Saheli

NATIONAL POPULATION POLICY

A WOMEN'S PERSPECTIVE

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CENTRE FOR WOMEN'S DEVELOPMENT STUDIES
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NATIONAL POPULATION POLICY
A WOMEN'S PERSPECTIVE

CONTENTS

PREFACE .... 01 - 03

DOCUMENT A .... 04 - 13
Correspondence with the Chairman, Expert Group on National Population Policy

DOCUMENT B .... 14 - 18
Memorandum submitted to Expert Group

DOCUMENT C 19
A letter from Centre for Gerontological Studies to Member Secretary, Expert Group on National Population Policy

DOCUMENTD 20
Letter by Task Force Members of Rajiv Gandhi Foundation to the Ministers and MLAs of Rajasthan and Haryana

DOCUMENT E & F .... 21 - 24
Letter of Protest by Women's Organisations and reply by Dr. M.S. Swaminathan

DOCUMENT G 25
Statement Issued by Smt. Devaki Jain, Member, Expert Group on National Population Policy

DOCUMENT H .... 26 - 27
Explosion of Numbers - article written by Dr. M.S. Swaminathan

DOCUMENT I .... 28 - 43
Statement on National Population Policy

DOCUMENT J .... 44 - 55
Population Policy : Authoritarianism versus Cooperation
Extracts from the Lecture by Prof. Amartya Kumar Sen

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PREFACE

In 1993, as preparations for the Cairo Conference on Population and Development began to gather momentum, women's organisations learnt that the Government of India had appointed an Expert Group - under the Chairmanship of Dr. M.S. Swaminathan - to draft a National Population Policy. The organisations had already presented several memoranda to the Minister for Health and Family Welfare. These opposed the use of hazardous contraceptives in the Government's family planning drives, and coercive measures - direct or indirect - being practiced by government functionaries on millions of women across the country. Inevitably, it was the poor majority - without access to information about adverse side effects of some concentraceptives - who were victims of such coercion - and target practices.

Women's organisations had questioned the lack of transparency and top down methods practised by the government in its single-minded pursuit of population control, and had, on repeated occasions brought to the notice of the Government and the general public the adverse social consequences of some new reproductive technologies (including amniocentesis and sex selection techniques) which had been contributing to the accelerated decline of the already adverse sex ratio. These were summarised in a joint statement issued by seven national women's organisations after the release of the provisional results of the 1991 Census - recording **a renewed decline in the sex-ratio, a decade after the '81 census joyously reported the first improvement at the national level after 100 years of continuous decline.**

"The decline in women's conditions and the rising trend crimes of violence against women are part of the same social process, which cannot be combated by a few token programmes for women. We have identified other aspects of the process of social change which indicate advancing subordination of women with declining access or control over basic resources and power to lead their lives with dignity and basic human rights. We have struggled to make society aware of these multifaceted problems as our concerns extend far beyond women's survival to the health, progress and values of the nation as a whole. Yet, our demands and priorities have been viewed only as a sectional interest, ignoring the fact that women do not constitute a class, caste, or community.

We can only reiterate our persistent plea and demand - empowerment of women at all levels to participate effectively in the political process to decide the future of this country. Protection and improvement of women's rights cannot be made subservient to other policies like population control. By what right has the Government of India restricted the right to maternity benefits among women employees? Who has given Government that right? Is the population policy or the fourth Pay Commission above the Constitution?"

Sd/-

All India Women's Conference
All India Democratic Women's Association
Centre for Women's Development Studies
Joint Women's Programme
Mahila Dakshata Samiti
National Federation of Indian Women
YWCA of India

Agitations resulted in a series of state legislations as well as a national one to regulate and control the abuse of amniocentesis and sex selection techniques - known to have resulted in large scale female foeticide. The Centre for Women's Development Studies was very much involved in these debates and advocacy efforts.

From the late seventies, many of us had engaged in efforts to redirect government's social and economic policies from a women's perspective - to achieve gender equality and equity. Some of these efforts had crystallised in the introduction of a Chapter on Women and Development in the Sixth Five Year Plan, which,

and health care were essential to translate the constitutional guarantees of gender equality into reality for the large masses of Indian women.

The organisations therefore decided to place their point of view forcefully before the Expert Group at its very first meeting on the 21st October 1993. (See *Document A* with its two annexures). We had a fruitful discussion with the Members of the Expert Group, followed by a formal request from the Chairman of the Group, asking women's organisations to place their positive suggestions for a National Population Policy.

Before doing so, CWDS organised a public debate with concerned health professionals, representatives of various ministries of the Government of India, other concerned citizens, women activists and human rights groups on the 11th November 1993 at Delhi. The meeting was chaired by the Member, in charge of Health and Family Welfare in the Planning Commission, and included among participants the Director General of Indian Council of Medical Research. This was followed by a memorandum jointly prepared by eleven organisations of women and research institutes committed to gender equality which was submitted to the Expert Group. *(Document B)*

We received very positive responses from members of the Expert Group to our suggestions and were therefore utterly shocked by some recommendations of its Report. Our suggestions for a paradigm shift - from a negative to a positive Population Policy - had other advocates also. The Centre for Gerontological Studies, Trivandrum, consulted by the Expert Group - took a similar measures, and strongly advocated a comprehensive social approach emphasising women's empowerment through economic and educational means, in place of "a fertility oriented policy". (*Document C*).

The implementation strategies section of the Expert Group Report applauded the new laws enacted by Rajasthan and Haryana on Panchayati Raj, introducing a political disqualification of persons who did not voluntarily accept the two child family norm for holding offices in Panchayati Raj institutions - "as expressions of political will". This statement ignored the protest lodged with the two concerned Governments (as well as MLAs) by the Rajiv Gandhi Foundation's Task Force on Panchayati Raj, as attempts **"to dilute and subvert the spirit of the 73rd Constitutional Amendment" and violation of "women's basic democratic rights".** (*Document D).*

Women's Organisations launched a major protest against the recommendations of the Expert Group (*Documents E&F*). A public meeting convened by the women's groups on 11th July 1994 to explain their objections had a startling denouement. Smt. Devaki Jain, who had served as a Member of the Expert Group from the beginning, disassociated herself from its final recommendations **- as a "betrayal" of the "six pillars of the paradigm shift agreed upon by the Expert Group in its earlier meetings".** (*Document G*).

Even the Chairman of the Group recorded his feelings of discomfort by virtually disowning his personal support for some of the measures recommended by the Group in a statement published in the Hindustan Times. (*Document H*).

The Swaminathan Committee's Report was tabled in both Houses of Parliament in June 1994. An attempt by the Ministry of Labour to restrict maternity benefits to two children only a few months later had to be withdrawn because of strong protests by women's organisations and by the National Commission for Women. Since nothing further was heard through 1995 and 1996, we believed that the women's movement's united stand on population policy measures had dissuaded the Government from its efforts. It was therefore a great shock to receive from the National Commission for Women, a new Draft Statement on National Population Policy in early January of this year (*Document I*). The National Commission for Women has constituted an Expert Group to examine this document "in order to make it more gender equitable and gender sensitive". **We hope that the Commission will carry out its statutory functions in defending the fundamental, democratic rights of women.**

This collection of documents has been put together from the files of the CWDS and is being offered to promote an informed public debate on the draft Population Policy Statement - both inside and outside Parliament. **The women's movement has always advocated transparency in government action and opposed disjunction between the rhetoric in statement of policy objectives and actual implementation measures, of which the Draft Population Policy Statement is a clear example. Our critique of the Swaminathan Committee's Report was also based on the evidence of a similar disjunction.**

The present statement of the Government suppresses most of the positive ideas of the Swaminathan Committee - emphasising the need for social development measures in the forefront of a population policy, and picks up the negative measures e.g. political disqualification from holding elective offices at all levels of government for failure to accept the two child norm or debarring victims of child marriage from public employment. The basic suggestion for integrating social development with family planning services is abandoned. **The document retains the existing mindset of the Ministry of Health and Family Welfare. There is no paradigm shift, nor any evidence of sharing or decentralising the responsibilities of the Union Health Ministry. The "*Panchsheel*" for gender relations offered as a sop "to achieve gender equity or gender balance" can only be described as ridiculous in a country which lead many others in guaranteeing total gender equality in its Constitution, and is currently engaged in celebrating the 50th Anniversary of its Independence.**

We appeal to all members of the public to join us in opposition to the Draft Population Policy which violates fundamental democratic rights of its citizens, and of women in particular. We also appeal Dr. M.S. Swaminathan and members of his Expert Group to join us in this protest, to prevent misuse and abuse of their views, language and recommendations. We also appeal to all Members of Parliament **not to be swaed by the hypnotic effect of population numbers but to remember that population refers to people and their basic human rights. To assist their deliberations we have included in this collection a lecture by Prof. Amartya Kumar Sen**, which points out with scholarly objectivity and years of comparative research in this area the disadvantages and inefficacies of authoritarian population policies *(Document J)*.

Kumud Sharma

New Delhi
February 1997

Director
Centre for Women's Development Studies

DOCUMENT A

CORRESPONDENCE WITH THE CHAIRMAN, EXPERT GROUP ON NATIONAL POPULATION POLICY

21 October 1993

Dr. M.S. Swaminathan
Chairman
Expert Group on Population Policy

Dear Dr. Swaminathan:

As members of women's organisations and participants in the women's movement we have for long been deeply concerned with the formulation and the implementation of population policy. We are extremely happy that an expert group under your guidance will be examining the matter to advise the government. We hope you will be able to convince the Government of India that *a population policy cannot, and should not be reduced to one of demographic control only in a democratic political system.* Unfortunately the mistakes of the past has left people only this negative image of government's attitude to this critical issue.

We would like to remind the expert group that the first demands for contraception services in this country came from some women's groups. *Unfortunately today women's reproductive capacity is being projected as the major threat to India's survival. Population functionaries regard women as inanimate beings whose desperate need for safe contraception can be used to force on them either sterilisation with inadequate follow up or unsafe and inadequately tested contraceptive technologies with no thought to their health.*

Our concerns and apprehensions against such measures in the context of the declining quality of public health services (which in their present state are incapable of providing the necessary monitoring or follow up care to the recipients of such contraceptives) have already been communicated to the Minister for Health recently. A copy of our joint memorandum is enclosed for your information.

The draft document prepared by Dr. Pravin Visaria for discussion by your group, emphasises the demographic diversity of India (page 7-8). It is surprising that a social scientist of Dr. Visaria's stature should have overlooked the fact that this diversity can virtually be matched by the diversity in indicators of women's status worked out by several other members of his own discipline. During the last twenty five years, an enormous volume of literature has come from Indian and Western demographers, which identify backwardness of the status of women as the crucial variable that explains India's demographic diversity.

When you were Deputy Chairman of the Planning commission, in your dialogues with many of us before the Plan was finalised, you had agreed that educational advance, economic independence, and access to safe family planning and health care were essential to translate into reality the constitutional guarantees of gender equality for the large masses of our women. The Working Group on Employment of Women (1977-78) argued that economic and political empowerment of women were *essential means to achieve the national objective of reducing population growth.* We are surprised that the document prepared fifteen years later does not show the same sensitivity, or *even the basic understanding of the link between women's effective empowerment and fertility control, but believes that population control can be achieved by coercive techniques more or less on the model of China (page 10).*

Despite frequent references to 'grassroots' or 'a bottom up' approach, what has disturbed us greatly in the draft document are (a) indications of shifting responsibilities for needed health care support from the public health system to 'commercial' or 'social marketing' channels; (b) the proposed system of *incentive and disincentives which would automatically disqualify a large number of women, particularly in the backward areas, from participating in the empowering provisions of the 73rd and 74th Constitutional Amendments;* and (c) the fairly clear attempt to preempt the possibility of the newly constituted local self government bodies having any say in the formulation and implementation of demographic policy.

One could find many other points of criticism but our only intention now in to *request the expert group to share our belief (which is backed by years of experience) that effective and informed participation by women in management and improvement of the quality of contraceptive and after care services and their general empowerment in decision making at the grassroot level through the decentralised political system that we are attempting to construct would be a far safer and certain guarantee against the population 'disaster' than the kind of top down approach that displays scant respect for human life and regards women as only reproductive machines.*

Our basic suggestion to the expert group is to *recommend a full national debate going right down to the grassroots with men, women and youth before any policy is finalised.* A population policy in a democracy should be projected in positive term with qualitative goals (e.g. eradication of illiteracy, provision of social security/protection, health care, wider opportunities for economic and political participation etc.) rather than in the negative terms of demographic control with quantitative targets. *We are really trying to say that the latter is not possible without a much larger dose of democratic participation, particularly of women.*

Our third suggestion is that the expert group should recommend that population policy should not continue to be the responsibility of one Ministry, since it is a multisectoral issue requiring both policy as well as resource and knowledge inputs from other agencies of government. Since this coordination has never been achieved in all these decades even within the Ministry of Health - despite repeated directions from the Planning Commission - (from the Fourth Plan onwards) the group should address the problems of structural rigidities and vested interests that have become obstacles to greater transparency, open debate and collaboration in policy formulation.

We express our full confidence that the group will take firm positions in protecting the democratic and human rights of the millions of women in this country, whose poverty, powerlessness, and lack of access to information and services make them victims not only of frequent pregnancies *but also of unscrupulous measures at demographic control.* However, we would like to state in clear terms a few positions, which for the women's movement are non-negotiable. We have arrived at these on the basis of very painful experiences acquired over the last few decades.

1. No quantitative targets - overt or covert;

2. No incentives/disincentives that seek to erode women's basic human or constitutional rights;

3. No invasive hormonal technology until the quality of health care services have improved to provide the necessary monitoring;

4. Contraceptive responsibility and contraceptive investment to be equally shared by and on men and women;

5. Full information on possible side effects, need for after care/monitoring etc. o*n all contraceptives to be made available to all recipients.* There may be a need for some penal provision for failure to do so.

May we also make a last request to the expert group? Most of us have often been accused that as urban middle class educated women we know nothing about the plight of the millions of poor women in rural or urban areas in our country. Perhaps the expert group could enlighten such critics that all our concerns have been for those millions whom we are not supposed to know. Because each of us, thanks to our class status are in a position to obtain the information, the services and use all these technologies by paying for them.

A LETTER FROM NATIONAL WOMEN'S ORGANISATIONS TO THE MINISTER FOR HEALTH AND FAMILY WELFARE

The Minister for Health and Family Welfare,
Nirman Bhawan,
New Delhi- 110001

Sir,

Women's organisations have for a long time been voicing concern over the new trend of introducing hazardous, long-acting, provider controlled, hormonal methods of contraception.

We have repeatedly approached the government for restraining them from the use of such contraceptives because :

In the name of giving women a better choice, they infact take choice away from women and subject them to short-term side effects such as cardiac problems, hypertension, depression, clotting disorders and a number of long-term hazards as well.

These contraceptives require sophisticated procedures for screening and monitoring users, since contra-indications are numerous and include 'liver disease, diabetes, hypertension, suspected malignancy etc. among other conditions. Services to carry out screening and follow up do not exist in our country for the vast majority and existing services are being dismantled or privatized at a fast pace.

These contraceptives have a high potential for abuse because they can be administered without a woman's consent and not removed either by the very design of the contraceptive (as in injectibles) or by the choice of the medical practitioner (as in implants).

These contraceptives are being promoted in the name of reducing maternal mortality. However, with their life threatening side-effects and the inability of the health system to deal with the same, they are going to led tremendously to morbidity as well as mortality. Target orientation, social marketing and camp approach are infact a pointer that the concern is more with meeting demographic objectives than with peoples health. Not enough is known about the mechanism of these contraceptives which upset the entire bodily function by acting on the higher brain centres. Only one of the effects is that of preventing conception.

Under Indian conditions, lack of patient records, inaccessibility of the health system to the vast majority means that effective service delivery is also not possible, leading to high failure rates, which would mean pregnancies and birth of children with congenital malformations - thereby adding a new problem for the society.

We are only too aware that women in our country have a need for birth control, and are asking for safe methods to control their fertility. But this need cannot be met by any of these methods.

We have repeatedly asked for the promotion of barrier methods, and have available at our disposal adequate data to show that these methods is available at our disposal adequate data to show that these

methods in conjunction with back up abortion services provide the safest contraception. We fail to understand why methods like the diaphragm, despite being approved in India are not promoted. There is a similar disinterest in the promotion of vasectomy and male condom. We also fail to understand why women are targeted with a whole range of cafetaria, where each product is of dubious value, while new methods of vasectomy such as no-scalpel vasectomy are limited to one or two premier institutions in the country.

The world over, there is enough experience to show that contraceptive provision is useful only for people ready to adopt a small family norm when their life circumstances improve. In the absence of this, contraceptives are used as weapons to meet targets set by the government and do little to meet the reproductive needs of people. There is also enough evidence to show that maternal mortality is reduced not merely by fewer births, but much more when health services reach people and they have enough to eat, clean water to drink and education to be aware or their health needs.

We find that conditions are being created in our country which will lead to a growth in population, because there are increasing cuts in the area of basic necessities. Prices of all essential commodities are rising. People are being forced to pay for services in public hospitals and essential drugs are out of the reach of a majority. Thus, the well accepted maxim that social development leads to decreased growth of population, is not being followed in our country. The only programme being given great impetus is the family planning programme where increasingly, sophisticated and expensive drugs for contraception are being introduced.

