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The Family Welfare Programme in India: Changing Paradigm

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Early Start but Slow Progress

India set the goal of Population stabilisation in the very first Five-Year Plan (1951-56) which was formulated soon after India attained independence in 1947. In spite of the completion of seven Five-Year Plans, the goal of population stabilisation remains distant. The population continues to grow at a faster rate than anticipated by India's planners and policy makers and every decennial census sends shock waves to them.

Can India's Ministry of Health and Family Welfare deliver the goods? Has foreign aid and expertise really helped India?

Without a deep understanding of Indian society and an intimate knowledge of the field situation at the grassroots level, demographers tend to view the population problem in terms of statistics alone and in this process the more important non-statistical aspects are overlooked. This distorts the understanding of the population phenomenon.

Demography must look far beyond decimal points; otherwise demography will remain a dismal science of population, dominated by doomsday predictions based on mechanical projections which can now be worked out in a matter of minutes on an electronic computer. Statistical competence is not enough to understand the population problem and to solve it mere competence in reproductive biology and contraceptive technology is not enough. It is unfortunate that in most discussions on family planning, the family is never discussed: the obsession is with contraceptive technology. The poverty-stricken masses in India still rely on the solidarity of the family for their survival and are disillusioned by the Government's anti-poverty programmes and the growing leakage's in the delivery of these programmes. In short, *state intervention in curbing the birth rate has not inspired India's masses to take to the small family norm.* Events during the short-lived Emergency in India (1975-77) have amply demonstrated the power of the people in a democracy: a mighty Government was humbled and the issue was family planning. As someone then commented:

"Coercion in family planning is likely to bring down the government faster than the birth rate".

The Planning Commission clearly recognised the need for population control right at the beginning of the planning exercise. To quote the First Plan (1951-56):

The recent increase in the population of India and the pressure exercised on the limited resources of the country have brought to the forefront the urgency of the problem of family planning and population control. It is, therefore, apparent that population control can be achieved only by the reduction of the birth rate to the extent necessary to stabilize the population at a level consistent with the requirements of national economy. This can be secured only by the realisation of the need for family limitation on a wide scale by the people. [1]

The Planning Commission did not, however, spell out in statistical terms the implications of the goal of "stabilizing India's population". No doubt the plan made an impressive start by advocating family planning as a state policy and India proudly claims that she was the first country in the world to have advocated family planning as a state policy, but our record of the last forty years in the field of family planning is far from impressive.

Pandit Jawaharlal Nehru had the right perception of India's population problem when he described the problem not as one problem but 400 million problems! He further spelt out that the problem was of providing food, clothing, shelter, education, medical aid and employment to every person. In other words, he perceived the problem essentially as a problem of development.

India's first Health Minister, Amrit Kaur was a Gandhian and a princess. She started the family planning work very cautiously. The emphasis was on the rhythm method and the family planning programme was a part of the health programme. In 1966, a new Department of Family Planning was created. The accent was on communication, financial incentives for the practice of family planning, particularly sterilisation, and high-powered advertising of new methods of family planning like the IUCD. A new methodology was evolved to monitor the family planning programme. Detailed targets were set for each family planning method by the Department of Family Planning. There is no doubt that during this period, there was a tremendous increase in the infrastructure of health and family planning and foreign advice and aid played an important role.

The Janata Government which came to the helm in 1977 changed the nomenclature of family planning into family welfare but did precious little by way of introducing the welfare content and expanding the family planning

programme either in qualitative or quantitative terms. The Janata Government fell in 1980 and Mrs. Indira Gandhi came back to power. The new Government did not change the Janata nomenclature of family welfare. Mrs. Gandhi proclaimed in her new 20 point programme that family planning was to be promoted on a voluntary basis as a *people's movement*. She also made a sincere effort to fill the family welfare basket with nutrition and maternal and child health programmes.

In this context, we would like to refer to two international conferences: The World Population Conference held at Bucharest in 1974, where the leader of the Indian delegation, Dr. Karan Singh coined the famous slogan: "Development is the best contraceptive", a slogan which is part of the world literature on population today. The United Nations organised the next such international conference on Population in Mexico City in 1984. Interestingly enough, the US delegation which had opposed the Indian viewpoint in 1974 took a somersault and made the following statement at the Mexico Conference:

First and most important, population growth is of itself a neutral phenomenon. It is not necessarily good or ill. It becomes an asset or a problem only in conjunction with other factors such as economic policy, social constraints, need for manpower and so forth ... population control programmes alone cannot substitute for the economic reforms that put a society on the road towards growth, and, as an after effect, toward slower population increase as well ... Our primary objective will be to encourage developing countries to adopt sound economic policies and, where appropriate, population policies consistent with respect for human dignity and family values. [2]

Looking back at the turn of events, specially the somersault in the US stand on population issues, one cannot but admire the foresight of Professor Nicholas J. Demerath, an American sociologist, who worked as a family planning expert in India in the 60s, and wrote a critique in 1976. Demerath devotes a whole chapter to discuss "why family planning fails in poor countries". He observes that "the first reason why family planning fails in poor countries is the obsession of the experts with techniques of contraception. The belief that just about any problem can and will be fixed by some new tool or techniques is as Anglo-American as apple pie. [3]

Demerath goes on to say: "Instead of employing proven psychological and social principles of motivation, family planning training courses typically exclude them. It is the mechanics and forms of bureaucratic administration that are emphasised along with a little demographic and reproductive physiology. It is thought that the more advanced the management system, the better meaning, the more quantified, computerised and routinised". [4]

This is exactly what has happened in India. We have got into a rut of mechanically fulfilling family planning targets without paying adequate attention to the qualitative aspects of the family planning programme.

