Population and Society
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Lecture No. # 32

National Population Policy

We have spent three days on defining population policy. And we have seen, what population policy is, what does it cover, what kind of statements can be called population policies statement, how can we judge effectiveness or success of population policy, what are the difficulties in monitoring and evaluation. And we have also seen, a distinction between family planning and beyond family planning factors, when it comes to policies regarding fertility control.

Now after this, we would spend sometime on national population policy of India (Refer Slide Time: 00:58). So, today I will just generally discuss how the national population policy in India has evolved. And in the next lecture, I will particularly focus on the statement issued by Doctor Karan Singh, which is also sometimes seen as first population policy statement. Then, I will go to Janata policy and then to latest developments and particularly the national population policy 2000.

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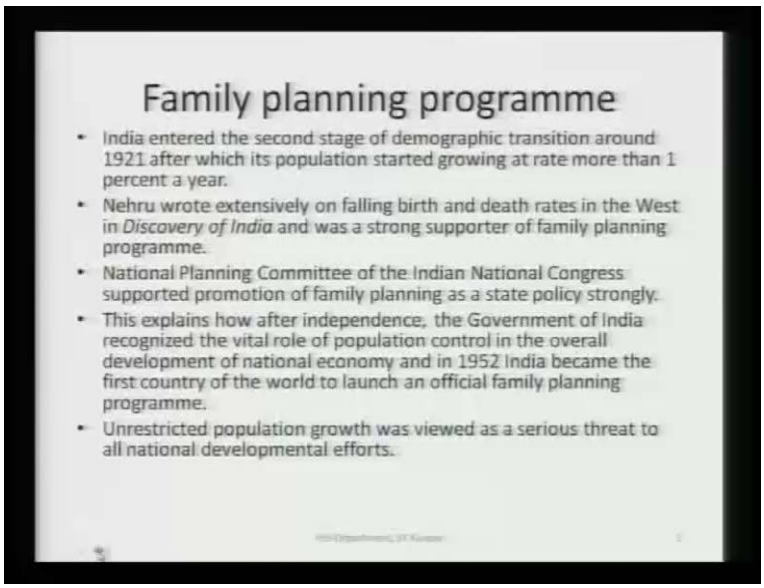

So to begin with I must say that, population policy right from the beginning, population policy in India has been more focused on population control programs or fertility control programs and that means family planning. India's population policy does not include anything about migration, there is at least in the so called first population policy statement by Doctor Karan Singh or Janata policy; there is nothing about migration, there is nothing about social mobility.

Population policy in India focuses specifically on how to reduce birth rate. Another component of population process (( )) or marriage yes because, marriage is closely associated with fertility. So, in all policy documents you have some mention measures to raise age of marriage in the country.

As you have seen when we discussed population of India and history of population growth in India that, India entered the second stage of demographic transition around 1921 after which its population started growing at rate more than 1 percent per year. Till 1921, our fertility was high, average number of children was around 7, mortality was also high; so, life expectancy was 20 to 22 years, and the population growth was mere 0 or population will sometime rise sometime fall. The long run tendency of population was to remain almost stationary.

After 1921, however, due to industrialization, economic development, more awareness and development initiatives undertaken by the colonial government, our mortality started improving to some extent; and as a result of that, our rate of growth of population increased. In much of 20 th century right from the beginning much before independence, there was concern about falling birth and death rates; and Pandit Jawaharlal Nehru in his Discovery of India wrote extensively on falling birth and death rates in the West.

Actually our self when I read Discovery of India after becoming a demographer I was surprised to find, how Nehru is dealing with the subject of demographic transition in the West in academic (( )) no less than the discussion experts or consultants or pure demographers can help. Nehru was the strong supporter of family planning program.

Discussing demographic transition, he knew that eventually when mortality has declined, fertility would also declined, but left to itself it may take a long period of time; and for the purpose of planning in the country, we need it a rapid control of fertility. Therefore, he was Nehru was in support of family planning program. And the National Planning

Committee of Indian National Congress, from the beginning supported promotion of family planning as a state policy strongly in this respect. As you have seen, Nehru also differed from Gandhi, Gandhi supported population control, but he was not in favor of family planning program. And Nehru believed that, just Brahmacharya or Celibacy or natural methods of family planning program would not help, we must have a modern and effective family planning program.

This explains how after independence, the Government of India recognized the vital role of population control in the overall development of the national economy and in 1952 India became the first country of the world to launch an effect effect to launch an official family planning program; there was no country in the world before that, with official family planning program. And unrestricted population growth was viewed as a serious threat to all national developmental efforts.

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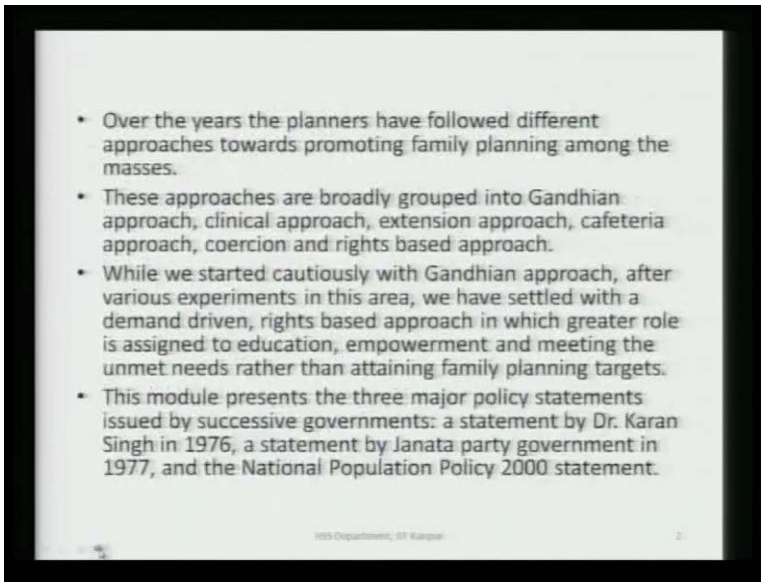

Now, over the years the planners have followed different approaches towards promoting family planning among the masses. And today, I just wished to sensitize you to these different approaches. These different approaches can broadly be grouped into Gandhian approach, clinical approach, extension education approach or simply an extension approach, cafeteria approach, coercion and rights based approach.

While we started cautiously with Gandhian approach, after various experiments in this area, we have settled with the demand driven, rights based approach in which greater

role is assigned to education, empowerment of women and meeting the unmet needs rather than attaining family planning targets.

So in between, you had different experiment. The first experiment was Gandhian it was thought that in 1952, country was not ready to talk about family planning program or a fertility control measures or sexuality. And therefore, a (( )) indirect approach would be better, which is also consistent with the value system of Indian society. So, Brahmacharya is being consistent with the value system of Indian society; and Gandhiji favoring Brahmacharya we had Gandhian approach.

Also because at that time, the health minister Rajkumari Amrit Kaur was a devoted disciple of Gandhiji; and they they thought that, it will be a good beginning if a if at least with sensitize people to need for population control and propagate only Brahmacharya in that.

So, this module presents three major policy statements issued by successive governments: a statement by Doctor Karan Singh in 1976, a statement by Janata party government in 1977, 1 year later and the National Population Policy 2000 statement. Actually really speaking, this National Population Policy 2000 must be seen as the first declaration of National Population Policy in India. Before this, like Doctor Karan Singh Doctor Karan Singh used to say that, he had himself drafted the whole document.