In this context we were particularly alarmed when we were informed of the new plans to promote family welfare, at a meting called by the Secretary, Family Welfare on 18.6.93. We were informed that Depo Provera and Cyclofem are going to be introduced into the country without any trails. NET-EN is also to be introduced despite a case pending against it in the Supreme Court. We were told that oral hormonal contraceptives were going to be sold from non-medical outlets. Over and above this, the government is going to help NGOs/private practitioners to set up sterilization centres in areas where PHCs don't have this facility.

Last year women's groups had specifically raised an objection against the introduction of NORPLANT. This year ICMR has reversed its plans and is going to carry out a trial even though the sheer volume of biased promotional literature makes us believe that the decision to introduce this contraceptive has already been taken.

Time and again we are told that these contraceptives are approved in the US. However, we would like to point out that the right to information as well as the protection of patients, systems of screening and follow up are very different and these can make a vital difference to safe delivery.

We demand that:

1. The Drugs Controller be restrained from licensing untested contraceptives.
2. NET EN not be introduced till the questions raised before the Supreme Court are satisfactorily resolved.
3. Testing on NORPLANT be immediately stopped and all biased literature on NORPLANT BE DESTROYED.
4. No provider controlled method, hormonal or immunological, be introduced within the country.
5. Social marketing of oral pills be stopped immediately.
6. Money earmarked for sterilization centres be diverted to upgrading PHCs and CHC where other needs of people can also be met.
7. End the target oriented and camp approach where there is no possibility of meeting the needs of the people.

8. Appropriate contraceptive technology be promoted which can be used without coercion, is safe, and takes care of other infections i.e. barrier methods. Our specific objections to each of the proposals of the government are presented in *Annexure I.*

SPECIFIC OBJECTIONS TO PROPOSED SCHEMES OFGOVERNMENT OF INDIA

Depo Provera: It is being introduced without Indian Trials and in addition

1. Depo Provera like any other injectable progestogen only contraceptive causes menstrual chaos. Acting on the Hypothalmus-pituitary axis it affects the functioning of the brain and the body, and thereby causes many mental and physical symptoms such as depression, myocardial infarction thromboembolism, abnormal weight gain or loss, allergies, hirsuitism, etc. In particular it also causes bone loss.

2. Even though the WHO has given clearance to the drug on count of carcinogenicity, the studies in this regard are based on small samples and are not conclusive and conclusions have been drawn which err on the side of the manufacturer.

3. In the Indian conditions it is impossible to screen women for contra-indications which involves screening them for early pregnancy, hypertension, liver function, cancer, diabetes, alongwith a general clinical examination. Therefore there is every chance that it may be administered to women in early pregnancy resulting in congenital malformation among children born after in utro exposure to Depo Provera. These defects may be manifested in virilization of female children whereas male children would be susceptible to feminization. These risks are indeed high on women using Depo Provera because the drug causes pregnancy like symptoms and thus women might receive more than one injection while pregnant.

4. As such there is no logic for introducing any contraceptive without Indian trials. This has been amply demonstrated from the fact that Indian women require different dose regimen (trials with NET-EN and RU 486).

5. Mode of administration makes it possible to administer it to women without their knowledge and consent.

6. It has a negative impact on subsequent fertility.

7. The contraceptive need of women differ, however, all these contraceptive methods are catering to women who need continuous protection.

8. None of these contraceptive contribute to the prevention of AIDS and STDs which has to be an important criterion for new contraceptives particularly when an epidemic is said to be imminent.

Cyclofem: It is a combined injection of estrogen and progestogen which will be introduced without trials.

1. All evils of hormonal contraception have been blamed on Estrogen by the medical scientists. In fact the absence of Estrogen has been used as a ground for promoting Progestogen only contraceptives such as NET-EN and Depo Provera. Obviously Cyclofem lacks even this dubious advantage.

2. Like other injectables it can be given to women without their knowledge and consent.

3. Not only is it impossible for the health services to screen women for contraindications but also to reach them every month for administering Cyclofem making high failure rates a distinct possibility.

NET-EN: It is being introduced despite the fact that the Andhra Pradesh government has admitted to very high failure rates with this injectable. Further a petition filled by women's organisations against Net-en is pending before the Supreme Court.

All objections to Depo Provera apply to Net-en also and in addition there is no study to establish its safety in the long run. Indian studies on return of fertility indicate that a substantial number of women fail to even conceive after using this drug.

All these injections are being promoted as being easy to administer just on the basis that the immunisation programme has made health workers adept giving injections but the government has failed to comment on the ability of the health system to screen and monitor women and to reach them at regular interval to ensure a low method failure.

Divorcing Contraception from Health Care and Commercializing Contraceptive Delivery.

This will be done under a proposed scheme to set up six bedded sterilizatic centres in areas where the Primary Health Centres are ill equipped, by giving grants to private practitioners and NGOs. The grant would amount at non-recurring amounts for equipment purchase and a recurring one for running the establishment.

The logic of this scheme is completely untenable. Firstly if Operation Theaters are to be set up in areas which lack modern facilities why should they cater only to the family planning programme. Why are these not being set up in PHCs where they can meet the health needs of people more integrally.

Secondly, given the low level of compensation being offered to the private practitioners, it is unlikely that any private practitioner who has already established a practice is unlikely to set up this unit. There is every likelihood of substandard care being provided at these centres.

Thirdly, given the shoddy drafting of the scheme it is unlikely that it would even succeed in doing contraceptive delivery satisfactorily because there are no allocations for even minimal equipment needed for screening and for supplies the allocations are very low.

Given the above it is very unlikely that any worthwhile NGO would even take this grant. NGOs which have a decent reputation among the people do not have it for pushing government programmes but for viewing people's problems integrally. For them this concentration on sterilization in the absence of health facilities is not going to have any meaning. Yet this scheme has enough money for unscrupulous people to set up NGO shops to misuse this grant.

At any rate it is not clear how 1000 such centres can set up at all. Even if NGOs were willing to work on the scheme it would be difficult to find 1000 doctors and specially gynecologists to man these centres. If indeed there is such a large pool of human resources waiting to get going with sterilization targets why has the government not been able to find enough doctors to fill vacant posts?

It is obvious that this scheme would be misused for substandard service delivery by unscrupulous elements. Such a scheme is being promoted in a context where people are being forced to pay to avail of services at government run hospitals. In other words the government has money to squander on private practitioners but not for the people of this country for whom medical care is becoming inaccessible.

There is another contradiction in government's stand on contraception. All contraceptive delivery is being done in the name of women's reproductive health of women who are being told that while the government

has no money to even treat you for diseases and you will be charged for all medical assistance pregnancy is the biggest danger in your life which will be put to an end free of charge.

Social Marketing of Hormonal Contraceptive Pills

All hormonal contraceptives including pills require that the potential user is screened for contraindications and are monitored during use.

If these pills are sold through non-medical outlets they will be used indiscriminately by women. There is adequate experience from Bangladesh that the pregnancy rate has gone up with social marketing because users mistakenly believe that they are under contraceptive protection even when they take pills irregularly. Further, purchases are made by men who have little idea of their wive's health status. Leave alone lay men and women studies in India indicate that even health workers are not aware of the contraindications and do not know how to advise women who have been irregular.

People of India have been forced to seek medical attention from private practitioners because of poor availability of governmental health service which have failed to satisfy their needs. Now this compulsion of people is being turned into an argument against them and women are being asked to pay for the pill saying that people do not like what they get for free. In the meeting held on 18th June were informed by the Secretary that social marketing presumes that the women have already consulted a doctor before buying pills. This is another instances where the government is feigning ignorance of rural reality.

If this channel is extended to include injectable contraceptives hell will break loose, with three different formulations being in the market and illiterate women being unable to distinguish one from the other. This is not a figment of our imagination because newspaper reports have warned us that injectable contraceptives are being cleared for social marketing. All in all, social marketing is a clear strategy to reach contraceptives to people who will be out of the reach of the health system.

NORPLANT Trials: NORPLANT is an expensive long acting progestogen only hormonal contraceptive. The government was all set to introduce it but had to delay its plans because of opposition from women's organisations. Our opposition to NORPLANT is based on the requirements of the contraceptive which means facilities for extensive screening, long term follow up and surgical insertion and removal by specially trained doctors. It may require emergency removal if life threatening adverse reactions are experienced by the user. Experience with another version of NORPLANT in India shows clearly that even during the trials researchers failed to keep track of a significant proportion of women. Since removal cannot be done by all doctors women who have participated in these trials are on record to say that they were forced to continue with NORPLANT against their wishes.

The logic of promoting NORPLANT is that it releases only a very small quantity of hormone and is therefore less harmful than many other hormonal contraceptives. This claim is contested by many reputed medical scientists.

The safety of NORPLANT is premised on its approval for use in many countries of the first world. Needless to say that their screening and monitoring systems are qualitatively different from ours and most women are offered NORPLANT as one among many contraceptives. In USA, NORPLANT has a considerable record of misuse where women on welfare and in jails.

In Finland, doctors do not consider it to be a contraceptive of first choice. Finish doctors also tend to treat irregular bleeding due to NORPLANT with a completely irrational estrogen therapy.

As such we have maintained that there is no place for an expensive and sophisticated contraceptive like NORPLANT in our country. There have been cases in other Third World countries where after fully subsidizing training donor agencies have suddenly stopped free supply of NORPLANT and the concerned

government has been unable to continue with NORPLANT because of its high cost. High cost of the device has also meant extreme reluctance on part of the doctors in removing it before five years leading to coercion. At any rate even though the trials with NORPLANT are yet to commence a lot of promotional literature has been printed and is being widely circulated which means that the trials are just an eyewash and the decision to introduce NORPLANT has been already taken by the government. The white paper on family planning has already make assertions in this regard. Promotional literature on NORPLANT is highly biased and is not based on Indian information. Clearly therefore this is an attempt to mislead Indian women into accepting NORPLANT.

Misleading women about NORPLANT is in fact built into the very design of the Phase III trials where in the name or promoting choice an experimental contraceptive is being put on par with approved contraceptives.

Using Abortions as a means of Family Planning: While we have no difference on the question of abortion of services being available to women of this country who conceive due to circumstances beyond their control or due to contraceptive failure we are unable to accept abortion as a method of contraception as has been portrayed in promotional literature of the ministry and in the scheme for private practitioners. This would subject women to endless hazards because men would become increasingly more irresponsible and women more than willing to subject themselves to unnecessary surgical procedures.

In this context, we would also like to mention RU486 which is undergoing phase III trials. This pill is being promoted as a do it yourself abortion pill and as a method of abortion which is far cheaper than vacuum aspiration. Easy availability of RU486 would play havoc with the lives of many unsuspecting women who actually require medical supervision when they take it or may collapse due to its side effects if left without medical supervision. We are concerned that social marketing of hormonal pills will pave the way for unmonitored sale of RU486 leading to the death of every 40th woman who uses it. Now with laws being liberalised we would not even know how many women have suffered from RU486 when the tragedy strikes.

DOCUMENT B

Memorandum submtted to Expert Group in November 1993

PERSPECTIVES FROM THE WOMEN'S MOVEMENT ON A NATIONAL POPULATION POLICY

1. This statement is in response to the request of the Expert Committee set up by the Government of India to formulate a National Population Policy. It is not as if the Government has not had a population policy so far. It has been one of fertility control, pursued relentlessly, and at times coercively, through three decades, bringing disrepute to the Family Planning Programme, compromising women's health, and accelerating the already declining sex-ratio. Now we find that more of the same recipe is being institutionalised through disincentives and constitutionally questionable legislation. Monetary incentives have already proved a corruptive influence and added economic pressure to women's powerlessness.

2. The women's movement has all along been in favour of family planning, and has advocated women's control over their fertility. Pursuing demographic goals however, is not synonymous with family planning. We do not accept that population growth is mainly responsible for all India's ills, i.e. poverty, environmental degradation etc. Government however, refuses to recognise that the population rise is a direct consequence of increasing iniquities and dispossession among the majority and seeks to address the symptom of population rise without addressing the economic and social structures and policies which are the root cause. We maintain that demographic goals of reduced fertility cannot be imposed by a fait of the Government, as at present. Hence our demand for a national debate before any policy is finalised. While challenging the validity and limitations of Government's current approach, we offer an analysis and constructive suggestions. This statement should be read in conjunction with the memorandum dated 21st October '93, submitted by some of us to the Expert Committee on the 23rd October.

3. **"Sustainable Development":** In the context of the existing gap between India's stated Constitutional goals on the one hand and the present increasingly iniquitous social reality on the other, the just demands for a better life and future of the deprived section of our population must be included. Since the present population policies are mainly directed at this section of the people, the inclusion of their rights to survival with dignity should not remain mere rhetoric or constitutional dreams to be misused as electoral promises. It requires definite policy measures and intervention in the areas of health, employment, education, socio-political environment, and the freedom to participate in decisions that affect their lives.

4. In international fora official representatives of India have rightly challenged the assumption of the developed world's definition of sustainability as being one that must guarantee the continuation of the North's profligate over-consumption of scarce natural global resources. However, the other side of this assumption - that the depletion of global resources are attributable to the over-population of third world countries which require emergency control measures - seems to have become the unstated bedrock of present government approaches.

5. On the first point, we feel that it would enhance the credibility of the government's position - nationally and internationally - if it addressed itself to the reality of the over-consumption of resources by India's miniscule elite, among whom we are forced to include the Government itself. It the background of the ongoing process of restructuring India's economy we are sceptical of

how such a recommendation would fit in with the present domination of "market' considerations. However, national approach to population issues can ignore the total imbalance of control of productive resources and subsequent consumption patterns. In India, increasing inequalities of income and consumerist values which are again fall outs of the restructuring process. The experience of all other countries undergoing structural adjustment proves that the size of the population under the poverty line has drastically increased.

6. Although it is not the purpose of this statement to go into the details of the extremely adverse impact of the present economic policies on the bulk of our population, the references have been made necessary because of the approach advocated in the draft circulated to the Expert Group which seeks to disenfranchise further precisely those sections already hearing the brunt of the burden of the economic crisis.

7. One important aspect of the present policies is the reduction in real allocations to essential services which include the public distribution system and access to food, health education etc. Privatisation of health services, charging of fees for tests in government hospitals are going to further worsen the already fragile health profile of India's poor. As women's organisations, our experiences indicate that the fast deteriorating position of women's health, indicated by malnutrition, anemia, increased vulnerability to illness etc., is directly related to increased levels of poverty, lack of access to primary health services and not primarily to maternity related problems as perceived by official analysts. In this context, we consider the equation of health with family planning to be nothing short of criminal. The very fact that successive five year plans have increased allocation and attention to family planning at the cost of basic health services to the extent of the former exceeding the latter in the Seventh Plan should make our point clear.

8. The other aspect is the still shockingly high figures of infant mortality. We were horrified to learn that some of the international agencies who are closely involved in "advising" the government of India on the direction of economic policies, circulated a document advocating cuts in allocation for child survival strategies as a way of overcoming the "population trap". We have little indication of the government's response in this matter. The present trend of increasing child labour, in particular the labour of girl children points to the reality of children being seen as assets providing livelihood to a large number of families. What we wish to stress is the crucial role that non-demographic factors play in determining the size of the family for a vast number of India's poor.

9. Therefore to see population control as a precondition for the reduction of poverty goes counter to the history of demographic transition in other parts of the world and against the living reality of India's poor majority. Further, to see women as primarily responsible for the increase in population and to devise methods to control their fertility at all costs, is a position that the women's movement in India can never accept.

10. We wish to reiterate that poor women in India want and need easy access to safe contraception. However this need cannot be exploited to reach demographic goals in the "shaping of which they have had no hand" - at the cost of their health, their earning capacities and their futures. As elaborated in our memorandum submitted to the Health Minister, a copy of which we enclose, the key question is not the need for easy accessibility to contraceptives per se, but to **SAFE** contraceptives. A 'choice' which includes contraceptives unsuitable for use in India is no choice at all. We have detailed our position on each contraceptive which the Government plans to include at some stage in the Family Planning Programme in the said memorandum, which we request you to consider as part of this statement. Further, as an example of Government policy we refer you to the agreement signed with USAID on 30th Sept. 1992. It specifically relates to fertility control of women in Uttar Pradesh (one of the worst states as indicators of women's status or infant mortality demonstrate), and the measures suggested include hormonal implants to be

carried out with a grant of US Dollars 385 millions over a ten year period. We consider this agreement, signed in secrecy and still not publicly available to be both anti-women and anti-national and strongly recommend its cancellation.

11. It is astounding that the Government of India in setting the demographic goals, seems to have ignored the vast body of literature which identify the status of women as one of the crucial factors influencing demographic trends. During the last two decades the shocking increase in female infanticide, sex determination tests followed by abortion of female foetuses, proves that setting of such demographic goals without tackling the roots of the problems of women's inequality will have the most disastrous impact on the already unbalanced sex ratio prevailing in this country, and further depress their status, apart from providing rationalisation to the unethical practices and misuse of science by a section of the medical profession.

12. We strongly recommend the end of the target oriented, disincentive approach of the Government of India and reversal of all related policy decisions e.g. the reduction of maternity benefits to only two children. We also recommend withdrawal of the present Bill before Parliament disqualifying persons with more than two children from standing for election. We believe that such a measure will automatically disqualify precisely those economically deprived sections of our population, including women who most need political empowerment. This measures could also become an instrument of discrimination against minorities who already feel threatened because of recent political developments. We also see this measure as militating against the concept of grassroot democracy as enunciated for instance in the 73rd Constitutional Amendment on Panchyati Raj which for the first time has sought to expand women's participation in decision making at these levels of government, on the demand of the women's movement.

