

MAE-005

POPULATION AND DEVELOPMENT EDUCATION

HOW TO CONTROL?

Per	Population Addition	
	World	India
Minute	250	60
Hour	15000	3600
Day	360000	86400
Month	10800000	2592000
Year	131400000	31536000 (One and a half Australia)
Decade	1314000000 (One India)	315360000 (15 Australias)

THINK OF IT!

Block

3**POPULATION CONTROL MEASURES: INDIVIDUAL,
NATIONAL AND INTERNATIONAL**

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January, 2013

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ISBN : 978-81-266-6309-5

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Further information on the Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi.

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by the Registrar, MPDD, IGNOU, New Delhi.

Laser Typeset by Tessa Media & Computers, C-206, A.F.E.-II, Okhla, New Delhi.

Printed at : Hi-Tech Graphics, D-8/2, Basement, Okhla Industrial Area, Ph-II, New Delhi-20

COURSE MAE-005: POPULATION AND DEVELOPMENT EDUCATION

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 - Unit 2 Demographic Concepts
 - Unit 3 Determinants of Population Change
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-

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-

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-

BLOCK 3 POPULATION CONTROL

MEASURES: INDIVIDUAL, NATIONAL AND INTERNATIONAL

Introduction to the Block

While Block 1 has presented an overview of population and development education, Block-2 focused on family life education and quality of life. Without coverage of effective measures of population control at different levels, the course on population and development education would remain incomplete. Hence, the final Block, i.e. Block 3 of this course, deals with different measures of population control – individual (pre-marriage and post-marriage measures), national (population policies and programmes) and international (role of international agencies in information dissemination, funding, consultancy and training, among others). It has the following three Units.

Unit 10 “*Individual Measures of Population Control*” highlights different pre-marriage and post-marriage measures of population control by an individual, be it male or female, can take to control population change at micro level, i.e. at his/her family level, which actually determine population change at the level of the community, the nation and the world. It covers the measures such as compliance by the individuals to legal measures, voluntary or non-legal measures by the individuals including adoption of different types of temporary and/or permanent methods of contraception. It also describes the characteristics of an ideal contraceptive that will be helpful to the adult married individuals in deciding upon adoption of suitable contraceptive(s) as a part of their contribution to the control of population change in the desired direction.

Unit 11 titled “***National Measures of Population Control***” explains the need for and significance of state intervention to control population change. It describes national population policies and programmes aimed at population control with an emphasis on the shifts and trends in these policies and programmes. It highlights rationale for institutionalization of population education at different levels as an important means to increase the impact of these policies and programmes on population matters.

Unit 12 “*International Measures of Population Control*” discusses the role of international agencies in information dissemination, funding, consultancy and training. It also describes the roles and functions of selected international agencies like United Nations Fund for Population Activities (UNFPA), United Nations International Children’s Emergency Fund (UNICEF) and International Planned Parenthood Federation (IPPF).

UNIT 10 INDIVIDUAL MEASURES OF POPULATION CONTROL

Structure

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 - 10.4.2.5 Female Sterilization (Permanent Methods)
 - 10.4.3 Ideal Contraceptive: Characteristics
- 10.5 Let Us Sum Up
- 10.6 Answers to 'Check Your Progress' Questions
- 10.7 References

10.0 INTRODUCTION

In Unit-9 of Block-2, as you may recall, we have highlighted the unmet need of family planning with special reference to gender inequity and inequality in terms of lack of awareness and practice of family planning methods by the individuals. The knowledge and understanding of individual measures of population control will help the individual in regulating the population change not only as a married individual but also prior to the marriage, in a manner that will contribute to better quality of individual and family life and development.

In Unit-10 (of Block-3), we will, therefore, cover various individual measures of population control.

10.1 OBJECTIVES

The discussion in this Unit lays emphasis on different measures that the individual will be able to take prior to and after marriage for controlling or regulating the population change, with and without adopting the contraceptive

methods and techniques. After going through this unit, we expect you to be able to:

- Explain the significance of the pre-marriage and post-marriage measures that the individuals can take to control population change in the given direction;
- Identify and analyse the relative merits and demerits of different methods and techniques of contraception, both temporary and permanent;
- Choose appropriate method(s) and technique(s) of contraception in the given context of individual measures for population control; and
- Promote adoption by others of appropriate methods and techniques of contraception with a view to enhance contribution of all the capable and eligible individuals to population control.