Under the Indian Constitution, health is on the State list while social and economic planning, including family planning is on the Concurrent list. But in effect, the family planning programme has operated as if the subject was on the Union list as it has always been a 100 percent centrally financed programme. The programme has emerged as massive monolithic programmes. Centrally financed, directed and monitored while the implementation of the programme is left to the states. Several states take an interest in family planning only because the programme brings money from the Central Government. There is a feeling in the Planning Commission that if the states are asked to share financial responsibility, the Family Planning Programme will collapse. In fact, when the, Community Health Workers Scheme (currently called the Health Guide Scheme), launched in 1977 as a centrally sponsored programme, was subsequently modified by the National Development Council in terms of 50:50 sharing by the Central and State Government, the scheme virtually collapsed in several states. Only when it was made a Centrally Sponsored Scheme again, the scheme revived but as the money was disbursed from the family planning budget, the administration of the programme at the Central level was transferred from the Department of Health to the Department of Family Welfare. In spite of frequent recommendations in international and national seminars and conferences for the integration of health and family planning, our historical experience shows the continued lack of integration of health and family planning all along the line, right from the Central Government to the grass roots level. To make matters worse, there is quick money in the family planning programme for motivational work but there are no such incentives for health work. A suggestion that the Government award for good family planning performance may be given for the combined performance of maternal and child health (MCH) and family planning was quickly shot down by the bureaucracy. Yet, time and again, we are reminded about the inter-relationship between infant mortality, fertility and family planning.

A major drawback of our centralised family planning programme has been the lack of adequate appreciation of the problems created by; regional disparities in the demographic situation. For the bureaucrats in New Delhi, a uniform directive to all the states is most convenient. The worst part of the story is the setting of family planning targets by the bureaucracy in New Delhi (on the lines of cement and steel quotas) and the relaying of these targets to the state governments which, in turn, relay these to the District Medical Officers, who pass them on to the Block Medical Officers. Finally, the targets reach the helpless Auxiliary Nurse

Midwives (ANMs) and Multi-Purpose Workers (MPWs) at the sub-centre level. In spite of the government's stand that India's family planning programme has a 'cafeteria approach' and the people are free to choose whatever method they want, in effect, the programme is basically a sterilisation programme and (in recent years a female sterilisation programme). At the grass roots level, the only concern is to get more cases for sterilisation, regardless of the impact of such sterilisation on the birth rate.

To sum up, the major weaknesses of India's family planning programme are: (a) unrealistic foreign orientation based on contraceptive technology, (b) monopoly of bureaucrats, (c) monopoly of the Central Government, and (d) sole concern for quantitative targets and their achievement irrespective of the impact on the birth rate.

To assess the achievement of the family planning programme one has to look at the trend of the birth rate. A source of data is Sample Registration System (SRS) under the Office of the Registrar General in the Ministry of Home Affairs. The SRS data are more reliable than the Family Planning performance data. In any case, we are more interested in the trend rather than in the yearly figures as such. The SRS data reveal that the birth rate has been stagnating, both in rural and urban areas, for over a decade. The stalling of the birth rate has generated considerable debate among demographers.

The Health and Family Welfare Ministry has argued that success should be judged by the number of births averted and not merely by the trend of the birth rate. They argue that but for the government programme, the birth rate of India would have been higher.

The Planning Commission is not impressed by this argument. As the Approach Paper (May 1990) to the Eighth Five-Year Plan (1990-95) puts it: "The measure of the success of any family planning programme should be targeted at the reduction in the birth rate and not the number of births averted". [5]

The 'births averted' exercise is questionable and much depends on the statistical assumptions. One could argue that if the Family Planning Programme were not put on the wrong track in 1966 by the powerful international lobby which advised our government to separate family planning from health, the number of births averted would have been much higher. One could also argue that if a powerful political upstart had not derailed the family planning programme during (1975-77) the decline in the birth rate would have been much faster, but all these are hypothetical arguments.

India's demographic predicament can be described as follows:

1. The credibility of the family planning programme in large parts of India and especially in the states of Bihar, Haryana, Madhya Pradesh, Rajasthan and Uttar Pradesh is near zero. The illiterate masses have still not fully recovered from the shock of the crude body-snatching sterilisation programme during the Emergency. In India, sex is sacred because marriage is sacred. The assault on the sex life of couples in the name of family planning is totally unacceptable to the masses. In particular, women (who are half the number of voters) were incensed by such a body-snatching programme in the name of their welfare.
2. The politicians have burnt their fingers on the family planning issue. The mighty government of Indira Gandhi was swept out of power in 1977, mainly on the issue of family planning. In Uttar Pradesh, the most popular state of India, the ruling party could not win even one seat in parliament out of the 85 seats in that state. Such was the fury of India's illiterate masses. Today the politicians tend to blame the bureaucracy (even Indira Gandhi blamed the over-zealous bureaucrats for making a mess of the family planning programme). On the other hand, the bureaucracy blames the politicians for their singular lack of political will when it comes to family planning motivational work which should be a priority concern for the elected representatives of the people. Some of our politicians and parliamentarians are more eager to visit China, Indonesia, Singapore, Thailand etc: to learn about family planning than visit Bihar, Uttar Pradesh or Rajasthan to study for themselves where we have gone wrong.

