

**POPULATION POLICIES AND PROGRAMS SINCE ICPD, 1994:
ISSUES AND CHALLENGES AHEAD**

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Population Policies in India

As part of the Indian Delegation to the International Forum on Population and Development we had presented there India's Country Report 'Population and Development: 10 years since ICPD' on 7 September 2004 in Wuhan, China. India, being a signatory to the Program of Action (PoA), which was endorsed by the 179 participating countries at the conference in Cairo, had responded positively and had taken several initiatives since 1994. The PoA expanded the scope of population policies from a sole concern with fertility reduction to include an emphasis on reproductive health, reproductive rights and gender equity. The concerns over education of girls, gender equity and empowerment of women; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health were raised during the Cairo conference. Apart from the ICPD-PoA, another noteworthy report was that of the National Committee on Population, headed by M.S.Swaminathan. This had been submitted to the Government of India in June 1994, and was critical of the earlier target oriented approach that had led to large-scale statistical manipulations of official data, deterioration in the quality of services offered to couples and was anti-women. The report clearly recommended that India's population policy should be pro-poor, pro-women and pro-nature. The historical perspective of India's population policies since Independence by Prof. Srinivasan had rightly categorized the earlier target oriented approach until 1976 as follows: the HITTS model i.e. health department operated, incentive based, target-oriented, time-bound and sterilization-focussed program; thereafter the coercion approach during the emergency period from June 1975 to March 1977, and then recovery period, and finally the RCH approach since 1994 (Srinivasan, 2001). It is the due to the efforts of such critical reports and evaluation studies, in addition to the and deliberations and recommendations of the ICPD conference that provided the background for the paradigm shifts in India's population policy since 1994. Several initiatives undertaken by the Government of India since ICPD had been highlighted in the country report presented at Wuhan, China.

The major paradigm shifts from the earlier target oriented to a target-free approach (TFA) in April 1996 and then to a client centered and demand driven Community Needs Assessment (CNA) approach, which was later renamed as Reproductive and Child Health (RCH) approach in October 1997 were initiated to translate the promises made at Cairo into policy and program actions in India. The essential components of the RCH were prevention of unwanted pregnancies by promoting contraception for both spacing and limiting children, providing services for safe motherhood, improvement in child survival by expanding immunization coverage,

¹ The author expressed his deep sense of gratitude to all the members of the Indian Association for the Study of Population (IASP) for reposing confidence in him by electing him the president for the term 2004-06 and assured his utmost endeavor to fulfill the high expectations from the office of the president.

treatment of diarrhoeal diseases and acute respiratory infections, etc. Most of these concerns were raised at the ICPD conference and in the evaluation reports and were under active consideration by the population policy committee formulating the National Population Policy.

The National Population Policy (NPP), announced by the Government of India on 15 February 2000, had clearly enunciated short, medium and long run objectives of the policy. The immediate objective enshrined in the NPP-2000 document was to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective was to bring the total fertility rate (TFR) to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective was to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection. Obviously, the short, medium and long-term objectives are intertwined and failure on short or medium-run goals would have serious implication for the long-run objective of population stabilization.

Given the scale and diversity of India's population, it has often been voiced that region-specific solutions need to be elicited towards achievement of these national goals. Furthermore, in a resource constrained regime and given the regional variations in the incidence of poverty, illiteracy, unemployment and under-employment, public and private health care facilities, malnutrition, etc. the regional specific strategies need to prioritize alternate aspects of the RCH and the socioeconomic development package to suit the local needs and requirements. The prioritization of alternate strategic elements in the RCH package would bring about cost-effective policy alternatives towards achievement of the national socioeconomic and demographic goals. The thematic scheme of the present conference "Poverty, RCH and Population Stabilization in India" has emanated from some such concerns in the background.

India's Current Population Scenario

India's population crossed the one billion mark on 11 May 2000 and was enumerated as 1027 million on 31 March 2001 as per Census results. India is expected to graduate to a rank of the world's most populous country somewhere in thirties of the present century. The country is in the middle of demographic transition. A lag in the decline in fertility in relation to mortality has resulted in the sizable growth of India's population so far which will continue in the following several decades. India's mortality levels started falling since the 1920s basically because of better control of famines and epidemics, improvements in sanitation, ready availability and adoption of medical facilities, and an overall improvement in the nutritional standard of the people in general. Obviously, it was a desirable phenomenon. However, fertility declines have also set in all over the country. A deceleration in the population growth process has been witnessed since the 1980s. Despite this the massive population base of around 1100 million at present and coupled with a natural increase of 1.7 percent in India is a matter of serious concern. The NPP-2000 document clearly stated that population growth in India continues to be high

