from the vantage of the world as a whole. The aim should not be to force people to change their reproductive behaviour. Rather, it should be to identify such policies that would change the options men and women face, so that through their reasoned choices their fertility rates would be lowered to replacement levels (Dasgupta, 1994, p 151, 169).

Although on paper the NPP 2000 ‘affirms the commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target-free approach in administering family planning services’ it still follows the target-oriented approach, given its obsession with achieving net replacement level fertility by 2010. In addition, the proposed incentives to poor couples for sterilisation and rewards to local bodies for their performance, euphemistically described as ‘promotional and motivational measures’, could encourage coercion. The specific disincentives as envisaged by the NPP 2000, MPP and TNPP, are listed in Annexure 3.4. The MPP entirely promotes the two-child norm through disincentives. Tamil Nadu, in its urgency to reach the fertility rate target of 1.4 by 2012 (the state population policy is silent as to why this floor figure was chosen), states that more IEC activities will be carried out against...

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51 Inaugural address of Shri K.C. Pant, then Vice-Chairman, NCP and Deputy Chairman, Planning Commission during the Conference on Convergence of Social Sector Programmes for Population Stabilization held on 4th October 2001.

52 The importance of “local” environmental issues is stressed and particularly explored by Partha Dasgupta (1993) in An Inquiry into Well-Being and Destitution (Oxford University Press).
early marriage and couples will be encouraged to accept tubectomy with two children or even one child [GoTN, 2007].

There are also substantial differences in availability and utilization of health care services and mortality and fertility rates not only between states but also between districts in the same state; as a result there will be differences in type of intervention needed and also the time taken by them to achieve population stabilization. The regional contrasts within India strongly argue for a context specific collaborative approach.

Over the past five decades, numerous studies have assessed levels, trends, differentials and determinants of fertility in India. The conclusion is that fertility decline has been low to moderate with a few pockets of more rapid transition [Guilmoto et al, 2001, p 713]. In India, the inter-state and intra-state dichotomy is present, which may even require two sets of policies running simultaneously to deal with the respective conditions. A general top down approach cannot work in such a unique situation.

Now the ‘problem’ of low fertility—is this of relevance to India?

Quite oblivious to problems that were occupying the rest of the world, concern with below-replacement fertility first emerged in Europe in the 1930s. This was a cause of great alarm to governments wherever it occurred, raising the spectre of absolute declines in population size in the near future\(^{53}\). Dire economic and political consequences were predicted for countries whose populations failed to replace themselves\(^{54}\). Theoretical frameworks were similarly used to explain such low fertility [Wilson, 2001, p 1].

In many industrialized countries, fertility rates have plummeted well below the replacement mark and thrown much planning based on past population projections out

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of gear. After all these years it is now accepted that the TFR prescribed of around 2.1, is little more than a convenient analytical device. “Having discarded the logic of replacement level fertility as a plausible end-point in the fertility transition for the developed world, it naturally followed that there was nothing sacrosanct about this end point for the developing world either” [Basu, 2003, p 554].

Does low fertility matter? This question is now answered more and more in the affirmative. Greater certainty about the issue of low fertility, however, is not matched by certainty about the appropriate range of policies to address low fertility [McDonald, 2000b, p 1]. Since its 1998 Revision, the UN no longer takes 2.1 as the eventual end point of the transition [Bongaarts, 2002, p 419]. In fact the UN [2004, p2] Report, revised its earlier stand and stated, ‘total fertility is assumed to decline, at a varying pace dictated by country circumstances, to a below-replacement level of 1.85 children per woman’. This has in turn, led to a plethora of wide ranging policies that might be used to stop or reverse the downward slide of fertility rates. The preaching continues, albeit in the opposite direction. Since fertility is a context specific issue, it cannot be generalized. Demographers are again running the risk of generalizing the whole issue to arrive at simplistic solutions, namely, one blueprint for all.