To make matters worse, at the district level and primary Health Centre and sub-centre level, the medical bureaucracy resent-the bossing over by the IAS (Indian Administrative Service) bureaucracy and the IAS bureaucracy hold the medical bureaucracy in contempt. Then we have a gang of target chasers at the grass roots level, in particular, revenue officials, school teachers, health workers including the poor and frightened ANMs. One has to do field work to realise the absurdity of the situation. The health personnel always complain that they have no powers and no leverage in getting sterilisation cases. On the other hand, the revenue officials have a clear advantage at least in terms of fertilisers, etc. The most ridiculous situation is in regard to helpless persons who are approached by as many as five types of motivators for obviously a single, sterilisation operation. In such a situation, the victim (or acceptor) quotes his own price - very similar to an auction price, particularly in February and March. But alas, the Government will give Rs. 160 and no more, unless you are in special states like Gujarat and Haryana. So the poor health worker often has to shell out money from his or her

pocket to get a case. The tragic part of the story is that in this endeavour, nobody is bothered about the eligibility of the person so that the national cause of reducing the birth rate is helped. All that one looks for is a case, which helps in fulfilling the target we have described this disease as targetitis.

Let us briefly list the major problems facing India's family planning programme as follows:

1. No Government programme can overcome what we call demographic fundamentalism, which is a deep-rooted phenomenon in India society. By demographic fundamentalism, we mean the craze for sons and the relentless efforts to try and get a son even when five or six daughters are born. On the basis of empirical data from primary health centres all over India, we have observed that *two living sons is the cut-off point*. Therefore, a family planning programme, which is wanting a couple to have only two children, by definition, would imply that couples should have only sons and no daughters. Therefore, this introduces an element of contradiction in the policy as formulated by the government and the requirement of the masses in terms of their own perception. It is doubtful if a bureaucratic programme can dilute the force of demographic fundamentalism merely by putting posters and banners that "sons and daughters are the same". It calls for social transformation. This task can be entrusted only to enlightened social reformers.
2. One of the reasons why our family planning programme has not succeeded is the obsession with technology and the neglect of the geographical socio-economic context. For example, it was thought at one time that the Ernnakulam Experiment of mass vasectomy camps in Kerala would pave the way for a drastic reduction in the birth rate. Similar camps in Uttar Pradesh led to tetanus deaths and the camps were abandoned. Obviously, U.P. is not Kerala. Then came the much advertised IUG (Lippie's Loop). It was soon abandoned by our women, we now have a new technology called copper T. Then came the laparoscopic method of female sterilisation. Here was a high-tech method, which saved time and money, and this was seen as a revolutionary step in the Indian family planning programme. However, the most callous use of this technology by our medical doctors brought a bad name to this technology. The failure rate is high, the pregnancy rate is high and there have even been deaths as a result of this operation. The latest in the field of technology is amniocentesis or sex determination before birth. Interestingly enough, this modern technology, which was originally used for detecting genetic disorders, is being misused in India for a massive programme of female foeticide. As soon as a couple is told that the pregnancy will result in the birth of a girl, abortion is resorted to. Amniocentesis raises

moral, medical and ethical issues, which have to be sorted out. It is unlikely that a mere legal ban will succeed in weeding out this technology.

3. A related problem is that our family planning programme has got booked to technology. The whole issue of population control centres around sterilisation, or the terminal method of family planning. To make matters worse, under misguided foreign advice, we started paying money as compensation to acceptors of sterilisation. This immediately put a premium on sterilisation. Now we have come to grief. It is clearly recognised that the use of money power has led to widespread corruption. Further, this has discounted the use of non-terminal methods. Worst of all, this has put the whole family planning programme upside down. Instead of starting with marriage and immediate practice of contraception after marriage, our focus is on the "exhausted generation" of women at the fag end of their reproductive life. This is one of the main reasons why we have not been able to make a dent on the birth rate. By and large, poor people have gone for sterilisation only after they have had two living sons: in short, only after their family building process was completed. They went for the operation to get some money. This is the state of their poverty. Rs. 160 cannot buy even a good shirt or nutrition for children for a month. The money was therefore put to an interesting use; the husband of the sterilised woman bought alcoholic drinks and drank it all! This is the economics of the compensation money as understood by our people. We do not blame the people because it is manifestly foolish to try to entice people by giving Rs. 160. We are familiar with the standard argument that this money is not incentive money. But anybody who is familiar with the field situation will tell you that there is no difference between *condensation and incentives* in reality.

Short-term Key Issues

We believe that the following steps can be taken immediately by the Ministry of Health and Family Welfare, to improve the state of affairs:

1. Making the health delivery system really work at the grassroot level all over India and in particular, in the states of U.P., Bihar, M.P., and Rajasthan which account for 40 percent of India's population. This is basically a management problem.
2. Improving the quality of service and follow up of sterilisation cases.
3. Improving the credibility of the Family Welfare Programme in the eyes of the people.

4. Moving away from a target-oriented programme to a people-oriented programme.
5. Restoring and revamping the village health guide scheme. At least selectively.
6. Reducing the level of corruption by discontinuing cash awards for family planning to states and compensation money and other individual incentives for undergoing sterilisation.
7. Announcing a firm policy regarding transfer and promotions of doctors and para-medical staff at the block level, PHD level and sub-centre level.
8. Improving the mobility of medical and paramedical staff.
9. Making more imaginative and flexible rules for grants to NGOs for health and family welfare work.

Long-term Key Issues

In our view the long-term key issues are as follows:

1. Modify the ICDS programme to include the adolescent age group (specially girls in the age group 6-18 years).
2. Empower people through information.
3. Review foreign-aided area projects.
4. Introduce literacy plus strategies.
5. Inforce demographic discipline in the government and organised sector.
6. Implement compulsory registration of births and deaths through the Public Distribution System.
7. Introduce compulsory registration of marriages.
8. Take steps to decentralise the family planning programme.
9. Introduce volunteerism in a big way.
10. Integrate health and family planning.