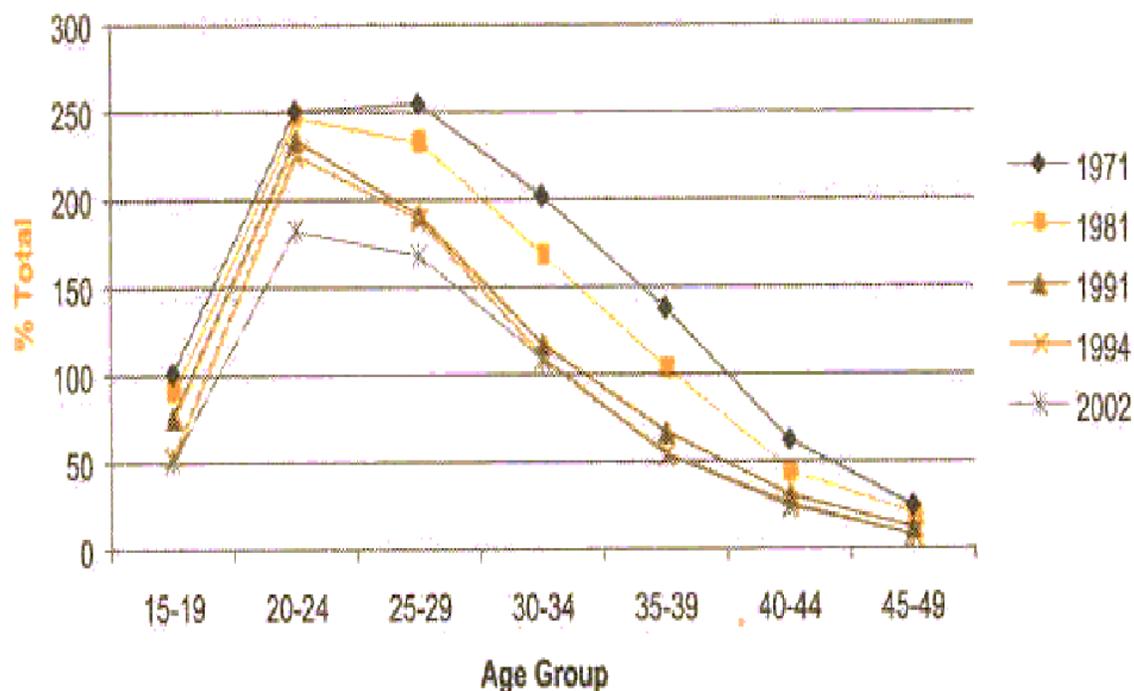
on account of a demographic momentum (estimated contribution 58 percent), higher wanted fertility due to a high infant mortality rate (estimated contribution of about 20 percent) and higher fertility due to unmet need for contraception (estimated contribution 20 percent). Thus, we cannot be oblivious to the in-built demographic momentum in India's population because its younger age structure is expected to contribute around 60% to the expected population growth. Furthermore, 20% of the growth potential is attributed to higher wanted fertility and 20% to unwanted fertility because of the higher unmet need of contraception. Conceptually the unmet need of contraception because of definitional deficiencies and measurement errors has been debated upon in the past (Sumati Kulkarani, 2001). Some of the long-term population projection studies have indicated that the effect of unwanted fertility on total expected population growth could be even more than 20 percent.

Fertility Scenario

Fertility decline in terms of total fertility rate from 5.2 per woman in 1971 to 2.9 in 2001 is a significant achievement. Fertility has declined throughout the country though at a varying pace in rural and urban areas and in different states. The total fertility rate has declined in all the states since the early 1970s. The southern states of Kerala, Tamil Nadu and Goa have already reached the replacement level or below replacement levels (TFR of 2.1). Moreover, the estimated urban TFR has also been close to replacement level in the urban areas of Andhra Pradesh, Karnataka, Maharashtra, Punjab, Orissa and West Bengal. In these states the rural total fertility rate has also come down to around 3. In general fertility in urban areas has been lower compared to rural areas in all the states of India.

Compared to the southern states, fertility has been appreciably higher in the northern states of the country. In fact, the regional fertility differentials have widened. Fertility levels have declined more in states with initially low levels of fertility. In the southern states of Karnataka and Andhra Pradesh and in the northern and western states of Gujarat, Maharashtra, and Punjab and in West Bengal in the East, at the turn of the century the reported TFR declined to levels between 2.4 and 3.0. Fertility has also begun to fall in the large north Indian states mainly in recent years between 1986 and 2000, but it is still relatively high in this region and ranges between a TFR of 4.0 (MP) and 4.8 (UP). However, fertility declines have been taking place even in the high fertility regions of the country over the recent past.

Figure 1.1 Age-Specific Fertility Rates For All India , 1971-2002



As evident from Fig.1.1 that depicts age-specific fertility rates for selected years during 1971-2002 for all-India, fertility has fallen for women at all ages both in rural and urban areas. The greatest fall, however, has occurred at older ages within the reproductive span, indicating that fertility is increasingly being controlled within marriage through adoption of family planning. At the younger age group of 15-19, fertility decline mainly reflects a rise in the age at marriage of girls, which increased from around 17 years in 1971 to around 20 years now. Furthermore, fertility earlier used to peak at 20-24 and 25-29; it now peaks only at 20-24 implying that the average span of childbearing has also declined considerably.