13. There has been a demand from some sections that the increased number of women members in the local self government bodies under the new amendments should be made responsible for programmes of women and child development. We oppose this demand. The diagram attached as appendix to this document represents substantially the overlapping and close interconnection between the needs of women and children and various other areas of public policy and governance. We recommend that women should be inducted into all the important standing committees with a view to ensuring the much needed coordination through their personal knowledge and stakes in the success of policies for education, health care, child development, environmental improvement, livelihood improvement etc. They would also need the support of women's organisations (local, block level, district, state etc.) educational/research/scientific institutions to **respond** to their articulated information/training/technological/other needs.

14. We believe that not enough attention has been paid to the adolescents in Indian society. Recent attempts to identify discrimination against girls have only noted their deprivations but not examined the psychological consequences of their being forced to assume adult roles from a very young age, particularly among the poor. Many in Western industrialised countries (whose model we adopted for economic growth and the education of our youth) are admitting (a) collapsing social cohesion, (b) declining desire to participate constructively in economic/social/political life and (c) proneness to violence as serious problems among their youth. Some sensitive leaders relate the rising tide of xenophobia also to the same sources. Our youth have not yet come to share all these tendencies but the situation, especially in metropolitan cities is changing rapidly and increasing violence is manifesting itself in many forms. A Population Policy for the 21st Century cannot and must not continue the mistakes of the 20th Century, and ignore the critical importance of the generations that must be the leaders for the next century.

15. Conventional demography generally includes fertility, mortality, labour force participation and structural distribution of the population between age-groups and geographic areas (e.g. rural, urban). Even gender is not always included in this basic morbidity and malnutrition need to be

included in this basic list, particularly in view of the questions being raised in the context of Kerala and Tamil Nadu where the demographic transition has been rapid. In the Indian, the regional and global context of today, migration - seasonal, long term, internal and international - have emerged as critical, even explosive issues. There are distinct class, gender and age differentials, with vital consequences on the structure of the family, the distribution of livelihood, work burden and responsibilities for the care of children and old dependents, which have yet to find a place either in demographic research or in population policies.

16. We wish to reiterate the importance we give to grass root level institutions like gram sabhas and district councils for participatory decisions and interventions in the non-demographic factors that ultimately affect family size. We therefore recommend certain incentives to local bodies for positive achievement like the following:

a. improving the rate of child survival; provision of centres for child care and development;

b. improving maternal and other health services (out reach and quality) for all - ensuring fully staffed adequate primary health centres;

c. Achieving full enrollment of all children in the appropriate age group in primary and middle school;

d. Organising informed participation and achieving support from the people in implementing all connected policies;

e. Eradication of child marriage and illiteracy;

f. Reversing declining trends in the sex-ratio especially at birth and in early childhood.

We feel provision of such incentives to local bodies would strengthen the spirit of the Constitutional amendment and provide a sense of direction and possibly changing cultural attitudes at the grassroots level, thus enabling the local bodies to play an effective role in achieving the desired broad policy objectives that we suggest. However, this will only be possible provided the Government of Indian makes enough resources available to state governments to strengthen the financial capacity of the local bodies. This would mean altering the present trend of curtailment of funds. Secondly we recommend that the transfer of resources for various purposes must not be linked to meeting demographic targets.

17. **Research and Development in Health and Reproductive Technology:** We have already requested the Expert Group to look into this aspect and make information on this area available to the public for scrutiny and debate. We are aware that even Members of Parliament do not have this information. Marketisation of R&D in these vulnerable areas should be resisted at all costs. India's experience in sex-selection tests alone should provide enough evidence for this position.

18. **Conclusion:** At the higher levels of government, the multidimensional tasks/needs of a population policy call for some major restructuring of the machinery - (a) to achieve a holistic coordinated functioning (as conceptualised in the theory of 'collective responsibility') - and improve its capacity to **respond** to the demands coming from the lower levels: (b) to evolve a smooth process of transfer of authority, power, and resources (including knowledge) - to make decentralisation a reality; and (c) to reorient its functioning and thinking in order to **exchange its present self-image as leaders or 'the nation', to one of catalysts to assist the people and their democratic institutions to function legitimately.** Without the major restructuring and devolution of power/resources/authority, we do not think cosmetic changes like creation of a Population Commission, or Cells within various ministries, or a National Institute for Research/Training/

Documentation etc. Can create any serious impact. It is time for the Government itself to practice some fertility control in reproducing bureaucratic infrastructures.

Sd/-
All India Democratic Women's Association
Centre for Women's Development Studies
Institute of Social Studies Trust
JAGORI
Joint Women's Programme
Mahila Dakshata Samiti
Multiple Action Research Group (MARG)
National Federation of Indian Women
Purogami Mahila Sangathan
SAHELI
YWCA of India

DOCUMENT C

CENTRE FOR GERONTOLOGICAL STUDIES

TRIVANDRUM 695 011, INDIA.

Prof. (Dr.) P.K. B. Nayar
Chairman

Dr. J.P. Gupta
Member-Secretary
Expert Group on National Population Policy
National Institute of Health & Family Welfare
New Delhi- 110067

Dear Dr. Gupta,

Thank you so much for giving me the honour of making a few suggestions for consideration by the Expert Group (vide your letter No. NIHFW/DIR/1-31/93 dated Sept. 20, 1993). I give below a few remarks:

The policy so far implemented by GOI has been, in effect, a policy of controlling women's fertility. This is more so in the light of the stupendous fall in vasectomy and heavy emphasis on female sterilisation. The strategy has been "strike the nail that goes". Again, in temporary methods used by women have not been proved safe beyond doubt.

This women's - fertility - oriented policy needs a drastic revision. From the position of women as easy targets by the promoters and even husbands, women have to be treated as having only equal and not more responsibility in population control.

This can be partly achieved if women are given all the options available in the field to choose from and not just those which could be imposed on them because of their vulnerability. This requires a SOCIAL approach as against the present bureaucratic approach to fertility control. The Strategies followed in "Saksharatha Programmes" are worth considering. This will also motivate men to come forward for sterilisation in larger numbers than at present.

In the long run, only empowering women - through economic and educational means - alone will be a permanent remedy against women alone being used for population control.

Population policy should extend to all segments of the population and not just the "target groups". It should cover both children and old people. Children are adequately covered by various programmes (e.g. ICDS) but old people are left high and dry. We do not have a policy on our elderly. This also should be incorporated in the new population policy.

In summary, it is suggested that the population policy should have two parts, viz.,**a contingency plan,** and **a long term plan.**

The objective of the contingency plan should be to achieve defined targets through safe methods. The objective of the long term plan is to have a stable population which uses healthy, safe and acceptable methods of population stabilisation and to take care of the needs of all segments of the population.

With best regards,

Yours sincerely
Sd/-
P.K.B. Nayar

DOCUMENT D

Letter sent by the Task Force Members of Rajiv Gandhi Foundation to the Ministers and MLAs of Rajasthan and Haryana

RAJIV GANDHI FOUNDATION
New Delhi

The members of the Task Force on Panhayati Raj set up by the Rajiv Gandhi Foundation took a serious view to the attempts made by some state governments to dilute and subvert the spirit of the 73rd Constitutional Amendment. The 73rd and 74th Amendment on the Panchyats and Municipalities incorporate Article 243 of the Constitution of India and provide reservation of seats to SC, ST, BC and Women. Provision of one-third representation of women on these bodies of local self government was hailed as a significant step in women's struggle for equality of opportunities and giving them a voice in the local decision-making process. It is expected that around 8 lakhs women will be represented on Panchayati Raj Institutions.

Though the Panchayati Raj Act contained mandatory provisions on core structural issues, the details were left to be worked out by the States. The Haryana Panchayati Raj Act (1994) enforced since 22nd April 1994 under Chapter XX and Rajasthan Panchyati Raj Act under provisions (Section 19(1) regarding provisions relating to election includes a section on disqualification and debars anyone who has more than two living children from becoming a member of Gram Panchayats, Panchayat Samitis and Zila Parishads. It further provides that "a person having more than two children on/or upto the expiry of one year of the commencement of this Act, shall not be deemed disqualified".

Such attempts tantamount to direct attack on democratic rights of people. We are all aware that women hardly have an active role in the decision-making process within the home on such issues. Moreover, representation of women from the weaker sections will be adversely affected by such a measures which means disenfranchisement of women through back door.

Going by the experience of some states which held elections in recent past, a significant number of women elected are from the younger age groups, many are neo-literate as education was given a premium by those supporting the candidates. Given the fact that they are in the early reproductive age group and with son preference in our culture, the options open to them will be taking recourse to female foeticide, infanticide or opting out of the election process.

The members of the Task Force were of the view that even those who are committed to small family norm do strongly believe that it should be done on a purely voluntary basis through education and motivation,.

We strongly urge upon you to take up this issue in the Assembly and get it deleted from the Section on **Disqualification** in the Act as it violates women's basic democratic rights.

Yours sincerely

Sd/-	Sd/-
D. Bandyopadhyay	Ghanshyam Shah
Pulok Chatterji	V. Ramachandran
M. Shiviah	Mani Shankar Iyer
Kumud Sharma	L.C. Jain
M. Aslam	Y.K. Alagh
	O.P. Rehan

DOCUMENT E

8th July 1994

Dear Dr. Swaminathan
and all Members of the Expert National Committee
on Population Policy

On behalf of the lakhs of women we represent and millions of poor women who are currently victims of the population control policies of the Government of India we register our strong protest and objections to the overall thrusts of the recommendations of your committee. For us working in the field of women's rights the recommendations of your Committee are NOT an issue of academic debate: they are matters of life and death and fundamental human rights.

We had hoped that the members of your Committee with the proven record of independence and integrity which many of you hold would provide the women's movement with some strength and support of scientific opinion, by contextualising the whole debate on population within the wider sphere of economic and social deprivation and exploitation - hall-marks of present day India. We had therefore fully cooperated with the Committee and provided it with the information to which we had access and at your request made alternative recommendations. We had also assured many of our members that the Committee had promised to adopt a pro-women, pro-poor and pro-nature position.

We are shocked to find that our basic framework has been totally rejected and the Committee has gone even beyond what the government has so far not dared to do in the way of coercive disincentives. You have thus provided the government with a convenient cover to bring into place the most unconstitutional, anti-poor and anti-women policies.

1. The recommendation to use the number of children as a disqualification for contesting elections is both anti-democratic and unconstitutional. While women in Rajasthan and Haryana are fighting this clause you have upheld it as a model for the entire nation.

2. At a time when rising unemployment and poverty cause the gravest threat to the majority of our people, you recommend that persons with more than two children be debarred from employment in the organised sector. It appears that you are unaware that even the government was forced to retreat from its decision to curtail maternity benefits to two children, because of protests from the women's movement.

3. It is astounding that you recommend that victims of child marriage be penalised by being debarred from employment in the organised sector at a time when ground realities show that child marriage is spreading among certain sections of the population to avoid dowry.

4. Even more shocking is the Committee's proposal to utilise the Army and paramilitary forces in achieving 'population stabilisation'. We doubt whether even the most coercive regimes have ever utilised the army for this purpose.

The Committee has recommended that all types of contraceptives be provided under the guise of 'informed choice', thus giving sanction to the present policy of introducing the most hazardous provider controlled astronomically priced contraceptive technologies in the family planning programme. This cafetaria approach for such sophisticated technology is like offering a menu card to the starving millions. It shows that the crucial question of women's health and provision of safe contraception was of no concern to the Committee.

We would also add that import of such expensive technologies will cut into the budget for life saving drugs and only benefit the MNCs and their Commission agents.

We find the Report extremely self-contradictory. On an another occasion a member of the Committee had said "the government uses a language of the movement but negates the ethics". Similarly while you have accepted that the elite are responsible for over-consumption and acknowledged that the gap between the poor and rich has been widening, you have made no recommendation to address these basic issues . Instead, you have blamed the poor for their poverty and advocated unhindered fertility control as the panacea for the removal of India's poverty.

We hope that even at this stage some of you at least will have the courage to disassociate yourself from these recommendations.

Sd/-

AIDS AWARENESS GROUP
ALL INDIA DEMOCRATIC WOMEN'S ASSOCIATION
ALL INDIA MAHILA DAKSHATA SAMITY
ALL INDIA PROGRESSIVE WOMEN'S ASSOCIATION
CENTRE FOR WOMEN'S DEVELOPMENT STUDIES
JAGORI
JOINT WOMEN'S PROGRAMME
MULTIPLE ACTION RESEARCH GROUP
NATIONAL FEDERATION OF INDIAN WOMEN
PUROGAMI MAHILA SANGATHAN
SAHELI
YWCA OF INDIA

M.S. SWAMINATHAN RESEARCH FOUNDATION

M.S. Swaminathan
Chairman

MSS/VS/13 July, 1994

Dr. Vina Mazumdar
Centre for Women's Development Studies
25 Bhai Vir Singh Marg
Gole Market, New Delhi-110001

My dear Vinaji,

I am most grateful to you and to the other Members of the different women's groups for your valuable comments on the draft National Population Policy Report. My views on your comments are as follows.

1. I note you have not made any observation on either the draft National Population Policy or the suggestions relating to "new Structures" (PART B - I). I therefore presume that you are in agreement with the suggestions contained in these sections of the report of the Expert Group. The new structure, namely, the Population and Social Development Commission provides a powerful mechanism for monitoring and avoiding the kinds of concerns you have rightly highlighted, since it provides for a whole time Member to be in charge of gender and ethical issues in technology introduction and testing.

2. Your concerns all relate to the suggestions contained in PART B - II titled "Other Measures". As you will note from both my forwarding letter and the Introduction, we had specifically requested the Minister for Health and Family Welfare to regard our report as a paper for discussion with a wide range of organisations and experts. Your important inputs are therefore timely. I hope there will be similar suggestions from other organisations and individuals, since I regard the process of preparation of a Policy Statement as important as the **product.** (I have stated this in my forwarding letter to the Minister).

3. I share your concerns. What is important is the formulation of alternative sentences to clarify the intent of some of the proposals, as for example the one relating to the use of Army personnel for helping to take health delivery systems to the unreached (the Army is currently helping flood victims in Assam). Some suggestions like those relating to disqualification for political and government positions can be deleted, if on balance these will do more harm than good to the socially and economically underprivileged sections of the society.

4. I hope you and your colleagues will ensure that your comments are not used to set aside all the suggestions contained in the report and to keep the bureaucratic control intact. If his happens, it will represent the greatest disservice to women from the economically and socially disadvantaged sections of the society whose interest you and I would like to serve.

With warm personal regards,

Yours sincerely

Sd/-
M.S.Swaminathan

DOCUMENT F

19 July 1994

Dr. M.S. Swaminathan,
Chairman, and all Members of the Expert Group
National Committee on Population Policy

Dear Dr. Swaminathan,

Thank you for your letter dated July 15 addressed to Dr. Vina Mazumdar in response to our joint letter to you and other members of the Expert Committee. We appreciate your prompt response and your categorical assurance that you share the concerns we had expressed in our earlier letter.

In para 3 of our letter you state "Some suggestions like those relating to disqualification for political and government positions can be deleted, if on balance these will do more harm than good to the socially and economically under-privileged sections of the society". We welcome this statement. We urge upon you to act on it by ***formally deleting*** these recommendations from your policy document, which we regard not only as "coercive disincentives", but also as injurious to women's status.

In our experience of work in the women's movement, policy makers in the Government are adapt at picking out certain portions of reports/recommendations which suit a particular policy direction while paying lipservice to others. In the case of population policy, the government has ***already*** set in motion a series of measures which are highly detrimental to women's rights such as sterilisation quotas, pushing of unsafe contraceptives, legislations affecting democratic rights (Haryana, Rajasthan legislations etc.). Your recommendations in these areas, which go even further, will greatly strengthen and add ***weight*** to what the Government is already doing and which we, on behalf of poor women, are fighting. This is important. Given the policy thrust of the government on the population question, we fear that these are most likely to be implemented and this will become even greater victimisation of millions of women. Therefore, since you also draw attention to the dangers of keeping "bureaucratic control" in fact, there is absolutely no ground for giving Government the opportunity to utilise the name of the Expert Committee as a sanction for its policies which by their very nature will ensure "bureaucratic control".

In para one of your letter you say that we have not "made any observations on eigher the Draft National Population Policy or the suggestions relating to **New Structures (Part B-I)"**. In our letter we had stated that we find the report "self-contradictory" and there were certain basic policy thrusts with which we disagreed. However, these are matters which can be further discussed. We do intend to make a more detailed analysis of the report which we would send to you.

We would request you to inform the Government also of your views regarding deleting the recommendations mentioned above at least before Parliament discusses the policy report.

Sd/-
AIDS AWARENESS GROUP
ALL INDIA DEMOCRATIC WOMEN'S ASSOCIATION
ALL INDIA MAHILA DAKSHATA SAMITY
ALL INDIA PROGRESSIVE WOMEN'S ASSOCIATION
CENTRE FOR WOMEN'S DEVELOPMENT STUDIES
JAGORI
JOINT WOMEN'S PROGRAMME
MULTIPLE ACTION RESEARCH GROUP
NATIONAL FEDERATION OF INDIAN WOMEN
PUROGAMI MAHILA SANGATHAN
SAHELI
YWCA OF INDIA

DOCUMENT G

Statement Issued by Smt. Devaki Jain
(Director, ISST & Member, Expert Group on Population Policy)
at a Meeting on Population Policy
on July 11th 1994

The final version of the National Population Policy statement is shocking.

At the very first substantive meeting of the Expert Group set up to prepare a draft Population Policy Statement, it was unanimously agreed to abandon the entire current package of incentives and disincentives - including barring of entry into legislatures, and organised sector employment, etc., on the basis of size of family. It was agreed that such policies were not only coercive but discriminatory against the poor, the scheduled castes, scheduled tribes and women, and wholly repugnant to the Directive Principles of the Constitution.