11. Introduce inter-special coordination through an effective mechanism.

National Population Policy (1976): Political Debacle

This policy was announced by the Indira Gandhi Government on 16th April 1976. As Dr. Karan Singh was the Minister for Health and Family Planning at that time, we shall call this policy Karan Singh's policy. The policy states:

Considerable work has been done in our country in the field of family planning, but clearly only the fringe of the problem has so far been touched. In this context, after a thorough and careful consideration of all the factors involved as well as the expression of a wide spectrum of public opinion, Government has decided on a series of fundamental measures detailed below which, it is hoped, will enable us to achieve the planned target of reducing the birth rate from an estimated 35 per thousand, in the beginning of the Fifth Plan to 25 per thousand at the end of the Sixth. Allowing for the steady decline in the death rate that will continue due to the improvement in our medical and public health services and the living standards of our people, this is expected to bring down the growth rate of population in our country to 1.4 per cent by 1984. [6]

Of course no such thing happened and the birth rate by the decade 1981-91 was as high as 2.14 percent per year. The dream of bringing down the growth rate to a level of 1.4 percent by 1984 was not realised. On the contrary the policy which had a coercive element, did permanent damage to the family planning programme. Even till this day the people in Haryana for example, have neither forgiven nor forgotten the emergency experience of coercive sterilization. Further, Indira Gandhi was a victim of her own policy of press censorship. This encouraged rumours and as the subsequent evidence before the Shah Commission set up by the Janta Government revealed, the actual number of forced sterilization was very small but the rumour spread like wild fire and the number of cases was highly exaggerated. Coming back to the fundamental measures proposed by Karan Singh, we find that several of these were sound propositions. In short these were:

1. Raising the age at marriage: Minimum age of girls should be raised to 18 years and of boys to 21 years. (This was subsequently legislated by Parliament in 1978)
2. Freezing of seats in Lok Sabha and the State Legislatures on the basis of the 1971 Census till the year 2001. (Necessary constitutional amendments were made to implement this proposal and even now the seats are frozen)

as per 1971 Census and no account has been taken of the 1981 and 1991 Censuses).

3. In the matter of Central assistance to State plans, eight per cent will be specifically earmarked against performance in Family Planning. (This formula never worked. However, the Gardgil Formula has been modified from time to time by the Planning Commission).
4. The Policy recognises the "correlation between illiteracy and fertility and gives special emphasis to formal literacy and the education of girls, particularly upto the middle level, as well as non-formal education for young women in backward States. (This was a recommendation for the State Governments).
5. Emphasis on "introduction of population values in the educational system" so that "the younger generations grow up with an adequate awareness of the population programme and realisation of their national responsibility in this regard".
6. It was realised that "the adoption of a small family norm is too important a matter to be considered the responsibility of only one Ministry". A directive was to be issued by the Prime Minister to all Ministries of the Government of India and the letter addressed to all the Chief Ministers about the responsibility of other Ministries as well as the State Governments to take up family planning as "an integral part of their normal programme".
7. In view of the desirability of limiting the family size to two or three, "it has been decided that monetary compensation for sterilisation will be raised to Rs. 150 if performed with two living children or less, Rs 100 if performed with three living children and Rs 70 if performed with 4 or more children". (In the absence of a reliable birth registration system, this differential incentive could not be implemented and as a matter of fact, this never worked even during the emergency).
8. "Suitable group incentives will be introduced for the medical profession. Zila and Panchayat Samities, cooperative societies, assistance and for labour and the organised sector." It was clearly recognised that family planning cannot succeed unless voluntary organisations were drawn into its promotion in an increasing measure, particularly, youth and women organisations.

9. Special attention was to be given to research in reproductive biology and contraception in the scientific institutions.
10. The most perverse aspect of this policy was in regard to the issue of compulsory sterilisation. Para 15 of the policy statement reads as follows:

The question of compulsory sterilisation has been the subject of lively public debate over the past few months. It is clear that public opinion is now ready to accept much more stringent measures for family planning than before. However, the administrative and medical infrastructure in many parts of the country is still not adequate to cope with the vast implications of nation-wide compulsory sterilisation. We do not, therefore, intend to bring in Central Legislation for this purpose, at least for the time being. Some States feel that the facilities available with them are adequate to meet the requirements of compulsory sterilisation. We are of the view that where a State legislature, in the exercise of its own powers decides that the time is ripe and it is necessary to pass legislation for compulsory sterilisation, it may do so. Our advice to the States in such cases will be to bring in the limitation after three children, and to make it uniformly applicable to all Indian citizens resident in that State without distinction of caste, creed or community. [7]

In our opinion, this was the most damaging part of the Karan Singh Policy Statement because it is a permissive clause to introduce compulsion in family planning. It was totally unacceptable to the Indian mass and also violated human rights. It was also decided to leave to each individual state the question of measures directed towards their employees and other citizens in the matter of preferential allotment of houses, loans etc. This again was resented by the people for example, sterilisation certificates were demanded by the Government (very often, fake certificates were submitted by the people) before allotting land.

The policy statement says that "a new multi-media motivational strategy is being evolved by the available channels including the radio, television, the press, films, visual displays and also include traditional folk media such as the jatra, puppet shows, folk songs, and folk dances".

Finally, the policy assesses that "this package of measures will succeed in its objective only if it receives the full and active cooperation of the people at large. Dr. Karan Singh states "It is my sincere hope that the entire nation will strongly endorse the new population policy which is part of a multifaceted strategy for economic development and social emancipation and is directed towards building a strong and prosperous India in the years and decades to come." As the 1977 general elections revealed the nation totally rejected this new population policy.