Unwanted Fertility Scenario

The NFHS surveys indicate that there are significant inter-state variations in the unwanted fertility. Rather, at the national level the unwanted fertility had risen from 22 percent in 1992-93 to 25 percent in 1998-99 (NFHS-1 and NFHS-2). Nevertheless, unwanted fertility as percent of TFR declined in the low fertility southern states of Kerala, Tamil Nadu and Andhra Pradesh and increased in most of the high fertility EAG states like Bihar, Rajasthan, Uttar Pradesh, Madhya Pradesh, and Orissa over the same period. However, if the unwanted fertility component is taken care of or gets eliminated then the TFR would come down to replacement level (TFR of 2.1) or even below that in most parts of India. Perusal of Table 1 reveals that if unwanted fertility is accounted for then the fertility level reaches below replacement level in almost 58 percent of India's population. Furthermore unwanted fertility is high mostly in the high unmet need of contraception in the EAG states of India. This is indicative of the fact that family planning programs in the EAG states needs to be strengthened.

Table 1: Population, Fertility and Contraception, All-India and Major States

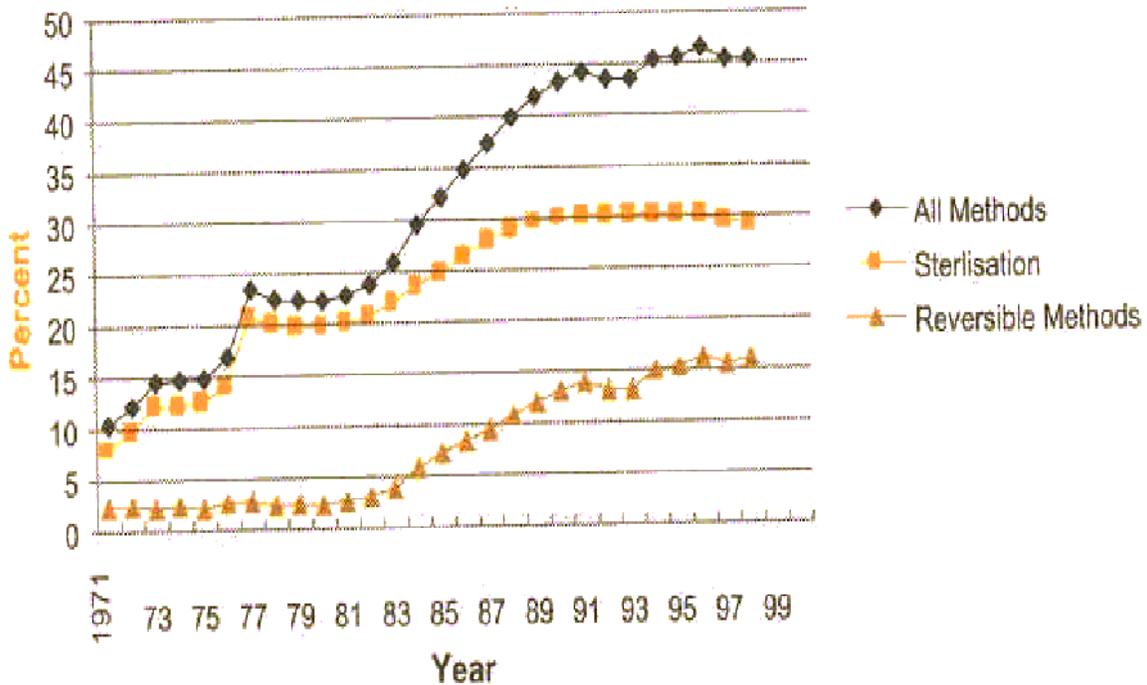
| State | Population 2001 Census (In Millions) | Percent of India's Population | TFR in 1998-99* | Unwanted Fertility 1998-99* | Unwanted Fertility as Percent of TFR | Contraceptive Prevalence Rate-1999 | Unmet Need of Family Planning |
|---------------|--------------------------------------|-------------------------------|-----------------|-----------------------------|--------------------------------------|------------------------------------|-------------------------------|
| Kerala | 31.8 | 3.1 | 1.96 | 0.15 | 7.7 | 40.5 | 15.0 |
| Tamil Nadu | 62.1 | 6.0 | 2.19 | 0.48 | 21.9 | 50.4 | 21.3 |
| A.P. | 75.7 | 7.4 | 2.25 | 0.37 | 16.4 | 50.3 | 13.9 |
| Karnataka | 52.7 | 5.1 | 2.13 | 0.57 | 26.8 | 55.4 | 15.2 |
| Gujarat | 50.6 | 4.9 | 2.72 | 0.64 | 23.5 | 54.5 | 19.7 |
| Maharashtra | 96.8 | 9.4 | 2.52 | 0.65 | 25.8 | 50.1 | 19.6 |
| Punjab | 24.3 | 2.4 | 2.21 | 0.66 | 29.9 | 66.0 | 14.4 |
| Haryana | 21.1 | 2.0 | 2.88 | 0.78 | 27.1 | 49.7 | 17.5 |
| Assam | 26.6 | 2.6 | 2.31 | 0.56 | 24.2 | 16.7 | 37.6 |
| West Bengal | 80.2 | 7.8 | 2.29 | 0.51 | 22.3 | 32.9 | 12.1 |
| Orissa | 36.7 | 3.6 | 2.46 | 0.56 | 24.2 | 39.0 | 22.0 |
| MP | 81.2 | 7.9 | 3.31 | 0.91 | 27.5 | 46.5 | 27.2 |
| Bihar | 109.8 | 10.7 | 3.49 | 0.91 | 26.1 | 19.7 | 42.0 |
| Rajasthan | 56.5 | 5.5 | 3.78 | 1.21 | 32.0 | 36.4 | 28.2 |
| Uttar Pradesh | 174.5 | 17.0 | 3.99 | 1.16 | 29.1 | 38.2 | 38.4 |
| All-India | 1027.0 | 100.0 | 2.85 | 0.72 | 25.3 | 44.0 | 25.3 |