In India, owing to the differential pattern of fertility decline, some states like Goa, Kerala and Tamil Nadu have already reached below replacement level of fertility and the declining momentum is continuing. Viewing the state as a distinct unit, the prospect of declining fertility levels is bound to impact on the economy of that state. Governments accordingly have to devise policies to deal with the same. Hence, thought the issue of low fertility may not be of relevance at the all India level, its relevance to those states experiencing low fertility levels cannot be undermined.

**Is there need for a population policy in India?**

Population policy has always attempted to derive an optimal growth rate of population that would lead to sustainable development. To put it simply, it is evident that there exists no silver bullet owing to the inter play of different, and at times even conflicting, issues. Is a population policy required then? To answer this, the question
posed in the beginning of this chapter needs to be slightly rephrased. What is the focus of the Indian population policy: does it consider achieving the ‘desired’ population size an end in itself or, as a means to an end?

Facts have borne out, as indicated in this chapter, that ‘population stabilisation’ has been the core essence of the Indian population policy, independent of whether coercive or non-coercive methods were used to achieve the targets. It has also always been a top down policy, where the government sought to ‘override’ the grass root level socio-cultural moorings prevalent in the society. In fact, the prevailing ideology is that what holds good for the developed western nations must also hold good for India. The diversity that defines India has never been considered.

Myrdal [1987] stressed that the contributions, which the developed countries can make to the implementation of birth-control programs in underdeveloped countries, are relatively limited. In particular, he averred that governments of developed countries should refrain from giving advice in population matters; such advice is often rendered without a thorough knowledge of the specific and very different conditions in these countries. However, he also felt that the most important contribution from developed countries is the research on the new birth control technology.

Similarly, McNicoll [1998, pp 168-169] also comments, ‘it is a striking, though seldom noted, fact that the strategy for fertility reduction that Western countries promote for the third world is unlike anything that could be drawn from their own experience’. He adds fertility transition in these countries was associated with social and economic changes as well as cultural changes that influenced the environment of decision making of couples regarding having more children. However, what they recommended to others were ‘government extension schemes to provide subsidized contraceptive supplies and services – schemes at odds with the increasingly anti-statist views now found in other areas of development policy’. According to him, ‘fertility policy that is designed with close reference to the institutional setting in which it is to operate should be able to marshal collateral support and lessen the social costs it imposes, or their equivalent political costs’ [ibid].
There are studies that indicate that the population policy has failed, even as Srinivasan\textsuperscript{55} calls it, ‘a saga of great expectations and poor performance’. These studies point out that the demographic goals set in various government documents have been overly optimistic and have been continually postponed so much so that any statements in this regard ‘fail to enthuse anyone’ [Bhat, 2005, p 376]. An analysis of Tamil Nadu and Maharashtra, such as that done above, as well as research show that there is a difference in the way each State has responded, thus leading to a distinct pattern of fertility decline. Consequently, the need is to develop a differentiated policy that is suited for each local condition. ‘Any one policy may have different effects across space and time because the totality of policies and the way they are perceived may vary’ [McDonald, 2007, pp 25].

By keeping the population numbers at centre stage, governments have tended to come up with myopic policies. Of course, the world seems to be in a hurry to solve the population problem that is considered to be arising largely from the developing and less developed nations; however, time is a major factor. This is acknowledged at the government level as well. As noted by the Vice Chairman, NCP and Deputy Chairman, Planning Commission, ‘There is no doubt that in due course as social changes take place, education spreads, the age of marriage of the girl goes up and more people insist on economic development, the demographic stabilization would take place gradually. But it may not be possible for us to wait for these developments and hence, the need for reorienting policies and programmes of various sectors to help the process of early demographic stabilization’\textsuperscript{56}. However, it must be realised that fertility levels take their time in going up (as in now being acknowledged by countries experiencing very low levels of fertility) as well as in declining, as demographic changes take place in terms of generations.