And therefore, it may may be called what was in the (( )) of the then health minister, ministry of health and family welfare, and cannot really be called the population policy of India as such because, it was not signed by president of India.

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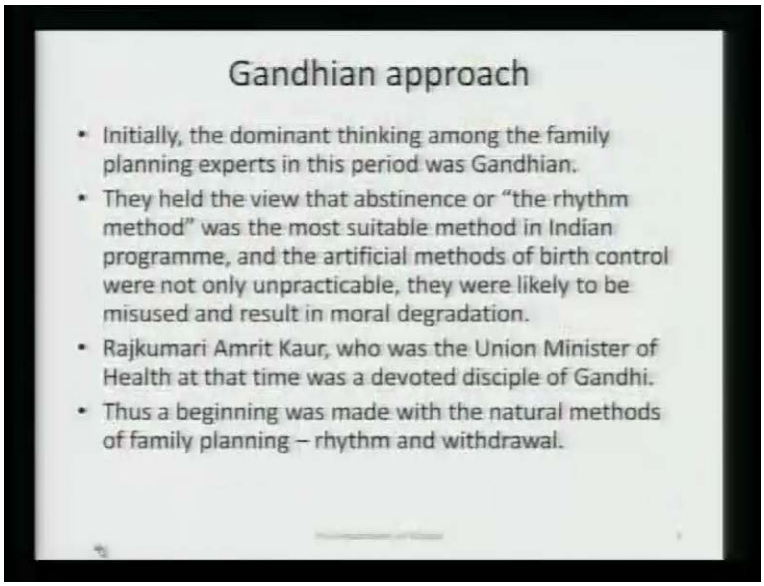

To begin with in Gandhian approach, we started with Gandhian approach, because the dominant thinking among the family planning experts in the period was Gandhian. What is Gandhian? They held the view that abstinence or the rhythm method was the most suitable method in Indian program, and the artificial methods of birth control were not only unpracticable, they were likely to be misused and result in moral degradation.

At that time, this was the (( )) all natural methods like raising age of marriage, practicing Celibacy or Brahmacharya. Or in the (( )) Gandhiji would say, in the worst situation then, if you cannot control yourself at least follow the rhythm method which means, rhythm method is based on the assumption or based on the fact.

There are certain days in the menstrual cycle of a women during which only she can become pregnant; every month nearly 14 days before the (( )) starts, a women releases egg. And at that point of time, she has intercourse and the egg can combine with men's sperm, then fertilization is possible otherwise not. So that means, there are and since you know sperm and egg, they can survive for certain hours and for a few days. So, there are in between during the menstrual cycle in between, there are 4 or 5 days when the chance of pregnancy is highest; and in the beginning of the cycle and towards the end of the cycle, there is no chance of conception, this was rhythm method.

Gandhiji would say that use Brahmacharya and one should have sexual relationship only when one wants to produce a baby. And going for sex for for producing a baby is not the

violation of Brahmacharya, then one can have sex once twice may be three times, but not more. In the worst case, if you cannot control then, Gandhiji would permit you to go for rhythm method. And interestingly at some places Gandhiji also accepted the sterilization, but that was only for some criminal type of persons; he believed that, if somebody is suffering from some deceases which can be inherited by children (( )) (( )) (( )), he can be permitted to go for sterilization.

So, for very special cases he would say that, he would permit sterilization and that too only of males, Gandhiji would not permit sterilization of females, he permitted sterilization of males only. So, Gandhian method is essentially the natural method and the rhythm method. Thus the beginning was made with the natural methods, rhythm and withdrawal.

The subsequent experience showed that, this Gandhian approach was not producing results and therefore, a gradually and as the family planning program was became more confident; as ministry became more confident, and its consultants and experts developed more confidence in running a family planning program, clinical approach was developed.

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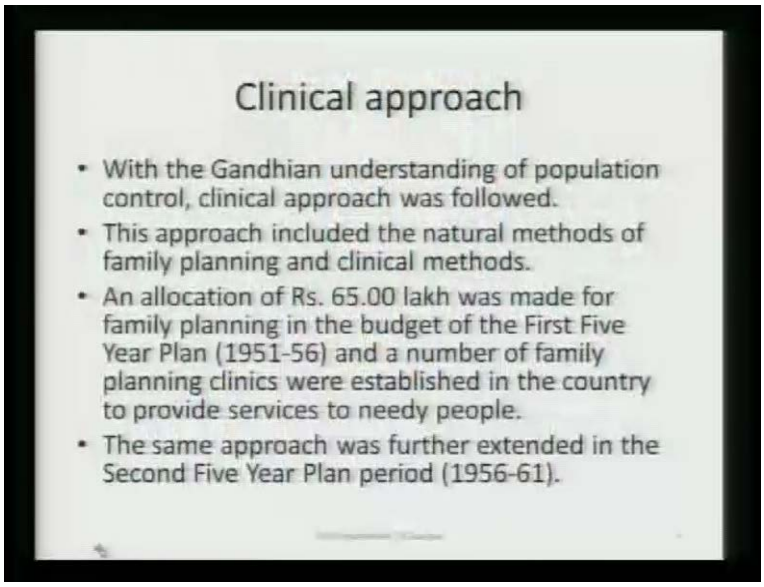

This approach as the name itself suggest clinical approach, included the natural methods of family planning methods and also clinical method. In the first five year plan, a small allocation of 65 lakh rupees was made for family planning in the budget and a number of

family planning clinics were opened in the country in different hospitals, particularly in women's hospitals to provide services to needy people.

The clinical methods can methods for which the clients were expected to approach doctors or family planning clinics in hospitals, they all can be included in clinical approach; the pills, IUCD, today sterilization, all these methods can be included in clinical approach. The idea was that, by then due to government propaganda, Gandhiji's support, Nehruji's support and the fact that at several places in the country some family planning clinics were opened due to private initiative in Maharashtra, in Gujarat at a few places.

The time had come to establish clinics, where needy people that already a number of people require controlling fertility and then, they are in need of family planning methods. So, these people can come to clinics, discuss with the doctors available there discuss what are all the methods and they can pick up the method of their choice. The same approach was further extended in the second five year plan and more allocation was made.

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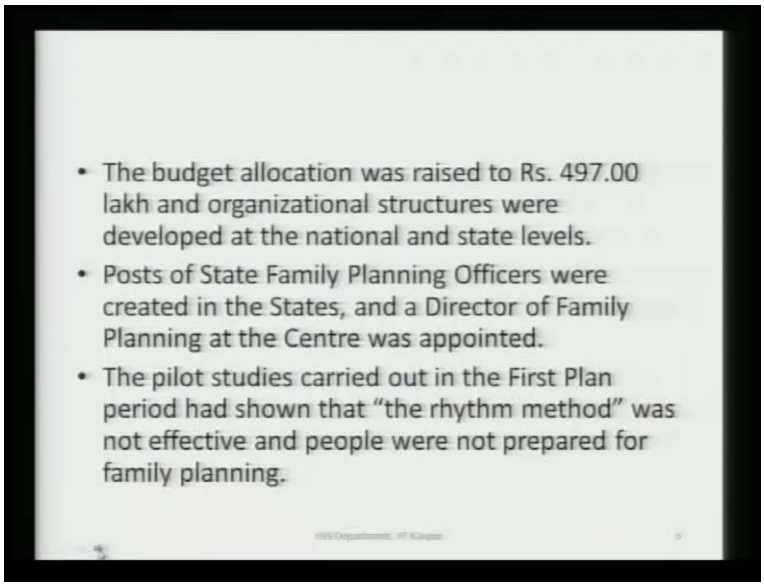

The budget allocation was raised from 65 lakh to rupees 497 lakh and organizational structures were developed at the national and state levels. It was realized that, for population control, for limiting family size, you require a separate approach, separate

strategies other than strategies under health program; and you require separate positions organizations roles and responsibilities for running family planning program.