10.2 INDIVIDUAL MEASURES OF POPULATION CONTROL: AN OVERVIEW

Individual measures of population control can play significant role in determining the size of not only the family but also the community, nation and the world. At the micro-level, these measures assume greater significance as they have direct bearing on the individual(s) concerned as well as the entire family. The conditions under which the individuals are required to resort to birth control (spacing or prevention) vary from individual to individual. Thus, the basic objective of the individual measures is to protect and promote the health of the individual partners/parents, depending upon their own conditions and the welfare of their progeny.

Let us have a brief overview of the conditions under which the birth control measures by individuals become either compulsory or voluntary, within the relevant choices available to them.

10.2.1 Conditions for Birth Control by Individuals

There are some medical conditions in respect of individuals which serve as essential conditions for birth control. These conditions, according to Hannah and Abraham Stone (1976, pp.122-123), include the following.

- 1) There are several medical conditions which make a pregnancy hazardous to the woman. Certain diseases of the heart, for instance, or of the kidneys, tuberculosis, diabetes, previous caesarean sections, or even certain types of psychopathic disorders may make childbearing or child birth dangerous. Under such circumstances the use of birth control measures become medically necessary to conserve the health or even to preserve the life of the woman.
- 2) The use of contraceptives may also become necessary for eugenic reasons. When either the husband or the wife suffers from a physical or mental disorder that might be transmitted to offspring.
- 3) Regarding the question of the spacing of children, it is quite generally accepted that there should be a definite interval between successive childbearing. Lack of proper spacing of births has deleterious effect upon both the mother and her offspring as has been shown by a number of statistical studies.

In the context of familial and social life, the reproductive stage of life of an individual can effectively be divided into two significant stages – *pre-marriage life* and *post-marriage life*. Both the stages can be effectively controlled by the individual with a view to regulate the population change at family level as well as to improve the quality of family life as an individual member prior to marriage and as a marriage partner later. This is possible only when the individual is aware of different measures that he/she can take to control the population change at the individual level.

10.2.2 Classification of Individual Measures of Population Control

Here, we attempt to present you an overview of broad classification of different individual measures of population control. These measures can be conveniently divided into the following two broad types.

- i) **Pre-marriage measures:** The pre-marriage measures include adhering to the legally prescribed age of marriage and delaying the marriage beyond legal age of marriage till the person is sound enough to sustain the married life so as to make it more meaningful and enjoyable with better quality of life than it otherwise would be. While the individual's choice here is limited to delaying the marriage, his/her decisions in this regard are mostly dependent on factors such as educational level, sex, religion, economic status or income which have serious implications at micro level, i.e. individual and family level.
- ii) **Post-marriage measures:** These measures are many and varied and primarily aim at delaying the conception or spacing the child births – adoption of contraceptive methods and techniques to plan or control the family size. These measures can be conveniently classified into the following broad categories.
 - Male methods and female methods of family planning.
 - Primitive methods of birth control and modern methods of planned parenthood.
 - Spacing methods and sterilization methods or temporary methods and permanent methods of contraception.

Irrespective of the categorization, the range of methods and techniques that fall under any type of classification is the same and include the following.

- a) *Natural methods* such as celibacy, abstinence/continence, coitus interruptus, coitus reservatus, lactation or breast-feeding, safe period/rhythm (calendar and temperature methods).
- b) *Chemical methods* like douche, suppositories, tablets and powders, jellies, pastes and creams, foam powder, etc.
- c) *Mechanical devices* like sheath or condom, diaphragm, cervical caps, intra-uterine contraceptive devices (IUDs);
- d) *Immunization against conception* such as spermatoxins and synthetic hormones – oral pills, emergency contraceptives;
- e) *Injectables and implants*.

- f) *Sterilization (Permanent methods)*: Exposure of sex glands to heat or X-rays, male and female sterilization through surgery.

With this brief overview, we will now discuss the pre-marriage and post-marriage individual measures in detail.

10.3 PRE-MARRIAGE MEASURES OF POPULATION CONTROL BY INDIVIDUALS

As mentioned above, the pre-marriage measures are limited and include the following: i) adhering to the legal age of marriage, and ii) delaying marriage beyond the legal age of marriage and follow the age that is ideal for one's marriage. The legal age of marriage is aimed at ensuring minimum maturity on the part of an individual so as to enable him/her to cope up with and sustain the married life and to reduce the mean duration of marriage and natural fertility.