McNicoll [1998, p 170] notes that ‘institutional dominance creates and then is reinforced by dominance of ideas; as that a country seeking to lower its fertility


\textsuperscript{56} Inaugural address of Shri K.C. Pant, then Vice-Chairman, NCP and Deputy Chairman, Planning Commission during the Conference on Convergence of Social Sector Programmes for Population Stabilization held on 4th October 2001.
should establish a family-planning programme now has the status of a truism’. He holds that lumping together of examples like China and Indonesia, where fertility policy had a coercive tinge, ‘obscures such distinctions, creating the impression – and often the reality - that a family planning programme is something that can be taken off the shelf’. As also strongly noted by Birdsall et al [1999], ‘the new and more convincing evidence that high fertility constrains economic growth does not in itself provide a rationale for public interventions to reduce fertility, particularly not if the means to reduce fertility (such as coercive family planning programs) compromise the well-being and rights of individuals’.

However, although overt use of force and muscle power is now absent in India, a covert form of coerciveness is felt in all government programmes that have a bearing on population. Indian Government’s population policy has as its focus the ‘control’ and ‘reduction’ of population, and not on ‘quality’ of population. This is to be achieved through various routes. The NPP 2000 hopes to achieve this via multi policy and inter sectoral coordination through the National Commission on Population (NCP). ‘A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all states and UTs, and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministries and Departments, for example, Department of Woman and Child Development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, and reputed demographers, public health professionals, and NGOs as members’ [MHFW, 2000, p14]. Another initiative is the Jansankhya Sthirata Kosh (JSK) (National Population Stabilisation Fund), registered as an autonomous society of the Ministry of Health and Family Welfare. The Government has provided an Rs100 crore Corpus fund to signify its commitment to the activities of the JSK. What is important in this context is the ‘climate of opinion’ created by such commissions and institutions. As stated earlier, the central theme projected is that of population stabilisation, whereas, it is the well-being of the population that needs to be the centre of focus.

Again, by narrowing the focus on achieving a few targets, the totality (direct and indirect) of the impact of any policy or programme becomes difficult to comprehend.
Jackson [2001, pp 39-40] states that ‘the relationship between policy and demographic change in general, and population ageing in particular, is easier to understand if the term policy itself is first paid some analytical attention’. Demographers also make distinctions between ‘explicit’, ‘implicit’, ‘direct’ and ‘indirect’ policy and focus on ‘unintended’ and ‘net’ policy effects. According to her, ‘it is essential to understand that policies that have no demographic objectives often have demographic effects, yet also that it is almost impossible to determine precisely which factor delivered (or did not deliver) which effect’.

It is also acknowledged that the empirical testing of the impact of government policies on fertility is difficult. In this situation, a more plausible explanation to understanding fertility would be the presence of a *fertility cycle* that is generated by who people decide to have more or less children in response to an existing environment. The term environment is used in a broad sense covering social, economic, cultural, geographical etc as well as all government policies that could influence decisions regarding children and thus cause fertility levels to accordingly rise or fall. For instance, the baby boom in the West is largely considered a fall out of the World Wars; in India also during the decade 1941-51, birth rates fell and the next decade saw a spurt in the growth rate of population, thus becoming the baby boom period. The *fertility cycles* follow different time paths and therefore, each country has a different fertility pattern. Becker [1998, pp 90-91] refers to the causal relationship between family behaviour and cycles in aggregate output and other variables, confirms that ‘for centuries marriages, births and other family behaviour have been known to respond to aggregate output and prices. Unlike the other macro models of business cycles, Keynesian, monetarist, neoclassical or real, ‘declining population growth was a major cause of the secular stagnation feared by Alvin H Hansen almost 50 years ago. Although family behaviour presumably has only a small part in the generation of ordinary business cycles, it is likely to be crucial to long cycles in economic activity’.