So, Posts of State Family Planning Officers were created in the states, and director of family planning at the centre was appointed, so separate administration. This means giving more autonomy, also creating some positions some giving fixing responsibilities by creating position of State Family Planning Officers at the state level. Each state, would have a Family Planning Officer, who will (( )) the family planning program; through whom funds will flow through, whom the strategies will made, through whom monitoring and evaluation will be done, and who will be basically accountable for the whole program.

Then pilot studies were carried out in the first plan and they had shown that, the rhythm method was not effective and people were not prepared for family planning. Two things, one that the value system of that time or the level of awareness among people was such that people were not ready for family planning program. The idea of limiting family size was not popular.

And people also did not know about the rhythm method why of that time. Even now, I think some 2 months before, I was doing some small field work in Shivpuri district of Madhya Pradesh and during that field work, I learned that during last 30 when I was a student and I asked these questions in field work in for my PHD; when is the chance of conception highest.

In villages of Etawa district, people said that immediately after the menstruation period is over, chance of conception is highest. The same thing I found in Shivpuri villages of Shivpuri district of Madhya Pradesh 2 months back. The knowledge of reproductive cycle is far from the exact, actually what people say or what people believing is on the basis what they see in the natural world, they do not have the experts knowledge of reproductive cycle.

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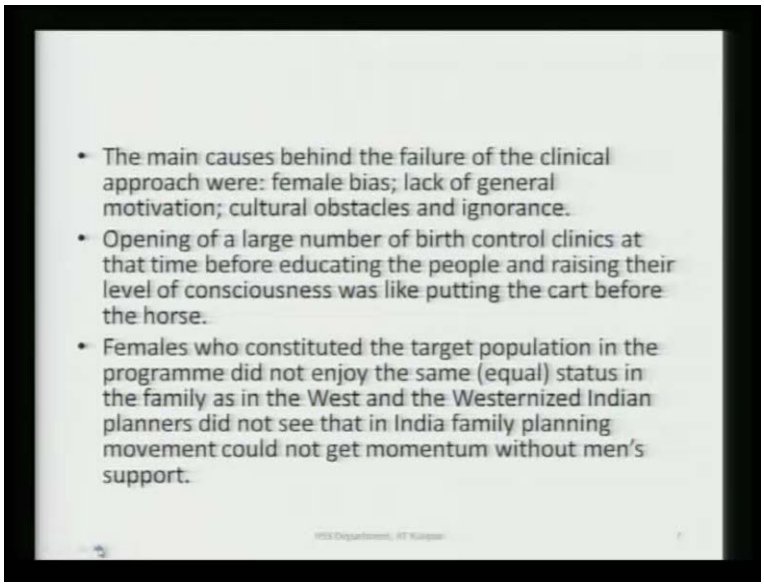

So, first there was not much receptivity towards family planning program and second the correct or scientific understanding of rhythm method was not there. So, rhythm method or Gandhian approach could not be the suitable approach for running family planning program in India.

When in 1960 one census, it was found that in place of reducing our growth rate it increase, before 1951 population was growing at 1 percent, now it was growing at more than 2 percent. So, that means your Gandhian approach and your clinical approaches were not yielding. So, a question arises, why? What are the main causes behind the failure of the clinical approach? A study showed that, there was a female bias in the sense that most of the doctors, who were made responsible for running family planning program for women.

And in Indian society such major decisions like limiting family size or using family planning methods are not women's decisions, ours is a patriarchal society a joint family system. A patriarchal society in which major decisions regarding buying or selling of property, marriages, family size etcetera etcetera taken by men. And since, clinical approach neglected men; this was a great limitation in a limiting family size at the national level.

Then lacks of general motivation people were not motivated. You are expecting that, people are actually behind the clinical approach we are assuming that people are already

motivated and those who are motivated, those who are needy will come to clinics and avail services referral consultancy services. But, this was not case this was not the case people were not motivated to limit family size, the value system the level of understanding, the socio cultural political climate were not favorable to family planning program.

There were also cultural obstacles religious, religious obstacles, obstacles created by joint family system by kingship and there was a general ignorance. So, opening of a large number of birth control clinics at that time before educating the people and raising their level of consciousness was like putting the cart before the horse. What was needed was, first to motivate to make people aware of the need for family planning. What are the advantages of limiting family size for the nation, for the community and for the individual households, and for individual themselves; and then only we could expect them to come to clinics, where we open clinics without sufficiently motivating the people.

Females who constituted the target population in the program did not enjoy the same status in the family as in the West and the Westernized Indian planners did not see that India that in India family planning movement could not get momentum without men's support. So, these were some limitations of clinical method.

Gandhian method you can ignore. You can say that, it was only a stepping stone towards launching a family planning program at a time when climate was not ready to develop a family planning program in the country. But, clinical approach is the first serious and scientific strategy towards population control and it failed, because the survey showed the people were not motivated. And therefore, something has to be done to motivate the people to limit family size and this paved the way for what we call extension education approach.

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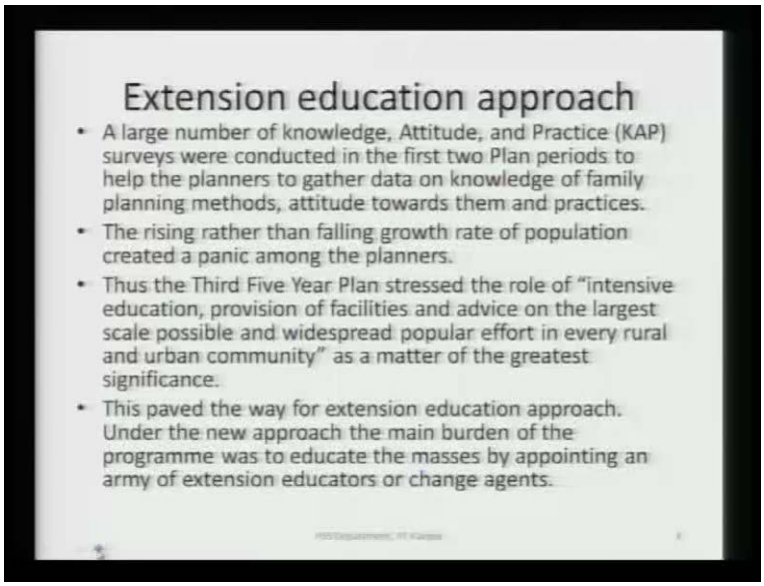

Now, after clinical approach and spending lot of money to open clinics in hospitals, and health facilities other than hospital, a large number of Knowledge, Attitude and Practice in short KAP. KAP surveys were conducted in the first two plan periods to help the planners in gathering data on knowledge of family planning methods, attitude towards them and practices. What do people know, are people familiar actually much before we try to know to what extend people are familiar with different methods; we must know whether they think that it is in their hands to decide how many children they would have.

In a traditional society people think that it is not in their hands it is god, who decides how many children a family will have. Each family size subject to rational control and how that control can we exercise then the issue of knowledge of family planning methods come; and then how many people are practicing family planning.