Contraception Scenario

Perusal of Fig 1.2 reveals a steady increase in couple protection rate (CEP) during 1970-2000. The steady increase in the use of contraception has been the major determinant of fertility decline in India. Other socioeconomic development factors like rising levels of education, influence of mass media, continuing urbanization, declines in infant and child mortality, etc. also motivate couples to adopt contraception for fertility reduction. Furthermore, the rising the age at marriage also must have played role a towards the reduction in adolescent fertility in the earlier age groups of 15-19 and marginally for the group 20-24. At the national level, the use of contraception increased from 10 percent of couples effectively protected (CEP) in 1970 to over 45 percent in 2000. The overall performance of the official family planning program has averted around 257 million

births until 2001 (MoHFW, 2001). Possibly, some more credit may be attributed to the family planning program for neutralizing the increase in natural fertility due to the effects of modernization on the post-partum amenorrhoea period on account of changes in lactation patterns and post-partum abstinence (Srinivasan, 2001; Gulati, 1987).

Figure 1.2 Percentage of Couples Effectively Protected by Family Planning Methods , All India , 1971-2002



The official family planning program was viewed to have had a setback after the emergency period because of the coercive approach adopted during 1975-77. There was some revival of the program thereafter. Furthermore, declaration of the target free approach in April 1996 was also viewed to have a declining impact on CEP rates, as the percent women using any method became stagnant during 1994-1997 at around 45% but however, the effect on fertility rates was not discernable as the CBR declined from 28.3 to 26.4 during the same period. This anomalous situation may be explained in terms of possible factors for instance lower parity women might have been involved in the FP program, induced abortions as a family planning method, usage of contraceptives from non-governmental sources might have gone up (Srinivasan, 2001). However, the official statistics indicate that couples effectively protected during 1995-97 had gone up from 40.6 to 48.2.

The unmet need of contraception has often been debated upon for its conceptual and measurement deficiencies. Its measurement is based on the gap between the reproductive intentions of couples and their contraception behavior and construed as the potential demand for contraception, which has often been questioned (Kulkarni et al. 2001). Conceptually, the non-use of contraceptives by couples revealing their desire of

not having a child temporarily or permanently is being termed as the unmet need of contraception. However, the unmet-need even with such limitations can possibly be taken up as a good proxy indicator for the latent demand for contraceptives. Thus, 20 percent of the expected population growth potential because of unwanted fertility due to the higher unmet need of contraception in India could be taken care of through focussed attention on the provision of affordable quality contraceptives to the potential users.

The expected higher population growth potentials attributable to higher wanted fertility also need to be taken care of by concerted efforts towards socioeconomic development, which may be quite long drawn and resource intensive. Nevertheless, ideally there is a need to improve the quality of life through better outcomes in health, education, nutrition, alleviation of poverty, illiteracy and unemployment, women's empowerment, elimination of cultural barriers like son preference, etc. which are obviously long term initiatives. Though these are ideal and desirable goals to be achieved on their own merit but can we afford to wait when the population size is increasing alarmingly. Though we may be skeptic about the one child family policy and its socio-demographic implications as experienced in some other parts of the world, its long term gains should be contrasted with the pains of a potential massive population base over the future course. Now the question arises how best we should strategize to achieve quicker population stabilization along with an improvement in the quality of life. Thus, in case we are able to bring down the wanted fertility in future even then we need to strengthen the family welfare program to account for the potential increased demand for contraception because of a lower desired fertility (Gulati, 1987).

