MIDS WORKING PAPER NO. 216

Family planning programs in India: An overview and need for a revision

K. Srinivasan
Former Director and Senior Professor, IIPS, Mumbai
and National Fellow, ICSSR, New Delhi

mids Madras Institute of Development Studies

MIDS Working Paper No. 216, March 2014

Family planning programs in India:
An overview and need for a revision

by K. Srinivasan

Rs.25.00

Madras Institute of Development Studies
79, Second Main Road, Gandhi Nagar
Adyar, Chennai 600 020
Tel.: 2441 1574/2589/2295/9771
Fax : 91-44-24910872
pub@mids.ac.in
http://www.mids.ac.in

Family planning programs in India: An overview and need for a revision

K. Srinivasan[1]

Abstract

Indian Family Planning Program, though started in 1952 on solid developmental and women's welfare grounds, has had over the years rapid upswings followed by downswings either because of bad and hurried population policies such as during national emergency in 1975 or setting unrealistic targets or removing them because of succumbing to the international pressure caused by women's groups through the International Conference on Population and Development (ICPD) held at Cairo in 1994. Though India has on the whole done fairly well in reducing its fertility levels very close to the levels desired by the married couples in many states, there are still large variations across the states on fertility and many development indicators. Increased contraceptive use and lowered fertility levels have been found to be closely related with developments in many areas at the micro and macro levels and the human development index, not only within India but across the globe. There are two major problems caused by the India program: first, large interstate variations in population growth, fertility and mortality levels across the states and second, the setting of unrealistic targets leading to falsification of figures. These are matters of serious concern for the country both from the point of view of maintaining the high rate of economic growth witnessed in the past largely in the states that had already achieved low fertility levels and surplus household incomes to invest in a better investment climate and also maintaining political stability. We suggest some recommendations for more effective and less controversial program of family planning in the country.

[1] Former Director and Senior Professor, International Institute for Population Sciences, Mumbai and National Fellow, Indian council for Social Science Research (ICSSR), New Delhi and affiliated to the Madras Institute of Development Studies (MIDS), Chennai

I. Population Concerns before independence

Population concerns have a long history in India. Though the idea of family planning was planted from the West, it developed its own local roots, cultural support and social and political patronage in India. Until 1920, India's population had been growing very slowly owing to the heavy toll from famines, epidemics, and wars and the birth rates were only marginally higher than the death rates. According to census reports, the population of the country within its present geographical boundaries actually declined between l911 and 1921, from 252.1 to 251.3 million because of the high mortality inflicted by the influenza pandemic of l918-19. It is estimated that about 5 percent of the country's population - some 13 million persons - died in that epidemic. Both the birth and death rates hovered between 45 to 48.The population increased steadily since l921, largely because of epidemic and famine control measures undertaken simultaneously with sanitation programs by the provincial governments. Hence 1921 is considered as the demographic divide in India. For the first time, since the initiation of a systematic population census in l881, India's population increased slightly by more than 10 percent, (or by 27.7 million) in a decade, with the l931 census enumerating a population of 279.0 million (Hutton, 1932).

In this context explicit concern over such an unprecedented rapid rise in population arose from four quarters: intellectuals, echoing the neo-Malthusian concerns frequently publicized in England and Europe; social reformers, like Maharishi Karve interested in improving the status of women; the Congress Party (the leading political party that spearheaded the movement for political independence) and the provincial governments such as the princely state of Mysore under the Maharajah that opened the two first official family planning clinics in the world ,one in Vani Vilas Hospital in Bangalore and the other in Cheluvamba Hospital in Mysore in 1930.

Neo-Malthusian leagues were set up in Madras and Mumbai in the 'thirties and there were heated debates among intellectuals as how to deal with the continuing rise of population in the country. There was also a strong women's movement supporting adoption of modern methods of family planning by women, to liberate them in the words of Margaret Sanger "from the wheels of child bearing and hazards of induced back-street abortions by women to get rid of unwanted pregnancies". The All India women's conference held in Trivandrum in 1935 passed a unanimous resolution recommending modern methods of family planning for married couples. According to Margaret Sanger who introduced the term family planning it connoted "enabling couples to have babies by choice and not by chance". "Choice" is inherent in the idea of family planning. There was some moralistic opposition from Mahatma Gandhi on the use of artificial methods of birth

control but this was not shared by other congress leaders as Jawaharlal Nehru and Subhas Chandra Bose. With the demise of Mahatma Gandhi in 1948 even this single lone moralistic objection to family planning was not there. (For details on these see Srinivasan, 1995)

However the trigger for specific policy and action at the national level came after the Bengal Famine in which 1.5 million people succumbed during 1943-1944. The report of the Bengal Famine Inquiry Committee constituted by the Government of India that submitted its report in l945 contained a chapter on the potential dangers to the economy and life of people arising out of rapid population growth, especially a population living in abject poverty and deprived of the bare necessities of life and forced to live close to the sea or areas susceptible to flooding and famines. Similarly, the Health Survey and Development Committee popularly called, the Bhore Committee, which was set up in l943 to make an assessment of the health conditions in India submitted its report in l946 and recommended a suitable health infrastructure for the country. It also stressed the need for a national program of family planning for improving the health status of population. The reports of these two committees, the Bengal Famine Enquiry Committee and the Bhore Committee, one for sheer survival and the other for the improvement of the health of the population, paved the way for the Government of India to adopt a National Program of Family Planning after attaining its political independence in l947. Thus the national program of Family Planning in India had solid intellectual, social, developmental and women's health base, prepared since the late 1920's before it was articulated as a firm national policy in the first five year developmental plan (1951-56) launched after independence. It was not a program started off the cuff as a mere neo-Malthusian policy but as a deliberate measure to protect women's health and accelerate overall development.

II. Policies and Programs since independence, the upswing until 1976

The population policies formulated and the national programs of family planning implemented after independence until the present can be considered in three phases: first until until 1977 including the emergency period of 1976-77; the second the post emergency period of 1977-1995 when the program was gaining increased acceptance with women coming forward in large numbers; and the third after 1995 (post ICPD period) till date. We will briefly discuss the program strategies and impacts during each of these three periods.

In the first phase, the program started with a "clinic approach" and went through a number of modifications both in commitment and program strategy and the first phase of upswing lasted until 1977 and can

conveniently be classified into four sub-periods as follows:

1. Clinic Approach (1952-61);
2. Extension Education Approach low intensity HITTS model (1962-69);
3. High intensity HITTS Approach (1969-75) and;
4. Coercive approach (1976-77).

1. Clinic Approach: 1951- 61

In April l950, Government of India appointed a Population Policy Committee under the Chairmanship of Minister of Health and upon its recommendations; a Family Planning Cell was created in the office of the Director General of Health Services. The first Five Year Plan document presented to Parliament in December l952, referred to a program for Family Limitation and Population Control, terms, which may be considered objectionable on human rights grounds at present.. As an important component of its developmental strategy it sought to reduce the birth rates to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy. A modest sum of Rs 6.5 million (or US $ 1.44 million at the exchange rate of 1 US $ = Rs 4.5 that time) was allocated by the Central Government for the family planning program which included a plethora of activities such as motivation, education, research and clinical services. The initial approach adopted by the Government was a clinic approach; a number of family planning clinics were opened throughout the country mostly in urban centers and it was assumed that there was already a strong desire to space and limit family size among the couples and if contraceptive services such as condoms, diaphragm and jelly, and vasectomy for men were offered in a clinic setting, it would be sufficient to reduce the birth rate. The clinic approach was extended during the second plan period, 1956-61, increasing the number of clinics from 147 to 4165. During this period the percentage of eligible couples using contraception increased insignificantly from practically 0 percent to 0.2 % in 1961.