While it is possible for a woman to bear as many as 15 children in her lifetime, as a result of natural fertility. But, this is rare. Rather, parents universally chose to limit family size because too many children present costs in excess of benefits. Thus, many traditional values and practices foster procreative restraint. Pregnancy can be avoided by celibacy and late marriage and sexual abstinence. Celibacy, however, is not advisable as it is not in the best interest of continuation of the race of human population. Hence, in this section, we will focus on the legal age of marriage and delayed marriage.

10.3.1 Adhering to Legal Age of Marriage

Age at which marriage is conducted among males and females has direct bearing on several social and demographic outcomes, particularly on the mean duration of marriage and fertility. The legal marriageable age for men and women in India is 21 and 18 years respectively. Among the ever married women in rural areas, age at consummation of marriage is below 18 years (violation of legal age of marriage) in the case of 48.8 percent of them, as against 32.6 percent in the case of the urban ever married women. However, the overall mean age at marriage is 24 years for men and 19.8 years for women, which conforms to the legal regulation. About 87 percent of the unmarried women are aware about the legally prescribed minimum age at marriage for boys and girls in India. Expressing their opinion regarding the ideal age of marriage for boys and girls, ninety percent of the unmarried women reported the ideal age of marriage for boys and girls as 21 years and above and 18 years and above respectively (IIPS, 2010, See http://www.rchiips.org/pdf/INDIA_REPORT_DLHS-3.pdf). But, the study would have given more meaningful finding had it exactly come out with specific ideal age ranges for boys and girls.

Nevertheless, it is clear from the above that there is strong need to prevent existing trend in marriages of women occurring in violation of legal age of marriage (48.8 percent rural, and 32.6 percent urban). If the individuals stick to at least the legal age of marriage, let alone the ideal age of marriage, that would be their significant contribution towards population control.

10.3.2 Delaying Marriage to an Ideal Age of Marriage

At the country level, mean number of children ever born to women in the age group 15-49 is found to be slightly less than three children (2.81 children per

woman) comprising on average 1.48 male children and 1.33 female children ever born (IIPS, 2010, *ibid*). There is a need to bring down this mean number of children to 2.0 by promoting two-child family norm.

Women's education has a strong bearing on reproductive health care, contraceptive behaviour and fertility. Many studies (UN, 1961; Coale and Tye, 1961; Nag, 1962; Agarwala, 1962; Mukherjee, 1962; Driver, 1963; Jain, 1964; Wyon and Gordon, 1971) also indicated lower fertility for women who marry late compared to those marrying at younger age. Several studies (Dubey, et al, 1974; Mukherjee, 1975; Ranade and Ramachandran, 1975; Chaudhury, 1977) have revealed that even in the societies where social, cultural and economic pressures on early marriage are high, women's education and their employment have an effect on marital post-ponement and, thus, on fertility. According to Agarwala (1972, mentioned in Lakshmi Reddy, 1993, pp.5-6), if the age at marriage for girls in India is increased to 19 years or more, the birth rate may decline by 25% to 30% by 1991-1992. Of course, such legal or policy measure had not happened till date.

Beyond legal age of marriage, ideal age of marriage may vary from individual to individual, and from society to society, depending upon the prevailing circumstances. However, since the mean age at marriage in India, according to IIPS (2010) is 24 years for men and 19.8 years for women, the same ages accordingly can be considered as average practice in India and thus can be considered as the ideal ages of marriage for males and females respectively. *Thus, it is time that India raised the legal age of marriage to 20 for females and 23 for males in India.* Nevertheless, till then, all the responsible citizens, and more so the persons with higher educational qualifications, need to behave rationally to play their role by delaying their own marriage at least up to 21 years of age if they are females, and up to 24 years if they are males, and also by promoting such practice among other concerned citizens.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 1) Explain the significance of pre-marriage measures of population control by individuals.

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10.4 POST-MARRIAGE MEASURES OF POPULATION CONTROL BY INDIVIDUALS

Desperate measures to control family size are frequently taken by those who lack better options. For example, perhaps, there are 20 million pregnancies a year, and more than one-tenth of them are ended by septic (criminal) abortion, despite serious risks to the mothers (http://www.eoearth.org/article/Human_population_explosion?topic=54245). Here, comes the role of male and female partners to individually and jointly determine the family size through effective adoption of suitable methods/techniques of family planning. While the practices such as abstinence may be followed by some men and women, it cannot be recommended for all. In this method, both wife and husband occasionally abstain or refrain from sexual relationship or intercourse for avoiding pregnancy during particular period or periods. It is the oldest and effective method. Yet, it cannot be advocated or advised as a general practice for the following reasons: i) it is not feasible to avoid sexual intercourse by many normally-sexed couples living in intimate daily contacts of marital life; ii) it requires high degree of self-control over the sex desires; iii) prolonged continence in married life is physiologically and psychologically undesirable as it leads to physical stresses, emotional strains, sexual disharmonies and marital conflicts.