Similarly, the Group also agreed at the earliest stage, that basic needs, food security, livelihoods - that is, a basic social and economic security floor for the poor was a necessary condition for enabling them to make reproductive choices. Further that the high tech. Contraceptives should not be introduced, and that the whole matter needed to be made transparent and an ethical committee set up to screen the import and/or introduction of contraceptives.

These were some of the agreed six-pillars of the paradigm shift as described by the Group's Chairman, Dr. M.S. Swaminathan. These were incorporated in the rough draft which I prepared at March end, as a Member of the Group's Drafting Committee. What happened since which led to the abandonment of the basic pillars remain a mystery. The turn about in the Group B approach is a betrayal. It converts the final document into a war on the poor, the scheduled castes, the scheduled tribes and women. This can not be

I could not attend the last two meetings of the group which were held subsequent to the rough draft submitted by me in March. But I had written to the Chairman that unless these agreed elements were retained and the final draft shown to her, I would not be able to subscribe to the final draft. I am not a signatory to the final report of the group.

Sd/-
(Devaki Jain)

DOCUMENT H

EXPLOSION OF NUMBERS
Population Policy is Pro-poor and Pro-woman*

By
M.S. Swaminathan*

The preliminary draft of a national population policy submitted to the Minister of Health and Family Welfare by a group of experts headed by me, has provoked the kind of debate that the members of the Export Group wanted very much. For this, we are indebted to a few women's organisations that drew attention to the potential harm that a few of the suggestions in the report could cause to women. A precondition of progressive demographic transition in a developing society is the recognition that population policy is not a matter of birth control alone, but of promoting human development and of all-round progressive social change. Enlightened population policy requires a special recognition of the need to defend the rights of women and to combat gender oppression, and of women and women's organisations as instruments of change.

The draft emphasises that gender equity is fundamental to population policy and to achieve a better life for all. It stress the importance of an enabling environment and of empowerment mechanisms for achieving our population goals, rather than targets for specific contraceptive methods. It calls for shifting the scene of planning and action to the panchayat and nagarpalika levels. It calls for empowering nearly one million women members of elected local-level bodies.

In the second section of the draft, the establishment of a Population and Social Development Commission, chaired by an eminent social worker, has been recommended. The Commission is to be structured on the so-called "Homi Bhabha Principle", that is, it should be vested with the necessary authority to operate a Population and Social Development fund and at the same time be free from rigid rules and bureaucratic procedures.

The major criticisms of women's organisations relate to four points in the next section of the draft, titled "Other Measures". I present my personal views on these issues.

In democratic societies, signals that help to achieve, agreed social goals are often incorporated in public policies and government procedures. In the draft, it was suggested that "employees of the central government, State Governments, municipalities as well as employees of various public sector undertakings must give the lead in adopting the small family norm. The service rules would be suitably modified to ensure that the small-family norm is adopted by their employees. Similarly, all new entrance to the Government who are married before the age of 21 years in the case of boys and 18 years in the case of girls will be debarred from recruitment". This recommendation refers only to employment by the State.

The fear has been expressed that such policies may affect poor women and children adversely. I think that the following question is still relevant: what then are the most appropriate social signals to indicate the need to achieve a total fertility rate of 2.1 per annum by the year 2010, failure to achieve which would be a social and ecological disaster. If, however, after careful analysis it is felt that the

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* Published in the Hindustan Times, July 1994
* The author is Chairman, Expert Group on National Population Policy.

incorporation of the provision relating to the age at marriage in recruitment rules would do harm to women, then it should be dropped.

Paragraph 9.2 of this part of the draft is poorly worded and can, I must admit, evoke fears of coercion. The background to the proposal is the following: India has had some success with Ecological Battalions, made up mainly of ex-servicemen who help with afforestation and other ecology-related tasks in remote areas. In this context, it was felt that ex-servicemen, known for their discipline and devotion to national causes, could help, "wherever feasible", to take health care systems to the unreached. As pointed out, however, the words of the present draft, and particularly the first sentence ("the army and para-military forces have a better opportunity of promoting the small family norm") are ill-chosen, and can create legitimate fears of coercion; hence the purpose behind this suggestion needs to be explained in unambiguous terms.

Paragraph 13.1 under "Other Measures" refers to the Rajasthan and Haryana legislations that recommend that persons who do not adopt the two-child-family norm be debarred prospectively from contesting elections. I wish to make it clear that I personally reject the legitimacy of any legislation that prevents a person from standing for election at any level on the basis of the number of children that she or he has. I do feel however, that, persons in public life "should adopt voluntarily the small family norm" and that "elected people's representatives... become role models for the public to emulate". I strongly feel, as the draft says, that "further legislation in this area....should safeguard the interests of women, particularly those belonging to the socially and economically underprivileged sections of society.

The draft states that the "identification of family planning with contraception/ sterilisation has limited the perspective of the family welfare programme and has created a negative image in the minds of the people.... it is essential to erase its present negative image and substitute it with the positive image of the programme. Such a programme will emphasise measures like higher age at marriage, literacy, education, reduction of infant mortality, increasing birth spacing, management of infertility and the desirability of having a planned family". At various points, the Expert Group was urged to explicitly condemn certain contraceptives - particularly some injectable contraceptives - in the draft document. We decided not to do so. The draft does not advocate or condemn any specific contraceptive method; such an analysis, we felt, is more appropriate to a technical paper than a policy paper. At the same time, however, the draft makes it quite clear that we reject any contraceptive method that is scientifically unacceptable.

The central objective of the draft document on national population policy prepared by the Expert Group on Population Policy is to stress human development issues in population policy and to do so from a pro-poor, pro-woman perspective. It is a draft document, intended for wide circulation and wide public debate. In the light of the apprehensions voiced by some concerned women's organisations, I have no hesitation in stating my personal opinion that paragraphs 9.1, 9.2 and 13.1 of the last section of the draft (which relate to employment by the state, the role of the armed forces and the Rajasthan and Haryana Legislations) will benefit from redrafting to allay genuine concerns.

DOCUMENT I

STATEMENT ON
NATIONAL POPULATION POLICY

1. Towards a National Population Policy

1.1 In 1951, India launched the first official Family Planning Programme in the world, with the objective of "reducing the birth rate to the extent necessary to stabilise the population at a level consistent with the requirement of the national economy". A Statement on National Population Policy was made in 1976, and a Policy Statement on the Family Welfare Programme was made in 1977. The National Health Policy of 1983 emphasised the need for "securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation". The National Health Policy stated the need for a separate National Population Policy. The National Development Council (NDC) appointed a Committee of the NDC on Population in 1991. The report of this Committee, endorsed by the NDC in 1993, recommended that "a National Policy on Population should be formulated by the Government and adopted by the Parliament". A Group of Experts was set up to prepare a preliminary draft of the Population Policy. This Group has made some valuable suggestions. This Statement on National Population Policy is a culmination of the exercise initiated with the NDC' Committee on Population.

2. Population in India's Planning Process

2.1 Improving the quality of human life based on the principles of self-reliance, social justice and harmony between human population and nature has been a cornerstone of India's development policies and strategies since the beginning of the First Five Year Plan in 1950-51. India has been one of the first countries in the post World War II era to attend seriously to population issues. This has led to substantial achievements. However, the growth rate of population continues to be high.

3. Variations between States

3.1 Uneven progress among States in population stabilisation has been one of the factors responsible for a high national growth rate. Thus, while for the country as a whole the Total Fertility Rate (TFR) was 3.5 in 1993, it was 5.2 in Uttar Pradesh, 4.2 in Madhya Pradesh, 4.5 in Rajasthan and 4.6 in Bihar. On the other hand, the TFR was 1.7 in Kerala and 2.1 in Tamil Nadu, the two major States which have already reached below replacement level of fertility. The four large states contributed 42 per cent of the net increase in India's population during 1981-91. It is thus evident that population stabilisation strategies will have to keep in view the diversity prevailing among States in total fertility rate, death rate and infant mortality rate. Policies and programmes will have to be tailored to suit the particular socio-cultural and socio-economic factors prevailing in each area. Recent developments provide an excellent opportunity for promoting the concept of Unity in national population goal but diversity in implementation strategies. With the Panchayati Raj Acts coming into force in all States and Union Territories consequent on the 73rd Amendment to the Constitution of India, there is a real opportunity for planning at grassroot level. Hence, this Population Policy is structured on the basic premise : **think, plan and act locally and support nationally**. Such a shift in approach is fundamental to achieving a population policy driven by peoples' perceived needs. Based on the national population policy framework, each panchayat and nagarpalika can develop a blue print for action based on integrated attention to health, education and environment with sensitivity to gender and poverty issues.

4. Population and Poverty

4.1 The World Health Organisation (WHO) defines health as "a state of complete, physical, mental and social well being and not merely absence of disease or infirmity". To achieve this, it is necessary not only to adopt a holistic approach to health but also to recognise the need for giving priority to effective implementation of our policies and programmes designed to ensure poverty eradication, environmental protection and gender equity. The current global development pathways are leading to a continuous increase in the gap between the incomes of the poor and the rich, besides damaging basic life support systems of land, water, flora, fauna and the atmosphere. Development which is not equitable will not be sustainable in the long run. Programmes for generating an enabling environment where all people can experience a healthy and productive life will call for speedy and effective implementation of the Minimum Need Programme and in particular, for according the highest priority to (a) safe drinking water and good sanitation, (b) ensuring the health of families, (c) providing opportunities to plan the size of one's family, (d) education of children, with particular attention to the girl child, (e) provision of creches and child care services to support working mothers, and (f) increasing the income earning capacity for both men and women.

5. Population and the Environment

5.1 Gandhiji said "We have enough for everyone's need, but not for everyone's greed". The consequences of our failure to achieve a continuous improvement in the quality of life of all in harmony with nature are grave. Prime farm land is getting diverted at a rapid fate for non farm uses. Per capita land and water availability is declining to levels where both national food and drinking water security are at grave risk. Nearly 50 per cent of the irrigation water now comes from ground water and increasingly, the static component of ground water (which is not annually replenished by rainfall) is being exploited. Precious biological diversity is getting lost due to the destruction of coastal, mountain and forest habitats rich in genetic diversity. Pollution by non-biodegradable and toxic wastes is also growing. The unsustainable life styles of both wealthy nations and wealthy people everywhere are posing threat to climate, particularly precipitation and are contributing to a potential rise in sea levels and ultraviolet radiation. Under such circumstances the loss of every gene or species limits our capacity to adapt to new situations. It is high time the limits to the human carrying capacity of the supporting echo-systems are recognised.

6. Gender Equity and Gender Balance

6.1 The emergence of grassroot level democratic structures provides opportunities for correcting the prevailing gender imbalance in the acceptance of contraception. The neglect of the girl child, the higher levels of child mortality of females as compared to males, persistence of female child labour, low literacy rates for women, the high drop out rates for girls, the low age at marriage, the high proportion of teenage high risk mothers and low birth weight babies, the high maternal and infant mortality rates and increasing violence against women are all areas where urgent remedial action is called for. The decline in sex ratio is a warning signal. The sex ratio for the country of 927 females per 1000 males observed in the 1991 census is indicative of extensive discrimination against women. Only Kerala has a sex ratio exceeding unity. Women's participation in formal groups such as panchayats or informal groups such a Mahila Mandals, Mahila Swasthya Sanghs and voluntary organisations are the most effective and sensitive vehicles for ractifying gender imbalances and promoting the interests of women. Nearly one million reserved seats will be available for women in panchayats in the country as a whole. Such political and social empowerment, if supported by steps designed to strengthen the capability of women in decision making processes, should help us to make a new beginning in integrating gender equity in plans for health and family welfare and also help to arrest and reverse the declining sex ratio.

6.2 Men have often misused their power to satisfy their greed for more and more and have resorted to unsustainable and irreversible exploitation of natural resources to the detriment of the less power segments

of society whose primary needs cannot be met because of the greed of the high and mighty. Observance of Panchsheel of gender relations would emancipate men from their mindset of greed, encourage women to rise to their full potential, achieve gender equity and eliminate gender conflicts.

'PANCHSHEEL FOR GENDER RELATIONS'

i. Equality of Status
ii. Respect for the views and independence of the other even in situations of interdependence.
iii. Gentle courtesy in personal and social relations
iv. Extending maximum assistance to the other to achieve full potential.
v. Abjuring possessiveness.

7. Enablement and Empowerment for Population Stabilisation

7.1 Annually more people are added to the population of India than any other country in the world. Even now, those living below the poverty line are numerically as many as the total population of India at the beginning of the First Five Year Plan, i.e. about 360 million. Population, poverty and environmental degradation have close linkages and quest for food, education, health and work for all will remain illusory unless success is achieved in limiting the growth of population. It must be recognised that given India's age structure and the current levels of fertility and mortality, the population has an inbuilt momentum for continued growth. This implies that the population will continue to grow for the next few decades in spite of continuing decline in the birth rate. By the year 2000, a population of over 1000 million seems inevitable. In terms of employment, this would mean that nearly 100 million new jobs will have to be created by the end of this century. An enabling environment and empowerment mechanisms are needed to accelerate the march towards the goal of population stabilisation by achieving a Total Fertility Rate (TFR) of 2.1 by the year 2010.

8. Empowerment Mechanisms and Policy Initiatives

8.1 There is need to achieve a proper match between steps to promote an enabling environment and those designed to empower governments, communities and families in achieving the family welfare goals. The proposed empowerment mechanisms are enumerated below:

8.1.1 **Family :** The tendency to shift the entire responsibility for family limitations to women will be checked and the culture of joint responsibility of the couple in all matters relating to the family will be nurtured through various steps including the removal of gender bias in textbooks, media and public services. The contraceptive services provided to the family will be based on informed choice and decisions will rest with the users.

8.1.2 **Panchayati Raj and Nagarpalika Institutions :** Each panchayat and nagarpalika will be encouraged to prepare a socio-demographic charter for the respective village, town or city. The village/town/city level charter will have specific goals for population stabilisation developed after discussion among the people of the area. The charter will pay particular attention to achieving a balance between human population and resources available to the community. In addition, the charter will indicate the steps which the local community plans to initiate for ending social evils like dowry, child marriage, female foeticide and infanticide and female and male illiteracy. It will also develop guidelines for improving the quality of life. Such a charter will include a blue print for action, which will spell out the financial and technical support needed.

8.1.3 **District :** At the district level a broad-based administrative mechanism will be formed by networking of existing departmental and elected bodies with NGOs, social workers etc. This mechanism will monitor progress in implementing the village and town socio demographic charters and ensure their success. An important responsibility of this arrangement would be to

achieve convergence and synergy among all ongoing governmental and non-governmental programmes in the areas of population containment and social development. The structure of this district level mechanism may vary from State to State and existing bodies may be entrusted this task. Central funds under the Family Welfare Programme and various other social sector programmes may be granted directly to the district level.

8.1.4 **State :** A major role of State Governments will be the promotion of integrated quality of life improvement measures, with a focus on education and population limitation methods. The quality and adequacy of the health care and contraceptive delivery systems will need particular attention. Effective and safe contraceptive methods, chosen on the basis of informed choice, should be available to all who want to use them.

8.1.5 **National Level :** A Cabinet Committee on Population and Development will monitor the implementation of the National Population Policy, besides providing political and policy guidance. It will be chaired by the Prime Minister and will consist of the Ministers incharge of Health & Family Welfare, Finance, HRD, Welfare, I&B, Rural Development, Urban Development, Environment and Deputy Chairman, Planning Commission and others as decided by the Prime Minister.

9. Freezing of Seats in Parliament and State Legislatures

9.1 To ensure strong political commitment, legislation will be undertaken to prospectively debar persons who do not adopt the small family norm from all elective office. Political leaders at all levels will be encouraged to refer to family planning and family welfare in all their public communications, in any forum whatsoever.

9.2 As of now, the seats in Parliament and State legislatures are frozen till the year 2001. Consistent with the goals of this policy, it is proposed to extend the period of freezing of seats upto the year 2011.

10. International and Internal Migration

10.1 The problem of migration will be addressed in all its aspects including the proliferation of urban slums.

10.2 Documented international migrants will be accorded rights and responsibilities according to the national law.

10.3 Potential international migrants will be made aware of the conditions for entry, stay and employment so as to deter undocumented migration. Legal action will be taken against those who organise undocumented migration and exploit such migrants. The return of undocumented migrants to their countries of origin will be encouraged and facilitated.

10.4 In view of the rapid urbanisation and resultant pressures on civic amenities and the environment, a balanced spatial distribution of the population will be fostered. This will take into account the role of economic and environmental policies, sectoral priorities, infrastructure investment and balance of resources among central, State and local authorities.

11. Goals:

11.1 The following goals, incorporating the goals adopted by the International Conference on Population and Development (ICPD), 1994, are set:

(i) Universal primary education by the year .... A.D. and universal female literacy by the year ....A.D;

(ii) Infant Mortality Rate (IMR) of below 35 per 1000 live births by the year 2015 A.D;

(iii) Under 5 Child Mortality Rate (CMR) of below 45 per 1000 population in the age group, by the year 2015 A.D;

(iv) Maternal Mortality Rate (MMR) below 75 per 100,000 live births by the year 2015 A.D.;

(v) A life expectancy at birth greater than 70 years, both for men and women, by the year 2015 A.D.; reduction of morbidity and mortality differentials between males and females, as well as between geographical regions, social classes and ethnic groups;

(vi) Universal access to quality reproductive health care, through the primary health care system, including both services and information, by the year 2015 A.D.;

(vii) Reduction in the incidence of marriage of girls below the legal age of marriage to zero, by the year 2000 A.D.;

(viii) Increase in the percentage of deliveries conducted by trained personnel to 100 per cent by the year .......A.D.;

(ix) Containment of HIV/AIDS and sexually transmitted diseases;

(x) Full civil registration of births and deaths by the year 2000 A.D.; registration of marriages to be made compulsory by law.