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

However the 1961 census showed a continued rise in the population growth rate and increase in the fertility levels. As a reaction, for the first time in the country, a demographic goal was set in 1962, to reach a crude birth of 25 by 1972. Since then reduction in fertility levels was the sole objective of the India's population policy until the early eighties. Incentives were offered to vasectomy acceptors and to women who were accepting IUD insertions

and the clinic approach was replaced by extension approach in which the family planning workers were asked to make house to house visits to motivate couples to accept family planning methods; targets on the number of contraceptive acceptors to be recruited were fixed to the workers. The concept of improvident maternity to indicate all births of order 4 and above as accidental and not really wanted by the parents themselves was proposed. Mr. R A. Gopalswamy ICS, who was the first Registrar General of independent India (1951 census), who was also earlier the member secretary of the Bengal Famine enquiry Committee whose report was submitted in 1945 and wrote the special chapter on the need for family planning to avoid famines . He became the chief secretary of Madras Presidency after his assignment as RG. He worked out in a simplistic fashion that if we can do 7 vasectomies per thousand population per year among eligible couples with 4 or more children for 10 years, all the improvident births (order 4 and above) can be averted, the crude birth rate will drop to 25 and the population growth rate will become manageable. Incentives were given to those who accepted vasectomy after the third child and Madras led the way in the ushering in of the long spell of controversial incentive -based vasectomy program in the country

In the center, a separate department of family planning was set up and the departments of health in the states were renamed, over time as Departments of Health and Family Planning. Family planning program was fully funded from the central funds with staffing patterns and methods of functioning formulated by them.

With the setting up of demographic goals, state by state, district by district, under the program, achievement of these goals was made the responsibility of the health departments through recruitment of a targeted number of contraceptive acceptors. The program became entrenched in a HITTS model: i.e., health department operated, incentive based, target-oriented, time-bound and sterilization-focused program. (Srinivasan, 1995) The year 1962 was the beginning of the HITTS approach which lasted until 1977 with varying degrees of emphasis on each of its components of involvement of health functionaries, change of incentives, targets and the time frame for achievement of targets. Vasectomy came to be regarded as the main fulcrum for fertility regulation and sine-qua-non for family planning.. However the demographic goals set in 1962, were extremely unrealistic, and had to be revised time and again at the end of each five year plan. Actually the CBR goal of 25 set in 1962 to be reached by 1972 was realized only 30 years later, by 2002. Table 1A gives the goals set at different periods of time by the central government for the period 1962 to 1985 and Table 1 B for the period 1985 to 2012.

3. HITTS Approach: High Intensity -1969-76

The HITTS approach initiated in 1962 was not as successful as it was expected to be. Sample surveys done in the late 'sixties in different parts of the country revealed that the birth rate was not declining but on the other hand was even rising in some areas. There was frustration building up in many quarters that the population growth rates were not declining and the 1971 census confirmed these fears. High population growth was considered as one of the key factors responsible for retarding the economic development of the country in spite of increased investments in the five-year plans. Hence vasectomy camps were organized, first as mini camps (where not more than 30 vasectomies were done in one day) and then as large camps such as the Ernakulum camp in Kerala in 1970 where over 60,000 vasectomies were done over a week. Government officials from many other departments, other than health, were involved in the organization of these camps and incentives both in cash and kind were offered in addition to those officially sanctioned by the Government of India. The involvement of officials from revenue and police departments added a touch of coercion and even compulsion in the program.

Such a camp approach had a significant impact on the contraceptive use with couple protection rate rising to 14.8% by March 1974 but the crude birth rate remained still high.

4. Coercive Approach: The Emergency Period, 1975-77

India went through a phase of national internal emergency under the Prime Minister ship of Mrs. Indira Gandhi during June 75 - March 77 when the rights of individuals were largely suppressed, the freedom of the press restricted and the powers of the judiciary curtailed with the government at the center assuming enormous authoritarian powers over the individuals and the state governments. For the first time, a National Population Policy was formulated and adopted by the Parliament (April 76) which called for a 'frontal attack on the problems of population' and which inspired the state governments to 'pass suitable legislation to make family planning compulsory for citizens' and to stop child bearing after three children, if the 'state so desires'. Many other measures were introduced such as stipulations to government officials in the health and revenue departments to recruit given numbers of vasectomies from their areas of operation, failing which punishments were to be meted out to them. Various other coercive tactics were used to control the fertility levels, mainly though increased number of vasectomies. The Commissioner for Family Planning at the center assumed enormous powers under the program and the government officials not only in the center but also in the states became powerful. The incentive payments

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

A Constitutional Amendment froze representations to parliament from each state frozen at the l971 census level up to the year 2001, making it politically unattractive for any state to increase its relative population size in the hope of securing greater political strength at the Centre. Vasectomies were conducted in railway stations, quickly arranged camp sites, even in educational institutions and it is alleged that in the northern states of Uttar Pradesh and Bihar men were forcefully subjected to sterilization under some reason or the other. The strategy during this period can be termed as 'Coercion'. However news of these excesses leaked out very quickly through informal channels and there was general public agitation brewing up all over the country. The number of sterilizations done in India during April 1976 to March 1977 was 8.26 million, more than the total number done in the previous five years and more than the number done in any other country in the world until that time. By March 1977 the percentage using contraception surged to 23.5%, a rise by 8 percentage points in 3 years. Table 2 A reviews the program performance until 1975

III. The second phase: Collapse and recovery phase (1977-1994): Post-Emergency period (1977-94)

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

There was a strong political reaction to the policy of April l976 in the post emergency government that assumed power in March l977. There was a tremendous backlash on the family planning program especially its insistence on targets for vasectomy. The new government changed the name of 'family planning' to 'family welfare', reduced the targets on sterilization and chose to achieve demographic change through a program of education and motivation. A judicial commission was appointed to enquire into the wrong doings during the emergency period including forced sterilizations.. A revised Population Policy adopted in l977 was totally against compulsory sterilization and legislation of any kind and stated that 'Compulsion in the area of family welfare must be ruled out for all times to come. Our approach is educational and wholly voluntary'. The 1977 policy was welcomed as a type of liberation for the expression of individual opinions and attitudes on family size and freedom of choice of contraceptive methods

to be used by couples. The backlash on the program was felt severely on the number of vasectomies done in the year 1977-78 which was less than 1 million, one fifth of the number performed in the previous year, although the expenditure incurred in that year remained the same as in the previous year. However, the new government enacted into law the proposal by the earlier government, the policy of raising the minimum age at marriage of 18 for girls and 21 for boys which came into operation in October 1978.

The period after 1977 can be considered to be a Recoil and Recovery phase for the family planning program. During 1977 to 1980, the effective couple protection rate (CEP) declined slightly from 23.5 to 22.3. But, the women of the country took on their shoulders the responsibility for limiting their family size by taking to tubectomy operations, mostly post-partum after the third child. Female sterilization began to replace male sterilization from 1980 and became the dominant method of family planning in India.

Table 3 reviews the program performance from 1976 to 2011 and Figure 1 presents the trends in the percentage of couples effectively protected by the program since 1980 for India as a whole and for two of the most developed states, Kerala and Tamil Nadu and two of the least developed states, Uttar Pradesh and Bihar.

The change of government again in January l980 marked a turning point and helped to restore the family planning program garbed as family welfare program. The emphasis on sterilizations continued though on a voluntary nature. During the revised sixth Five Year Plan, l980-85, a Working Group of Population Policy was set up by the Planning Commission to formulate long-term policy goals and program targets for family welfare programs. The long-term demographic goals were revised in terms of achieving Net Reproduction Rate (NRR-1) by the year l996 for the country as a whole, on an average, and by the year 2001 in all the states. These goals are yet to be realized. These goals were translated into achieving a crude birth rate of 21, a crude death rate of nine, and infant mortality rate of 60 and expectancy of life at birth of 64 years and contraceptive prevalence rate 60 percent among eligible couples by modern methods of family planning to be achieved in all the States by the year 2000.