On paper, it will look a simple exercise conducting survey of knowledge attitude and practice, but actually it was a very difficult. Technically, very complicated and complex exercise; how to measure knowledge, knowledge of family planning methods in general, and knowledge of specific methods how to measure attitudes; sometimes simple single item base questions were included in surveys to major attitudes; sometime it is a very sophisticated psychometric scales were developed to measure attitudes of people towards small or big family size and towards family planning and practice.

In practice again, there are so many issues like the issue of ever users, never users, present users, present non users, but anyway through these surveys, demographers have had a considerable understanding of people's motivation knowledge and decision making process. The rising rather than falling growth rate of population created a panic among the planners.

On the one hand, we tried to collect lot of data on knowledge attitude and practice and started thinking more seriously what can be done to control family size in the country. And on the other hand, (( )) result 1961 then, 1970, 1971 (( )) results again showed that the population of India was growing at more than 2 percent rate per year, nobody could imagine. When we started our planning process it was thought that in a short period of time, our growth rate which was around 1 will come to 0; but in place of coming to 0, it increased to 2 percent and the 2 percent or more than 2 percent was sustained, that cause anxiety among the planners.

Thus the third five year plan stressed the role of intensive education, provision of facilities and advice on the largest scale possible and widespread popular effort in every rural and urban community as a matter of greatest significance. This paved the way for what we call extension education. Under the new approval the main burden of the program was to educate the masses by appointing an army of extension educators or change agents.

So, Gandhian approach then, clinical approach and then on the basis of KAP studies and the realization that people are not interested in family planning. So, how to make them understand, how to provide them knowledge, how to motivate them, how to create more favorable attitude towards family planning for this purpose, then extension education approach was followed. This was a new a third milestone new approach under this approach, although mass media was also to be utilized for promotion of idea in favor of birth control.

But, there was greater reliance on (( )) agents that in urban and rural areas, for urban and rural communities separately at the grass roots level; certain (( )) agents you call the family planning workers would be appointed, who will go door to door talk to people couples into productive ages and discuss with them what are the advantages and disadvantages of large and small family. And why it is important for the nation to have

population control, why is it important for the village or community or individuals, who have smaller number of children. And that it is possible to have smaller number of children, what are the methods and where are they available. The idea that by involving these educators, we create a climate in which more and more people go to clinics and see, advice of experts.

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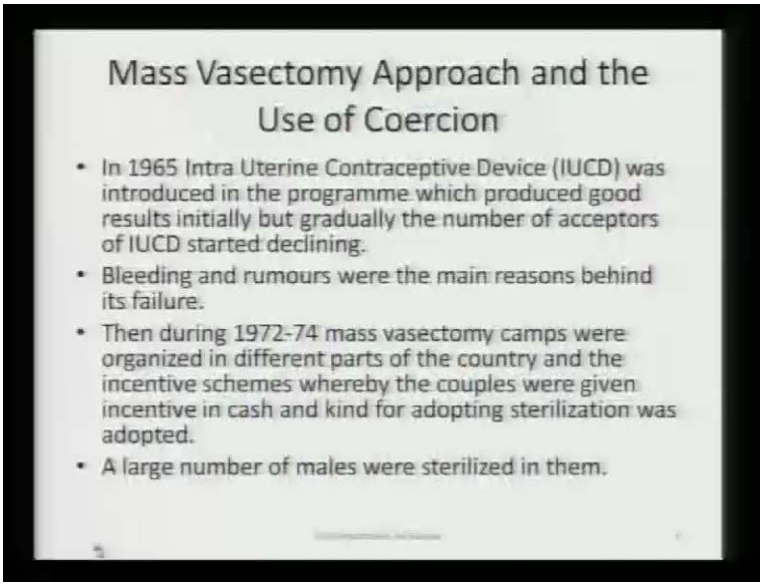

Again very soon, the planners became disillusion with extension education approach also a (( )) group that something more has to be done. In between in 1965 Intra Uterine Contraceptive Device or IUCD sometime called Lou or copper t, this was introduced in the program.

IUCD was known for its effectiveness and acceptance in several countries of the world, including Japan and it was thought that introduction of IUCD in family planning program in India would solve India's problem. Initially for a few years in 65, 66, 67 the number of acceptors of IUCD grew that is also true, but gradually the number of acceptors of IUCD started declining.

There were all kinds of rumors, rumors particularly about bleeding, rumors that in some cases the thread or IUCD or the copper t which was placed in women's body. They were rumor that went off and you know sometime sophisticated surgical operation involving huge cost only that could be removed, so it was unsafe.

Bleeding is very common and this is a fact also that IUCD can lead to bleeding. But, we know that, it is bleeding does not last long, it is only for a few days or a few weeks; and if a women can tolerate that bleeding for a few days or a few weeks then that bleeding subsides. But, people were frightened already there was very poor motivation for family planning and when through incentives or advice or counseling or advocacy people were taken to clinics and IUCD were inserted, if it let to bleeding obviously, all kinds of rumors and anxieties people got frightened; so, the number of acceptors of IUCD starting declining.

Then during 1972, 74 mass vasectomy camps were organized which was the fourth milestone you can say in different parts of the country and the incentive schemes were developed whereby the couples were given incentive in cash and kind for adopting sterilization as a (( )). And a large number of males were sterilized.

In Ernakulum district of Kerala, there was one very dynamic district collector Krishna Kumar, he started this mass vasectomy camps in Kerala and lots of incentives were provided. One of his ideas was that initially people were shy to go for family planning. So, if people are made to go for family planning in groups in processions in collective in collective ways, then that shyness goes and there is greater acceptance; incentives in a poor society like ours incentives also work sometime.

If you tell that for those you will get sterilize in the mass vasectomy camp. So, first there in mass vasectomy camps, there are two mass and second incentives. So, by making family planning acceptance mass, the traditional or individual early hesitation to go for family planning was removed; and through incentive then people was also attracted to this. So, they were given radios, they were given transistors, they were given food grains, they were given cash incentives, different kinds of incentives were given; and people will come in procession as though some marriage procession is coming or some religious procession is coming.

So, people will come in procession get sterilize, get the incentive amount and go back. And it was thought that, this will make vasectomy more popular vasectomy (( )) (( )) operation. And this happened a large number of males were sterilized in them.

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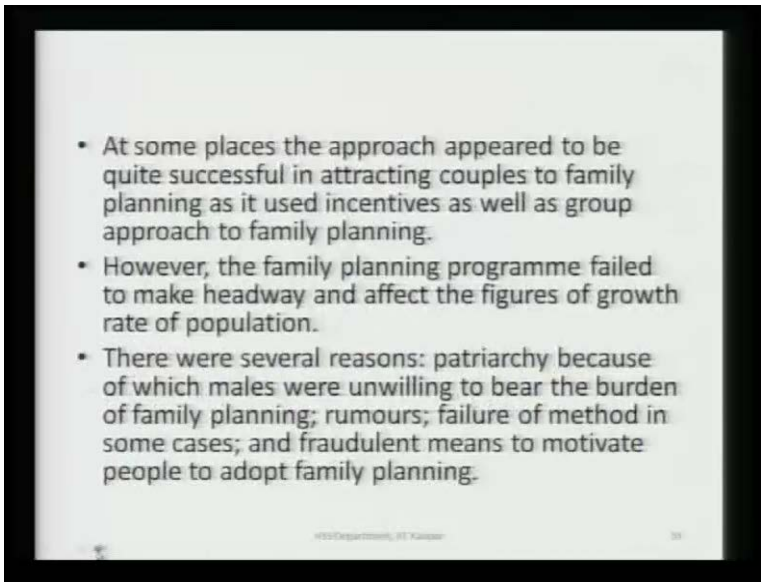

At some places the approach appeared to be quite successful in attracting couples to family planning as it used incentives as well as group approach to family planning. Incentives plus (( )) sometime people ask a question whether Muslims are also accepting family planning program. I could find report of study of mass vasectomy camps in which the issue of religious composition was studied; and to my surprise in the early days of mass vasectomy camps, Muslims came for family planning in a large number I do not know, why (( )) tendency got increased later or what happened. But, this is not the case that, there was any religious bias in family planning at least not in the early days of mass vasectomy camp not in Kerala.