RCH Utilization and Infant Mortality Scenario

Focussed attention on reproductive and child health since the inception of the RCH approach set out to promote antenatal, delivery and postnatal care and children's immunization. The recent district level household survey (DLHS), during 1998-99 with reference periods of 3 years prior to the surveys, indicate that skilled attendance by professional doctors and nurses at the time of birth, whether in the home or at health institutions was only 40 percent whereas health-institution deliveries are still only 34 percent. The pattern of obstetric care over the states reveals that in the southern states, the utilization of reproductive health care is much higher compared with the backward EAG states. The institutional deliveries in the southern states like Kerala and Tamil Nadu are over 75 percent whereas in the EAG states it can vary from just around 15 percent in Bihar to 23 percent in Rajasthan and Orissa. Similar regional patterns emerge for the occurrence of safe deliveries which are much higher in the southern states of Kerala (86%), Tamil Nadu (75%), Andhra Pradesh (63%), and Karnataka (60%) compared with the EAG states which vary from just 10% in Bihar to 33% in Orissa. We still have to cover a lot of ground to bring the EAG states to the potential levels observed in the southern states. Furthermore, reasons extended for a lower utilization of antenatal and delivery care are that there is no need or cost of obstetric care. Sensitization of women and family members, especially mothers-in-law, about the significance of antenatal and delivery care in controlling maternal and infant mortality can hardly be overemphasized.

Nevertheless, the achievement of NPP goals of institutional deliveries of 80 percent and safe deliveries of 100 percent by 2010 seem to be out of question.

Table 2: RCH Care Utilization and Infant Mortality, All-India and Major States

| State | Percent Mothers With Full ANC | Institutional Deliveries | Percent Safe Deliveries | Children >1 & <3 Fully Immunized | Infant Mortality Rate | |
|---------------|-------------------------------|--------------------------|-------------------------|----------------------------------|-----------------------|---------|
| | | | | | NFHS-I | NFHS-II |
| Kerala | 86.1 | 97.0 | 97.4 | 84.0 | 23.8 | 16.3 |
| Tamil Nadu | 75.3 | 78.8 | 82.4 | 91.5 | 67.7 | 48.2 |
| A.P. | 63.4 | 50.6 | 59.8 | 74.5 | 70.4 | 65.8 |
| Karnataka | 60.1 | 50.0 | 59.9 | 71.8 | 65.4 | 51.5 |
| Gujarat | 42.7 | 46.1 | 55.9 | 58.1 | 68.7 | 62.6 |
| Maharashtra | 54.8 | 57.1 | 61.2 | 79.7 | 50.5 | 43.7 |
| Punjab | 25.4 | 40.5 | 54.7 | 72.7 | 53.7 | 57.1 |
| Haryana | 23.9 | 25.7 | 32.7 | 66.0 | 73.3 | 56.8 |
| Assam | 24.8 | 23.8 | 31.9 | 46.7 | 88.7 | 69.5 |
| West Bengal | 33.4 | 38.9 | 45.6 | 51.5 | 75.3 | 48.7 |
| Orissa | 32.5 | 23.4 | 32.7 | 57.8 | 112.1 | 81.0 |
| MP | 20.2 | 21.5 | 27.5 | 48.4 | 85.2 | 86.1 |
| Bihar | 10.1 | 14.9 | 19.0 | 22.4 | 89.2 | 72.9 |
| Rajasthan | 16.6 | 22.5 | 33.4 | 37.1 | 72.6 | 80.4 |
| Uttar Pradesh | 11.2 | 16.2 | 20.8 | 43.7 | 99.9 | 86.7 |
| All-India | 42.9 | 34.0 | 40.2 | 54.2 | 78.5 | 67.6 |

Immunization of children born over three years prior to the DLHS periods was only 54 percent for India. The regional patterns of the immunization were no different than the obstetric care. In the southern states we find the extent of children's full immunization is ranging from 75 percent in Andhra to 92 percent in Tamil Nadu compared with the EAG states ranging from just 22 percent in Bihar to 58 percent in Orissa. Even at the all-India level we find that the increase over 6 years between 1992 and 1998 in BCG was from 62 to 72 percent, in DPT(3) from 52 to 55 percent, in Polio from 54 to 63 percent and in Measles from 42 to 51 percent, respectively. So an increase of just around 5 to 10 percent in different vaccinations over 6 years indicate that universal immunization by 2010 goal seems to be extremely over-ambitious one set in the NPP-2000.

The infant mortality rate in India has come down from 134 in 1972 to 71 in 1998 (SRS). Perusal of the table reveals that as per NFHS reports, the IMR declined from 79 to 68 during 1992-98. Infant mortality levels are lower in the southern states compared with the northern states of India. Haryana has made substantial progress in lowering the infant mortality. The extent of children's immunization clearly depicts an inverse linkage with infant mortality. Despite an impressive decline in the IMR from 134 in 1972 to 71 in 1998 and thereafter the declines in IMR have not been very impressive. Thus, to achieve an IMR of 30 by 2010 we have to go a long way whereby regional and gender differentials especially in infant and child mortality seem to be a major hindrance towards the achievement of the targeted national goal.

Neonatal and post-neonatal mortality rates have also continued to fall significantly, although the pace of their decline has varied. The post-neonatal mortality

has fallen at a faster rate between 1970 and 2000 from 54 to 25 deaths per 1000 live births or by 54 percent (Leela Visaria, 2004). The neonatal mortality fell from 75 to 46 or by about 39 percent during the same period. This implies that the share of neonatal mortality in infant mortality has increased over time. It is true that the world over the neonatal mortality is inherently more difficult to reduce. Added to this is the fact that in large tracts of the country the age at marriage and at childbearing among women continues to be unacceptably low, increasing the risk of complications at the time of childbirth for both the newborn and the mother.