Post-marriage measures by individuals should, therefore, pertain to comfortable, choice-based, practicable ones that promote voluntary planned parenthood to regulate the family size through birth spacing and sterilization methods and techniques. We will, therefore, focus our discussion on the methods of contraception/family planning on the basis of their relevance to male and female partner of the family.

10.4.1 Male Methods and Techniques of Family Planning

There are limited options available for male regarding birth-spacing or permanent methods and techniques of family planning. These are basically aimed at prevention of deposition of semen/sperms in the vagina and are discussed below.

10.4.1.1 Natural Methods: Physical or Behavioural Methods

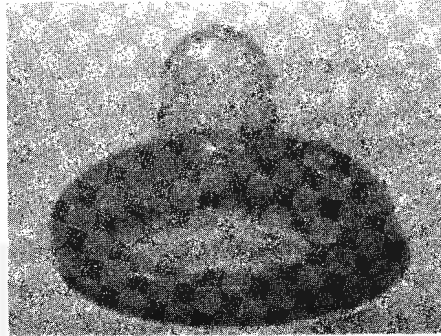
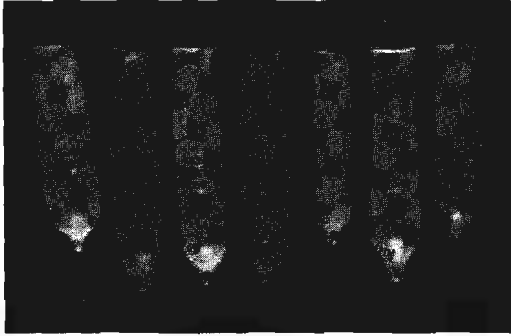
The natural methods of family planning that can be followed by male individual include the following.

- i) **Coitus Interruptus or Withdrawal method:** It is the oldest method of contraception known to mankind. It requires a man to withdraw his penis from the vagina just before his semen is ejaculated, so that the semen is not deposited in the vaginal canal. The main advantage of this method is that it does not cost anything. Its main disadvantage is that it creates certain amount of tension in both the partners. The effectiveness of this method solely depends on the efficiency of the male partner to withdraw penis at the right moment to ensure that semen is not deposited into the vagina.
- ii) **Coitus Reservatus:** In this method, unlike coitus interruptus, while the male maintains the contact of the penis with vagina, he withholds ejaculation or abstains completely from an ejaculation during sexual contact. This is technically called 'coitus reservatus'. It is equally effective as the coitus interruptus. However, this practice requires high degree of physical and

emotional control which only a few people possess or could acquire, nor is it known whether this method might not ultimately be harmful to the man (Hannah and Abraham Stone, 1976, p.142).

10.4.1.2 Mechanical Method: Sheath or Condom

Condom or sheath is made of soft and thin rubber which is worn over the erected penis before sexual intercourse. The ejected semen remains within the condom and, thus, it prevents entry of semen into the vagina. The newer polyurethane (plastic) condom are also used which are odour free, thinner and more sensitive than latex condoms, but are more expensive. The brand name of condom subsidized by the Government of India is 'Nirodh'.



Source: <http://www.avert.org/condom.htm> Source: <http://en.wikipedia.org/wiki/Condom>

The main advantage of the condom is its triple protection nature. It can prevent: i) spread of sexually transmitted diseases (STDs) including HIV/AIDS, and ii) occurrence of unwanted pregnancies. It is easy to use with a little practice and also cheap, easily available, reliable and harmless. The main disadvantages of using condom are: it can be only effective if the condom is tested properly before its use and then used correctly. Since, it is used once there is erection, some men object that condom interrupts sex, or embarrasses them. Further, it prevents direct contact of the organs during the sex relation and tends to diminish sensation for both husband and wife (Hannah and Abraham Stone, 1976, p.144).

Other advantages of use of condom include the following (<http://www.americanpregnancy.org/preventingpregnancy/malecondom.html>).

- It is one of the few forms of birth control that provides any reduction in the transmission of sexually transmitted diseases.
- Condoms are inexpensive and easily obtained.
- No side effects, except allergy to latex in certain cases.
- It does not require a prescription
- Condoms are small, easy to carry, and disposable.