Kerala anyway is a different population with disproportionately higher proportional of Muslims and Christians and it is more secular kind of society than many other states in the country. So, everybody came Hindus came, Muslims came, rural people, urban, educated, uneducated, from diverse occupations, all kinds of people came for mass vasectomy camps; it became very successful thing and therefore, it was repeated in several other states of the country.

It is still the family planning program failed to make headway and affect the figures of growth of population. So, 1981 census figures again 1971, 1981 census figures again showed a growth rate of more than 2 percent. There was several reasons patriarchy, because of which males were unwilling to bear the burden of family planning. If you

look at statistics of family planning, today you find that majority of acceptors of family planning are acceptors of female sterilization; although female sterilization is much more complicated an operation as compared to male sterilization. But in majority of cases, it is women who are sent for sterilization, not the men.

Then there were rumors in surveys we have encounter a various types of rumors. That after sterilization, people become weak or they cannot ride a bicycle or they cannot take a (( )) work or they become sexually impotent, all kinds of rumors. It is possible that, since the average age of sterilization was quite high and people were ignorant about biology of reproduction and sterilization. So, anything happens to them after sterilization, they will attribute this to sterilization.

So, suppose somebody develops a (( )) disease they will say this is because of sterilization, although we know that there is no connection between cardiovascular diseases and sterilization. But, in rural ignorant traditional illiterate society, all kinds of rumors were spread. And in some cases, there was also failure of the method which means that even after sterilization, some couples produce children. And there were fraudulent means to motivate people to adopt family planning (( )) lot of (( )) of updater.

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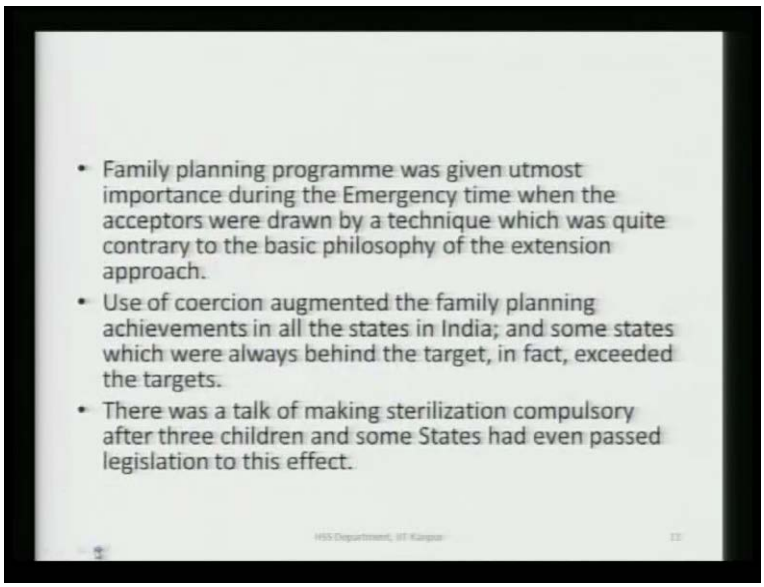

Family planning program was given utmost importance during the emergency time when the acceptors were drawn by a technique, which was quite contrary to the basic philosophy of the extension approach. Use of coercion augmented the family planning

achievements in all the states; and some states which were always behind the target, in fact, exceeded the target. In students of sociology they can very well understand that, if targets are given to government officers including police officers; you are distributing targets for sterilization to all kinds of people including teachers, police officers, (( )), revenue officials, income tax, sales tax in all department.

If you give such targets to grassroots workers, they will go to people and try to convince them about utility. So, this family planning program was given utmost important during the emergency time. There were many other points in (( )) program of the (( )) prime minister, family planning was one of the most important thing. When the acceptors were drawn by technique, which was quite contrary to the basic philosophy of extension education or giving knowledge important knowledge, communication.

There was coercion this can be easily understood that if you give I have seen one article on coercion in family planning in emergency time. And the basic idea was that, if you give targets to police department. What are the methods can they use other than coercion, you tell a that (( )) up to this month you will have to produce 5 cases.

I remember I was a student at that time the coercion was so much, even for getting science subject at 11 standard in intermediate at 11 standard; children were asked to produce sterilization certificates of their parents all departments education, police, revenue, income tax, sale tax, roadways, railways, everywhere; government servants were given targets for family planning. And there was even a talk of making sterilization compulsory after three children at some states had even passed legislation to this effect, Maharashtra was one.

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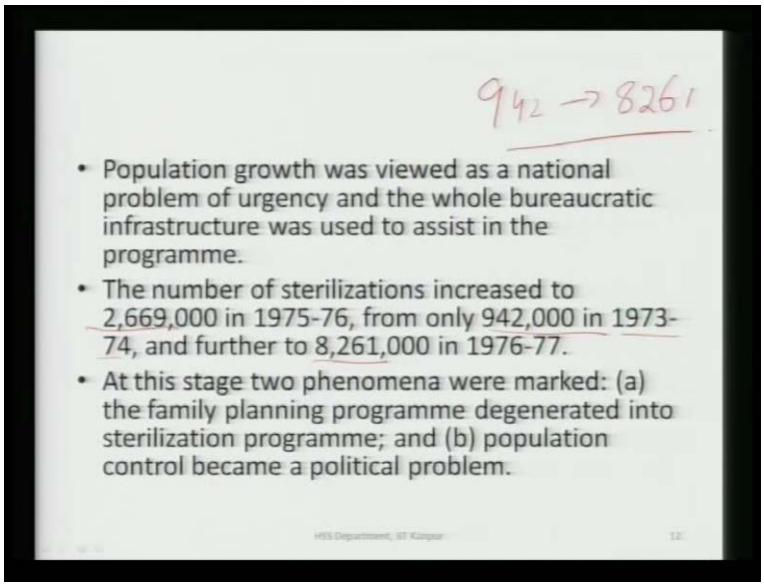

Population growth was viewed as a national problem of urgency and the whole bureaucratic infrastructure was used to assist in the program; as though this is the most important program of government of India. The number of sterilizations increased to a big figure from only 942,000 in 1973-1974, 942,000. 2669 in 1975-1976 that means in 2 years time number of sterilization increased roughly 3 times.

In 1976-1977 the following year, the number increased to 8,261,000 (( )). See, in 3 years time from 942,000 to you have 8261 8261 9 times, number of in 3 years time in a country like ours number of sterilization increasing 9 times certainly, this is not due to any evolution or certain rise in consciousness or empowerment or anything, this was due to coercion.