The health-based, time-bound target-oriented family planning program was revived with reduced emphasis on sterilization and greater emphasis on spacing methods and on child survival programs. These were to be implemented through all the sub-centers and Primary Health Centers in the rural areas, without any aggressive campaigns or mass camps for sterilization as were adopted in earlier years. With greater assistance from the international organizations, especially the UNICEF and the WHO, the Universal

Immunization Programs (UIP) and Expanded Program of Immunizations (EIP) were launched in a systematic manner covering all the districts of the country in a phased manner. However, the post-emergency collapse of the family planning program could never be revived fully in the subsequent years, especially in terms of acceptance of vasectomy by men, as a good method of family planning. With men almost refusing to come forward for vasectomy, and motivations for family size limitations continuing to rise because of the information- education campaigns and lack of easy availability of spacing methods, tubal ligation of women began to rise steadily and became a dominant method of family planning during the next five years.

By the late eighties, it came to be recognized that the mortality and fertility levels in some states are declining rapidly, more rapidly than anticipated though the expenditure on family planning was not much different in these states. (Zachariah, 1984). The crude birth rate of Kerala which was 37 in 1966, came down to 26 in 1976 and to 20.3 by 1988, below the goal of 21, the replacement level of fertility, recommended in the sixth plan document. By 1986 the infant mortality rate has declined to 27 infant deaths per 1000 live births, well below the goal of 60 recommended to be reached by the year 2000. Similarly, Tamil Nadu reduced its birth rate from 33.6 in 1970-72 to 23.1 by 1989, though its infant mortality rate in that year was 68, much higher than that of Kerala. Clearly something striking was happening in terms of demographic transition in the southern states. This phenomenon attracted scholars from various disciplines to analyze the factors that were behind such a transition and whether these could be replicated or adapted to other areas of the country where fertility levels were declining more slowly and many theories were advanced. (Srinivasan, 1995). Table 2 B reviews the program during this phase.

IV. The third phase: Post ICPD and toeing of international line and declines in program acceptance.

There were three major developments within the country and outside that marked the post 1994 period with regard to their influence on population policies and family planning programs in India. They were democratic decentralization within the country, economic liberalization and globalization and the rise of international women's groups expressing their strong voice on family planning in the International Conference on Population and Development (ICPD) held in Cairo in 1994. These are briefly discussed below from the point vie of their relevance to family planning.

A. Political and Economic Contextual changes in India

A major change in the political scenario of the country was introduced in 1992 with the passing of constitutional amendments 72 and 73 and

enactments of Panchayat Raj and Nagar Palika Acts setting in motion the process of democratic decentralization. These acts ushered in a three-tier system of political governance in the country, central government, state government and the panchayats in the rural areas and the Nagar palikas in the urban areas up to the district level, by which constitutionally, the powers, responsibilities and resources are to be shared by these three-tiers of elected bodies. The primary health care including family planning, primary education and provision of certain basic amenities to the people such as drinking water and roads became the responsibility of the panchayats. Another notable feature of this Act is the reservation of one third of the seats in Panchayats for women members. Thus at the grass root level the women are politically empowered by this act, on all decision making issues pertaining to social development including family planning. This is a great leap forward for the Indian democracy and empowerment of women. The process of this demographic decentralization is still going on with varying speed and intensity in different states. Generally, the states are reluctant to share their powers and resources with the elected bodies of the panchayats. Though such a reservation is sought to be made at the state and central levels, this has not been possible due to strong objections from many political parties in the national parliament. Family planning and primary health care are, legally, as of now in the domain of the panchayats and nagar palikas though funding for the same has to come from the state and the central governments. Family planning is still considered as a matter in the concurrent list between the center and the state. This democratic decentralization has further infringed on the powers of state government to impose any strong family planning program through its Primary Health Centers and Sub-Centers.

The second major change that took place since the late 'eighties and pursued vigorously in the 'nineties was the economic liberalization policies of the government and the slow but steady linking of the Indian economy with the global economy. Since independence India followed the 'socialistic pattern of society' with the economic modeling of the Soviet Union as the guideline with their seven-year plans modified to Indian five-year plans and developing a 'command and control' economy. With the collapse of the Soviet Union in the late 'eighties India was almost lost without a model to follow and serious balance of payments arose from repayment of loans and interests thereon to World Bank, IMF and other donor agencies . That left the country with no choice but to open its doors for the foreign investors and shift to market economy. The 'license raj' ended once and for all.

The launching of National Family Health Survey-I in 1991-92 for which preparations were started in 1989, was symbolic of opening up of the Indian economy. Until 1988 data from the censuses and large-scale surveys in the

country were not supposed the leave the country and taking original data even on placid demographic variables out of the country was considered a crime. Now data from a number of large-scale surveys in the country such as the NFHS and RCH series are in the public domain through web-sites for access to anyone in the world. This liberalization of the Indian economy and the society has also had its impact on population policies and programs in the country.

B. International women's movements and their views on family planning

Another notable development beginning the early 1990's has been organized intensification and expansion of the women's movements within the country and outside, questioning the policies and directions of the government with regard to role of governments on their reproductive rights and organized national family planning programs in which women had to shoulder major responsibilities for fertility regulation and demographic transition. Setting up fertility goals and related family planning targets by the governments was considered as an infringement on human rights, women's rights and especially on their reproductive rights. All family planning programs, they argue, have been ultimately targeting women through propagation of female methods of family planning, in the context of a target-oriented and incentive based system. The preponderance of female sterilizations as the dominant method of family planning in the country, it was argued, was because of the pressure brought on women by the officials, in the health department who were keen to fulfill their quotas of family planning. This became tantamount to an infringement on their fundamental rights. Thus family planning program landed itself in a quagmire where it could neither achieve its demographic goals of low fertility and population stabilization (through birth rate goals converted into family planning targets and pursuing these targets) nor withdraw from such a program in the context of a continuing rise in the yearly additions to its population.

C. International Conference on Population and Development at Cairo, 1994.

The International Conference on Population and Development (ICPD), organized by the United Nations in Cairo in 1994, was in its deliberations, by and large, dominated by women's groups. The Program of Action formulated at the end of the Conference and for which India is a signatory, postulated that population policies should be viewed as an integral part of programs for women's development, women's rights, women's reproductive health, poverty alleviation and sustainable development. Women's concern dominated the discussions at the Cairo conference, which felt that population policies which are based on macro demographic considerations and acceptor-

target-driven programs are unnecessarily and unevenly burdening women with the task of regulating reproduction to suit macro level policies. They argued that, henceforth, population policies should not be viewed with the sole concern of reductions in fertility rates considered desirable by planners and demographers, but by considerations of reproductive health, reproductive rights and gender equity. It was argued that developmental programs, which are not engendered, are not only sustainable but also endangered. The Program of Action adopted by the ICPD recommends a set of qualitative and quantitative development goals. They are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equity, equality and empowerment of women; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health.

From many angles the mid 'nineties marked a major shift in the policies and programs of the government with economic growth agenda dominating the social welfare and equity agenda that prevailed till that time. Consequently economic disparities widened , health of the people at large did not improve as expected and the impact of public health programs was far less than anticipated and contraceptive use and fertility declines slowed down. Just as the year 1921 is considered the demographic divide, 1994 can be considered the family planning program divide, globally as well as in India

V. Post Cairo Policies: RCH Approach since 1995 and second slow down of the family planning program

The Government of India, which was a signatory to ICPD Program of Action, promptly followed up on the recommendations by abolishing the acceptor based family planning targets since April 1995, in the country as a whole. It had already experimented with the 'target-free' approach in a few selected districts in the previous year but the effectiveness of the approach was not properly assessed. Since 1997, officially, the Reproductive Health Approach has been adopted as the national policy of the Government of India. The official RCH programs include the conventional maternal and child health services including immunization of children and contraceptive services to couples, treatment of reproductive tract infections (RTIs) and sexually transmitted diseases, provision of reproductive health education and services for adolescent boys and girls, screening of women near menopausal age for cervical and uterine cancer and treatment where required. Family Planning became 'embedded' in a cocktail of other programs. It was called an integrated and decentralized approach to family planning. The budget required for these additional services intended to be covered under

reproductive health are quite high, but only marginally higher amount wa allocated. It was known that the emphasis on contraceptive services will get diluted when budgets are not adequately increased to cover the wider goals of RCH programs but this was done. Population concerns go beyond reproductive health, though the latter is an important contributing factor for population stabilization.