What is also apparent from various studies is that the peaks of higher fertility are of shorter duration as compared to the troughs of lower fertility; for instance,

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‘Germany has been below long-term replacement fertility for the unusually long period of 31 years’ [Caldwell, 2002, pp1-2]. In this context, the assumption of the UN [2004, p2] Report, in its projections for the next 300 years, that countries already at the level or below the fertility rate of 1.85, and other countries when they reach it, ‘eventually return to replacement over a period of a century and stay at replacement indefinitely’ seems too simplistic. Given the current demographic trends, Dyson [2004, pp 147-148] also questions whether there will be a recovery in fertility and states, ‘the trajectory of world population growth will level out – probably before the end of the present century. Moreover, at some stage there is a strong likelihood of global population decline’. He goes on to affirm that fertility will never fall to zero. Thus one can only deduce that fertility rates will continue their decline up to a point after which the people may decide to have more children based on their perceptions of the environment and thus cause fertility rates to start rising again.

Is a separate population policy required then? The answer would be in the negative.

**Concluding Remarks**

As Lal [2002] 58 puts it, ‘population explodes only in the transition to a new sustainable equilibrium, as breeding adjusts with a lag to the new and desirable low mortality regime. As such, there is no population problem in India, or anywhere else, which requires governments to intervene in the most private of human decisions’. This study concludes that there is no need for a population policy that has, as its ultimate aim, the achieving of the desired population size and not the well-being of the population. By setting targets for reaching specific mortality rates and the replacement level of fertility of 2.1 it limits thinking to numbers and targets and sweeps issues of crucial importance to the periphery.

It is a fact that birth rates have declined across all states, although not at the same proportion or periodicity. This decline has occurred owing to the presence of various social, economic, cultural and other factors constituting the environment and not

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primarily because of government policy. Thus, individuals, acting independently in response to the environment have brought about changes at the aggregate level. A people-centric umbrella policy is the answer, when governments focus on policies that are relevant for a particular area, in social, economic and environmental spheres and the direct impact on population is assured. The micro figures then translate, through a capillary action, to the macro setting, be it a district, state, country or world. The “bottoms-up hands-on” participatory approach is what is required. ‘Although reproductive health problems per se are rooted in the bio-medical sphere, their origins often lie in human behaviour that is embedded in social and culturally constructed patterns of gender relations. A holistic perspective is needed, as reproductive health and rights are not issues that can be solved within the confines of population and health policies as they themselves are subject to the vicissitudes of changing paradigms and ideologies. Inter sectoral linkages and enabling circumstances addressing the socio-economic context and gender inequality that impinges upon reproductive and sexual health issues are needed’ [SAMA, 2005, p 169].
Annexure 3.1  TIMELINE of India’s Population Policy

Pre Independence

1946 Bhore Committee – Recommendation for development of population policy from a public health perspective.

1949 Family Planning Association of India was born, with the emergence of Neo-Malthusian concerns.

Post Independence

I  Five Year Plan (FYP) (1951-56) - The First Five Year Plan called for an explicit population policy and considered family planning as a step towards improvement in health of mothers and children. The ‘clinic’ approach, which was strongly influenced by the Planned Parenthood Movement in the West.

II  FYP (1956-61) – The document proposed for continuous study of population problems and for a suitable central board for dealing with family planning and population problems. First decade largely focused on providing education, marriage and child counselling rather than medical intervention for birth control.

III  FYP (1961-66) - In 1964, the Reorganised Family Planning Programme spoke of people's participation in formulating and implementing a policy the benefits of which would go to them. However, the ‘population control' programme began in earnest. During the 1960s, sterilisation programme intensified and intra-uterine contraceptive devices of condoms were promoted. The focus shifted from improving health of women and children towards controlling the rise in population.