So, at this stage two phenomena were marked. The family planning program degenerated into sterilization program, all other things were ignored here condoms, IUCD all other things or knowledge or rhythm or natural method, everybody was talking about sterilization only. So, family planning program degenerated into sterilization program, and **(( ))** in population control became a political issue.

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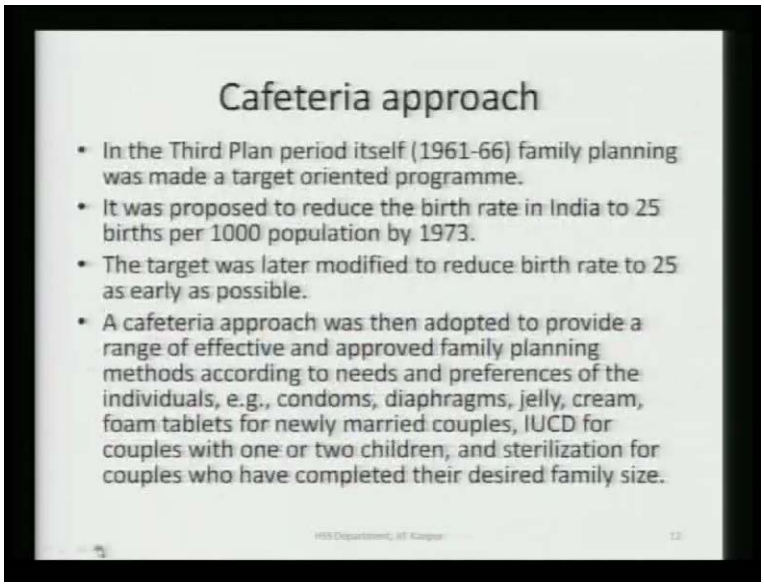

And therefore, when the parliament elections were (( )) after that, they were (( )) essentially on the issue of family planning and the congress party loss election. Then in the something must be said about cafeteria, because this cafeteria approaches this very popular in family planning literature in India. In the third five year plan family planning was made a target oriented program. And the target was to reduce birth rate to 25 by 1973. Later on it was modified to as early as possible realizing that, it may not be possible to reduce birth rate to 25 by 73 it was said as early as possible.

And a cafeteria approach was then adopted to provide a range of effective and approved family planning methods according to needs and preferences of individual; condoms, diaphragms, jelly, cream, foam tablets for newly married couples, IUCD for couples with one or two children, and sterilization for couples who have completed their desired family size.

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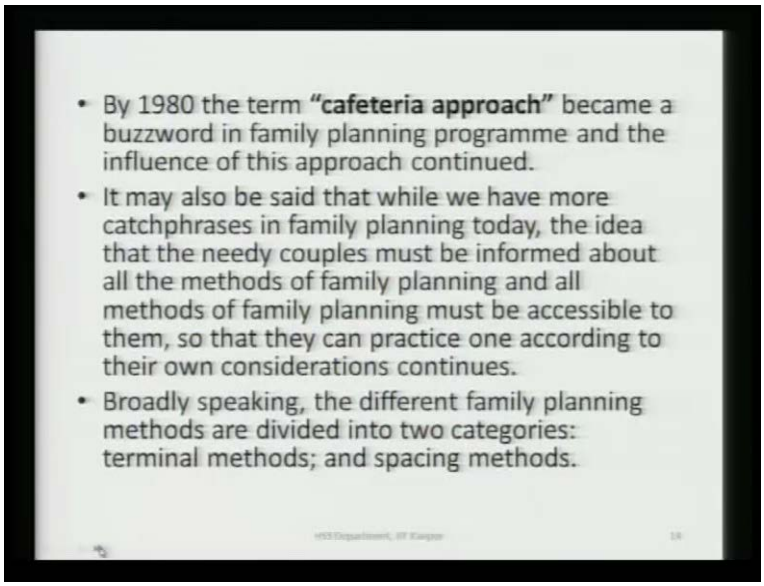

By 1980 the term cafeteria approach became a buzzword in family planning program and the influence of this approach continued. It may also be said that while we have more catchphrases in family planning today, the idea that the needy couples must be informed about all the methods of family planning and all methods of family planning must be accessible to them. So, that they can practice one according to their own considerations continues. Broadly speaking, the different family planning methods are divided into two categories: terminal and spacing.

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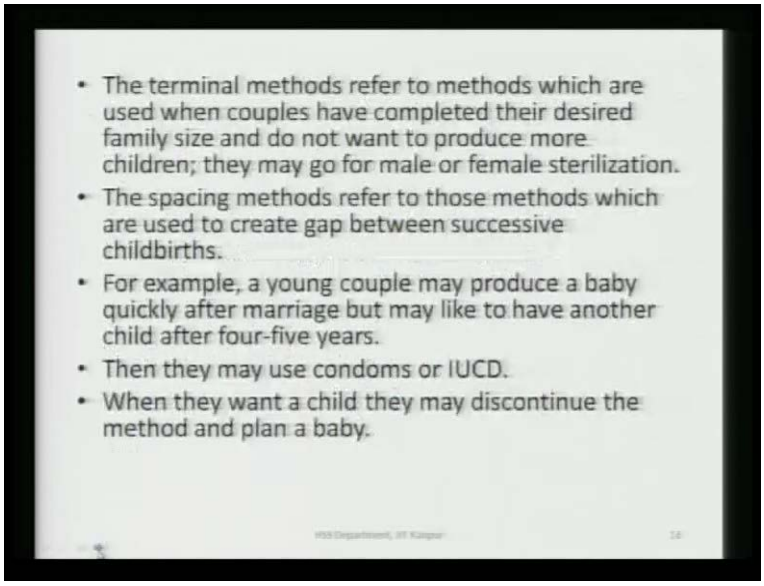

Terminal which are used when couples have already completed their desired family size and spacing when they when they are used to create gap between successive child birth. For example, a young couple may produce a baby quickly after marriage, but may like to have another child after four-five years. They can use condom or IUCD. When they want a child they may discontinue the method and plan a baby.

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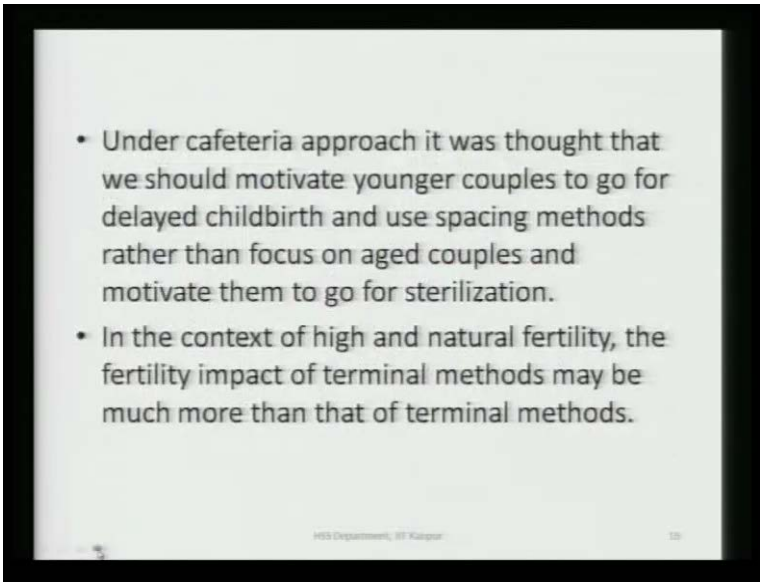

Now, under cafeteria approach it was thought that we should motivate younger couples to go for delayed childbirth and use spacing methods rather than focus on aged couples and motivate them to go for sterilization. In the context of high and natural fertility, the fertility impact of terminal methods may be much more than that of sorry a spacing it should be spacing (Refer Slide Time: 39:29). In the context of high and natural fertility, fertility impact of spacing methods must be much more than that of terminal methods.