At present three policies seem to be in operation in the country that have direct impact on population issues and availability of family planning services. These are the National Population Policy 2000 (NPP 2000), the National Health Policy (NHP 2002) and the National Rural Health Mission (NRHM 2005). A comparative summary of the objectives, goals, strategies and inputs into the program are given in Appendix 1 and 2. We will discuss them briefly.

A. National Population Policy 2000 (NPP 2000) and National Health Policy 2002 (NHP 2002)

National Population Policy 2000 (NPP 2000) and the National Health Policy 2002 (NPP 2002) came up one after the other within a gap of 2 years. NPP 2000 was announced with a lot of fanfare in February 2000 after almost 6 years of preparation and discussion of drafts by various committees starting with the M S Swaminathan committee on population policy. Innumerable discussions were held on the appropriate population policy by various committees set up by the Planning Commission (of which I happened to be a member of one committee) for a revised population policy for the country. The final policy document approved by the Group of Ministers and Planning Commission was launched in February 2000, by Sri. A.R. Nanda the then Secretary, Department of Family Welfare, later approved by the newly set up National Commission on Population under the Chairmanship of the Prime Minister in its first meeting held in July 2000 and later approved by the Parliament in 2001. Parliamentary approval became mandatory since the policy recommended a continuation of a Constitutional Amendment made in 1976 that froze the seats in parliament and state legislative assemblies on the basis of 1971 census until 2001. In 2001, on the basis of the recommendations of NPP 2000, the parliament extended this constitutional freeze of seats until 2021.

Compared to NPP 2000, the National Health Policy 2002 (NHP 2002) received much less fanfare and popular or professional discussions. Since independence, the population policies formulated from time to time, beginning with the policy in 1976, have aroused a high level of political interest and popular discussions compared to other policies, even health and development policies. This may be because of the long held mistaken view

that population problem is the mother of all the problems in the country and once we clinch this problem, in the sense that the population growth rate is arrested and brought down close to zero, all other problems will automatically solve themselves or become amenable to easy resolution. No other country in the world including China had so many population policies as India. China had only one policy, the one child policy, and just went ahead and implemented it.

NPP 2000 and NHP 2002 typify the impact or goal obsessed approach to policy rather than the inputs- processes- outcome oriented approach to policy. Knowing full well that certain goals are impossible to be realized, they are still stated in the policy documents under the assumption that stating the goal is in itself, half of the achievement of the goal. NPP 2000 has laid down three objectives, immediate, medium and long term and 14 quantitative goals, called the national socio-demographic goals to be achieved by the year 2010.. Most of the stated goals were known to be impossible of realization but the policy makers went ahead and put them in the document. For example, the goal for IMR stipulated in all the three policies was: IMR of 30 by 2010 in NPP 2000 and in NHP 2002 and by 2012 in NRHM 2005 is not achieved by 2012. Constant shifting the goal posts seem to be an unending posture in the government programs.

B. National Rural Health Mission 2005

The National Rural Health Mission 2005 (NRHM) launched by the Hon'ble Prime Minister himself is considered a flagship program in the country and is indeed a departure from the earlier policy and plan documents in two aspects. First, it takes the program in a "Mission Mode" probably encouraged by the success of the earlier Missions such as the Technology Mission. Secondly, more importantly it is not obsessed by the desired goals of impact but rather it focuses on inputs, strategies and programs to be done and leaves the ultimate impact as an outcome of what is done. This is a more realistic approach for the improvement of the health of the people. The "preamble' to the 'Mission Document' states that "Recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system". The Mission adopted a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aimed at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action included increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures,

optimization of health manpower, decentralization and district level management of health programs, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children." Appendix 1 and 2 states the objective and goals, respectively, of NPP (2000), NHP(2002) and NRHM(2005)

With regard to inputs into the program the emphasis of the NHRM is different from the NPP and NHP. Unlike the latter two documents that talk about percentage of GDP or percent of total government budget to be spent of public health, the NRHM talks about actual money to be spent which was Rs 6,500 crores during 2005-06 and raised by about 30 percent every subsequent year of the sum spent in the earlier year.. Similarly under inputs it talks of committees to be formed at each level, village, district and the state and the national levels, the activities including training and monitoring programs to be initiated. There will be a community liaison person in every village at the rate of 1 for 1000 population called ASHA an acronym for "Accredited Social Health Activist" similar to the Anganwadi Worker but functioning under the control and guidance of the health department. ASHA will be selected from the young the ever-married women of the village with at least middle school education and interested in the community. She will be given needed training in primary health care services focusing on maternal and childcare, will be paid a monthly honorarium and monetary incentives to take care of the pregnant women for arranging for and caring during institutional delivery. The success of the scheme is yet to be tested.

It is refreshing to note that the NRHM was more pragmatic in its approach and emphasizing more on inputs and strategies. The policy envisages a key role for the Central Government in designing national programs with the active participation of the State Governments. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. However, to optimize the utilization of the public health infrastructure at the primary level, a gradual convergence of all health programs under a single field administration is envisaged. Vertical programs for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programs, would need to be continued till moderate levels of prevalence are reached. The NRHM envisages that while the program implementation be effected through autonomous bodies at State and district levels, the interventions of State Health Departments may be limited to the

overall monitoring of the achievement of program targets and other technical aspects. The setting up of an independent Health Trust of India that will be financing the NRHM will give greater flexibility to the whole scheme. The relative distancing of the program implementation from the State Health Departments will give the district team greater operational flexibility. Also, the presence of State Government officials, social activists, private health professionals and MLAs/MPs on the management boards of the autonomous bodies will facilitate well-informed decision-making. Since 2005 the stated convergence of all programs at the field level has not taken place as expected. As with the concepts of " decentralization" and "integration" , "convergence : is also a desired concept not implementable in the field, since these concepts are interpreted differently at different levels of workers. These confusions have affected adversely the impact of various programs as we will see in the following section.

VI. Impact of post 1994 policies on reproductive and child health.

Post 1995 the bus words were "integration and decentralization". This did not work as we will see shortly in the case of reproductive and child health and family planning. The program of family planning or contraceptive education and services, post 1995, got a low priority since it was integrated with 13 other programs as education of adolescent boys and girls, immunization services for children etc. The program was also decentralized to the panchayat and nagar palika levels since according to the constitutional amendments 72 and 73, provision of basic health care that includes contraceptive services is the responsibility of the local institutions but the entire funding was from the central and state governments. The panchayat head had also a say in the program implementation through his involvement in the recruitment and supervision of the field workers "ASHA" and "AWW". There was a slow down not only in the acceptance and use of family planning methods but also in the use of maternal and other RCH services in the post RCH period. Let us examine it first by studying the state level trends in the percentage of couples effectively protected by contraception (CEP) , total fertility rate (TFR) and infant mortality rate (IMR) using official data from the family planning service statistics and sample registration system(SRS).

Tables 3 presents data on effective couple protection rate (CEP), the total fertility rate (TFR) and the infant mortality rate (IMR) for the years between 1980 and 2011 for All India and two less developed state , Bihar and Uttar Pradesh and two more developed states , Kerala and Tamil Nadu. These data were compiled from the official data sources, the Family Planning Service statistics published by the Ministry of Health and Family Welfare and the sample registration system of the Registrar General of India, The

time trends in CEP, TFR and IMR values are depicted as line graphs in Graphs 1, 2 and 3.

From the table and the related graphs the following conclusions can be drawn.