The disadvantages include the following (Ibid).

- Some men complain condoms dull sensations.
- May be considered an interruption during intimate foreplay.
- Requires consistent and diligent use.
- Typical use has a failure rate of approximately 14%.
- It places more responsibility on the male partner.

Further, there are two additional drawbacks. *First*, the condom keeps the seminal fluid from entering into the female genital tract. Should it eventually be proven, as some maintain now, that the absorption of this fluid from the vagina is of some physiological value to the woman; such benefit is naturally lost when this method is employed. *Secondly*, the male methods make the women dependent upon the man for contraceptive protection. If he is indifferent or careless or in an irresponsible condition, she may not be adequately protected. It is often, therefore, better that the wife takes necessary precaution (Hannah and Abraham Stone, 1976).

10.4.1.3 Male Sterilization (Permanent Methods)

Sterilization is a form of birth control. All sterilization procedures are meant to be permanent. Male sterilization involves application of methods that make male permanently sterile. By means of application of X-rays to the sex glands or through surgical operation it is possible to make a man permanently incapable of reproduction. Male sterilization may thus be done in the following ways.

- i) **Exposure of sex glands to heat or X-rays:** It has been shown that in animals the application of heat in the form of hot water, hot air or an electric light to the outside of the scrotum may arrest sperm formation for several weeks. Exposure of the sex glands to heat or X-rays affects the sperm production. The testes, for instance, are very sensitive to changes in temperature, and when they are exposed to heat their sperm-producing function is considerably diminished. This procedure has thus far been applied to men in a few experimental cases only and with further research it may be developed into a suitable contraceptive measure. Similarly, exposure of the testes to X-rays can also arrest their capacity to produce spermatozoa either temporarily or permanently depending upon the dose of the X-rays and the length of the treatment. The use of X-rays for contraceptive purposes, however, carries certain potential dangers. There is the possibility that the effect of the rays may be too lasting and that the man may become permanently sterile or that the spermatozoa produced later on may not be normal in quality and that as a result the future offspring may show certain defects in development (Hannah and Abraham Stone, 1976, pp.155-156).
- ii) **Sterilization through surgical operation:** Male sterilization through surgical operation is popularly called *vasectomy*. The surgical procedure consists of producing an artificial obstruction to the passage of the sperm cells from testes by blocking the vas deference. As the bulk of the seminal fluid comes from the seminal vesicles and from the prostate, the ejaculation will continue in a fairly normal manner and quantity, but the seminal fluid will not contain any spermatozoa and the individual will be rendered sterile. It is a safe, simple, quick and convenient surgery done under local anesthetic in just a few minutes in a clinic or office. It requires but a few days of rest and the recovery is quite rapid. It is very effective after 20 ejaculations or 3 months, till the semen sample is found to be negative for sperms. It does not affect the sexual ability or feelings. It also does not have long-term side effects.

There are simple but variety of methods of male sterilization – traditional vasectomy (which uses scalpel), no-scalpel vasectomy, and occlusion techniques (ligation/tying with suture material, cautery – electrosurgical or thermal coagulation, clipping, facial interposition – placing tissue barrier between two cut ends), and open-ended vasectomy or a combination of more than one of these methods/techniques.

Surgeons use a variety of surgical techniques for occluding the vas, which suggests that no single method has been shown to be superior to others. Facial interposition – which can be used with most occlusion techniques – when performed in combination with ligation and excision, reduces the risk of occlusion failure without increasing the cost or side-effects of the procedure (http://apps.who.int/rhl/fertility/contraception/CD003991_xiaozhangl_com/en/index.html).

Vasectomy Side Effects and Surgical Complications: As with any surgical procedure, there can be some side effects as follows, but major complications are very rare (<http://menshealth.about.com/cs/surgery/a/vasectomy.htm>).