National Population Policy (1977): Diluting Family Planning

A statement of policy on the family welfare programme was announced by the Janta Government in April 1977, after the fall of the Indira Gandhi Government. The main elements of the policy were as follows:

1. Motivate the people to accept family planning "voluntarily in their own interest and in the interest of their children as well s in the general interest of the nation".
2. Family planning must become "a part of the total concept of positive health" and "it must find meaningful integration with other welfare programmes, namely, nutrition, food, clothing, shelter, availability of drinking water, education, employment and women's welfare.
3. "There is no room for compulsion, coercion or pressures of any sort. Compulsion in the area of family planning must be ruled out for all times to come. Our approach is educational and wholly voluntary".
4. "Employees with the Union Government, State Governments, autonomous bodies and local bodies etc. will be expected to set an example and adopt the small family norm".
5. "We are totally against any legislation for compulsory sterilisation either at the Central level or by the States".
6. A comprehensive scheme of training individuals, midwives (dais) will be implemented.
7. Legislation will be initiated to raise the minimum age of marriage of girls to 18 years and of boys to 21 years (this was done in 1978).
8. "The principle of linking a percentage of Central assistance to the State plans with their performance in family welfare programme will be continued".
9. Steps must be taken to ensure that "the youth receive population education as part of their normal course of study."
10. Media must be activated to improve motivation for family planning.
11. Involvement of village panchayats and also trade unions, chambers of commerce, co-operative societies etc. in influencing public opinion. "Their

potential as change-agents needs to receive greater recognition and attention".

12. Involvement of voluntary organisations, youth and women's organisations etc.
13. Special attention to research on reproductive biology and contraceptives.
14. Involvement of other Ministries and Departments of the Government in the programme.

In short, the main difference between the Karan Singh Population Policy and the Raj Narain Population Policy was in regard to the question of compulsory sterilisation. Whereas Karan Singh's statement had a permissive clause for legalising such sterilisation, Raj Narain's policy totally ruled out compulsion in any form. It will be seen subsequently that the Swaminathan Committee report (1994) goes far beyond the population policy statement of 1976 or 1977, insofar as it links population to the ecosystem, brings gender issues at the centre stage, shows concern for the fulfillment of the minimum needs programme as a pre-requisite for the success of family planning and it promotes decentralised democratic planning through Panchayats and Nagarpalikas as per the 73rd and 74th amendments to the Constitution enacted recently by the Parliament. Thus the Swaminathan policy statement (Draft National Population Policy) is pro-nature, pro-women, pro-poor and pro-democracy. [8]

Working Group in Population Policy (1980): Extending the Horizon

After the fall of the Indira Gandhi Government in 1977 the Janata Government appointed a Working Group on Population Policy, under the Chairmanship of Dr. V.A. Pai Panandiker, Director, Centre for Policy Research, New Delhi. The Working Group prepared a fairly comprehensive report linking population to development and in particular, to the minimum needs programme. Some of the highlights of the report are as follows:

1. An important aspect of the report was the classification of the states into three categories A, B and C on the basis of the couple protection rate (The worst states were in A category and the best states in C category).
2. "The Group strongly recommends that the nation commit itself to achieving the long-term goal of NRR of unity by the year 1996 on an average, and by the year 2001 for all the States. This would mean that no State, in the country could have an NRR (Net Reproduction Rate) of more than 1 by the year 2001. The transition from the present level of NRR

which is estimated to be around 1.67 to 1.00 by 2001, that is, from the present family size of about 4.2 children to 2.3 children per couple, will be greatly facilitated if the anticipated reduction in mortality or in other words, the desired increase in the in the expectation of life are realised. This implies a reduction he death rate from the present level of 14 to about 9 per 1000 of population. It also implies a reduction in the infant mortality, rate from the present estimated level of about 120 to below 60 per 1000 live births by the year 2001. These assumptions are largely based on extra-population of past trends and model life tables. It is important that a concrete programme of health, nutrition and related services of the requisite dimensions be worked out to ensure the realization of the implicit reduction in mortality, particularly of infants. It is in fact a matter of regret that whereas targets have been set from time to time for reduction in fertility, no such targets are set for reduction mortality. We strongly recommend that the necessary efforts should be made to bring down infant mortality, which is at present rather high, to half its present level by the end of this century".

3. "Our target of NRR of 1 by 1996 for the country as a whole, on an average, will imply a birth rate of 21 by 1996, from 33 in 1978, that is, a reduction of 12 points in 18 years, which appears to be feasible given the necessary will".
4. "Our studies reveal that the percentage of eligible couples to be effectively protected by a modern method of family planning should be around 60, if the stipulated NRR of 1 by 1996 for the country as a whole has to be realized under the mortality assumption made by the Registrar General".
5. "On the basis of our classification, (based on the average of Percentage Of the couples protection in 1976-77, 1977-78 and 1978-79) the following groupings emerge":

Group A	(Percentage of couples effectively protected by contraceptive less than 15)	Bihar, Jammu and Kashmir, Rajasthan and Uttar Pradesh
Group B	(Percentage of couples effectively protected by contraceptive less than 15-25)	Assam, Karnataka, Madhya Pradesh, Orissa and West Bengal
Group C	(Percentage of couples effectively protected by contraceptive less than 25)	Andhra Pradesh, Himachal Pradesh, Kerala, Gujarat, Haryana, Maharashtra, Punjab and Tamil Nadu

We have recommended above that Group A States should achieve NRR 1 by the year 2001-2001, Group B States by 1996-97 and Group C States by 1991-92".

Pai Panandikar Committee took a broad view of population issues but unfortunately it got identified with one of its statistical simulation models which put a net reproduction rate of unity (NRR = 1), in all the states of India by the year 2001. As a major geographic goal, an NRR of unity is the first step towards eventual population stabilisation.

By the time the Pal Panandikar Committee completed its report, the Janata Government fell and the report was submitted in great haste to the Indira Gandhi Government. The Planning Commission incorporated in toto the statistical goals set forth by the Pal Panandikar Committee and the National Health Policy (1982) also included a statistical appendix, which incorporated these goals.