Annual Plans & IV FYP (1966-69; 1969 -74): Family Planning finds its place in the Plan as a programme of the highest priority. In 1966, a separate Department of Family Planning was carved out in the Ministry of Health in order to strengthen the population control programme. It was stated that the programme of family planning is likely to be more effective and acceptable if maternity and child health services are integrated with family planning.

V  FYP (1974-79) – Increasing concern about the rapidly growing population led to the National Family Planning Programme being included as a priority sector programme during the Fifth Plan. Emergency declared in 1975-76, with a coercive fertility control programme focusing on male sterilisation.

In 1976 the Statement of National Population Policy and in 1977 the Policy Statement on Family Welfare Programme were laid on the Table of the House in Parliament, but never discussed or adopted.

In 1979, the Programme was renamed as the National Family Welfare Programme and increasing integration of family planning services with those of maternal and child health and nutrition was attempted.

VI  FYP (1980-85) - The major thrust during the 1980s was to operationalise the WHO’s Alma Ata declaration of health for all by 2000 A.D. In 1983, the Government announced a National Health Policy, which adopted the recommendations of the Working Group on Population Policy as the long-term demographic goal of the country and emphasized the need for "securing the small family norm, through voluntary efforts and moving towards the goal of population stabilisation". While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy.

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Post Emergency, the system of monetary incentives and the women centric programme of sterilisation were important components of the Family Planning Programme.


**Annual Plans and VIII FYP (1990-92; 1992-97)** - In 1993, the Ministry of Health and Family Welfare appointed an expert Group under the Chairmanship of Dr. M.S. Swaminathan to draw up a Draft Population Policy. Report was submitted in 1994 and circulated among Members of Parliament and central and state agencies. It was anticipated that a national population policy approved by the National Development Council and the Parliament would help produce a broad political consensus. The Report basically related population growth to the basic needs, democratic decentralization, gender issues and eco-system. These features were incorporated in the Statement on National Population Policy prepared by the Ministry in 1996-97. The Department of Family Welfare abolished the practice of setting centrally defined, method-specific targets for contraception. It was replaced by decentralized area-specific need assessment (community needs assessment approach), planning and implementing programmes aimed at fulfilling these needs.

In 1997, Reproductive and Child Health (RCH) programme was launched. Family Planning Programme expanded its services to include Maternal and Child Health (MCH) and Child Survival and Safe Motherhood (CSSM) programmes.

**IX FYP (1997-2002)** - New Population policy announced in February 2000. Following this, a number of states have announced or are coming out with their own population policies. The two important demographic goals of the National Population Policy (2000) are achieving the population replacement level (TFR 2.1) by 2010 and a stable population by 2045. The National Commission on Population was constituted on 11 May 2000 under the chairmanship of the Prime Minister. ‘Empowerment of Women’ became one of the nine primary objectives of the Ninth Plan.

**X FYP (2002-07)** - During the Tenth Plan, the paradigm shift, which started during the Ninth Plan, was to be operationalised - from demographic targets to focussing on enabling couples to achieve their reproductive goals. The pace of implementation of the RCH programme was to be accelerated.

**XI FYP (2007-12)** – Time bound goals of reaching TFR of 2.1 and achieving Population Stabilisation by 2045. For the first time a monitorable target is set for raising the child sex ratio.
Annexure 3.2  Population Policy of Tamil Nadu

Tamilnadu formulated a State Population Policy in 1993, which was reformulated in 2007 to redefine goals and refine strategies in the context of the present indicators.

A. Objectives:

The objective is to achieve a stable population in Tamil Nadu by addressing the unmet needs for contraception and improving the overall health of the mother and child especially, in the poorer sections of the society.