(xi) Total Fertility Rate of 2.1 by the year 2010 A.D.

11.2 States which have achieved these goals or achieve them before the specified years should aim to achieve better socio-demographic and reproductive health indicators.

11.3 This Population Policy, if implemented by individuals and governments, irrespective of religion, caste or political affiliation, will help to provide a better common present and future to all our people. It is being introduced in a time of historic transition in the evolution of political instruments capable of enabling people in villages and towns to guide and shape their own destiny. If our population policy goes wrong, nothing else will have a chance to go right.

12. Strategy for Implementation

12.1 Primary Health Care

12.1.1 A package of Reproductive Health Care will be delivered through the primary health care system and efforts will be made to integrate the different components of health like MCH, reproductive and sexual health, as also the national programmes for the control/eradication of malaria, leprosy, tuberculosis, blindness, AIDS etc.

12.1.2 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 and reproductive tract-infections. The emphasis **will be on quality services for** prevention and cure.

12.2 Reproductive Health Care

12.2.1 The service delivery mechanism for health and family welfare services is already integrated through the Primary Health Centres and Sub-centres. The existing family planning and MCH services will be broadened to include other aspects of reproductive health care, at a pace appropriate to the capacity in each State, ensuring the quality of services rendered. Equipment and supplies required to provide the identified range of services, ensuring quality of care, will be provided.

12.2.2 The system of setting method wise contraceptive targets has already been replaced by decentralised participatory planning at the Primary Health Centre level.

12.2.3 Maternal health services will be provided through the primary health care system to reduced the maternal mortality rate. These would include education on safe motherhood, safe and effective prenatal care, assistance at delivery by trained personnel, emergency obstetric care, referral services, and post natal care. Measures will be taken to prevent, detect and manage high-risk pregnancies and births, particularly those to adolescents and late parity women.

12.2.4 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 in accordance with the law, and such facilities will be made more accessible.

12.3 Training of Staff

12.3.1 The service providers, namely the medical and paramedical personnel will continue to provide services in the rural and urban areas under State Governments. However, there will be an effective programme for induction, promotion, continuing education, training and orientation at all levels. There is also need for reallocation of duties and above all a change in attitude towards the whole programme. The Chief Medical Officer in each district, who should have public health training and orientation, will prepare a district morbidity, mortality and fertility profile. This will help in prioritising various ongoing health programmes. In this context, health management and skill formation will be key factors. The provision of quality health services and in particular, screening and aftercare services for all contraceptive acceptors are high priority issues. The credibility of the programme can improve only through improving the quality of services, efficient logistical support and better management at the grassroots level. The training will be planned at the district level. Training reserves will be created to enable release of personnel for training on regular basis. The content of the training input will be oriented to the practical.

12.3.2 Reproductive and Child Health and Public Health will be stressed in the medical education curricula.

12.4 Contraceptive Methods

12.4.1 The Indian Family Planning Programme in its earlier years mainly offered barrier methods for women, until some leading medical experts and administrators promoted the vasectomy operation for men as a terminal method. Female sterilisation also soon became will known, and as the programme spread from urban to rural areas, sterilisation became prevalent as it was a safe, one time procedure, freed the acceptor from further action, and limited the size of the family.

12.4.2 The balance between the numbers of vasectomies and tubectomies has drastically altered in recent years, and today women form the majority among acceptors of sterilisation operations. It is necessary to redress this. Men should come forward again for vasectomy where family limitation is desired, as also in adopting the condom method, thus sharing the responsibility for family planning.

12.4.3 Another crucial consideration lies in the fact the there should be as wide a range as possible of methods available from which to choose. Sterilisation still continues to be the leading method, but if it is resorted to by older couples who already have three or more children, it does not have the desired demographic impact. In view of the prevalence of early marriage, methods which help to space births need to be easily accessible with quality services for younger couples who, on completion of their family may choose sterilisation thereafter. Spacing of births undoubtedly has a positive impact on the health of women, and will be promoted accordingly.

12.4.4 Apart from the barrier methods, there now exist newer methods which women can use for spacing. It is possible that bio-medical research will yield non-terminal and reversible methods of contraception for men also. It has to be recognised that no medication, including that for contraception, it completely free from side effects. But India has an efficient scientific set-up for testing for safety, efficacy, reliability, and acceptability of contraceptive methods before introducing them into the family Welfare Programme. Although controversies are raised from time to time about various methods, there is no reason why a range of methods, provided they are scientifically tested and approved, meet ethical standards and are backed up by appropriate services, should not be made available to men and women. In delivering services, it must be ensured that all potential users can exercise a free choice, backed by full information and counselling about the safety, efficacy and possible side effects of each method, and how they should be used. Changing methods when so desired is also a part of informed, free choice.

12.4.5 Safe and effective methods, counselling, informed choice, quality services, adequate supplies, and careful follow up, are essential requirements for promoting contraception.

12.5 Incentives

12.5.1 Incentives in cash or kind given by the Central and State Governments for the acceptors of contraception as well as to motivators and service providers will be discontinued in a time-bound manner. Community incentives aimed at encouraging the community to undertake activities resulting in reduction of birth rate, infant and maternal mortality rates, increases in female literacy, increasing the age girls at marriage etc. have been introduced. The possibility of introducing income tax concessions, in the form of higher tax exemption limit or in other forms will be examined. Innovative schemes specifically directed to improve the status of the girl child and eliminating adverse sex ratio would be developed. Special attention will be given to the areas and States having a high TFR and IMR.

12.6 Organised Sector

12.6.1 The employees of the Central Government, State Governments, Municipalities, and employees of various public sector undertakings must give the lead in adopting the two child norm. The service rules in the Central and State Governments and their undertakings would be suitably modified to ensure that the two child norm is adopted by their employees. Similarly, all new entrants to the government who are married before the legal age of marriage will be debarred from recruitment. Promotion policies should be such that the adoption of the two child norm is encouraged. The entire organised sector (public as well as private) must also take similar steps in order to create an environment where the two child norm is adopted by these relatively better off classes of society.

12.7 **Health Insurance**

12.7.1 The Life Insurance Corporation and private sector insurance companies would be asked to draw up suitable schemes for group health insurance for workers in the unorganised sector and their families. It will be mandatory for the employers in the organised sector to provide for such group health insurance.

12.8 **Gender Code**

12.8.1 Every effort will be made to eliminate 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 girl through higher levels of school enrolment, skills 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.

12.9 **Population Programme as a People's Programme**

12.9.1 The Government bears the primary costs on the policies, planning and country wide promotion of programme for population and social development. At the same time, not only are its tasks made easier, but it is a part of good governance to evoke the whole hearted participation of the people in population stabilisation measures on the basis of shared perceptions and goals. Voluntary and non-governmental organisations can be particularly effective in mobilising the community, bringing about social change in attitudes and behaviour as in gender issues, fighting evil customs like dowry and increasing people's participation, through communication, management and marketing skills. They can also help to promote the adoption of orphan children after a couple have had a child of their own, so that children already born have a chance to have a happy life. Voluntary organisations will be fully involved in policy, planning and implementation of all programmes related to population stabilisation and social development. They will be given the necessary authority and autonomy to be innovative in socially relevant ideas, subject to financial accountability and ethical norms.

12.9.2 It is recognised that a large majority of the health functions can be handled by the community with effective support from functionaries of the health care system. This would involve transfer of knowledge and skills from the health workers to the community. Health workers and the community would be oriented in simple, inexpensive interventions to ensure the survival and development of children. While emphasis would be on prevention and management of common childhood diseases, recognition of danger signs when the child needs to be managed in a health facility would be taught to health workers and mothers. To provide effective referral support, a network of first referral units would be set up.

12.10 **Information, Education and Communication (IEC)**

12.10.1 Information, Education and Communication (IEC) efforts are vital for the successful implementation of the population policy. However, the infrastructure for implementing IEC measures, both at the Centre and in the States, remains inadequate. The IEC strategy tends to be centralised and the arrangements confined by and large to official sources.

12.10.2 The State Governments will take up the task of formulating State specific strategies on IEC. Panchayats, zilla parishads, nagarpalikas and NGOs will be involved in implementation and follow up. IEC will be an integral part of the population planning process at all these levels.

12.10.3 All IEC efforts will be such that informed choices on all issues are facilitated, educational efforts both formal and non formal are sensitive to population issues and the process of communication is holistic and focussed, keeping the diversities and imbalances in the country in view. The role of inter-personal communications, therefore health providers should be suitably trained.

12.10.4 The media as well as the institutions and individuals involved, whether of government or outside, should be persuaded of their social responsibility to take up issues relating to population and family welfare voluntarily.

12.10.5 The emphasis in IEC will be equally on men and women. Such an emphasis will be nurtured and maintained through various steps including the removal of gender bias in text books, and in print and electronic media.

12.10.6 Information, Education, Communication (IEC) efforts are not a substitute for actual service in the field or for the quality and reliability aspects of the programme. IEC activities are supportive to the programme; hence the linkages with the service delivery aspects and the ground realities will be strengthened.

12.10.7 Informed choice is a pre-requisite to a radical paradigm shift and change in the scene. Providing full information and supportive counselling that enables informed choice is the only way for sustained motivation and that will be a prime task of IEC.

12.10.8 Mass media should create a social environment for population stabilisation and echo the initiatives and programmes at the panchayat and nagarpalika levels, as is the case with literacy campaigns. School, college and university systems should have more vigorous population, family health and reproductive health education modules as part of syllabi at various levels in order to crystalise the concept of responsible parenthood and safe sex.

12.10.9 To strengthen a broad-based population stabilisation programme, sustained efforts will be made to utilise the services of various media of communication, corporate sector, private medical practitioners of allopathic and indigenous systems of medicine, members of professional and para professional organisations such as the Indian Medical Association, Medical Dental, Pharmacy and Nursing Councils, youth and women's' associations, and other reputed voluntary organisations. Special efforts will be made to communicate the family planning messages in the cultural context.

12.10.10The need today is for a more decentralised, locally relevant use of media of communication, in order to carry the messages effectively at the grassroot level.

12.10.11The motivation of field cadres in the social sector departments and their involvement in the population stabilisation efforts will be strengthened.

12.10.12Curricula at various levels of the education system, formal and non-formal, should encompass population issues and aspects related to family life.

12.11 Political Support for the Population Programme

12.11.1 Total and sustained political support for the positive goals involved in the population problem at all levels in the country will go a long way toward fostering a mind set favourable for achieving goals and the desired results. The increase in the population is one of the most serious problems facing the country today, and the political leadership cannot remain aloof to this issue. The increase in the population has ramifications involving not only the welfare and development of the country, but also social tranquility and harmony. Population issues, therefore, need to be addressed by political leadership irrespective of party or political affiliation/. Suitable mechanism

have to be developed at all levels to elicit support to the National Population Policy and to the population programme, similarly, other groups like social and cultural leaders, trade union, student bodies, professional associations of health care providers and employers in the organised sector will be sensitised for giving their support to the population programme of the country.

12.11. 2 The identification of family planning with contraception/sterilisation has limited the perspective for the Family Welfare Programme and has created a negative image in the minds of the people. This in turn has not been conducive to enlisting the voice and advocacy of many political entities. If the family planning/family welfare programme is to succeed in enlisting a broad spectrum of political and public support, it is essential to erase its present negative image, and substitute it with the positive image of the programme. Such a programme will emphasise measures like higher age at marriage, literacy, education, reduction of infant mortality, increasing birth spacing, promotion of breast feeding, management of infertility, adoption of orphan children, and the desirability of having a planned family.

12.12 Panchayats, Nagarpalikas and Community Participation

12.12.1 Under the new local bodies legislation, one-third of the members of these bodies will be women and one-third will belong to the weaker sections of the community. In order to make decentralised, democratic planning effective, every step will be taken to give the much needed information to all members of the panchayats, zilla parishads and nagarpalikas about various ongoing programmes and also upgrade their level of knowledge about the issues involved through continuous orientation programmes.

12.12.2 Initiatives should be left to the people to help themselves through community participation and voluntary efforts, thereby reducing their dependence on the government. There should be increasing community participation in areas like literacy, education, hygiene, sanitation, public health, family welfare and environment protection. Management of primary and community health centres and dispensaries and hospitals in rural areas will be passed on to the panchayati raj institutions.

12.13 Women and Children

12.13.1 During the last two decades, several programmes specifically aimed at the girl child, adolescent girls and women have been in operation. All such programmes will be reviewed, streamlined and strengthened. Every effort will be made to universalise female literacy and also ensure high enrolment rate for girls right upto the secondary school level. Circumstances which necessitate child labour will be addressed and the process of abolition of child labour will be accelerated. Adoption of orphan children will be promoted.

12.13.2 Health, including reproductive health, is another priority area. The use of diagnostic techniques for prenatal sex determination to avoid a female child has already been made illegal. Much more than this, it is important to build up public opinion and social pressure against such misdirected use of technology. Family life education and pre-marital and marriage counselling will be introduced in the appropriate cultural context for promoting responsible parenthood.

12.13.3 One of the factors which influence the use of contraception by couples is the degree of expectation of survival of their progeny. Birth rate tends to reduce with decrease in infant and child mortality rates. Acceleration of the decline in infant and child mortality rates would be ensured by addressing common causes of childhood morbidity and mortality.

12.13.4 Mortality in the newborn period contributes to over 60 per cent of the infant mortality. Special efforts would be directed towards reducing neonatal mortality. Traditional birth attendants, para

medical workers and the community would be oriented towards home management of newborn infants, with emphasis on prevention of common causes of neonatal mortality.

12.13.5 In addition to universalising immunisation of all infants against diphtheria, pertussis, tetanus, measles, tuberculosis and poliomyelitis and against other diseases, vaccination against which may be included in the Programme at a later date, prevention of child death due to diarrhoea diseases and acute respiratory diseases would be implemented.

12.14 Youth

12.14.1 India continues to be a youthful country and for several decades to come, the proportion of youth will continue to be high. Therefore, every effort will be made to inculcate in youth, the dynamics of population growth and the concept of responsible parenthood. Youth organisations like NCC, NSS, Scouts and Guides, Nehru, Yuvak Kendras etc. Will be harnessed for activities related to population and social development. Students of medical colleges will be involved in preparing the district health and population profile.

12.15 Non-Governmental Organisations (NGOs)

12.15.1 A new climate of partnership between government and voluntary and non-governmental organisations will be created to encourage the extensive participation of such organisations at all stages and at all levels in the national programme for population stabilisation and social development. After mutual consultations, criteria will be developed to identify such organisations as will be eligible for financial and technical assistance. Indices for accountability, monitoring and evaluation will also be developed.

12.16 Monitoring and Evaluation

12.16.1 Currently, the monitoring and evaluation of the family welfare programme is being done by the evaluation and Intelligence Division in the Department of family Welfare. A new system of reporting of client centred data, incorporating quality aspects, has already been introduced. At present, female Multi-Purpose Workers (ANMs) in sub-centres are burdened with several registers for maintaining and reporting routine data on MCH and family planning. The eligible couple registers are often not being maintained properly. A Management Information System (MIS) will be extended all over the country. It will also be necessary to conduct field surveys periodically to supplement the routinely collected data. It will be necessary to generate data on birth, death, maternal and infant mortality rates and age at marriage, at the district and block levels. At present, the vital statistics division in the Office of Registrar General conducts regular sample surveys under the Sample Registration System (SRS) to yield data on birth, death rates etc. But because of the size and scatter of samples, such data are not available at the district level, which is a prime requirement. The data generated at district and block levels will be fed back to the authorities at these levels to facilitate planning.

12.16.2 It is not necessary to centralise such data collection or estimation. The whole work can be decentralised to the State level and even district level, provided a uniform format is maintained for collection of such data and a proper manual prepared in order to eliminate any bias on the part of investigators. Modern techniques of sampling for generating statistics of small areas can be effectively used. In particular, data must be collected on the age at marriage and marriage rate in order to enforce the Child Marriage Restraint Act, which prohibits marriage below the specified age limits. The Central Government will enact a comprehensive Marriage Registration Act which will make it obligatory to register marriages all over the country. Judging by the experience of the Compulsory Registration of Births and Deaths Act which has so far not succeeded in getting reliable and complete data on births and deaths in most States of India, it would be unrealistic to

rely on legislation alone Hence, this is a fit area for a decentralised approach and accordingly, data on births, deaths and marriages will be collected and the fullest coverage ensured through village panchayats and nagarpalikas.

12.16.3 International migration as a proportion of total population is small. Nevertheless, at the local and sub regional level distress migration as well as illegal migration create serious problems with far reaching implications. The Census cannot give any estimate of illegal international migration. Therefore, a suitable monitoring mechanism will be established for confidential assessment of illegal migration on a yearly basis in order to take effective steps to deal with such migration.

12.17 Strengthening of Data Bases

12.17.1 In future, greater demands will be made on the statistical system by planners and policy makers in view of the key role assigned to social development in this policy. The decennial Census is the most important single source of demographic data. The office of the Registrar General will be strengthened in order to enable it to conduct smoothly the Census of 2001 A.D., covering over a billion people.