Mortality from many of the communicable diseases has indeed declined but morbidity from some of them continues to remain high. Lack of potable drinking water, and minimal liquid and solid waste management results in the communicable diseases. Although mortality due to gastroenteritis and dysentery has declined over time, diarrhoeal diseases continue to be an important cause of morbidity and mortality, especially among children.

In the quarter century after India's Independence in 1947, mortality fell considerably due to control of several major communicable diseases and the absence of major famines. The decline in mortality continued in the last three decades of the 20th century and the death rate fell to under 9 at the turn of the century. This reduction in mortality was evident in life expectancy at birth, which rose from around 50 years in early seventies to more than 63 years at present. Although in the last 30 years all states have reported a welcome decline in mortality, but the regional pattern of interstate differentials have persisted and thus there is lot of scope for improvements as depicted by Kerala and other southern states and obviously such improvements need region-specific interventions for the purpose.

Adolescent Reproductive Health

The National Population Policy of 2000 articulated the sexual and reproductive health needs of the adolescents in India. About 22 percent of India's population falls into the adolescent age group of 10-19 years. Despite the rising age at marriage, and laws prohibiting early marriage (Child Marriage Restraint Act of 1929 and its amendment in 1978) the average age at marriage for girls continue to be 19.2 for girls. Still about 31 percent of the girls marry below legal age at marriage with substantial rural-urban and inter-state differentials. Culturally for younger women in India, sexual relations occur overwhelmingly within marriage. But it is alarming to know almost 50 percent of all new HIV infections occur amongst younger people between the ages of 10-25 years. In a culturally sensitive Indian situation the knowledge about sexual health, reproductive tract infections, sexually transmitted diseases, usage of contraception, etc. counseling for adolescents is imparted to female health workers in rural areas but data from district-level Rapid Household Surveys indicate that 15 percent of the rural women, or households for that matter, were visited by the ANM/LHV at household during three months prior to the survey. Thus, programs and schemes need to be focus more on adolescents to impart knowledge about contraception, sexual health and HIV/AIDS.

Poverty Scenario

The poverty ratio has gone down at the macro level from 54 percent in 1977-78 to 37 percent in 1993-94 and further down to 27 percent in 1999-2000. It is projected to be brought down to 21 percent by the end of 2007 as per 10th Five Year Plan projections. Of course incidence of poverty is less in urban as compared with rural areas in India. Despite several major poverty alleviation and employment generation programs like Pradhan Mantry Gramodaya Yojana (PMGY), Swarnjayanti Gram Swarozgar Yojana (SGSY), Sampoorna Grameen Rozgar Yojana (SGRY), Swarna Jayanti Shahari Rozagar Yojana (SJSRY), and several rural food for work, employment generation and housing schemes like Indira Awas Yojana (IAY), etc, we find that regional variations in income inequalities and poverty differentials had accentuated over the period. Not unexpectedly, in the four larger north Indian states and in Orissa and Assam, the poverty ratio, according to the 1999-2000 NSS data, was significantly above the national average (27%) and ranged between 33 percent in Uttar Pradesh and 47 percent in Bihar. At the same time, the annual rate of decline in poverty in these states during 1983-2000 has been considerably slower compared with that in the states of Gujarat, Maharashtra, Punjab, and Haryana. Thus the persistent disparities between people of the two major regions appear to be widening rather than narrowing.

Millennium Development Goals (MDGs)

The United Nations Millennium Summit in September 2000 reaffirmed their commitment to working towards a world in which sustainable development and eliminating poverty would have the highest priority. The Millennium Development Goals (MDGs) and targets grew out of the agreements and resolutions of world conferences organized by the UN in the past decade. The indicators evolved to judge the achievements over the time-bound targets have been laid down in several UN documents (UNFPA, 2001). The goals had been commonly accepted as a framework for measuring development progress.

Goals, Targets and Indicators

Goals:

- Goal 1 Eradicate extreme poverty and hunger
- Goal 2 Achieve universal primary education
- Goal 3 Promote gender equality and empower women
- Goal 4 Reduce Child Mortality
- Goal 5 Improve maternal health
- Goal 6 Combat HIV/AIDS, malaria, and other diseases
- Goal 7 Ensure environmental sustainability
- Goal 8 Develop a global partnership for development

Targets & Indicators:

The time-bound targets are generally intended to be achieved before 2015. The targets characterized in terms of indices like poverty ratio, proportionate population suffering

form hunger, school enrolment ratios of boys and girls, gender disparity in terms of boy-girl ratios, IMR, MMR, incidence of HIV/AIDS, malaria and other major diseases, proportionate coverage of population with potable drinking water, reversal of bio-diversity losses and other natural resources degradation, etc. are desired to be achieved within the stipulated period. Midway achievements on the targets can be assessed and reported in some international meetings.