B. Goals:

Medium term goals to be achieved by 2012 i.e., at the end of XI Five Year Plan for achieving the main objectives are given below:

<table>
<thead>
<tr>
<th>SL.No.</th>
<th>Indicator</th>
<th>Goal for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Infant Mortality Rate</td>
<td>20.0</td>
</tr>
<tr>
<td>2.</td>
<td>Crude Death Rate</td>
<td>6.0</td>
</tr>
<tr>
<td>3.</td>
<td>Maternal Mortality Ratio</td>
<td>0.45</td>
</tr>
<tr>
<td>4.</td>
<td>Life Expectation at birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>73</td>
</tr>
<tr>
<td>5.</td>
<td>Crude Birth Rate</td>
<td>14.0</td>
</tr>
<tr>
<td>6.</td>
<td>Couple Protection Rate</td>
<td>65 %</td>
</tr>
<tr>
<td>7.</td>
<td>Total Fertility Rate</td>
<td>1.4</td>
</tr>
<tr>
<td>8.</td>
<td>Reduction of Higher order of births</td>
<td>10 %</td>
</tr>
<tr>
<td>9.</td>
<td>Male Participation in Contraception</td>
<td>10 %</td>
</tr>
<tr>
<td>10.</td>
<td>Still Birth Rate</td>
<td>7.0</td>
</tr>
<tr>
<td>11.</td>
<td>Child Sex Ratio</td>
<td>950</td>
</tr>
</tbody>
</table>

The basic premises of the policy are that
1. The well being of both current and future generations are the central point of the policy.
2. Government intervention is still essential and necessary to influence the individual (private) action in the interest of the common good.
3. Planning has to be decentralized and has to be district specific.
4. Convergence of strategies of various developmental schemes on the focal point of the population goals is required to achieve the objectives.

A holistic and comprehensive multi sectoral and multi departmental approach by government is required to implement integrated human development, which is the underlying philosophy of the State’s population Policy. Thus, the State Population Commission has been set up with the Hon’ble Chief Minister as Chairperson. The terms of reference of this commission is as follows:

i. To review, monitor and give direction in the implementation of family welfare and maternal and child health programmes in Tamilnadu with a view to reach the set goals.
ii. To promote synergy between demographic, educational, environmental and development programmes to achieve population stabilization in Tamilnadu by 2025.
iii. To promote intersectoral co-ordination in planning and implementation across Government Departments.
iv. To facilitate a development of a vigorous people’s movement in support of this National Programme.

Source: Tamil Nadu Population Policy (TNPP), 2007
Annexure 3.3  Population Policy of Maharashtra

When announcing the New Population Policy on 9 May 2001, the Government of Maharashtra put to the fore the reasons why the policy was formulated. In 60 years from 1901, the population of areas that now constitute Maharashtra had doubled. However, in 30 years since 1961, it had doubled again. Of the several reasons, the main was marriage of girls at an early age and preference for the male child. The policy stressed the need to vigorously implement the existing laws under:

- The Child Marriage Restraint Act, 1978
- The Pre-natal Sex Determination Act, 1994
- Registration of Births and Deaths Act, 1969
- Energetic activation of the Women’s Policy
- Provision of free education to girls.

State has accepted two children norm as ‘Small Family Norm’. The personal benefit schemes for government and semi-government employees will be linked to acceptance of the small family norm. Couples accepting the small family norm only will be eligible for subsidies under various schemes. Acceptance of the small family norm will be considered at the time of recruitment to government and semi-government employment. Employees accepting the small family norm will be given preference for sanctioning facilities like house building advance, vehicle advance etc. Only those employees limiting their family to two children will be entitled to reimbursement of medical expenses.

As a disincentive, eligibility from 1 May 2001 for contesting to get elected or being appointed/ nominated to Zilla Parishads, Panchayat Samitis, civic bodies from Municipal Corporations downwards, Government-owned corporations, co-operative societies, district co-operative banks, milk producers’ unions, etc., was restricted to those who have not more than two children. This was aimed at awakening the people to the need to restrict the size of the family as an ideal. Gram Panchayats slowing substantial gains in restricting births get financial support for wells, public toilets, repairs to Gram Panchayat offices, school buildings and roads.