A. Contraceptive Use

1) The percentage of eligible couples effectively protected by contraception (CEP) has actually declined between 1980 and 2011 , from 45.8 to 40.4. There was stagnation in the CEP level until 2008 and thereafter there was a steep decline. This has happened in spite of spending huge sums of money on the RCH program between 1995 and 2011 under RCH and NRHM. However the TFR levels declined from 3.5 to 2.4 during this period. This is a puzzle to be resolved. One assumption is that many couples had used the private medical and health facilities to get their contraceptive services including sterilizations paying substantial money from their pockets. Their numbers may not be counted in the official statistics

2) In Bihar the CEP declined from 24.1 in 1995 to 16.5 in 2011. However during the same period the TFR declined significantly from 4.6 to 3

3) In Kerala there was a continuous secular decline from 50.7 in 1995 to 31.8 in 2011. However the TFR levels remained at the level of 1.8 during this period

4) In Tamil Nadu there was again a continuous secular decline from 54.8 in 1995 to 41.5 in 2011. However the TFR levels declined from 2. 2 to 1.7 during this period

5) In Uttar Pradesh , there was a continuous secular decline from 37.1 in 1995 to 27.7 in 2011. However the TFR levels declined significantly from 5.0 to 3.4 during this period.

The fact that fertility levels also declined in most of the states even in the context of declining contraceptive use reported officially indicates that many of the users of sterilizations and temporary methods have switched over to the private sector paying a heavy price for such services.oce he table and the related graph reveal that in the country as a whole the CEP declined post 1995 substantially both in the developed as well developing states while huge additional investments were made in the program.

B. Sterilization as the dominant method of family planning in India

Since the very inception of family planning program in India in 1952 sterilization of the male was promoted as a method of family planning and

for the first time in human history incentives were given to the acceptors of this method. The first to begin this incentive method was the Madras state, now called Tamil Nadu. Mr. R.A. Gopalaswamy the Chief Secretary of the state started such a policy by providing an incentive of Rs. 10 per acceptor in 1954. He even postulated that sterilization of all married men with wife in reproductive ages with over four children over a ten year period will bring down its birth rate from 40 in 1956 to 25 in 1966. Children above birth order 4 were considered improvident maternity. Similar incentives were provided the next year in the state of Maharashtra and became a national policy in 1961.Tamil Nadu led the sterilization movement in the country.

Vasectomy over the following years became the dominant method of family planning partly because of increased incentive amount to acceptors, canvassers, and service personnel. It became a commercial endeavor. It has become a culture of family planning in India , initially targeting couples with four children, then with 3 children and then with two children. During the emergency period 1976, a few states even passed an act making sterilization, compulsory for couples with two children . Such a procedure was even recommended in the national population policy of 1976., Vasectomy camps, small and large, were conducted throughout the country and states and districts which did the best were rewarded by the central government. During emergency many vasectomy camps were conducted in railway stations, bus stands and other places. There were mini and major camps. The three camps held in Ernakulum made history. There were three camps held in this city, in Kerala state, first during Nov-Dec 1970 in which 16,006 vasectomies were done; the second during July 1971 in which 63,416 vasectomies were done and the third in July-August 1972 in which 15,536 vasetomies were done. People from all over Kerala state were brought to these camp sites for sterilization and it was done in a festive mood. The international organizations were very vocal in praising these camps and a good and supportive article was published in the "Studies in Family Planning", a publication of the Population Council , New York in 1974(Krishnakumar, Vol 25, No. 2, February 1974). After 1994 with the ICPD program of action adopted by many countries the same and many other international organizations began to play a low key on family planning and began to hold the flag of women's rights and women's empowerment and even start criticizing many national programs of family planning as infringing on these rights.

However in the country because of many forced sterilizations carried out during the emergency where ineligible couples were forcefully sterilized the program came into popular disrepute , popular agitations were organized and became one of the major planks on which the emergency had to be lifted, elections were called up and the then ruling party suffered a crushing defeat. It was written that these large vasectomy camps, instead

of bringing down the birth rates, brought down the government.

As discussed earlier, family planning program suffered its credibility of vasectomy campaigns and the program almost totally collapsed after the emergency was lifted in 1977. It goes to the credit and foresight of the women of this country to have come forward for tubal ligations in large numbers after 1977 and the female sterilizations have replaced the male sterilizations for preventing unwanted births. Sterilizations, tubectomy and laparascopic tubal ligation have now become the dominant method of family planning in India. The measures by the state and the central governments with various temporary and reversible methods such as IUD, Copper T, oral pills, condoms etc. have not been that successful. The motto of an average Indian couple seems to have as many children as desired and then go for sterilization. They do not want to mess around with temporary methods.

Table 4 gives data on the percentage of couples effectively protected by all methods (CEP) and the percentage effectively protected by sterilization during the recent years 2007 to 2011 for India as whole and for the four selected states.

In the country as a whole in 2007 the CEP was 46.7 and the CEP due to sterilization was 27.0 or 58% of the total protection and in 2011 it was 66%. In the developed states of Kerala and Tamil Nadu that have already achieved replacement levels of fertility the percentage protection due to sterilization in 2007 were 86 and 81,respectively and in 2011 were 90 and 82 ,respectively. In Bihar in 2007 it was 81% and in 2011 also 81%. Thus sterilization is as much the dominant method of contraceptive protection in high fertility states as in low fertility states.

C. Fertility Trends

The TFR for the country as a whole declined from 4.3 in 1985 to 3.5 in 1995 to 2.4 in 2011. The annual decline in TFR between 1995 and 2011 is smaller than in the 1985-95 period. The goal of reaching the replacement level of fertility, TFR of 2.1, set in the National Population Policy(NPP) 2000 and the National Health Policy (NHP) 2002 by 2010 has not been fulfilled as in the earlier plans. Graph 2 which gives line graphs of the TFR values for the country as a whole and in the four states reveals the following.

1) The fertility levels of the southern states have already reached low levels below replacement at TFR of 1.7-1.8 and are not likely to decline further in the coming years. Even if there be a decline in these states they will only be very marginal. Hence the future declines in national fertility levels have to come from the large Hindi speaking sates of the north , especially Bihar and Uttar

Pradesh. These two states hold the key for India as a whole reaching the replacement level of fertility in the near future.

2) The "integrated- decentralized -co0nvergent" approach to family planning services have only delayed fertility decline in these states and the unwanted fertility (unwanted by the couples themselves) among the poor may increase in the coming years unless appropriate changes are made in the program strategy and management in these states. In Bihar the pace of decline in fertility witnessed during 1980-1992 was the steepest and thereafter there has been a systematic slow down in the decline.

D. Trends in infant mortality rates

The following conclusions can be drawn from the IMR figures given in Table 3 and Graph 3.

1) For the country as a whole the IMR declined from 114 infant deaths per 1000 live births in 1980, to 80 in 1990, 68 in 2000 and to 44 in 2011. The goal of reaching an IMR of 30 by 2010 set in NPP 2000 and NHP 2002 has one again been belied.

2) In Bihar the IMR was 118 in 1980, declined to 69 in 1990 , to 62 in 2000 and to 44 in 2011. Bihar has followed the national trends in IMR. The fastest pace of decline in IMR in the state was during the period 1980 to 1990and thereafter a slow down until 2000.. Since 2000 there has been an increase in the pace of decline.

3) In Kerala the IMR was already low in 1980 at 40 (lower than the level of 44 in Bihar in 2011) further declined to 17 in 1990 , to 14 in 2000 and to 12 in 2011.The IMR in Kerala has stagnated between 12 to 14 during the past 12 years and is unlikely to decline further in the coming years and reach the level of 6 achieved in the developed countries.

4) In Tamil Nadu the IMR was 93 in 1980, declined to 59 in 1990 , to 51 in 2000 and to 22 in 2011. The state has achieved the national goal of 30 by 2010 and the fastest pace of decline was achieved during 2000-2011 and the lowest during 1990 to 2000.

5) In Uttar Pradesh, the IMR was very high at 159 in 1980, declined to 99 in 1990 , to 83 in 2000 and to 57 in 2011. Uttar Pradesh had the highest pace of decline during 1980-90 and the lowest during 1990-2000. With a population of 200 million this state holds the key for any future declines in all demographic parameters of fertility and mortality in the country.

E. Maternal mortality ratios.

One of the important impacts of contraceptive use is on maternal mortality rates, which is partly a consequence of avoiding poorly spaced births and unwanted births in any given health scenario.