India's Report on Targets and Achievements of MDGs

Perusal of Table 3 reveals the achievement until 2000 and goals as per 10th Five-year Plan document over most of the socioeconomic parameters such as poverty ratio, school enrolment amongst boys and girls, IMR and MMR, and provision of drinking water, which were enshrined in the MDGs. Several other parameters on fertility, contraception, mortality and morbidity, migration and urbanization, ageing and its implications, adolescent reproductive health, HIV/AIDS, and Gender Concerns in Reproductive Health Policies were highlighted in the Country's report.

Table 3: Human Development Goals for India, Outlined in Tenth Five-Year Plan 2002-7.

| Goal | Situation 1990 | Situation 2000 | Goal for 2007 | Goal for 2012 |
|--|-------------------|-------------------|------------------|------------------|
| Reduction in poverty ratio | 36 | 27 | 22 | 15 |
| Schooling of children: % 6-11 Year old attending school | | | | |
| Boys | 76 | 85 | 100 | |
| Girls | 59 | 78 | 100 | |
| All | 66 | 82 | 100 | |
| Reduction in gender gap in literacy | 0.71 | 0.77 | 1.0 | 1.0 |
| Reduction in IMR | 76 | 70 | 45 | 28 |
| Reduction in MMR | 480 | 407 | 200 | 100 |
| % with provision of drinking water | | | | |
| Rural | 61 | 79 | 100 | |
| Urban | 88 | 95 | 100 | |

Attainment of these goals would remain quite a challenge, especially in the poor states where besides infrastructure, governance also continues to be a difficult challenge. Aptly it was indicated in the report that further improvements in the spread of literacy, lowering of the gender-gap in education, reduction in infant and child mortality would be possible only if the states with adverse indicators are able to bring measures of efficiency in their delivery of the programs. The possibility of this occurring seems to be remote. However, some of these concerns have been under active consideration and recently the National Rural Health Mission's draft document has been deliberated upon and is awaiting Cabinet approval.

National Rural Health Mission

Under the mandate of the National Common Minimum Program (NCMP), health care has several commitments, for instance provision of primary healthcare, with special care to women and the girl child, control of communicable diseases, HIV/AIDS control. Further for the purpose a provision of drugs at reasonable prices, national health insurance for poor families and enhancement in investment in health to grow from current 0.9 percent to 2-3 percent of GDP is provided for. The National Rural Health Mission (NRHM) coordinating group will be chaired by the Prime Minister. Thus the National RHM steering group would be chaired by the Health Minister in which secretaries of three wings of health related departments, state governments, experts/NGOs would also be associated. On similar patterns state level RHMs would be constituted under the chairmanship of chief ministers. The higher powered national and state rural health missions are intended to strengthen the rural health care system in these 17 states. The Mission seeks to improve health care facilities to the underprivileged and the underserved population groups like women and the girl child, poor people, tribal communities, etc. as enshrined in the National Population Policy-2000. A subset of the Rural Health Mission called the North-East Health Mission is intended to provide focused attention for the North East States. The mission intends to integrate multiple vertical health programs at various levels alongwith their funds.

The Rural Healthcare Mission (RHM) draft plan was deliberated earlier with several experts and discussed at length at Tiruvananthapuram (MoHFW, October 2004). The RHM was intended to cover the rural areas of 17 states namely eight empowered action group (EAG) states viz. Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Rajasthan, Orissa, Jammu and Kashmir, Assam and seven other sisterly states over the North Eastern region. These states have often been viewed as lagging in terms of most of the socioeconomic and demographic parameters pertaining to reproductive and child healthcare, fertility decline, contraceptive usage, infant and child mortality and morbidity, poverty, education, nutrition, etc. Firstly, the 17 RHM states having much higher levels of IMR, MMR and TFR, lower levels of CEP, etc. would be covered under RHM and later on the scheme is intended to extend to the national level. Additionally, resurgence in communicable diseases in some areas of these states was of major concern to the NRHM. Coverage of these 17 states amounts to benefiting around 50% of India's population that settled in these 17 RHM states. Also from the underserved population group's point of view we find that around 32% of this 50% population of India can be categorized as being below the poverty line.

The RHM intends to strengthen the rural health infrastructure, especially at the village level, in terms of medical and paramedical personnel, availability and accessibility to drugs, medicines and healthcare facilities. Firstly, at the village level a local female worker categorized as Accredited Social Health Activist (ASHA), to be supported and selected by the village health committee consisting of MPW/ANM, AWW and local teacher and approved by the Gram Panchayat, will be instituted. The ASHA is supposed to manage the village level drug and contraceptive depot and provide referral information and advice to the villagers. She is supposed to maintain the Village Health

Register, and a Birth and Death Registration. The information would flow from the Village to Sub-center and ultimately to district towards formulation of the district health plans. Under RHM, the supply of essential drugs, equipment, etc. at the village level would be ensured. In addition, provision for emergency/catastrophe caused high cost care will be available through community health insurance or the District Health Fund, to be generated under the RHM.