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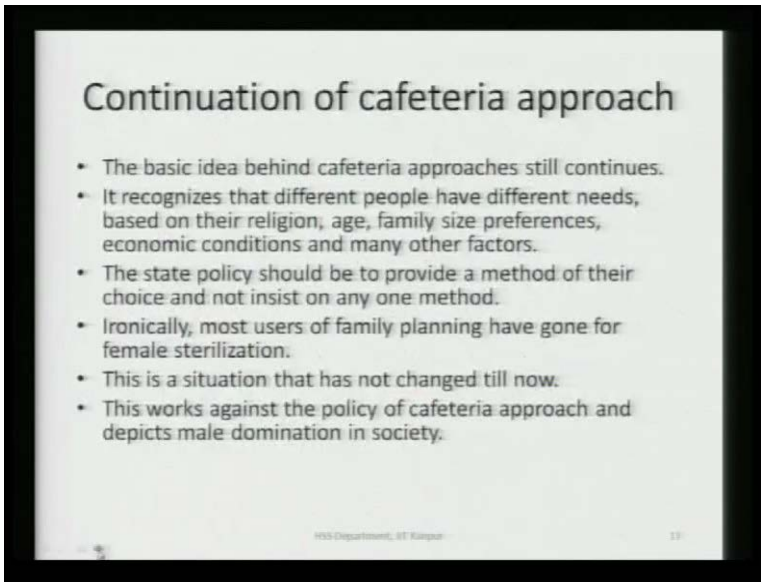

The basic idea behind cafeteria approach still continues. It recognizes that different people have different needs, based on their religion, age like Muslims may not go for sterilization, but they may go for condom or they may go for IUCD; age, younger people may need spacing methods, older people may need terminal methods, then there are different family size preferences, economic conditions and many other factors. So, you have a more differentiated approach to family planning.

The state policy should be to provide a method of their choice means choice of couples and not insist on any particular method as it happened during emergency time; when the total attention of the program was focused on statistics of sterilization creating lot of (( )) up of data wasted interest in showing high achievements, declined in the quality of acceptors.

Ironically, most users of family planning have gone for female sterilization. This is a situation that has not changed till now. And this works against the policy of cafeteria. So, in principle we talk of cafeteria approach, but in practice we have female sterilization, (( )) late government of India (( )) more couples to use condoms rather than other methods and that is more because of constitution of a stopping the AIDS epidemic.

Sterilization can help in limiting family size, but sterilization will not help us in fighting against spread of H I V AIDS epidemic. So, attention is shifting to condoms, but the fact remain that in different states 1, 2, maximum 5 percent couples are using condoms. Most

of the couples, who have gone for modern or effective methods of family planning, are using female sterilization. This is a sociological issue why in India, majority of couples are using female sterilization, while there are other simpler easy to use inexpensive methods which do not require any surgical operations.

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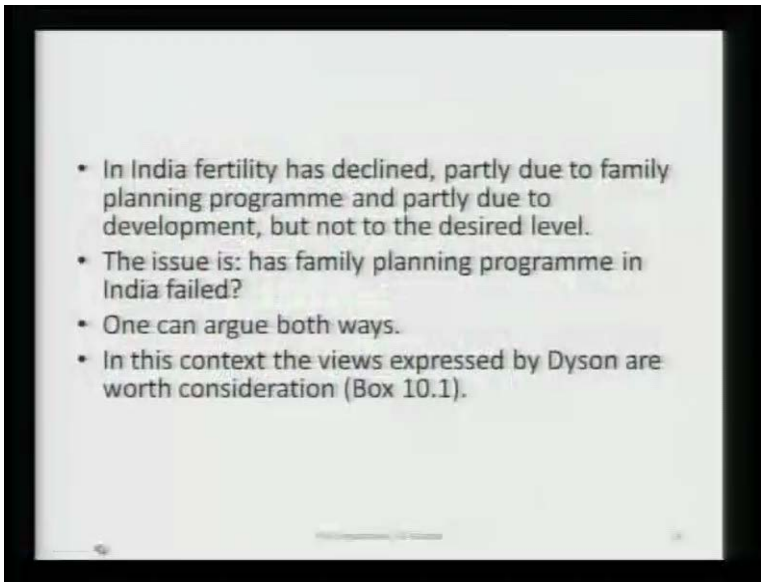

Now, in India fertility has declined, partly due to family planning program and partly due to development, but not to that desired level. The issue is: has family planning program in India failed? One can argue both I thought that to at the end of this lecture, I will (( )) something from in Dyson.

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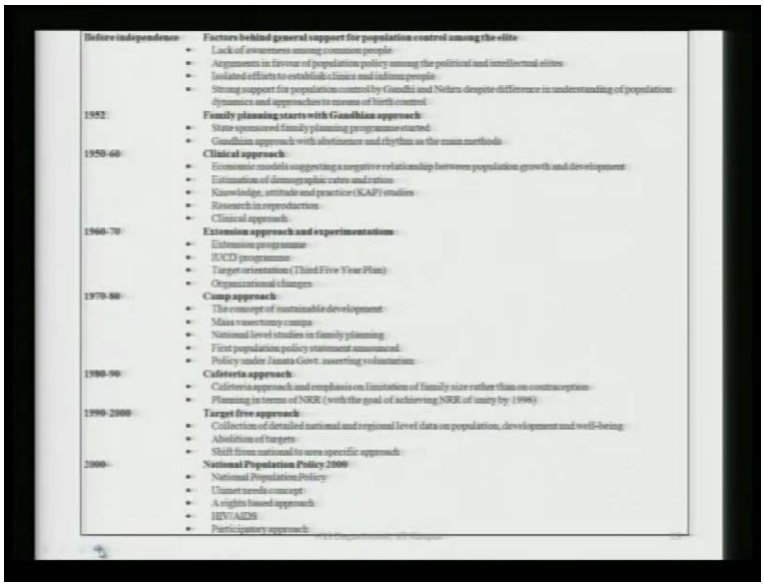

So, I will do that, so essentially today what we have talked about that before independence, there was idea in favor of population control, then in 1952 we went for Gandhian approach towards family planning; then we had clinical approach (( )) studies, researches. In 60 to 70, we had (( )) education and experimentation, IUCD, target orientation. 70 to 80 may be called the period of camp approach, mass (( )) camps starting from Ernakulum district of Kerala; and similar experiments conducted in other states with mass acceptance of the method.

Then cafeteria approach, then target yeah after 1990 there was a realization. That this target oriented approach or consultation on sterilization etcetera are not producing results, who want to use family planning methods; because they are educated enlightened aware developed or among whom, there is a transition of values of children, they are going for limiting family size. Among others family planning program family planning communication is not working much.

So, it was decided then that we will have a target free approach; and the purpose of target free approach should be to create more awareness and make family planning methods available to masses. Then in 2000, we have national population policy we will have 1 full hour discussion on population policy 1 day. So, this is a (( )) from Tim Dyson.