12.18 Social and Bio-medical Research and Technology

12.18.1 Networking among the existing institutions engaged in research and training in population dynamics, health and related subjects will be promoted and new areas of research taken up to give the crucial research back-up to population programmes and policies. At the same time, basic and theoretical research with long-term perspectives will be encouraged. All institutions concerned and in particular, the International Institute for Population Sciences (IIPS), the National Institute of Health and Family Welfare (NIHFW), State Institutes of Health and Family Welfare and the Population Research Centres at various universities and research institutions, will be given autonomy and the fullest academic freedom in order to generate an environment of creativity, original thinking and sensitivity to social concerns. Bio-medical research including traditional and frontier technologies will be promoted and funded in suitable institutions. Effective co-ordination with the Indian Council of Medical Research (ICMR), the Indian Council of Social Sciences Research (ICSSR) and other agencies will be ensured. The fullest co-operation of professional associations and selected NGOs will be sought in research and training programmes. A data base will be developed on indigenous knowledge systems and methods with reference to contraception.

12.18.2 Research on biomedical and social sciences relevant to population stabilisation will be strengthened. The ethical aspects of field testing of now 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.

12.18.3 Production technology for contraceptives, vaccines and equipment will be reviewed and upgraded, and efforts will be made to improve the level of self-sufficiency.

12.19 Differential Approaches

12.19.1 The Department of Family Welfare has an existing policy of providing additional resources to identified areas, mainly for augmenting infrastructure and training.

12.19.1 While the approach will continue, the areas to be selected shall be identified on the basis of :-

(i) Need for additional resources to compress the time required for reaching the stated goal of Total Fertility Rate.

(ii) Adverse indicators of reproductive health status of the population.

12.20 Nutrition

12.20.1 Provision of adequate and balanced nutrition to women and pre-school children are critical interventions for reducing maternal mortality arising out of nutritional deficiencies like anaemia, for ensuring proper growth of the foetus, and for ensuring the health and well being of children.

12.20.2 Pregnancy places a heavy demand on the nutritional needs of women. Her caloric requirements increase by about 600 kcal a day in addition to the increased requirements of iron, other micronutrients and vitamins. In the absence of proper care, a third of the children are born malnourished with a birth weight of less than 2.5 kg and start life at a disadvantage. One in five maternal deaths is due to cardiac failure attributable to severe anaemia.

12.20.3 The nutritional status during infancy and childhood has a pivotal role in determining child survival. Promotion of exclusive breastfeeding in early infancy and appropriate weaning practices would be undertaken.

12.20.4 A balanced diet is essential for healthy growth. Malnutrition increases the risk of infections and death in children and reduces the quality of life. Infections have an adverse impact on the nutritional status. Prevention and appropriate treatment of diarrhoea, measles and other infections in infancy and early childhood are important to reduce malnutrition rate. The degree of malnutrition and its detrimental effect on health is highest in the last trimester of pregnancy and in the first 12 months of life. If the vicious cycle of malnutrition and infections can be prevented in infancy and infants become healthier and better nourished, the positive impact will also be reflected in the older age groups. Focussed and concerted attention will be directed to improving maternal and infant nutrition through community awareness, and food and micronutrient supplementation.

12.20.5 All States and Union Territories will be encouraged to institute programmes for providing supplementary nutrition to pregnant and lactating women and pre-school children or sections thereof, identified either on the basis of socio-economic indicators or on the basis of health status.

12.21 Funding of the National Family Welfare Programme

12.21.1 The National Family Welfare Programme has continued to be under funded consistently, with the result that large arrears payable to States have accumulated. As reducing the rate of growth of population is recognised as a priority action area, funding shall be need based.

12.22 **Introduction of User Charges**

12.22.1 All States and Union Territories will be encouraged to introduce user charges for services rendered and supplies provided under the National Family Welfare Programme where demand for such supplies/services exists. Care will be taken to ensure that pricing does not restrict access.

12.22.2 Such user charges are intended not only as a method of funding the programme, but also for ensuring greater accountability of service providers to their clients and improving the quality of services rendered.

12.22.3 User charges may be introduced at a pace appropriate to the situation and graded according to various parameters, including the economic status of the user.

12.22.4 The institution or facility levying user charges shall be allowed to retain the collections and to utilise these according to policies/guidelines to be laid down by the State/UT. Recurring grants to such facilities/institutions being inadequate to meet the requirements for renovation and supplies, the user change could become a useful supplementary source.

12.22.5 Funding support to NGOs shall be designed to make the NGO self-sustaining, through user charges or through community support, including support from local bodies within a mutually agreed time frame.

13. Conclusion

13.1 This Policy is based on the premise that positive forward-looking and proactive efforts leading to the achievement of its goals within a specific time-frame are not only necessary, but their accomplishment is well within the capacity of the State and central governments and of the people.

No. N. 23011/2/93 - Ply
Government of India
Ministry of Health and Family Welfare
(Department of Family Welfare)

Annexure - II

Comments of Ministries/Departments of the Government of India on the Statement on National Population Policy and response of Department of Family Welfare.

Comments of Ministries/Departments	Response of Department of Family Welfare

No. N. 23011/2/93 - Ply
Government of India
Ministry of Health and Family Welfare
(Department of Family Welfare)

Annexure - III

STATEMENT ON IMPLEMENTATION SCHEDULE

Subject:- Statement on National Population Policy

Gist of decision required	Projected benefits/results	Time Schedule for implementation/Reporting to Cabinet Secretariat
Approval of the 'Statement on National Population Policy (Annexure - I).	An integrated, multi-sectoral approach to the population issue, leading to the achievement of the goals specified in the Statement on National Population Policy	(i) Will be presented to Parliament for adoption in the Session following approval by the Cabinet. (ii) Cabinet Committee on Population and Development to be constituted by Cabinet Secretariat.

(K.S. Sugathan)
Joint Secretary to the Government of India.

DOCUMENT J

POPULATION POLICY
AUTHORITARIANISM VERSUS COOPERATION*

Introduction

"In politics" said Samuel Taylor Coleridge in 1830, "what begins in fear usually ends in folly". Coleridge is not my favourite poet, but he was, I think, right to point to the blunders we commit out of fear. Something of a folly - indeed more than a folly - is, I shall argue, happening right now through frightened reaction to population growth. Despite noticeable deceleration in recent years, the rates of population increase remain quite high in many parts of the world, and there is an understandable interest in finding ways of bringing down these rates as soon as possible.

This concern calls for serious reflection on what might be the best response to "the population problem". But critical reflection is precisely the response that is missing when policymakers in different parts of the world rush to take direct control of birth decisions of families through authoritarian intervention. There have been several moves in that direction recently - most famously in China, but also in India and elsewhere. This essay is an attempt to examine the issues raised by authoritarian approaches to the population problem and a comparison of those approaches with that of working through cooperation.

There are many complexities in assessing the seriousness of the population problem, and in arriving at sensible policies to be followed. There are enormous diversities of understanding that divide the general public as well as specialists who write on this subject. There are, in fact, two distinct battlegrounds. The first area of disagreement concerns the seriousness of the population problem, covering such issues as the reading of the pressure of population, the possibility of catastrophe that may be generated, the impact of population growth on the growth of incomes and on other economic and social variables, and so on. The second area concerns the effectiveness of different influences through which population growth rates may come down in those countries and regions where they are currently very high. The pros and cons of authoritarian intervention, with which I am mainly concerned here, belong to this second area.

A Fundamental Dichotomy

The arguments in the case for and against authoritarian intervention relate to a basic attitudinal difference on the merits of the decisions that the family itself makes. There is, on the one side, an approach reflecting disparagement, which sees the family's decisions as either seriously undisciplined or incurably biassed, and often very wrong for the society as a whole and perhaps even for the respective families themselves. Arguing for a forceful and compulsive intervention from outside the family is a short step from this premise.

In contrast, an alternative approach sees the family's decision-making ability to be basically fine, even though adverse circumstances and external necessities may strongly constrain these decisions. There might, of course, be some divergences between social costs and private ones, but those who take a favourable view of people's ability to think and decide in a socially concerned way tend to expect that these divergences can be much reduced through reflections on social responsibility and the emergence of communal norms on family size. There is also the possibility of reducing the gap between private and social costs through correcting the imperfections of the market and making the prices faced by individuals reflect the social impact of their decisions more fully. It is, of course, true that governmental intervention

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* Reproduced from the Lecture by Prof. Amartya K. Sen, (1995, New Delhi) International Lecture Series on Population Issues, The John D. and Catherine T. MacArthur Foundation. For obvious reason the notes have been omitted.

in the markets and prices can be an indirect route to coercion, especially when the individuals are left with very few real options. But the corrections envisaged are usually much more moderate than that, in a way that would still leave much of the decision-making to the people themselves. In this general approach, the route to rational family planning lies in supporting and empowering those whose lives and responsible agency are most directly involved, and reflecting to them more fully the social consequences of their own decisions.

There is, however, a source of tension in this approach arising from conflicts and inequalities within the family, and this issue will be rather important in the analysis presented here. There can be a clash of interests between male and female members of the family, particularly given their typically asymmetric roles in child care. There can also be tensions between the different age groups and generations, particularly in a "joint family" - for example, the mother-in-law can be much more keen on a larger number of grandchildren than the daughter-in-law, who has to bear much of the burden of this achievement. In examining the intrusion of an outside bureaucracy into the affairs of the family, we must not overlook the divisions and internal tensions within the family. The route of cooperation involves the voluntary collaboration of adult family members in general, but particularly of those whose agency and well-being are most directly involved in these decisions - typically the young women who bear and, to a great extent, rear the children.

In its pure form, the cooperative approach contrasts sharply with the authoritarian one, and the battle between the two schools of thought can be seen plentifully in the literature on this subject. In practice, the contrast tends to be much less sharp and often quite a bit blurred. Nevertheless, various forms of coercion can be seen fairly clearly in the field of birth control in many countries. Sometimes coercion takes a direct form - for example, in the "one child policy" and other legal restrictions in contemporary China, and during Mrs. Indira Gandhi's "emergency period" in India in the mid-1970s. Quite often, however, that route is indirectly pursued, for example through regulations that disqualify parents of more than the specified number children from receiving public benefits of certain kinds, such as housing or government jobs. This has occurred in several countries, including China and some north Indian states. Sometimes the process chosen is "tied" services, whereby public medical attention is offered along with fairly forceful advocacy of birth control. Another form of effective coercion involves the use of uninformed consent of women, when the nature and consequences of the procedure to be used are not fully explained to the participating women. Another variant involves giving financial incentives for sterilization in circumstances that make them quite irresistible for impoverished people. I shall discuss the issue of coercion in its more frank form, but some of the arguments would apply to more concealed and less extreme forms of compulsion as well.

While the collaborative approach works, in general, through the empowerment of the persons directly involved and through increasing their effective freedom, the coercive strategy works through ordering them around and through reducing their freedom to decide. The two outlooks, in their pure forms, could not be further apart.

A Classic Debate

It may be useful to begin with a brief examination of a 200-year-old dispute between Malthus and Condorcet which relates closely to the contrasting approaches just outlined. Even though Malthus is credited with having provided the pioneering analysis of the possibility that population may tend to grow too fast, it was in fact Condorcet, the French mathematician and great Enlightenment thinker, who first presented the core of the scenario that underlies the "Malthusian" analysis of the population problem. Condorcet aired his questions thus:

> But in this progress of industry and happiness, each generation will be called to more extended enjoyments, and in consequence, by the physical constitution of the human frame, to an increase in the number of individuals. Must not there arrive a period then, when these laws, equally

> necessary, shall counteract each other? When the increase of the number of men surpasses their means of subsistence, the necessary result must be either a continual diminution of happiness and population, a movement truly retrograde, or, at least, a kind of oscillation between good and evil? In societies arrived at this term, will not this oscillation be a constantly subsisting cause of periodical misery?.

Malthus took of this analysis of Condorcet, and quoted it with great approval in his famous *Essay* on population, published in 1798: "Mr. Condorcet's picture of what may be expected to happen when the number of men shall surpass the means of their subsistence is justly drawn".

What Malthus did not like was the "solution" that Condorcet foresaw to the diagnosed problem, namely a cooperative response through the reasoned agency of the people themselves. Condorcet predicted the emergence of new norms of smaller family size based on "the progress of reason". He anticipated a time when "the absurd prejudices of superstition will have ceased to corrupt and degrade the moral code by its harsh doctrines", and when people "will know that, if they have a duty towards those who are not yet born, that duty is not to give them existence but to give them happiness". This type of reasoning, buttressed by the expansion of education, especially female education (of which Condorcet was one of the earliest and most vocal advocates) would lead, Condorcet thought, to lower fertility rates and smaller families, which people would choose voluntarily, "rather than foolishly to encumber the world with useless and wretched beings".

Malthus thought this most unlikely. In general, he saw little chance of solving social problems through reasoned decisions by the families involved. As far as the population problem itself was concerned, he was convinced of the inevitability of population outrunning food supply, and in this context, took the limits of food production to be relatively inflexible. And, most relevantly for the topic at lands, Malthus was particularly sceptical of voluntary family planning. While he did refer to "moral restraint" as an alternative way of reducing the pressure of population - alternative, that is, to misery and elevated mortality - he saw little real prospect that such restraint would work voluntarily. His conclusion was that "there is no reason whatever to suppose that anything beside the difficulty of procuring in adequate plenty the necessaries of life should either indispose this greater number of persons to marry early, or disable them from rearing in health the largest families".

It was because of this disbelief in the voluntary route that Malthus identified the need for - indeed the dominance of - a coercive reduction in population growth rates. He thought this would come from natural causes, that is, from what we can call the compulsion of nature. The fall in living standards resulting from population growth would not only increase mortality rates dramatically (what Malthus called "positive checks"), but would also force people, through economic penury, to have smaller families. The basic link in the argument is Malthus's conviction that population growth rate cannot be effectively pulled down by "anything beside the difficulty of procuring in adequate plenty the necessaries of life".

Scepticism about the family's ability to make sensible decisions about fertility can take us in a variety of directions. It led Malthus to oppose the public relief of poverty. Malthus saw the English "poor laws" as contributing greatly to population growth, and having the effect of depressing "the general condition of the poor". The reduction of population growth - through a lower birth rate in addition to an increased death rate - was nature's way of keeping the numbers in check, and public policy could not enhance the human condition, nor make this coercive reduction of birth rate be replaced by a reasoned cooperation of the families themselves.

That tradition of distrusting the voluntary route and of looking for some "solution" that coerces the families to have a smaller number of children has been a characteristic feature of a group of Malthusians and neo-Malthusians over the last two centuries. Sometimes the advocacy of compulsion is simple and straightforward - as in the official Chinese statements on the governmental policy of "one child family"- while in other writings some attempt is made to undermine the issue of coercion by questioning the

appropriateness of that diagnosis because of uncertainty as to what "coercion" might mean. There is, without doubt, some uncertainty here, and formally Garrett Hardin is right to point out that "the word `coercion' is not completely transparent" and that there is an "ambiguity" here. But the end result of that like of reasoning can be, as it often is, to lose the distinction between (1) a big dose of governmental bullying to make people do what they are extremely unwilling to do, and (2) inducing them to take note of the consequences of their own actions, including making corrections of market imperfections when necessary.

Indeed, the classic debate between Condorcet and Malthus remains very relevant today, and as Paul Kennedy has remarked, "This debate between optimists (Godwin, Condorcet) and pessimists (Malthus) has, in one form or another, been with us since then," and "it is even more pertinent today than when Malthus composed his *Essay*". The contrasting attitudes of coercive and cooperative solutions of the population problem in contemporary arguments relate quite closely to this classical debate.

As a matter of fact, the history of the world since that Malthus-Condorcet debate has not given much comfort to Malthus's point of view. Fertility rates have come down sharply with social and economic development. Some things "beside the difficulty of procuring in adequate plenty the necessaries of life" have made people choose radically smaller families, and the actual scenario-whether in the West or in the successfully developing regions in the rest of the world-has not been far from the one anticipated by Condorcet. The areas where fertility rates are high today are the poorer countries not yet experiencing much development, particularly those that are socially backward in terms of basic education (especially female education), health care, life expectancy, and women's empowerment.

Nevertheless, there has been quite a revival of Malthusian thinking in the recent years. Even the fear that the food supply is about to fall behind the growth of world population has been persistently aired, despite the continual *increase* in food per head in the world as a whole and in the major underdeveloped regions in particular. It is especially worth noting that the persistent increase in food supply per head has occurred despite a sharply falling relative price of food in the international market (with the consequent *reduction* in the economic incentive to produce more food). It is not surprising that some of the sharpest increases in food supply per head have occurred in countries such as China and India where the domestic production is less influenced by international prices of food.

There are different forms of neo-Malthusian worries that can be found plentifully in the literature-related to food supply, environmental deterioration, residential overcrowding etc. - but what characterizes the shared basic approach is distrust in the reasoned agency of people to bring about a change in the circumstances leading to the anticipated threats. While some of the threats are wildly exaggerated -especially in the case of the fear of the food supply running out-many of the concerns are by no means dismissable-particularly in regard to some strains on global and local environment. What is at issue is not the case for worrying about these prospects, which is a sensible thing to do; indeed, Condorcet had done it himself, in that famous passage which was used by Malthus to found his alarmist thesis. What is less sensible is to jump to the conclusion that coercion rather than cooperation is needed to respond to these worrying possibilities. It is a question of the approach to be taken in understanding how the population issue can be best addressed within the powers of reasoned agency of the people, rather than opting prematurely for a bureaucratic and authoritarian "solution".