In India though specific measures for reducing maternal mortality rates have been tin vogue for a long time , in recent years attention has been focused on promoting institutional deliveries as the main thrust area for reducing maternal deaths since many maternal deaths occur during delivery and post partum bleeding. This is organized under the Janani Suraksha Yojana (JSY)in which specific efforts are made to transport a mother in labor pain to the nearest health institution.

Table 5 give the values of maternal mortality ratios (number of maternal deaths per 100,000 live births) for India as a whole and the four selected states. The data on maternal deaths were compiled by the Registrar General of India based on a sample of deaths recorded in the sample registration system , the cause of death being identified through verbal autopsy methods in house visits. In the country as a whole the MMR declined from 398 in 1997-98 to 212 during 2007-09; in Kerala it declined from 150 to 81; in Rajasthan from 508 to 318; in Tamil Nadu from 131 to 97 and in Uttar Pradesh from 606 to 359.Thus there is still a wide variation in MMR values across the states. The goal of reaching an MMR level of 100 by 2010 set in the national Population Policy 2000 and the National Health Policy 2002 have not been fulfilled and may not be attained in the next five years.

The above analysis of weakening of family planning programs and on mortality measures are based on an analysis of data compiled from the service statistics and the sample registration system. Similar and more conclusive evidences are obtained from an analysis of the series of the data collected in the three rounds of national Family Health Surveys , 1, 2 and 3. These three surveys were carried out during the years 1992-93, 1998-99 and 2005 -06, respectively. The NFHS-2 survey conducted during 1998-99 can be viewed as the central point that divides the pre and post RCH era and a comparison of the findings between these two period is presented below. The changes observed in a number of variables between 2005-06 and1998-99 (RCH program period) can be compared with the changes during 1998-99 and 1992-93 the pre RCH period and an idea of the effect of RCH package on the magnitude of change can be assessed.

F. Comparative analysis of pre and post 1994 performance in RCH

A comparative analysis of changes in 29 parameters pertaining to RCH grouped into three categories; 7 on Marriage and Fertility ; 10 on

Family Planning and desired family size and 12 on Maternal an Childe Health during the period 1998-2006 with changes during 1992-1999. 1998-2006 change was measured by comparing NFHS-2 and 3 figures which can be considered as post RCH period and 1992-1999 change. NFHS-1 and 2 figures can be considered as the pre RCH period and NFHS 2 and 3 the post RCH period though of a limited duration. However the comparison revealed very interesting results.

Table 6 provides the annual change in the percentage values observed during 1998-99 and 2005-06 computed from NFHS-2 and 3 data and also the annual change between 1992-93 and 1998-99 obtained from the NFHS-1 and 2 . The last column of the table also provides a summary picture whether the post 1998 changes were worse off (slow down in progress) than the pre 1998 changes; "Yes" indicating that the pace of change post 1998 is worse off and "No" implying the opposite. This analysis refers to the country as whole. It is remarkable to note that in most of the variables, in 25 out of 29, the pace of improvement during 1998-99 to 2005-06 is slower than the pace of improvement during the period 1992-93 and 1998-99. For example take the case of the percentage of children 12 to 23 months fully immunized. This increased from 35.5 percent in 1992-93 to 42 percent during 1998-99 (an annual percentage point increase of 1.08 points) while in NFHS-3 the percentage was 43.5 implying an annual percentage point increase of 0.21 points in the post-1998 period. This implies that the full immunization program has undergone a dampening effect during 1998-99 to 2005-06 and the reasons for the same have to be explored. Similarly, the increase in the percentage of couples using modern methods of contraception was 1.05 percentage points annually during 1992-98 and this declined to 0.81 points post 1998 until 2005; the unmet need for contraception (spacing and limitation) declined by 0. 62 points annually during 1992-98 and this slowed down to 0.37 points during 1998-2005 and TFR decline slowed down from an annual decline of 0.09 points to 0.02 points.

Tables 7 provides data at the state level for 22 states for which information was available in all three rounds of NFHS surveys for most of the 29 indicators. The indicators were , as sted earlier , into three major categories: A Marriage and fertility; B: Family Planning and C: Maternal and Child Health. At the all India level the number of indicators covered in these three categories were 7, 10 and 12 respectively. For the different states the number of indictors for which such time series data were available and the number on which the pace of improvement in post 1998 period was less than the pre 1998 period is also give in the table. The computations were similar to that carried out at the national level. It can be seen from this table that in most of the states the pace of improvement in the post-1998 period is

less than in the earlier period; with the median values of 50 percent in the first category, 60 percent in the second category and 65 percent in the third category. A graphic presentation of the percentage of RCH variables on which the pace of improvements slowed down after 1998 in Figure 4. While in the country as whole there was a slow down on 72 % of the indicators, in Punjab it was 79 and in Karntaka, it was 72.

Thus the RCH program implemented after 1998 has not been particularly successful on a number of RCH indicators. If we adjust the effects for per capita expenditures spent on the RCH programs in pre and post-RCH period, the differentials get accentuated since the expenditure on RCH after 1998 has almost doubled on a per capita basis compared to 1992 to 1997 period.

G Extent of Wastage of Condoms in Public supply

During the post RCH period there was unduly high program emphasis on the use of spacing methods, especially the condom , since condom use was supposed to prevent transmission of HIV/AIDS in addition to preventing unwanted pregnancies. Beginning late 'eighties , due possibly to international pressure, the prevalence of HIV// AIDS in the country was unduly and irrationally over- estimated especially during the late 'nineties until 2005-06 when the NFHS-3 results on prevalence of HIV/AIDS based on actual blood tests of a sample population blew up this high prevalence assumptions. The NACO (National AIDS Control Organization) estimated that by 2006 there were 5.26 million HIV + ve cases in the country but the estimate based on actual blood test of a representative sample population in the country (NFHS-3) estimated the prevalence at only 2.6 million. The use of condoms in the population was unnecessarily exaggerated by the production and marketing companies of condom including government owned companies in the country. A quantitative estimate of the extent of such wastage of condoms was made possible by using data on actual use reported by couples in the third National Family Health Survey (NFHS-3) which collected information on use of various methods of contraception by married couple, including current use, method used, duration of use and source from which the services and supplies were obtained by the couple. The data on condom use obtained from this survey are used as benchmarks, against which we compare the official data on condom distribution and condom users published by the Ministry of Health and Family Welfare in their Year Book.

The data analyzed from the two sources described above on the number of condoms used and number of condom users was analyzed in detail. Table 8 provides the estimated number of condoms used in different states, according to the source from which the condoms were procured , free supply,

social marketing, and branded items extent of wastage as per the official service statistics in 2006-2007 published by the government. 'Free supply' connotes the condoms supplied free of charge by the government machinery directly to the needy couples; 'social marketing' supply denotes the supply of condoms made by the non-governmental organizations procuring condoms from the government sources free of cost and supplying to the needy couples on marginal cost and 'branded items" denote the sale of condoms in shops and pharmacies sold at market price. Table 9 presents similar data compiled from an analysis of data from NFHS-3. For details on the analysis of NFHS-3 see Srinivasan et al 2005. Taking as the bench mark and s the more reliable data on the actual use of condoms the extent of wastage has been done.

We found that out of interviews with married women in the country during 2005-06 there were 11.571 million regular users of condoms and at an estimated 72 pieces per year a total of 833.14 million pieces were used during that year. . However, according to official service statistics during the same year a total of 1,877.63 million pieces have been distributed in the country, giving an estimate of wastage /misuse of 1,044.49 million pieces or over a billion pieces. The percentage of is very high at 55.63 percent. This is appalling since more than half of the condoms distributed or reported to be officially distributed to the couples are not used by the couples. Probably they are used for various other commercial purposes reported in the papers or just been dumped and reported to have been distributed to the couples.