- ***Pain:*** Any pain or discomfort should stop after about a week. Most pain will respond well to mild analgesics.
- ***Infection:*** A small amount of redness, bruising and swelling is normal. If he develops a temperature, or if the swelling does not subside — go down, increases or becomes very painful — it is always better to seek medical advice.
- ***Granulomas:*** A benign (non-cancerous) lump may develop as a result of leakage of sperms from the cut end of the vas into the scrotal tissues resulting in an inflammatory reaction. This lump may be painful or sensitive to touch or pressure and is generally treated with anti-inflammatory agents. In a very small number of cases, sperm granulomas cause more serious complications; reversal of the vasectomy may be attempted to resolve this problem.
- ***Epididymitis:*** It occurs when inflammation at the site of the vasectomy can cause swelling of the epididymus (the tightly-coiled tube connecting the efferent ducts from the rear of each testicle to its vas deferens). Swelling should subside within about one week.
- ***Abscesses:*** These are rare; they are the result of infection from the operation, or may be picked up post-operatively.
- ***Erectile dysfunction or decreased sexual desire:*** It can occur in the form of impotence, premature ejaculation or painful intercourse. The cause may be mostly psychological in nature; the vasectomy may exacerbate previous difficulties and problems between sexual partners. Counseling may be required to resolve difficulties.
- ***Pregnancy Following a Vasectomy:*** In rare cases, pregnancy has occurred following vasectomy. The causes include a failure in the surgical procedure, the man not using additional contraceptive methods in the three months following the procedure, or complications following the vasectomy.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

- 2) List out different birth-spacing methods and techniques available for males as a part of their family planning efforts.

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- 3) What are the methods of male sterilization?

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10.4.2 Female Methods and Techniques of Contraception/ Family Planning

The sole objective of the female methods and techniques of family planning is to prevent spermatozoa from entering into the uterus or to prevent fertilization or to prevent the fertilized egg (zygote) from implanting or developing in the uterus. There are more methods and techniques available for a woman to adopt for avoiding pregnancy or for spacing and prevention of child birth. These are as follows.

10.4.2.1 Natural Family Planning Methods: Biological Contraceptive Methods

The biological methods of contraception are still in the experimental stage and future progress in contraception lies in this field.

Biological methods of contraception or natural family planning (NFP) methods are the inexpensive methods available to the married couples. There are four ways or methods of practicing NFP.

- a) Lactation or breast-feeding
- b) Safe period or rhythm method
 - Ovulation calendar method
 - Basal body temperature method
 - Cervical mucus method
- c) Sympto-thermal method.

i) **Lactation or breast-feeding:** The idea that a woman cannot conceive during the period of lactation has been widely held, yet there is little scientific basis for it. Many women, in fact, do conceive during the period of nursing. Among the primitive peoples, nursing is sometimes prolonged for many years supposedly in the belief that it acts as a contraceptive measure (Hannah and Abraham Stone, 1976, p.129). This is the method that is useful in spacing the next pregnancy.

ii) **Safe period or rhythm method:** In this method of NFP, the principle involved to prevent pregnancy is based on the understanding of the fertile phase of the menstrual cycle through biological signs and symptoms or the changes that occur in the body during the menstrual cycle as in body temperature, cervical mucus, etc. Essentially, this method involves restricting sexual intercourse to the infertile phase of the woman's menstrual cycle which is called 'safe period'. It is also called *rhythm method* or *calendar method* as it repeats in rhythmic manner in every menstrual cycle or month. It is based on the following biological facts and assumptions:

- Only one egg (ovum) is normally released during each menstrual cycle and this egg has an active life of about 12 hours and certainly not longer than 48 hours, during which it is capable of being fertilised by a sperm;
- The sperm has an active life of about 48 hours or more, during which it is capable of fertilising an ovum;
- Conception is possible only when sexual relations take place just around ovulation time; and
- Conception can normally occur during about 60 hours in each menstrual cycle, and if no sexual intercourse takes place during this period, pregnancy may be avoided.

While the average menstrual cycle is about twenty-eight days, there is usually a fluctuation of several days between one cycle and the another. As these cycles, in general, are irregular with some variation, some cycles are shorter and some are longer. However, the difference between the shortest and the longest cycles in a woman during a year is not more than about six to eight days. In a normal cycle of twenty-eight days, a woman presumably ovulates on thirteenth, fourteenth or fifteenth day, counting from the first day of her preceding menstruation. Three days are then added on each side for the possible survival time of the spermatozoa and the egg. So, her fertile period is between tenth and eighteenth days of her cycle and remaining days of the cycle together form infertile period or the safe period, i.e. from the first day of her menstruation to tenth day and again from the nineteenth day up to the onset of her next menstruation. To make allowance for the fluctuation in the

fertile period due to irregular cycles, if we add three days on each side *her fertile period extends from the eighth to the twenty-second day*, and *her safe period from first to seventh day inclusive, and again from the twenty-third day until the beginning of next menses*. Thus, suppose her period begins on the first of August, she would be relatively infertile from the first to the seventh of August and fertile from the eighth to the twenty-second of the month, and then infertile again from the twenty-third of August to the beginning of her next menstruation (Hannah and Abraham Stone, 1976, pp.134-135).