The argument for expanding knowledge and opportunity of family planning methods does, of course, remain strong in the poorer countries in the world. This priority is a part of the commitment to *expand* the freedom of the family to decide on its reproductive behaviour; it is not a component of coercion. Nevertheless, the question can be-and has been-posed as to whether that process would be further helped by actually coercing people to reduce the family size. I shall turn to that question presently, but before that I shall have to consider some general arguments for state intervention in reproductive decisions, which need not be based on Malthusian presumptions.

Consequences, Autonomy, and Family Decisions

The advocacy of force in changing the family's decisions on the number of offspring has sometimes come from modern economists, including the great Swedish economic theorist Knut Wicksell, who combined neo-Malthusian beliefs about the tendency towards over-population with elaborate theorization regarding the size of "the optimum population". The general approach of "optimum population" need not, however, be based on Malthusian empirical presumptions, and can be combined with any set of consistent empirical assumptions. Indeed, the idea of the best population size for the society can even be made to incorporate our concern about the *processes* that may be used to influence reproductive behaviour (starting from any given social state), in addition to the narrowly defined "end results". However, much of the extensive literature on optimum population makes rather simple ethical assumptions that give little room for the importance of freedom and autonomy, and treats decisions about family planning in much the same way as the choice of any other economic or social variable, where the process of decision making is not given anything other than derivative significance.

In this framework, the usual arguments based on "externalities", distributional equity, or informational limitation can be easily unleashed to make out an immediate case for direct intervention by the state in the family's personal decisions about the number of children to have. A family's decision to have one more child could influence the interest-or for that matter the sense of propriety-of other people, and this can yield an "externality" based argument for the state to intervene in the reproductive behaviour of the family. It is precisely this easy translation of interventionist arguments, from standard cost-benefit analysis, that needs close scrutiny in the context of family planning. The subject matter does make a difference.

First, family planning is an intensely private subject in which-to borrow a phrase from John Stuart Mill-there is "no parity" between the family's own direct involvement in its reproductive behaviour, and that of others whose interests or susceptibilities may be indirectly influenced by this family's behaviour. As Jacques Dre`ze has noted, "We must recognise that, for most of us, "adding a new person to the world's is first and foremost adding a new person to the *family"*. Furthermore, family planning consists of actions and decisions that are by their very nature deeply intimate, and involve choices in which others need not be given a prima facie say.

Reproductive behaviour is thus a matter that immediately and decisively forms a part of the personal lives of the family members, particularly of the mother-or of the potential mother. This is not an argument to ignore all else, but that "all else" has to be very powerfully contrary to outweigh the general presumption in favour of leaving reproductive behaviour to the family in general and to the woman in particular.

Second, the usual procedures of cost-benefit analysis proceed on the assumption of the preferences of the individuals involved being "fixed"- in particular, uninfluenced by the decision under scrutiny. But, again as Jacques Dre'ze notes, "The decision to have a child is a decision to change the nature of a family", and it is "a decision about extending love to an as yet unknown person and sharing that person's fate, with all its uncertainties and promise". The standard fixed-preference reasoning misses out on a "recognition of what procreation is about". Once again, this is not a reason to dismiss the possibility that there could nevertheless be a good ground for intervention in reproductive behaviour, but it is an argument for being cautious, and in particular for resisting the temptation to make mechanical translation of interventionist arguments based on fixed-preference models to the field of procreation.

It is reasonable to accept the possibility that there must be some kind of a threshold of influence on other people's interests beyond which state intervention in personal lives might well be plausible. Only a drastic libertarian would reject that possibility without further examination, and we need not embrace that position. But there is a much wider consensus on the need to avoid authoritarian intervention in matters as intimate and personal as reproductive behaviour. In particular, it is not a matter just of fine-tuning conventionally defined costs and benefits: comparing the "costs" to the family members resulting from the violation of their reproductive freedom (given their preferences) with the "benefits" to others (given their

interests and desires) that would result from that violation. There are reasons to see the problem rather differently. There are, in particular, grounds to question the status of coercion as a mechanical remedy for "externalities", when the decisions involved are central to personal life, and thus require us to consider the importance of elementary autonomy, personal liberty, and the contingency of our preferences.

Much would thus depend on how disastrous we think a further increase in population might be and how immediate the danger is. I have tried to examine these issues elsewhere both in the global context and specifically for countries in the so-called "Third World". It appears that the dangers, especially in the short run and at the global level, are much exaggerated. But there are certainly reasons for concern in the long run at the global level, and even in the reasonably short run for some local environmental issues. In order to resist the case for coercion, it is not necessary to dispute these worries and apprehensions. It is important, however, to seek a less breathless remedy that pays attention to issues of long-run sustainability as well as the exact process through which the reduction of population growth takes place.

Women's Agency : A Foundational Linkage

This brings us back to the contrast between the coercive and cooperative routes. Do we have any reason to believe that the coercive route would be much more effective and faster than the cooperative route that relies on the agency of the people directly involved? How does the issue of speed relate to the problem of sustainability of what is achieved? Are there indirect effects of coercion that have to be considered in assessing the case for it? I shall address these issues presently, but before that I must examine a basic relationship between women's well-being and their agency that is central to the problem of fertility.

One of the most important facts about fertility and family size is that the lives that are most battered by over-frequent child birth are those of the women who bear these children. This is especially so in the poorer and less developed economies in the world. It is not only the case that at least half a million women die every year from maternity-related causes through afflictions that are entirely preventable, but also hundreds of millions of women are shackled involuntarily to a life of much drudgery and little freedom because of incessant child bearing and rearing.

The impact of persistent child bearing on the freedom and well-being of young women can be very severely negative in the developing countries. The significance of this aspect of the problem requires us to look beyond the family as a decision unit to the specific part that women, particularly young women, may play - or may be allowed to play-in the making of these reproductive decisions. The nature of this role not only includes the power and control that young women may have over these decisions, but also the substantive opportunities they have to consider these problems with adequate assurance, independence, and knowledge.

Women's Empowerment and Its Determinants

Over the last couple of decades, the importance of women's power and agency has become more widely recongized, partly as a result of broadening of the women's movements in developing countries. The focus of attention has moved beyond working towards achieving better treatment for women - a more "square deal" - to noting the importance of women's agency. This relates to a clearer understanding of the role of women as active agents of change - as the dynamic promoters of social transformations that can alter the lives of *both* women and men. The reach of that agency can be very extensive indeed, and it does of course *inter alia* include the possibility of reasoned decisions about fertility.

There are different means through which a change in the decisional power of women may come about. The route that has received most attention in the context of fertility decisions is the impact of literacy and schooling of women, partly because of its intuitive plausibility (even Condorcet had pointed to this link 200 years ago), but largely because of the extensive statistical evidence linking women's education (including literacy) and the lowering of fertility, across different countries in the world. Other factors

considered include, among others, the involvement of women in so-called "gainful" activities outside the home , the opportunity of women to earn an independent income, the property rights of women, and the general status and standing of women in the social culture.

These connections have been observed within India as well, and the statistical relations between (i) women's education and women's opportunity to earn an outside income, on the one hand, and (ii) lower fertility rates, on the other, have been confirmed by several empirical investigations. The most recent - and perhaps the most extensive - study of this connection is provided by an important statistical contribution by Jean Dre'ze, Anne-Catherine Guio, and Mamta Murthi, dealing with data from the different districts of India in 1981 (the latest year for which adequately detailed data are available). Among all the variables included in the analysis presented by Dre'ze, Guio, and Murthi, the *only* ones that have a statistically significant effect on fertility are female literacy and female labour-force participation. The importance of women's agency emerges forcefully from this analysis, especially in comparison with the weaker effects of variables relating to general economic progress.

The powerful evidence in favour of these statistical relations has to be distinguished from the social and cultural accounting of these influences, including the common account - not implausible in itself - that both education and outside earning increase a woman's autonomy. There are indeed many different ways in which school education may enhance a young woman's decisional power within the family:through its effect on her social standing, her ability to be independent, her power to articulate, her knowledge of the outside world, her skill in influencing group decisions, and so on. Similar linkages can be suggested for the impact of outside earning on a young woman's decisional control. But plausibility at this general level must not be identified with taking these connections as established. Contrary arguments, disputing these links, can - and have - also been presented, and this is a subject of much controversy in India at this time.

More sophisticated ways of characterizing women's autonomy have been suggested, with a more complex linkage to the fertility issue. Some have questioned whether female schooling does, in fact, enhance women's autonomy. Alternative explanations of the observed statistical relations between women's education and lower fertility have also been suggested - for example, the possibility that men who want a smaller number of children may prefer to marry educated women.

It has also been argued that the role of school education as a force for social change may have been oversold. This line of reasoning has a special appeal to many people in positions of influence and power in India, given the predilection of Indian upper classes to dismiss the importance of schooling for the lower order. Not only is school education, especially of girls, one of the most neglected social objectives in India, the Indian upper classes have a long record of being extremely suspicious of the value of basic education for the masses. Despite the promise made by the Indian political leaders before independence to make India fully literate with great rapidity, things have moved with remarkable slowness in this field, in contrast with speedy expansion of governmental commitment in many other areas. Even today only half the adult Indian population is literate, and two-thirds of the women remain absolutely illiterate. The upper class politicians who make up the bulk of the leadership of the major political parties in India - both in office and in opposition - seem to find it perfectly bearable that a default of this magnitude has been allowed to occur and that it is not being remedied with any speed.

The general value of women's education is a much broader subject than its role in enhancing female autonomy or in reducing fertility - potentially important as these connections might be. Female education can still be one of the most important priorities in Indian social change, even if the scepticism about its role in strengthening the autonomy of young women, or in reducing fertility rates, were to be entirely vindicated. This has to be asserted with some force, given the history of neglect of school education - especially of girls - in India, and given the social forces that sustain that neglect - and which tend to welcome, with open arms, any ground for scepticism regarding the importance of school education for the masses. Having said this, it cannot, of course, be denied that the questions being raised are serious and deserve careful scrutiny. However, if the scepticism were to be sustained, it would not be adequate merely

to dispute the standard "story" that goes with the widely observed statistical relations; it would be also necessary to provide empirically confirmable, and not just speculative, alternative explanations of the observed statistical links, especially between female education and fertility.

If this complex issue were to be pursued more fully, it would also be important to distinguish between different aspects of this problem. In particular, it would be necessary to pursue the *distinction* between.

(1) women's power to make decisions in different fields (fertility decisions constitute one field among many - autonomy covers other areas as well);

(2) women's *direct* decision-making roles vis-a-vis the influencing that can occur through more *indirect* routes;

(3) the power of *younger* women - whose lives are most directly affected by fertility decisions - vis-a-vis older women in the family;

(4) the *congruence* and *conflicts* of interests and opinions within the family which may make the independent agency of younger women less or more crucial; and

(5) women's *absolute* power to decide on these matters vis-a-vis their *relative* power compared with others in the family (or outside it).

However, for the purpose of the arguments presented here, it is not crucial to resolve all these different issues. Nor is it necessary to determine *exactly* how - and precisely the *extent* to which - women's education (or outside employment, or property rights, or political participation) will influence women's autonomy or the fertility rates. There is ample evidence to indicate that fertility rates tend to come down quite sharply when some of these predisposing social conditions are changed. the important point to note is that authoritarian intervention and bureaucratic denial of reproductive freedom are not the only routes to lower fertility, and reduction can occur with shifts in decisional procedures within the family.

The case of Kerala, the most socially advanced state in India, is particularly worth noting here, because of its remarkable success in fertility reduction based on women's agency. While the total fertility rate (a measure of the average number of children born per woman) for India as a whole is still as high as 3.7, Kerala fertility has now fallen below the "replacement level" to 1.8 - even lower than China's fertility rate of 2.0. There is considerable evidence that Kerala's high level of female education has been particularly influential in bringing about the decline in birth rate, from 44 per thousand in 1951-61 to 18 by 1991. Furthermore, the importance of female agency roles and literacy in the reduction of mortality rates leads to another, more indirect, route through which women's agency - including female literacy - may have helped to reduce birth rates:via reducing mortality rates. Kerala also has some other favourable features for women's empowerment and agency, including a greater recognition, by legal tradition of women's property rights for a substantial and influential part of the community.

What does Coercion Achieve?

Coercive measures are often advocated for reducing fertility rates in the poorer countries. They have received attention in international debates and have been favoured by some population pressure groups. That route was explicitly rejected at the International Conference on Population and Development at Cairo last year, but that rejection has not made the issue go away. Coercion persists in various forms (not least in India), and it figures, directly or indirectly, in a great many proposals that address the population problem.

In the context of discussing the imperative need to reduce birth rates in the world, China's achievement in cutting down fertility rates over a short period through rather Draconian measures receives understandable admiration. It is often suggested, by particular pressure groups, that India should emulate China in this

important area. The fear of an impending crisis makes many policy advocates seek forceful measures in the Third World for coercing people to have fewer children, and despite criticism from diverse quarters, including women's groups, China's attempts in that direction have received much attention and praise. A comparison of China's and India's experiences is thus of direct relevance to the current topic.

Fairly Draconian measures have certainly been used in China to force the birth rate down. Coercive methods such as the "one child policy" have been tried in large parts of China since the reforms of 1979. Also, the government often refuses to offer housing and related benefits to families with too many children - thus penalizing the children as well as the dissident adults. By 1992 the Chinese birth rate had fallen sharply to 19 per thousand, compared with 29 per thousand in India, and 37 per thousand for the average of poor countries other than China and India. China's total fertility rate is now 2.0, just below the "replacement level" of around 2.1, and much below India's 3.7 and the weighted average of 4.9 for low-income countries other than China and India.

How good a solution is this to the population problem? There are several problems to consider here. First, the lack of freedom associated with this approach is a major social loss in itself. Human rights groups and women's organisations in particular have been especially concerned with the lack of reproductive freedom involved in any coercive system.

Second, aside from the fundamental issue of individual freedom, there are specific consequences to consider in evaluating compulsory birth control. Coercion works by making people do things they would not freely choose to do; if they would have done something anyway, there would be no need to coerce them. The social consequences of such compulsion, including the ways in which an unwilling population tends to react when it is coerced, can often be quite terrible. For example, the demands for a "one child family" can lead to the neglect - or worse - of infants, thereby increasing the infant mortality rate. Also, in a country with a strong preference for male children - a characteristic shared by China with India and many other countries in Asia and North Africa - a policy of allowing only one child per family can easily be particularly detrimental for girls; for example, in the form of fatal neglect of female children. This, it is appears, is exactly what has happened on a fairly large scale in China.

Third, it not by any means clear how much *additional* reduction in the fertility rate has actually been achieved through these coercive methods. It is reasonable to accept that many of China's long standing social and economic programmes have been valuable in reducing fertility, including those that have expended education (for women as well as men), made health care more generally available, provided more job opportunities for women, and stimulated rapid economic growth. These factors would themselves have tended to help in the reduction in the birth rate, and it is not clear how much "extra lowering" of fertility rates has been achieved in China through compulsion. For example, we can check how many countries in the world which match (or outmatch) China in life expectancy achievements, female literacy rates, and female participation in the labour force actually have a *higher* fertility rate than China does. Comparing all the countries in the world for which data are given in the *World Development Report 1994*, there are only three such countries: Jamaica (2.7), Thailand (2.2), and Sweden (2.1) - and the fertility rates of two of them are not materially different from China's figure of 2.0. It is thus not really clear what the *extra* contribution of coercion is in reducing fertility in China. The authoritarian admirers of China give it too little credit for its cooperative and supportive programmes, while falling for premature admiration of its coercive practices.

This is not to deny that China has, in fact, achieved something in its birth control programme that India has not been able to do. In terms of national averages, it is easy to see that China with its low fertility rate of 2.0 has got population growth under control in a way that India, with its average fertility of 3.7, simply has not achieved. the point to note here is that we would expect the fertility rate to be much lower in China given its higher percentage of famale literacy (almost twice as high as India's), higher life expectancy (nearly 10 years more), larger female involvement in gainful employment (three-quarters more, in terms of share of the total labour force), and so on. The question to ask, therefore, is the difficult "counterfactual"

one of the likely results that would have been observed in India had it done more in these supportive areas, to expand the possibility of cooperative reduction of fertility rates. This is, of course, a highly speculative question, but perhaps not entirely, since there are areas within India that have done much more than the Indian average.

In particular, the state of Kerala does provide an interesting comparison with China, since it too enjoys high levels of basic education, health care, and so on. Kerala's birth rate of 18 per thousand is actually lower than China's 19 per thousand, and this has been achieved without any compulsion by the state. Kerala's fertility rate is 1.8 for 1991, compared with china's 2.0 for 1992. This is in line with what we could expect through progress in factors that help voluntary reduction in birth rates. Kerala has a higher adult female literacy rate (86 per cent) than china (68 per cent). In fact, the female literacy rate is higher in Kerala than in every single province in china. Also, in comparison with male and female life expectancies at birth in china of 68 and 71 years, the 1991 figures for Kerala's life expectancy are 69 and 74 years, respectively. Further, women have played an important role in Kerala's economic and political life, and historically, also in property relations and educational movements.

It is also worth noting that since Kerala's low fertility has been achieved voluntarily, there is no sign of the adverse effects that were noted in the case of China - for example, heightened female infant mortality and widespread abortion of female foetuses. Kerala's infant mortality rate (16 for girls, 17 for boys) is much lower than china's (33 for girls, 28 for boys), even though both regions had similar infant mortality rates around the time of the introduction of the one-child policy in China. Further, while in China the infant mortality rate is lower for males (28) than for females (33), in Kerala the opposite is the case, much in line with what is observed in the more advanced countries.