Figure 5 presents the percentage of wastage in condoms by states according to three sources of supply to the couples. For the country as a whole the wastage figures are the highest among the "Free" supplies 78.15 percent, better in "Social marketing" 51.14 percent and the least in "branded /commercial" category 20.72 percent. For the state of UP ,(which is considered as the low risk state for the prevalence of HIV/AIDS)) the wastage figures were 95,81 and 88, respectively for the three sources of supply and for Tamil Nadu (which is considered as the high risk state for the prevalence of HIV/AIDS)) the wastage figures were 89,99 and 82 respectively for the three sources of supply. The wastage levels were equally high in high prevalence of HIV and low prevalence of HIV states. It has to be pointed out here that NFHS did not ask for the balance of condom pieces kept in the users' households and this can be estimated at the maximal level as the difference between the survey and official figures from "branded / commercial" source or 20.72. If we assume that the same percentage is kept as a stored supply in the "Free" and "Social Markets) category then the wastage in the "free" category is 57.43 percent and in the "social marketing" category is 30.42 percent.

H. Expenditure on the Program

Table 9 gives the outlay made by the central government under the family planning / welfare program in different plan periods. From the table it can be seen that the outlay and expenditures under family planning/ welfare have really sky rocketed during the 27 year period 1980-85 to 2007-12 from an annual outlay of rupees 2.022 billion to 181.116 billion an increase by 90 times without concomitant improvements in maternal and child health or declines in national fertility levels as desired from plan to plan. Between the eighth (1992-97) and twelfth plans (2007-12) it has gone up from 65 to 906 billion or by 14 times. In spite of such massive investments the outputs are not commensurate. Actually, there has been a slow down in the pace of performance in the post- ICPD era of "integration and decentralization" and also falsification of figures on a massive scale in the supply and use of condoms. This has to be corrected. In this spirit some suggestions are offered below.

VII. Way Forward: Reexamining the roots of family planning programs and redesigning their modus operandi.

Conclusions

The above paragraphs can briefly be summarized as follows.

1) The term "Family Planning" was initially coined to connote "to have babies by choice and not by chance" by Margaret Sanger in her pioneering social work promoting use of contraceptives in the slum population of , Harlem, New York in early twentieth century. It has become the universal term to denote use of contraception to limit or space births by couples. They were popularized by women's groups throughout the world as liberating women from the wheels of child bearing and preventing backstreet abortions. It was in the All India Women's conference in 1935 held in Trivandrum that it was resolved to advocate use of modern methods of contraception in India as a part of women's right to have babies by choice and not by chance.. Family Planning clinics came to be accepted as a part of efforts to save mothers from unwanted fertility. Protection of mother's health and life was the sine qua non of family planning. Thus .the roots of family planning lie at empowerment of women and protection of their health. The program was started in India with this objective

2) Over the years the program overlaid this objective with demographic objectives because it was felt and empirically established by economists that more rapid reduction in fertility would accelerate economic development. The micro level linkages between family size and economic development and the macro level linkages through increased savings

and investments were researched and published by a number of economists in the 50's and 60's notably those by Gary Becker, Ansley Coale and others.

3) The rich demographic dividends received by the south- east Asian countries because of their rapid reductions in fertility in the seventies and eightieshave been well documented. (See David Bloom 2000). China led this global rapid fertility transition. It declared a one child policy in the early '70s ,implemented it ruthlessly and reduced their TFR levels by half in 10 years (from 5.2 to 2.6) overriding individual rights. Other countries such as Korea , Philippines and Thailand were also under military dictatorship when they achieved rapid declines in fertility. These rapid reductions in aggregate fertility in most of the East Asian countries, especially in China, were associated with curtailment of human rights and women's rights in particular. This gave rise, to women' s movements throughout the free world which gathered momentum I the late 'eighties and came up with such strong resolutions on individual right, women's right and free choice as the crucial factors for promoting family planning in the International Conference on Population and Development held in Cairo in 1994. By this time India was in midst of her demographic transition and as a democratic country was caught in the cross fire of such global politics and signed the ICPD program of action. It is true that some mistakes have been committed in the past in the Indian program by over enthusiastic administrators but they are in no way comparable to the one child policy implemented in China.

4) The target free approach and the embedding of family planning services and education in a plethora of other activities by India since 1995 because of her commitment to the ICPD program of action have slowed down the pace of decline not only in fertility but in many other reproductive and child health parameters , especially in the states as Bihar and Uttar Pradesh where rapid reductions in fertility will have rich demographic dividends. But as of now, there is a sizable number of unwanted births taking place in these states due to lack of proper family planning education and services. To correct this imbalance between couple's desires and inappropriate state policy and strategy the following recommendations are made.

Recommendations

1) The program placed almost a total emphasis on sterilization as the major method of family planning from the very beginning, vasectomy until 1977 and tubectomy thereafter, and the quality of services offered in this regard was far from satisfactory and has not improved over time. With emphasis on sterilization, only high parity, older women accepted the method

and younger, high fertile and lower parity women were not covered by the program. While other developing countries such as, China, South Korea, Malaysia, Indonesia started their family planning programs with spacing methods and then introduced sterilizations after the spacing concept was ingrained in the psyche of the population, India went the opposite way with limitation as the ultimate goal of family planning. Spacing methods such as IUD, oral pills, injectables and condoms are being used only by a small proportion of the eligible couples even 50 years after initiation of the program. Though there are wide inter-state differentials in fertility levels, there are no large differentials in the pattern of use of various methods. Sterilization is as dominant a method of family planning in Andhra Pradesh, Kerala and Tamil Nadu with below replacement fertility levels as in Rajasthan and Bihar with TFR above 3. This trend has to be reversed by specific policy and program measures.

2) In most of the high fertility states there exists a very high level of unmet need for family planning, expressed by the women themselves, for limitation methods but there is also high unmet need for spacing methods and this is bound to increase in the coming years. Contraception has come to mean sterilization for most of the couples in the country. Spacing as a concept is yet to take root and the need of the hour is the offer of 'choice and quality of service'. While limiting their family size by sterilization is a choice, it is desirable for women to retain, as long as possible and feasible, their potential fertility, their god-given power and their right. I think to keep her power of reproduction is a woman's fundamental right and has to be respected. Sterilizations should be the last resort than the first one in the contraceptive choice. Thus there is an urgent need to expand the range of choice of contraceptives and the quality of services to the couples.

3) One way to start the process is to stop forthwith any incentives offered to sterilizations, to doctors, institutions and individuals. This can be achieved in two phases; first in those states, which have already achieved low fertility as Kerala, Andhra Pradesh and Tamil Nadu, and then in a phased manner to the other states. The money saved from incentives should be used to improve the quality of services. This suggestion is worth serious consideration.

4) Second, we should revert back to the clinic approach with which we started the family planning program, the Margaret Sanger way, in the first two five year plans.. Family planning clinics, providing good quality contraceptive services including induced abortion on medical grounds, should be set up in every teshil/block and the services there should be freely available for any couple below the poverty line asking for such services. Others above the poverty line should be asked to pay for the same

at subsidized rates. The era of extension education for family planning motivation is over. There are examples of such excellent clinics , run by NGOS as the "Surya Clinics " run by the NGO, Janani, in Bihar and Rajasthan and Marie Stopes clinics by the Parivar Seva Sanstha (PSS) in Delhi and other places have men and women lining up to avail of high quality contraceptive services, paying for them. In the high fertility states there may be a need to continue with subsidies for all types of contraceptive services and in the setting up of these clinics by qualified NGOs, but there is no need for subsidy in states where the fertility levels are already low.

5) In our view the time and resources of the existing maternal and child health program personnel should not be wasted any more to motivation of cases for family planning and they should be asked to concentrate on their maternal and child care duties. We seem to have come a full cycle in the delivery of contraceptive services and it is time to de-link the same with maternal and child health program. Family planning clinics, recommended above, should not be a part of the health system and if agreed upon can be considered a part of the Department of women and Child Welfare. The design and construction of such clinics should be done by professional and should carry the same insignia throughout the country. With our economy galloping at top gear, it will be a wise investment to establish these clinics across the country. They should operate independently as clinics under a private agency or a governmental agency. The possibility of setting up a separate national corporation to establish and run these clinics can also be considered. Family planning should not erode into public health programs. In my view integrating them with primary health care has slowed down the health care services especially maternal and childcare services and is beginning to harm both. While in some states as Kerala, they can deal primarily with problems of sterility in others they can deal with facilitating women to space and limit their family size.