Normally, ovulation takes place 12 to 16 days before the next menstrual period begins. The period during which the likely occurrence of conception is determined is two days before ovulation and half a day after it, taking into account the active life of the sperm and the ovum. Thus, in the case of regular cycles/periods of 28 days, the *fertile period extends from 10th to 17th day from the day of preceding menstruation* (safe period is from 1st to 9 day and 18th to the last day of the cycle). In other words, *11th to 18th day preceding the next menstrual date is the fertile period*, and the remaining days together form safe period. Therefore, if the time of ovulation is known, it is easy to practice this method. As the safe period has to be determined on the basis of next menstrual period, it becomes difficult to determine it accurately, and more so when the periods are irregular and if reliance is placed only on the probable date of the next menstruation.

There are three ways in which the “safe period”, that is, the period during which a woman will not become pregnant, may be determined: a) the calendar method, b) the temperature method, and c) cervical mucus method.

a) The Calendar Method (Calculation of time of ovulation): After keeping a record of the menstrual cycle for eight to twelve months, a woman identifies her shortest and longest cycles. From the shortest cycle she subtracts 18 to determine the first fertile day of her cycle. Then she subtracts 11 from her longest cycle and determines the last fertile day of her cycle. This calculation may be explained by the following illustrations (i.e. if the variations between cycles are not too great the probable time of ovulation can still be estimated).

- Suppose a study of the menstrual calendar of a woman shows that during the year the cycles had varied from twenty-six to thirty-two days. If the woman's menstrual period, let us say, now begins on the 1st of August, then her next menstrual period would presumably come not earlier than the twenty-seventh of August and not later than the second of September. If we, then, consider that ovulation occurs about twelve to sixteen days before the onset of next period, in this case it could happen on any day between 11th and 19th of August.
- Suppose, after maintaining a record of 12 months, another woman finds that her shortest cycle was 27 and her longest cycle was 29 days, then the 9th day (27-18) becomes the first fertile day and the 18th day (29-11) becomes her last fertile day. Thus, sexual intercourse should be avoided from the 9th to the 18th day, that is, the fertile or the “unsafe” period during the menstrual cycle, if pregnancy is not

desired. A simple variation of the calendar method is to allow sexual intercourse only during the first and the last week of the menstrual cycle, and allow for a longer period of abstinence. The calendar method of practicing the rhythm is useful for those women who menstruate fairly regularly, but does not allow for occasional irregularities. This method, however, cannot be applied immediately after delivery, during lactation and when a woman is approaching her menopause.

- b) *The Temperature Method (Basal Body Temperature Method):*** It has been found that the body temperature of a woman is quite low after the menstrual cycle and may fall still lower on the day of ovulation, after which it starts rising and remains high until a day or two before menstruation begins, and then drops again when menstruation begins. It is possible for a woman to determine the time of ovulation by taking her temperature every day with the help of specially designed thermometer, which shows the slightest variations. The temperature has to be taken every morning as soon as woman wakes up; before she gets out of bed or indulges in any activity, she must record a temperature on the chart. She must also learn how to read and interpret the monthly charts correctly, allowing for a change due to illness, emotional disturbances or changes in climate. Sexual intercourse allowed only during the post-ovulatory phase, if pregnancy is not desired. (Hannah and Abraham Stone, 1976, pp.136-137).

By combining the basal body temperature method with the calendar method, fertile days can be predicted correctly and the risk of unintended pregnancy can be lessened. A woman's temperature rises slightly (between 0.4 and 0.8 degrees) when she ovulates. If she records temperature every morning before she gets out of bed using a special high-resolution thermometer, and she discovers a rise one day then you can presume that she has ovulated and she should refrain from unprotected sex (<http://www.dummies.com/how-to/content/natural-family-planning-the-basal-body-temperature.html>).

Advantages of the basal body temperature method: These include the following (Ibid).

- Because this is really an accompaniment to the calendar method, the same advantages apply – it does not require any doctor appointments and it comes without side effects.
- Basal body temperature is best used as proof that the calendar method is working. Having some measure of proof of natural family planning (aside from not being pregnant) can provide reassurance.
- If pregnancy is desired, the basal body temperature is a good predictor to have sexual intercourse.
- Other advantages of this method are that a woman learns to tell the fertile time of her monthly cycle, knowing which a couple can avoid vaginal sex, or they use condoms, or follow withdrawal during the fertile time. No special equipment is required; it is enough to have a calendar, a thermometer and graph paper on which the temperature is recorded.