It is also necessary to examine the claim in support of compulsory birth control programmes that the speed with which fertility rates can be cut down through coercive means is very high; in contrast, the voluntary processes are expected to be inherently slower. The world, we are told, does not have the time to spare. But this piece of generalisation is not supported by Kerala's experience either. Its birth rate has fallen from 44 per thousand in the 1950s to 18 by 1991 - a decline no less fast than that in China. It could, of course, be argued that looking at this very long period does not do justice to the effectiveness of the "one-child family" and other coercive policies that were introduced in 1979, and that we ought really to compare what has happened between 1979 and now.

Kerala, in fact, had a *higher* fertility rate than china in 1979 (3.0 as opposed to China's 2.8), and by 1991 its fertility rate of 1.8 is as much *below* china's 2.0 as it had been above it in 1979. Despite the added "advantage" of the one-child policy and other coercive measures, the Chinese fertility rate seems to have fallen more slowly than in Kerala.

Another Indian state, Tamil Nadu, had an even faster fall, from 3.5 in 1979 to 2.2 in 1991. Tamil Nadu has had an active, but cooperative, family planning programme, and it could use for this purpose a comparative good position in terms of social achievements within India: the third highest literacy rate among the major Indian states, high female participation in gainful employment, and low infant mortality (also third among major states in both respects). Coercion of the type employed in China has not been used either in Tamil Nadu or in Kerala, and both have achieved much faster declines in fertility than china has achieved since it introduced the "one child policy" and the related measures.

Within India, contrasts between the records of Indian states offer some further insights on this subject. While Kerala and Tamil Nadu have radically reduced fertility rates, other states in the so-called "northern heartland" (such as Uttar Pradesh, Bihar, Madhya Pradesh, and Rajasthan) have much lower levels of education, especially female education, and of general health care. These states all have high fertility rates - between 4.4 and 5.1. This is in spite of a persistent tendency in those states to use heavy-handed methods of family planning, including some coercion (in contrast with the more "collaborative" approach used in

Kerala and Tamil Nadu). The regional contrasts within India strongly argue for collaboration (based *inter alia* on the active and educated participation of women), as opposed to coercion.

The Temptations of Coercion

While India has managed, with a few exceptions, to escape falling for the enticement of seeking to coerce its way to success in the field of family planning, it is clear that this prospect greatly attracts many activists in India. In the middle 1970s, the government of India, under Indira Gandhi's leadership, tried a good deal of compulsion in this field. The northern states, as was mentioned earlier, have various regulations and conventions that force family control measures, particularly in the irreversible form of sterilization, often of women.

Even when coercion is not part of official policy, the government's firm insistence on "meeting the family-planning targets" often leads administrators and health-care personnel at different levels to resort to all kinds of pressure tactics that come close to compulsion. Examples of such tactics include verbal threats, making sterilization a condition of eligibility for anti-poverty programmes, depriving mothers of more than two children of maternity benefits, reserving certain kinds of health care services to persons who have been sterilized, and forbidding persons who have more than two children from contesting panchayat elections.

It is quite extraordinary that the last measure - recently introduced in Rajasthan and Haryana - has been widely praised, even though it involves a strong violation not only of personal liberty but also of basic democratic rights. Even the government's draft National Population Policy, despite placing emphasis on the need to reject coercive methods, gives support to this measure as one means of meeting the overriding goal of bringing the total fertility rate down to 2.1 by the year 2010. There is a strong possibility of the proposed measure being adopted at the all-India level, and extended to diverse forms of political participation going beyond the contesting of panchayat elections. Indeed, there is proposed legislation now in the Indian parliament that would bar anyone from holding national or state office if he or she has more than two children. The patent unfairness of this proposed regulation has been pointed out by many critics - including its effect of debarring large numbers of leaders of less privileged sections of the Indian community and operating particularly against rural leaders - but the legislation has not yet been withdrawn. The lesson that fertility reduction calls for cooperation and collaboration, rather than compulsion and coercion, has not been at all learned.

The point is sometimes made that in a poor country, it is a mistake to worry too much about the unacceptability of coercion - a luxury that only the rich countries can afford. It is not obvious what this argument is based on. The people who suffer most from these coercive measures are often among the poorest and least privileged in the society. The regulations and the way they are operated are also particularly punitive with respect to women's exercise of reproductive freedom. For example, the assembling of poorer women in sterilization camps, through various kinds of pressures, is a practice of remarkable barbarity and injustice practiced in many rural societies in north India, as the deadline for meeting "sterilization targets" approaches.

It is not clear how the acceptability of coercion to a poor population can be tested except through democratic confrontation. While that testing has not occurred in China, it was indeed attempted in India during "the emergency period" in the seventies when compulsory birth control was tried by Mrs. Gandhi's government, along with suspending various legal rights and civil liberties. The policy of coercion in general - including that in birth control - was overwhelmingly defeated in the general elections that followed. The impoverished electorate of India showed no less interest in voting against authoritarian extremism than it takes in protesting against economic and social inequality. Furthermore, voluntary birth-control programmes in India received, as family-planning experts have noted, a severe set-back from that brief programme of compulsory sterilization, since people had become deeply suspicious of the entire family-planning movement. Aside from having little immediate impact on fertility rates, the coercive

measures of the emergency period, were, in fact, followed by a long period of *stagnation* in the birth rate, which only ended in 1985.

Since the advocacy of coercion, in different forms, has been growing in India, it is important to emphasize that it achieves little and destroys a lot. It does not seem to work faster than what can happen through the cooperative route, and its other consequences, including side effects, can be quite horrendous. The alternative is to facilitate ways of relying on those whose well-being and agency are most directly involved, particularly young women. This has worked elsewhere, and there is no reason why it will not work in India as well. To some extent, it is already happening in some parts of India, and these parts are being a lot more successful than the states which are falling for coercive measures. Cooperation can contribute something that coercion cannot provide.

npbk/n/pt

PERSPECTIVES FROM THE WOMEN'S MOVEMENT ON A NATIONAL POPULATION POLICY

1. This statement is in response to the request of the Expert Committee set up by the Government of India to formulate a National Population Policy. It is not as if the Government has not had a population policy so far. It has been one of fertility control, pursued relentlessly, and at times coercively, through three decades, bringing disrepute to the Family Planning Programme, compromising women's health, and accelerating the already declining sex-ratio. Now we find that more of the same recipe is being institutionalised through disincentives and constitutionally questionable legislation. Monetary incentives have already proved a corruptive influence and added economic pressure to women's powerlessness.

2. The women's movement has all along been in favour of family planning, and has advocated women's control over their fertility. Pursuing demographic goals however, is not synonymous with family planning. We do not accept that population growth is mainly responsible for all India's ills, i.e. poverty, environmental degradation etc. Government however, refuses to recognise that the population rise is a direct consequence of increasing iniquities and dispossession among the majority and seeks to address the symptom of population rise without addressing the economic and social structures and policies which are the root cause. We maintain that demographic goals of reduced fertility cannot be imposed by a fiat of the Government, as at present. Hence our demand for a national debate before any policy is finalised. While challenging the validity and limitations of Government's current approach, we offer an analysis and constructive suggestions. This statement should be read in conjunction with the memorandum dated 21st October'93, submitted by some of us to the Expert Committee on the 23rd October.

3 "Sustainable Development": In the context of the existing gap between India's stated Constitutional goals on the one hand and the present increasingly iniquitous social reality on the other, the just demands for a better life and future of the deprived section of our population must be included. Since the present population policies are mainly directed at this section of the people, the inclusion of their rights to survival with dignity should not remain mere rhetoric or constitutional dreams to be misused as electoral promises. It requires definite policy measures and intervention in the areas of health, employment, education, socio-political environment, and the freedom to participate in decisions that affect their lives.

4. In international fora official representatives of India have rightly challenged the assumption of the developed world's definition of sustainability as being one that must guarantee the continuation of the North's profligate over-consumption of scarce natural global resources. However, the other side of this assumption - that the depletion of global resources are attributable to the over-population of third world countries which require emergency control measures - seems to have become the unstated bedrock of present government approaches.

5. On the first point, we feel that it would enhance the credibility of the government's position - nationally and internationally - if it addressed itself to the reality of the over-consumption of resources by India's miniscule elite, among whom we are forced to include the Government itself. In the background of the ongoing process of re-structuring India's economy we are sceptical of how such a recommendation would fit in with the present domination of "market" considerations. However no rational approach to population issues can ignore the total imbalance of control of productive resources and subsequent consumption patterns

in India, increasing inequalities of income and consumerist values which are again fall outs of the restructuring process. The experience of all other countries undergoing structural adjustment proves that the size of the population under the poverty line has drastically increased.

6. Although it is not the purpose of this statement to go into the details of the extremely adverse impact of the present economic policies on the bulk of our population, the references have been made necessary because of the approach advocated in the draft circulated to the Expert Group which seeks to disenfranchise further precisely those sections already bearing the brunt of the burden of the economic crisis.

7. One important aspect of the present policies is the reduction in real allocations to essential services which include the public distribution system and access to food, health, education etc. Privatisation of health services, charging of fees for tests in Government hospitals are going to further worsen the already fragile health profile of India's poor. As women's organisations, our experiences indicate that the fast deteriorating position of women's health, indicated by malnutrition, anaemia, increased vulnerability to illness etc., is directly related to increased levels of poverty, lack of access to primary health services and not primarily to maternity related problems as perceived by official analysts. In this context, we consider the equation of health with family planning to be nothing short of criminal. The very fact that successive five year plans have increased allocation and attention to family planning at the cost of basic health services to the extent of the former exceeding the latter in the Seventh Plan should make our point clear.

8. The other aspect is the still shockingly high figures of infant mortality. We were horrified to learn that some of the international agencies who are closely involved in "advising" the Government of India on the direction of economic policies, circulated a document advocating cuts in allocation for child survival strategies as a way of over-coming the "population trap". We have little indication of the Government's response in this matter. The present trend of increasing child labour, in particular the labour of girl children points to the reality of children being seen as assets providing livelihood to a large number of families. What we wish to stress is the crucial role that non-demographic factors play in determining the size of the family for a vast number of India's poor.

9. Therefore to see population control as a precondition for the reduction of poverty goes counter to the history of demographic transition in other parts of the world and against the living reality of India's poor majority. Further, to see women as primarily responsible for the increase in population and to devise methods to control their fertility at all costs, is a position that the women's movement in India can never accept.

10. We wish to reiterate that poor women in India want and need easy access to safe contraception. However this need cannot be exploited to reach demographic goals in the "shaping of which they have had no hand" - at the cost of their health, their earning capacities and their futures. As elaborated in our memorandum submitted to the Health Minister, a copy of which we enclose, the key question is not the need for easy accessability to contraceptives per se, but to SAFE contraceptives. A 'choice' which includes contraceptives unsuitable for use in India is no choice at all. We have detailed our position on each contraceptive which the Government plans to include at some stage in the

Family Planning Programme in the said memorandum, which we request you to consider as part of this statement. Further, as an example of Government policy we refer you to the agreement signed with USAID on 30th Sept. 1992. It specfically relates to fertility control of women in Uttar Pradesh (one of the worst states as indicators of women's status or infant mortality demonstrate), and the measures suggested include hormonal implants to be carried out with a grant of US Dollars 385 millions over a ten year period. We consider this agreement, signed in secrecy and still not publicly available to be both anti-women and anti-national and strongly recommend its cancellation.

11. It is astounding that the Government of India in setting the demographic goals, seems to have ignored the vast body of literature which identify the status of women as one of the crucial factors influencing demographic trends. During the last two decades the shocking increase in female infanticide, sex determination tests followed by abortion of female foetuses, proves that setting of such demographic goals without tackling the roots of the problems of women's inequality will have the most disastrous impact on the already unbalanced sex ratio prevailing in this country, and further depress their status, apart from providing rationalisation to the unethical practices and misuse of science by a section of the medical profession.

12. We strongly recommend the end of the target oriented, disincentive approach of the Government of India and reversal of all related policy decisions e.g. the reduction of maternity benefits to only two children. We also recommend withdrawal of the present Bill before Parliament disqualifying persons with more than two children from standing for election. We believe that such a measure will automatically disqualify precisely those economically deprived sections of our population, including women who most need political

empowerment. This measure could also become an instrument of discrimination against minorities who already feel threatened because of recent political developments. We also see this measure as militating against the concept of grassroot democracy as enunciated for instance in the 73rd Constitutional Amendment on Panchyati Raj which for the first time has sought to expand women's participation in decision making at these levels of government, on the demand of the women's movement.

13. There has been a demand from some sections that the increased number of women members in the local self government bodies under the new amendments should be made responsible for programmes of women and child development. We oppose this demand. The diagram attached as appendix to this document represents substantially the overlapping and close interconnection between the needs of women and children and various other areas of public policy and governnance. We recommend that women should be inducted into all the important standing committees with a view to ensuring the much needed coordination through their personal knowledge and stakes in the success of policies for education, health care, child development, environmental improvement, livelihood improvement etc. They would also need the support of women's organisations (local, block level, district, state etc.), educational/ research/ scientific institutions to respond to their articulated information/training/technological/other needs.

14. We believe that not enough attention has been paid to the adolescents in Indian society. Recent attempts to identify discrimination against girls have only noted their deprivations but not examined the psychological consequences of their being forced to assume adult roles from a very young age, particularly among the poor. Many in Western industrialised countries (whose model we adopted for eco-

nomic growth and the education of our youth) are admitting (a) collapsing social cohesion, (b) declining desire to participate constructively in economic/social/political life and (c) proneness to violence as serious problems among their youth. Some sensitive leaders relate the rising tide of xenophobia also to the same sources. Our youth have not yet come to share all these tendencies but the situation, especially in metropolitan cities is changing rapidly and increasing violence is manifesting itself in many forms. A Population Policy for the 21st Century cannot and must not continue the mistakes of the 20th Century, and ignore the critical importance of the generations that must be the leaders for the next century.

15. Conventional demography generally includes fertility, mortality, labour force participation and structural distribution of the population between age-groups and geographic areas (e.g. rural, urban). Even gender is not always included as a significant variable for all purposes. We feel morbidity and malnutrition need to be included in this basic list, particularly in view of the questions being raised in the context of Kerala and Tamil Nadu where the demographic transition has been rapid. In the Indian, the regional and global context of today, migration - seasonal, long term, internal and international - have emerged as critical, even explosive issues. There are distinct class, gender and age differentials, with vital consequences on the structure of the family, the distribution of livelihood, work burden and responsibilities for the care of children and old dependents, which have yet to find a place either in demographic research or in population policies.

16. We wish to reiterate the importance we give to grass root level institutions like gram sabhas and district councils for participatory decisions and interventions in the non-demographic factors that ultimately affect family size.

We therefore recommend certain incentives to local bodies for positive achievement like the following:

a. Improving the rate of child survival; provision of centres for child care and development;

b. Improving maternal and other health services (out reach and quality) for all - ensuring fully staffed adequate primary health centres;

c. Achieving full enrolment of all children in the appropriate age group in primary and middle school;

d. Organising informed participation and achieving support from the people in implementing all connected policies;

e. Eradication of child marriage and illiteracy;

f. Reversing declining trends in the sex-ratio especially at birth and in early childhood.

We feel provision of such incentives to local bodies would strengthen the spirit of the Constitutional amendment and provide a sense of direction and possibly changing cultural attitudes at the grassroots level, thus enabling the local bodies to play an effective role in achieving the desired broad policy objectives that we suggest. However, this will only be possible provided the Government of India makes enough resources available to state governments to strengthen the financial capacity of the local bodies. This would mean altering the present trend of curtailment of funds. Secondly we recommend that the transfer of resources for various purposes must not be linked to meeting demographic targets.

17. <u>Research and Development in Health and Reproductive Technology</u> : We have already requested the Expert Group to look into this aspect and make information on this area available to the public for scrutiny and debate. We are aware that even Members of Parliament do not have this information. Marketisation of R&D in these vulnerable areas

should be resisted at all costs. India's experience in sex-selection tests alone should provide enough evidence for this position.

18. <u>Conclusion</u> : At the higher levels of government, the multidimensional tasks/needs of a population policy call for some major restructuring of the machinery - (a) to achieve a holistic coordinated functioning (as conceptualised in the theory of 'collective responsibility') - and improve its capacity to <u>respond</u> to the demands coming from the lower levels; (b) to evolve a smooth process of transfer of authority, power, and resources (including knowledge) - to make decentralisation a reality; and (c) to reorient its functioning and thinking in order to <u>exchange its present self-image as leaders or 'the nation', to one of catalysts to assist the people and their democratic institutions to function legitimately.</u> Without the major restructuring and devolution of power/resources/ authority, we do not think cosmetic changes like creation of a Population Commission, or Cells within various ministries, or a National Institute for Research/Training/Documentation etc. can create any serious impact. It is time for the Government itself to practice some fertility control in reproducing bureaucratic infrastructures.

Name / Organization

1. [illegible] - National Federation of Indian Women
2. Kalpana Mehta SAHELI WOMEN'S RESOURCE CENTRE
3. Asha Ramesh - MULTIPLE ACTION RESEARCH GROUP (MARG)
4. Brinda Karat : All India Democratic Women's Association (AIDWA)
5. Sadhana Ganguli : Young Womens Christian Association of India.
6. Sucharita Puregami Mahila Sangathan
7. Suman Krishan Kant MAHILA DAKSHTA SAMITI
8. Vina Mazumdar Centre for Women's Development Studies
9. Kumud Sharma Centre for Women's Development Studies

10. Sarojini : JAGORI

11. Jyotsna Chatterji: Joint Women's Programme

12. INSTITUTE OF SOCIAL STUDIES TRUST