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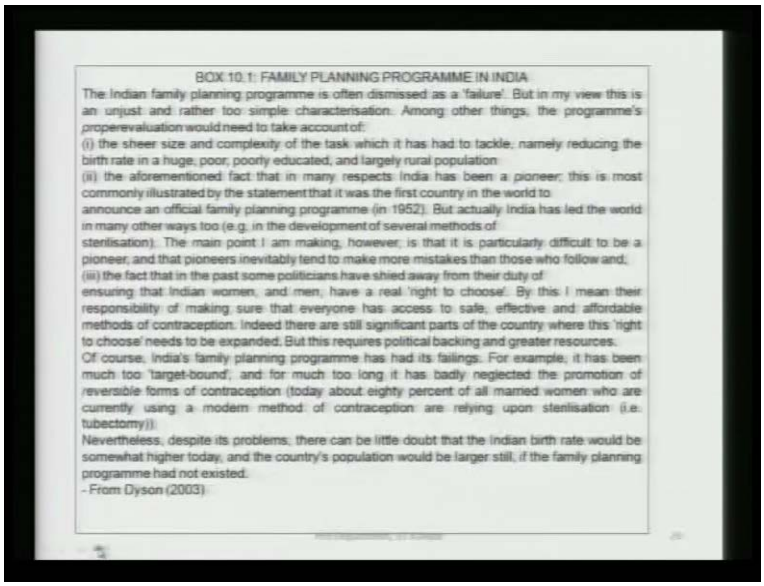

The Indian family planning program is often dismissed as a failure. But, in my view this is an unjust and rather too simple characterization. Among other things, the program's proper evaluation would need to take account of: one, the sheer size and the complexity of the task which it has had to tackle, namely reducing the birth rate in a huge, poor, poorly educated, and largely rural population.

Two, the aforementioned fact that in many respects India has been a pioneer, this is most commonly illustrated by the statement that it was the first country in the world to announce an official family planning program in 1952. But, actually India has led the world in many other ways too like the development of several methods of sterilization. The main point I am making however, is that it is particularly difficult to be a pioneer, and that pioneers inevitably tend to make more mistakes than those who follow.

And third, the fact that in the past some politicians have shied away from their duty of ensuring that Indian women, and men, have a real right to choose. By this I mean their responsibility of making sure that everyone has access to safe, effective and affordable methods of contraception. Indeed there are still significant parts of the country where this this right to choose needs to be expanded. But, this requires political backing and greater resources.

Of course, India's family planning program has had its failings. For example, it has been much too target-bound, and for much too long it has badly neglected the promotion of

reversible what I called spacing methods forms of contraception. Today about 80 percent of all married women, who are currently using a modern method of contraception are relying upon sterilization you know Dyson wrote this in 2003. But, the situation has not changed yet.

And nevertheless, despite its problem, there can be a little doubt that the Indian birth rate would be somewhat higher today, and the country's population would be larger still, if the family planning program had not existed. And we can (( )) this in 2010 much more confidently, because we know that our total fertility rate has already come below 3.

And in several states, we have already reached replacement infertility. So, its family planning program in India has several milestones and and a history of rise and fall optimism and pessimism and different experiments. Today, I was be able to show that the major experiments in this field were Gandhian clinical existential education, mass (( )) camps and a cafeteria approach. And now, we have rights based approach, we will spend 1 full hour on rights based approach when we come to national population policy 2000, thank you this is all that I wanted to say today.

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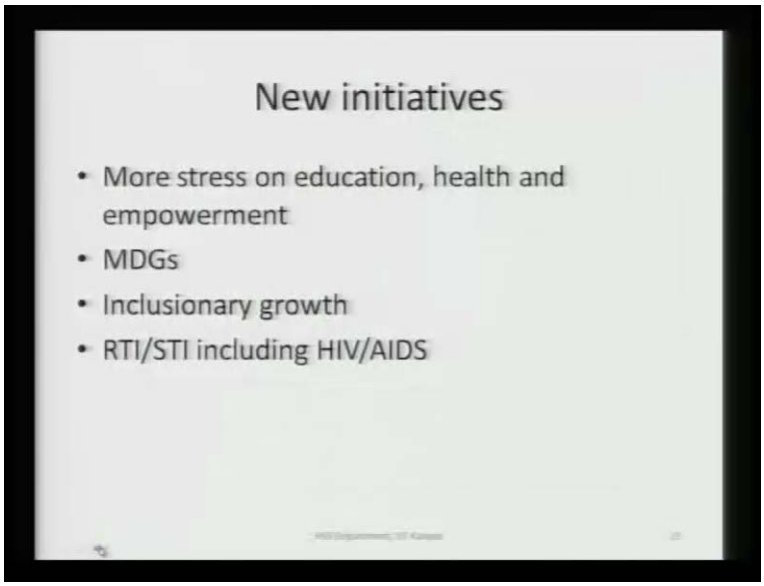

We are also taking some new initiatives in the field of education, health empowerment, millennium development goals, inclusionary growth and RTI STI including HIV AIDS. I hope that, you are provoked to ask one or two questions.

Sir this is a India (( )) first country in the world to India officially introduce the family planning in 1952 (( )) reason for that, they as now national population growth policy up to 2000 that is a reason because, already you have an family planning program. So, there is no, but this national population policy. So that means, without (( )) without making a formal population policy statement, we were implementing a policy yes you are right.

But, national population policy also focus on family planning, there are so many methods to regulate or to control the population. But, this national population policy also more focused on family planning I think I think you may had a.

Yeah.

Not focused on the other other aspects of other, there are so many other aspects to control the population, but why this because we have introduced in 1952 then, but after 50 years also we have focused on this issue, that is family planning lot of other ways to control the population.

In national population policy 2000, so as you are right, that we were implementing a policy without formally announcing it. And the major difficulty in arriving at a formal policy statement was that in a democratic and diverse country like ours, parliamentarians were finding it difficult to develop a draft on which there can be consensus from all political parties, religious groups, NGOS, experts, academicians and other civil society act; and anyway the if the purpose was to reduce growth rate of population, we were running family planning program.

But, in national population policy 2000, two things were marked. One that our ability to develop a consensual model. So, now, we have consensus our policy has been signed by the president of India, and there is a consensus regarding this policy document among all sections of diverse sections, different political parties and civil society group. And the second thing, there is a paradigm shift; so far, there is a feeling that this target we had more of target orientation, more of coercion, and more focused on sterilization.

Now in place of target orientation, we are moving towards a satisfying the unmet needs and let there be no targets. Let us, identify which people which couples want to use family planning methods and we create such mechanism we we provide them all the

knowledge and facilities, so that they can choose their own method for implementing their plans.

Second is consensus and third is paradigm shift from family planning to rights based approach and in this so called right based approach. We are focusing more on education, health and (( )) the idea is that much of the statistics of family planning that we have for the past are unreliable, due to target orientation, coercion, incentive, disincentives (( )) of (( )) up of data also took place.

And the quality of acceptance of family planning was not good, if somebody is already produced five or six children, and he is going or she is going for sterilization, what are we achieving, what is its impact on births averted or reduction of birth rate. But, if you have a rights based approach, you bring younger couples under the ages of this population control program that is much better.

And the quality of statics the quality of acceptance, quality of acceptors of family planning in terms of age socio-economic background education state or region urban, rural, (( )) community would be much better. If you go for rights based approach, then the quality of acceptance of family planning it is not only numbers, but the composition of acceptors of family planning would also be more favorable to population control and will also be consistent with the value system of our constitution, directive principles or value system of India, thank you.