The goal of NRR-1 to be attained by the year 2001 translated in terms of birth rate and death rate meant 21 and 9 respectively, yielding a growth rate of 1.2 percent per year. According to the simulation model, this meant a couple protection rate of 60 percent. But it was surely not the Working Group's contention that a CPR of 60 percent would necessarily lead to a birth rate of 21 per thousand. However, in the minds of planners, policy-makers and administrators what stuck was only the figure for the birth rate, of 21 per thousand. But as the planning Commission soon realised in its exercises for the formulation, of the seventh and eight five year plan, the achievement of NRR of unity was a far cry. The target date has been shifted from time to time and now it stands at the year 2016. The Swaminathan Committee would like to look upon 2010 as the year for the attainment of this goal.

It has now been realised by all that more of the same thing will not do, that a sterilisation centred population policy will not work. Meanwhile, Ministers and Secretaries in the Ministry of Health and Family Welfare have been changed during the last few years. As a result, the family planning programme has lost all sense of direction.

In passing it may be mentioned that another Expert Group on MCH and Family Welfare was appointed by the Department of Family Welfare in 1982. This Group was headed by the Additional Secretary for Family Welfare. An overdose of bureaucracy did not lead the members anywhere and nothing much came out of the report.

Draft Population Policy (1994) Concern for Eco-System

Swaminathan Committee

Such is the state of cynicism about India's population policy that even if a new policy is formulated, the standard comment will be: "What is new about it? There is nothing wrong with the existing policy. It only needs implementation".

In July 1993, Mr. B. Shankaranand, Union Minister for Health and Family Welfare, appointed an Expert Group to draft a National Population Policy. The ten-member Group was headed by the renowned agricultural scientist, Dr. M. S. Swaminathan (hereafter called Swaminathan Committee).

The Swaminathan Committee, given the time constraint and even more importantly, the financial constraint did a professional job and submitted the draft Policy Statement to the Union Health Minister and also to the Prime Minister in the last week of May, 1994.

Unlike the earlier Expert Group under the Chairmanship of Dr. Pai Panandikar, appointed by the Janata Government in 1978, the Swaminathan Committee was not asked to prepare a report but prepare a draft Population Policy, presumably to be adopted by the Parliament. It may be recalled that another committee on population headed by Mr. K. Karunakaran, Chief Minister of Kerala was appointed by the National Development Council earlier and in its report it had suggested that a National Population Policy should be formulated for adoption by Parliament. The format of the Swaminathan Committee's "report" is such that the whole document running into 41 pages can be adopted by the parliament. Part A of the Statement deals with the policy framework and Part B with implementation.

The first point to note is that the Policy Statement takes a holistic view of the population problem and therefore, the solutions offered are also of a holistic nature. The members of the Expert Group were, therefore, not content with merely formulating a policy framework but went into details of a matching implementation strategy, spelt out under 13 heads.

In a sense, the policy is totally new. It gives primacy to the utmost need for ecological balance between population and the carrying capacity of the available land and water resources. It squarely faces gender issues and brings these issues into the mainstream of the population policy. It also gives primacy to the imperative need for fulfilling the basic needs of the people. Finally, it supports democratic decentralisation through panchayats (village councils) and nagarपालikas (municipalities) and seeks to dismantle the present vertical family

planning programme run from New Delhi. What the Policy does not do is to get involved with demographic quantification. What it does not endorse is the present policy of fixing targets, giving financial incentives and an overdose of bureaucratic control from New Delhi on the pretext that the Family Welfare Programme is 100 percent centrally financed. The Policy takes full note of the 73rd and 74th Amendments to the Constitution and the coming era of power to the people through panchayats and nagarpalikas.

In short, the Population Policy is pro-nature, pro-women, pro-poor, and pro-democracy (See Tables 1.1 & 1.2). The concerned Department of Family Welfare was considered inadequate to implement the new population policy and hence a new structure called Population and Social Development Commission (PSDC) is advocated, so also a new financing mechanism - Population and Social Development Fund.

Table 1.1: Getting Out of the Sterilisation Trap

<i>Four Pillars of Draft Population (Swaminathan Committee) Policy</i>
I Population <----> Eco-System (Pro-Nature)
II Population <----> Social Development (Pro-Women)
III Population <----> Basic Needs (Pro-Poor)
IV Population <----> Decentralised Model (Pro-Democracy) (Panchayats & Nagarpalikas)

Table 1.2: Paradigm Shift in the Population Policy

	Old Approach	New Approach
1.	Population-Centred	People-centred
2.	Over-emphasis on sterilisation	Informed Choice of contraceptives
3.	Quantitative targets	Qualitative targets
4.	Family Planning in a separate basket	FP merged with Health: One package for Health, MCH & FP
5.	Focus on 30 + women with 3 or 4 children	Focus on new operation, in particular, adolescents (15-25 years)
6.	No linkage with physical environment	Linkage with eco-system, conservation, environmental

		protection and day to day problems like drinking water and sanitation
7.	Insensitive to gender issues	Focus on gender issues and concern for gender equity and elimination of discrimination against women
8.	No linkage with basic needs of the poor	Priority for fulfilling the Minimum Needs Programme
9.	No consultation with people at the grassroots level	Decentralised programme run through panchayats & nagarpalikas
10.	Family Welfare Department- the sole custodian of population matters	Abolish the Department and establish a Population and Social Development Communion and Fund