The Savitribai Phule Kanya Kalyan Yojana was revised to focus on couples below the poverty line and linked to the education of girls and their age at marriage. Couples under 40 years of age but with only one daughter, and who opted for either a sterilization or vasectomy become eligible for a Fixed Deposit in the girl-child’s name until she attains 18 years of age. If the girl child completes her education up to the 10th Standard, she becomes eligible for another Rs 5,000 in a Fixed Deposit for another five years but encashable only if such girls marry after their 20th year. If the couple decide on sterilization or vasectomy after two female children, the FD is limited to Rs 5,000 in the first instance but the post-10th Standard reward is unchanged.

Source: Maharashtra Population Policy (MPP), 2001
Annexure 3.4

I. PROMOTIONAL AND MOTIVATIONAL MEASURES FOR THE ADOPTION OF SMALL FAMILY NORM- AS ENVISAGED IN NPP- 2000

- Panchayats and Zilla Parishads will be rewarded and honoured 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.
- The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child will continue. A cash incentive of Rs. 500/- is awarded at the birth of the girl child of birth order 1 or 2.
- Maternity Benefit Scheme run by the Department of Rural development will continue. A cash incentive of Rs. 500/- is awarded to mothers who have their first child after 19 years of age, for the birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with antenatal check up, institutional delivery by trained birth attendant, registration of birth and BCG immunization.
- A family welfare linked – Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilization with not more than two living children, would become eligible (along with children) for health insurance (for hospitalization) not exceeding Rs. 5000/-, and a personal accident insurance cover for the spouse undergoing sterilization.
- Couples below poverty line, who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded.
- A revolving fund will be set up for income – generating activities by village-level, self help groups, who provide community – level health care services.
- Crèches and childcare centres will be opened in rural areas and urban slums. This will facilitate and promote participation of women in paid employment.
- A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counselling services to enable acceptors to exercise voluntary and informed consent.
- Facilities for safe abortion will be strengthened and expanded.
- Products and services will be made affordable through innovative social marketing schemes.
- Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.
- Increased vocational training schemes for girls, leading to self-employment will be encouraged.
- Soft loans to ensure mobility of the ANMs will be increased.
- The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha on the basis of population at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilization. This freeze needs to be extended until 2026.
## Annexure 3.4 (contd.)

### II. INCENTIVES / DISINCENTIVES – GIVEN BY THE STATES

#### MAHARASHTRA

<table>
<thead>
<tr>
<th>Unit/Criteria</th>
<th>Nature of Incentives/disincentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money Awards to BPL groups:</td>
<td>An incentive of Rs. 10,000/- in the form of fixed deposit for 18 years to below poverty line couples accepting terminal method after one or two daughters (with no male child). This daughter(s) will be given an additional incentive of Rs. 5000/- each as fixed deposit for five years when she completes her schooling up to 10th standard and does not get married before 20 years of age.</td>
</tr>
<tr>
<td>Employment Benefits:</td>
<td>The condition of small family norm will be included in service rule amongst Government and semi Government employees. Those having not more than two children will be given House Building Advance, Vehicle Advance and Medical Reimbursement.</td>
</tr>
<tr>
<td>Electoral Disincentives:</td>
<td>Acceptance of small family norm as a condition for qualifying for elections to various bodies such as Zilla Parishad, Panchayat Samitis and Cooperative Societies etc.</td>
</tr>
</tbody>
</table>

#### TAMIL NADU

1. Deposit in the name of the child, Rs.3000/- per sterilization after first girl child and Rs.1500/- after the second girl child.
2. Special Casual Leave to Government servants for sterilization and vasectomy.
3. Payment of additional compensation to acceptors who undergo sterilization operation for a second time due to failure of earlier operation.
4. Monetary assistance of Rs.500/- to women to compensate for the loss of wages to them during the last 8 to 12 weeks of delivery.

*Source: National Commission on Population (NCP)*
References to Chapter 3