Under RHM schemes, the PHCs/CHCs are to be strengthened for improved referral services. Over time all CHCs are expected to operate as 24-hour First Referral Units (FRUs) through provision of more manpower, infrastructure, equipment and supply of essential drugs. Over the period, ambulance services and mobile clinics are supposed to provide coverage to difficult areas like hilly and desert areas, and tribal areas. Involvement of accredited private doctors and non-governmental organizations for providing better healthcare in the rural areas is also an important component of the RHM strategy. Constitution of the Hospital Committee at the CHC level, empowered to levy user fee and matching grant by GoI would also facilitate the provision of quality healthcare in rural areas. Improved access to tertiary care by having 6 new AIIMS-type institutions in the RHM states is also envisaged. The RHM scheme also intends to hire MBAs, Chartered Accountants, Social Work graduates for improving the planning and management capacities under the RHM scheme.

The RHM also proposes reforms at the national level under which would be integrated several national programs pertaining to family welfare, RCH, malaria eradication, leprosy eradication, Kala Azar, blindness control, iodine deficiency, and filarial. However, the National AIDS and cancer programs are not being integrated to these national level schemes. A funnel type approach would be adopted to ensure the integration of funds for all the national level schemes and thereby the flow of funds to the District Health Mission through the State Health Society. Thus, under the decentralization scheme the district is supposed to be the hub around which all health and family planning services are supposed to be planned and managed. The RHM strategy carefully mentions that the population stabilization goal needs focused attention on basic health care, and access to quality family welfare services for fertility choice, and not fertility control through coercion or disincentives or inducements.

The RHM would be launched after cabinet clearance, after which the budgetary provisions under the 10th Plan and annual outlays would be worked out along with consultations with state partners from the 17 states. Initially, the outlay of the RHM schemes is around Rs. 1933 crores for the remaining period of the 10th Plan. However, larger funds – about Rs. 6000 crores – are expected to flow into the RHM states under various interventions of RCH-II to improve the rural healthcare. Thus, out of around 8000 crores, the NE mission outlay is about Rs. 1300 crores. The proposed interventions of Health, FW and AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy) would be financed out of the existing budget of the DoFW. The budgetary outlays in the 11th Plan period are committed with an expected annual increase of 15%.

Issues and Challenges:

- All-India fertility decline phase has set in but the pace of decline is slow and bringing it down to replacement level (TFR=2.1) by 2010 is almost impossible.
- Unwanted fertility (0.72) in India out of TFR of 2.85 i.e.25%, is still very high, and sincere efforts on qualitative as well quantitative measures can bring us somewhere close to the set target.
- Unmet-need of contraception of 25 percent as per DLHS data is extremely high and thus vigorous social sector reforms, vigorous promotion of small family norms and making family planning as people centered program seem to be the only panacea.
- RCH utilization in India is abysmally low, ANC (43%), Institutional Delivery (34%), Children's Immunization (54%) in India during 1998-99, still worse in EAG or RHM states. Achievement of Institutional deliveries of 80% and safe deliveries of 100% by 2010 as per NPP document seems to be almost impossible
- IMR plateauing around 68 and higher MMR levels, especially in EAG or RHM states, need focussed attention to bring about further reduction to level of 30 by 2010
- Sex imbalance, especially amongst children 0-6 years, in some economically developed states of India, smacks of female foeticide because of strong son-preference and lack of women's empowerment
- Poverty ratio, though declining, is still high at 27% level in India, much higher in backward EAG states, and furthermore accentuation in regional disparities are alarming from the migration flows point of view
- Quality of public sector health and family planning services are extremely poor, especially in EAG states
- HIV/AIDS incidence is a potentially explosive bomb
- Budget allocations towards social sectors, especially health and education, are abysmally low
- Political commitment and bureaucratic efficiency in implementing the health and family planning programs are imminent towards achievement of the population policy goals
- Complacency on the part of international organizations towards population explosion issue in the developing countries is unwarranted
- Aging and social security issues in low fertility regions need to be tackled urgently
- Migration, urbanization, metropolitization and slummization needs prior attention

Remedial Measures

- RCH quality-care package and family planning program need priority attention towards achievement of population policy objectives
- Expand the range of choice of contraceptives and the quality of service to couples, especially in high-unmet need of contraception states
- Delivery care and children's immunization within RCH package need to be prioritized towards fertility reduction objectives
- Women's empowerment is essential to improve RCH utilization, contraception and thus achievement of fertility control and population stabilization objectives

- Public sector RCH and family planning services need to be improved especially in 8 EAG or 17 RHM states
- Increase in central and state budget allocations and resource mobilization from international sources for basic health and education need focused attention
- Budgetary allocations to states need to be linked with improvements in RCH care utilization parameters
- Poverty alleviation and employment generation, especially in the backward regions are desirable on their own merits and would improve quality of life and restrain migration flows
- Sensitization of people about the old age benefits from the public sector and strengthening of family institution for financial and emotional support to aged persons.
- Sensitization of politicians and bureaucrats along with people about significance of RCH and family planning programs, especially in EAG and RHM states

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