It must be noted that the Swaminathan Committee has not recommended that the Prime Minister should head the proposed Commission. It has suggested that the Chairperson should be an eminent social worker or a professional respected in the country for commitment to the cause of population stabilisation and social development. Likewise, all the four full-time members should be eminent professionals in their respective fields. The Prime Minister would head the Cabinet Committee on Population and Social Development. We were aware that in the past there were such Cabinet Committees but these were totally ineffective because there was no mechanism to service such Cabinet Committees. In our scheme of things, the proposed Commission on Population and Social Development would service the Cabinet Committee through an elaborate mechanism of co-ordination socio-demographic charters at the village/town level, district and state level and also at the national level. Instead of a centralised, bureaucratic programme run from New Delhi, the policy envisages an integrated and decentralised model. More importantly, the policy seeks to salvage the family planning programme from the tyranny of targets and focuses attention on fundamental aspects like literacy, education skill formation, particularly for girls, gender issues, informed choice of contraceptives, ethical aspects of new contraceptive technology, etc. In short, social development is linked to population and it is this nexus which alone can bring about demographic transformation. What is new in the draft population policy is a paradigm shift in our thought process which takes us out of "the sterilisation trap" of which the Department of Family Welfare is the main victim.

At the operational level, the main implementation strategy suggested is a restructuring of the Ministry of Health and Family Welfare (which really means dismantling the Department of Family Welfare). The Swaminathan Committee recommends that there should be one health care package of MCH, family planning as well as for ongoing programmes for tackling malaria, tuberculosis, leprosy, blindness and AIDS. No separate Secretary of the Department or Family Welfare is needed. The target oriented approach and vertical programmes must yield place to a people-oriented, decentralised approach. The focus is on linkages between population ecology, economy and social development-and not on sterilisation targets.

While discarding a narrow demographic approach in terms of targets and achievements, the Swaminathan Committee does suggest National socio-demographic goals for the year 2010.

The very first goal is: "Implementation in totality of the Minimum Needs programme, and a particular, universalisation of primary education and reduction in the drop-out rates..."

In view of my familiarity with the working of the Department of Family Welfare, I had an intuitive feeling that the Swaminathan Committee report would be scuttled by the bureaucracy. No bureaucracy anywhere in the world wants to part with its empire. I therefore, wrote to the Prime Minister pleading with him that he should himself read the report. I received a prompt reply from the Prime Minister who wrote to me: "I had occasion to browse through the report submitted by the Expert Group on National Population Policy, of which you were a member. We are having the recommendations made by the Expert Group examined" (letter dated June 6). I believe that the Prime Minister wants to act fast. The report has already been tabled in Parliament.

I shall conclude by quoting from the forwarding letter of Dr. Swaminathan to the Union Health and Family Welfare Minister - "We are convinced that business as usual approach will lead us to "social and ecological disaster". Policy headed by Dr. M.S. Swaminathan.

Socio-Demographic Goals in 2010

1. Implementation in totality of the Minimum Needs Programme, and in particular, universalisation of primary education and reduction in the drop-out rates of primary and secondary school students, both boys and girls, abolition of child labour and priority to primary health care.

2. Reduction in the incidence of marriage of girls below the age of 18 years to zero.
3. Increase in the percentage of deliveries conducted by trained personnel to one hundred percent.
4. Reduction in material mortality rate to less than 100 per 100,000 live births.
5. Universal immunization of children against tuberculosis, polio, diphtheria, whooping cough, tetanus and measles and reduction in the incidence of diarrhoea and acute respiratory infections.
6. Infant Mortality Rate (IMR) of 30 per thousand live births, and a sharp reduction in child mortality rate (1-4 years); also, a sharp reduction in the incidence of low birth weight babies (below 2.5 kg).
7. All individuals to have access to information on birth limitation methods, so that they have the fullest choice in planning their families.
8. Universal access to quality contraceptive services in order to lower the Total Fertility Rate (TFR) from 3.6 in 1991 to 2.1 by the year 2010.
9. Containment of AIDS and sexually transmitted diseases.
10. Full coverage of registration of births, deaths and marriages.

Gender Issues

Gender issues were considered in detail in all meetings of the Swaminathan Committee, which included, as already mentioned two distinguished women- Mrs. Avabai Wadia and Mrs. Devaki Jain as a member of the Group. I observed the respect with which Dr. Swaminathan received a somewhat angry delegation representing women's organisations. It seemed to us that some of these women activists were under the mistaken notion that the Swaminathan Committees would fall in line with international contraceptive lobbies advocating an injectable contraceptive. They were also agitated about the proposal to cut maternity leave beyond two children and other disincentives advocated from time to time.

Dr. Swaminathan gave the right lead to the Group by emphasizing at the outset the broad contours of the population policy which he said, should be "pro-nature, pro-women and pro-poor". Our checklist of items to be discussed did

include controversial issues like banning amniocentesis, ethical aspects of new contraceptive technologies, the role of women in the new system of panchayats, with one-third of seats reserved for women, the implications for women of the proposal to disqualify prospectively elected representatives of people with more than two children and a host of other gender issues. Our terms of reference were clear-we were to prepare a draft national population policy. We were, therefore, not preparing a report running into hundreds of pages. We had to take a clear stand from the nation perspective and draft a policy statement, which must necessarily be brief and could be adopted by the Parliament.

While working on the draft statement, the Group went through various documents prepared by individual members of the Group as well as other documents, which the Secretariat had received. We also had interaction with several women's organisations and some of us attended a number of relevant seminars and Conference. Instead of getting emotionally worked up, we discussed controversial issues scientifically and objectively and took a common stand (one of our members, Mrs. Devaki Jain was abroad when we finalized the Draft Policy Statement). Our report was unanimous.

Let me now select a few crucial items which were highlighted by women's organisations and give an idea of the recommendation of the Swaminathan Committee by giving a few excerpts below.