6) Demographically, the impact of the program on fertility so far has been by reduction in the fertility rates among women above the age of 30, because of the emphasis on sterilization as the major method of family planning. The program was nibbling, as it were, on the tail end of the fertility curve. The natural fertility or fertility of women in the absence of contraception has been increasing during the past three decades among younger women, below the age of 30, because of the forces of modernization. There is no evidence that the age at marriage for girls is increasing as expected even with the Minimum Age at Marriage Act enacted in 1977, specifying age at marriage as 18 for girls and 20 for boys. Practically the act has not worked. And there are scandalous situations where child marriages are conducted for groups of children at community level in Rajasthan and

Madhya Pradesh.. Recently the Supreme Court has ordered that when the girl is over 16 and she consents for marriage the marriage can be done. Almost half the marriages still take place in the high fertility states for girls below the age of 18. I do not see that age at marriage will rise rapidly in India in the near future especially n the rural areas. With the threat of HIV/AIDs looming large and exposure to so many sexually stimulating films in the media, it is natural that parents of adolescent boys and girls would like to get them married off as early as possible. With this likely trend, the proportion of teen age fertility to total fertility can be expected to rise further in the future There is a need to have a special program of family planning including premarital counseling for newly married couples including starting with some education from the marriage registrars and also the priests and purohits This should be an important activity of the family planning clinics. Only with increasing emphasis on spacing methods and quality of care in the family planning clinics, we can hope to witness a more accelerated decline in fertility of younger couples in the coming years.

7) During the period of emergency the parliament enacted a constitutional amendment freezing the seats in parliament and state legislations on the basis of 1971 census until the year 2000, making it politically unattractive to the states to have a higher rate of population growth. This freeze has been extended again by the parliament based on NPP 2000 recommendations until 2021. There are debates in the country whether this freeze goes against the democratic principle of one man-one vote and thereby goes against the fundamental rights and equality of citizens. This has not been tested in a court of law. The freeze has to be lifted some time or the other, sooner the better. When it is lifted there is bound to be large shifts in the regional political power equations in the country, which has to be faced. Politically the country has to be prepared for this. There should be national debate on this topic

8) As mentioned earlier different states are in different stages of demographic transition. There can be no uniform population policy at the national level. The center should encourage states to develop and implement their own state level population policies and serve as friend, philosopher and guide to the states. There is no need to have uniform demographic goals as achieving replacement level of fertility by the year 2010 as mentioned in NPP 2000. Each state should be encouraged to have its own goal in terms of meeting the unmet need of contraception and through the family planning clinics recommended above, whether in the private set up or in the government sector.

9) The organizational adequacy, effectiveness and efficiency of heath systems in different states vary widely. In the states of Uttar Pradesh and

Bihar the system is practically non-existent in many areas and even where few centers exist they are totally inefficient. Under these circumstances there is a need to take over 'health' in the central list of functions and the central government should operate the health system in selected states for specified time.. I do not know whether this is possible under the existing constitutional allocation of responsibilities between the center and the state and at least an effort should be made in this direction. Otherwise a Public Health and Medical Corporation can be set up at the state level in which professional health officials from the state and the center can play a vital role in setting up family planning clinic and revamping primary health centers. The best practices in the more successful states have to be adapted and implemented in the not-so-successful ones.

10) The program implicitly assumed that all married women in the reproductive ages are equal partners or contributors to the fertility of the population. No attempt was made to identify relatively more fecund couples and target the services to meet their needs. Research studies have shown that recently delivered mothers have higher fertility in the future compared to all mothers, even after controlling for age and parity, and targeting the program for them will have greater impact on fertility for the same couple years of contraceptive use. Post partum contraceptive services should be especially encouraged, since recently delivered mother have a higher level of motivation and need for family planning and have higher potential fertility. A given level of couple years of protection in recently delivered mothers after they resume menstruation, have a much higher impact on fertility than among women chosen at random from the reproductive ages. There is no need to have 60 to 65 percent couples protection rate to achieve replacement level of fertility. If the program is servicing only the recently delivered mothers 40 to 45 percentage of couple protection rate seems to be adequate to reach replacement levels of fertility as is found in Kerala and Tamil Nadu. (Srinivasan and Rajaram, 2005).

11) Finally, we feel that family planning services should be delinked from any population policy. Contraceptive services of high quality, method choice and easy access including treatment facilities for primary and secondary sterility are the rights of every couple and these should be met with empathy. There is enough empirical evidence that increased spacing between births and limitation of family size contributes not only to improvements in the living standards, education of children and health of all the family members but also serves as a catalyst to accelerate economic growth and poverty reduction; but the goals of any economic policy should not include any specific component of fertility reduction and targeted number of family planning acceptors.. Fertility reduction will automatically take place

as a bye product of meeting the unmet needs of couples for spacing and limitation, as discussed above. The fact that family planning provides an opportunity for couples to realize their developmental aspirations is a justification in itself for revamping the program on the lines suggested above.

References

Bloom, David, David Canning and Pia Malaney. 2000. 'Demographic Change and Economic Growth in Asia', *Population and Development Review*, Vol. 26, pp. 257-290

Coal Ansley and Edgar Hoover. 1985. 'Population Growth and Economic Development in Low Income Countries', Princeton University Press, Princeton, NJ

Department of Family Welfare. 2012. 'Family Welfare Year Book 2011', Ministry of Health and Family Welfare, New Delhi

Hutton, John Henry. 1932. Report of the Census of India 1931, Vol. 1, pp. 1-32.

International Institute for Population Sciences, Mumbai and ORC Macro, 1995, National Family Health Survey -1: 1992-93 India and the States, IIPS, Mumbai.

International Institute for Population Sciences, Mumbai and ORC Macro, 2000, National Family Health Survey -1: 1998-99 India and the States, IIPS, Mumbai.

International Institute for Population Sciences, Mumbai and ORC Macro, 2008, National Family Health Survey -1: 2005-06 India and the States, IIPS, Mumbai.

Malthus T.R. 1976. 'An Essay on the Principle of Population', W.W. Norton, New York, p. 132.

Ministry of Health and Family Welfare. 1976. 'National Population Policy: A Statement of the Government of India 16 April, New Delhi', Government of India, New Delhi.

Ministry of Health and Family Welfare. 1977. 'Family Welfare Program: A statement of Policy', Government of India, New Delhi.

Ministry of Health and Family Welfare. 2000. National Population Policy (2000), Government of India, New Delhi.

Ministry of Health and Family Welfare. 2002. National Health Policy (2002), Government of India, New Delhi .

Ministry of Health and Family Welfare. 2005. National Rural Health Mission (2005), Government of India, New Delhi.

Registrar General India. 2009. Compendium of India's fertility and mortality Indicators 1971-2007 (Based on the SRS), New Delhi.

Registrar General India. 2013. Sample Registration System Statistical Report 2011, Report No.1 of 2013, New Delhi.

Srinivasan K. 1995. Regulating Reproduction in India's Population: Efforts, Results, and Recommendations, Sage, New Delhi.

Srinivasan K and S. Rajaram. 2005. 'Recency of birth as an indicator of future fertility of women: Empirical findings and implications for organizing contraceptive services', Demography India. (Forthcoming)

Srinivasan. K,Chander Shekhar, P. Arokiasamy. 2007. 'Reviewing Reproductive and Child Health Programmes in India', *Economic and Political Weekly*, Vol.XLII, Nos. 27 and 28, July 14.

UNDP. 2003. Human Development Report 2003, United Nations Development Programme, Oxford University Press, New Delhi.

UNDP. 2012. Human Development Report 2011, United Nations Development Programme, Oxford University Press, New Delhi.

United Nations. 1994. Programme of Action of the 1994 International Conference on Population and Development, United Nations, New York.