Discrimination against women

The Draft Policy says "Every effort will be made to eliminate before the end of the century all discrimination against women. In this context the media and advertisement agencies must develop a gender code which eliminates glorifying violence and vulgarity. Steps will be taken to provide special care for the girl child and the adolescent girls through higher levels of school enrolment, skill formation and income generating capacity. This will also be conducive to raising the age at marriage and adoption of contraceptive methods based on informed choice".

Maternity leave

The Swaminathan Committee did not endorse the suggestion of cutting down maternity leave beyond two children. Such measures would only harm the health of women. However, the Committee did recommend that "The service rules in the central and state governments and their undertakings would be suitably modified to ensure that the small family norm is adopted by...their employees". It further recommended that "the entire organised sector, (public as well as private) must also take similar steps in order to create an environment

where the small family norm is adopted by these relatively better off classes of society."

Holistic approach to health

The Policy says:

"A holistic and comprehensive approach to health would be identified and implemented. This will mean that the programme will be reaching beyond maternal and child health care and family planning services to cater to gynaecological and sexual problems, safe abortion services and reproductive health education. The health package will include attention to AIDS. The emphasis will shift from a curative approach to a prevention and control approach. Research and development efforts would strive to identify ways to integrate the necessary components relating to reproductive tract infections with ongoing health and social welfare programmes, instead of evolving new vertical programmes".

New contraceptive technologies

The Policy says:

"The ethical aspects of field testing of new contraceptive technologies will be thoroughly examined. Every effort will be made to attract young scholars to work on population issues, particularly on building indigenous knowledge systems and practices relevant to health and family planning".

Abortion

According to the Policy Statement:

"Another critical area deserving attention concerns the large number of unsafe abortions conducted by unqualified persons which has led to high morbidity and mortality among women. Every effort will be made to reduce such unsafe abortions. Primary health centres and community health centres will be properly equipped to carry out, safe abortions and such facilities will be made more accessible".

Amniocentesis

To quote the Policy:

"Health, including reproductive health, is another priority area. The use of amniocentesis and chorionic villus biopsy and any other technique for prebirth sex determination to avoid a female child, will be declared illegal. Much more than this, it is important to build up public opinion and social pressure against such misdirected use of technology. Sex education and premarital and marriage counseling will be introduced for promoting responsible parenthood".

Restricting family size of Panchayat Members

" ... It may be recalled that Rajasthan and Haryana have enacted laws which debar prospectively persons who do not adopt the two child family norm from contesting elections for panchayats, zilla parishads and nagarpalikas. The Swaminathan Committee noted that "this reflects political commitment" but goes on to say that "even if such legislation does not exist, there should be a code of conduct which enjoins on all elected representatives of the people, from parliament to panchayat, to adopt voluntarily the small family norm. Elected people's representatives will then become role models for the public to emulate. Future legislation in this area at central or state level should however safeguard the interests of women, particularly those belonging to the socially and economically underprivileged sections of society".

The last sentence needs some elaboration. Some women's organisations felt that such legislation may keep out leadership from poorer sections of the community as these communities have a high fertility pattern. This is a valid point, but it must be remembered that such legislation refers to the future and not the past. That is to say at the time of election, if a person has say, six children, he or she will not be debarred from standing for election. But if a person has two children and after the election produces a third child, he/she will be disqualified. The whole idea behind such legislation (whether or not it succeeds is another matter) is that politician and elected leaders should be the first to recognise the need for a small family norm. Otherwise population stabilization will be a far cry".

The pro-women attitude of the Swaminathan Committee would be evident from the following sentence from the forwarding letter of Dr. Swaminathan to the Union Health and Family Welfare Minister: "In addition to social empowerment mechanisms, vigorous steps to abolish all forms of gender discrimination including the more vicious forms, such as dowry and female foeticide and infanticide are needed. Further, gender equity is fundamental to achieving the goal of a better life for all".

Gender issues thus have been brought into the main stream of the national population policy.

Political Will

The Congress Government of Haryana and the BJP Government of Rajasthan have passed a legislation, which disqualifies elected members who produce more than two children and thus violate the small family norm (a cut-off date is announced in advance). This does show some political commitment and an attempt to rope in the politicians in the population stabilisation programme. Without being cynical one may say that politicians are not role models anywhere in India, in the eyes of the masses or the elite. We could do without such political will. Field work all over India indicates that the credibility of politicians is at an all time low in India (for that matter, all over the world). Should we therefore hang on political will? Why not get on with the job in a professional manner with an effectively functioning health delivery system at the grassroots level and also a real involvement of the people in formulating executing and monitoring various programmes, and in particular, anti-poverty programmes as well as programmes for total literacy, women and child development environmental protection, etc.

It may be noted that Tamil Nadu, a much larger state than Kerala, has done fairly well on the family planning front. It may be recalled that a great nationalist and social reformer. Feriyar E.V. Ramasami Naicker was responsible for creating a band of political leaders. He was very conscious of the population problem and advocated a higher age at marriage of girls and the practice of family planning. When his disciples came to power in Tamil Nadu, they gave full support to the family planning programmes. Tamil Nadu had also the distinction of a highly efficient bureaucracy, which implemented the programmes effectively. The present Chief Minister has recently launched an excellent 15 Point Programme for Child Development.

The whole philosophy of the Swaminathan Committee's report is to get over the midst of equating family planning with sterilisations and considering issues like the nexus between population and the ecosystem, gender issues, poverty and decentralised democratic planning. In short, it pleads for a paradigm shift. It is to be seen if the Prime Minister and the Union Minister for Health and Family Welfare have the political will to dilute the bureaucracy and launch a people-oriented programme through panchayats and nagarpalikas, in accordance with the 73rd and 74th Amendments to the Constitution. But if political will does not assert itself, the panchayats may well become the outposts of bureaucracy.

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