Disadvantages of the basal body temperature method: These include the following (Ibid).

- The same disadvantages of the calendar method apply here as well – it is not a particularly reliable method of birth control, especially for women with irregular cycles. Plus, outside factors, such as a lack of sleep, can cause a woman's temperature to vary.
- Basal body temperature alone cannot be relied upon because sperm can live for two to three days and any sperm deposited ahead of time can still impregnate the woman. This means that a woman must also follow the calendar method, which precludes sex during much of the month.
- Other disadvantage is that it is not an easy method to practice and requires a high degree of motivation. Many couples find it extremely restrictive. It is also not suitable when the menstrual cycle is not regular.

c) ***Cervical mucus method:*** This method is also known as Billings or the ovulation method. Dr. John Billings and his wife Evelyn Billings developed this method of natural family planning. It is based on the changes in the cervical mucus throughout the menstrual cycle due to changes in the sex-hormones. A woman feels sensation on her vulva and the changes that occur in her cervical mucus. After menstruation, the woman feels dryness for a few days followed by wet and sticky mucus which indicates her possible fertile phase. Gradually, the mucus becomes clearly visible, slippery, lubricating and stretchy. This phase indicates the greatest fertile phase and continues for a few days. The last day of the lubricating and stretchy mucus is the peak day. Three days later the fertile phase ends. During this period, the mucus becomes thick and sticky and a dry sensation starts. From the fourth day of the peak day of the mucus, until the first day of the onset of the next menstrual cycle, the late infertile or post-ovulation phase continues. *For avoiding pregnancy, the couple should abstain from sexual intercourse from the day woman begins to experience wetness or mucus until the third or fourth day after the peak day of the mucus.* A variation of the Billings method of ovulation is known as the modified mucus method developed in India during the 1980s. This method reduces the period of abstinence and relieves the couple from maintaining the chart of the mucus pattern. It is, thus, a simple single-indicator method and easy to understand and practice. It helps achieve the pregnancy as well as avoid the pregnancy without any external manipulation or use of drugs or other devices. Its demerits are that: it preaches long abstinence to the beginners, which is difficult; it involves charting of the menstrual cycle in order to identify the mucus pattern and know the fertile and dry (infertile) days; and it requires a good deal of understanding and cooperation between the spouses (Seshadri and Pandey, 1991, pp.267-268).

iii) **Sympto-thermal method:** This method of NFP is a combination of BBT method and cervical mucus method which the couple can adopt by observing a number of symptoms. Besides watching the basal body temperature and changes in mucus pattern, the couple can take note of other physiological changes related to ovulation as indicators like tenderness of the breasts, sensation and wetness around the vulva, position of the cervix and abdominal

mid-cycle pain, spotting or bleeding that occur before or at the time of ovulation. As these indicators signal the fertile period, couples abstain from sexual intercourse in order to avoid pregnancy. From the first day of appearance of the wetness around the vulva to the third day of the increased basal body temperature or until the fourth day after ovulation or peak day of the mucus, the abstinence should be maintained. Since it is a combination of two methods, it has a higher probability of success in avoiding pregnancy. However, it is a cumbersome method, as it is based on the principles of BBT and cervical mucus methods and necessitates the observation of several other indicators (Seshadri and Pandey, 1991, pp.268-269).

The rhythm method, also called the *fertility awareness method*, is thus a form of pregnancy prevention where couples calculate a woman's fertile time using a calendar and fertility signals, like cervical mucus, temperature and date of her last menstrual period (<http://www.livestrong.com/article/39387-advantages-disadvantages-birth-control/>).

Advantages: The advantages of rhythm method include the following (Ibid).

- The rhythm method doesn't require a doctor's prescription because couples practice it at home, so it's a method couples always have access to.
- Many couples like the rhythm method because it's all natural form of birth control and doesn't require taking synthetic hormones or inserting medical devices for pregnancy prevention.
- Many couples see the rhythm method as a form of birth control whose responsibility is equally divided between both the partners.

Disadvantages: The disadvantages of rhythm method as follows (Ibid).

- The sperms live an average of three days in the body, but for some women, sperm can live in their bodies for up to seven days. This makes it difficult to plan when it's completely safe to have sex.
- Because each woman's menstrual cycle is different and factors like diet, stress and age can cause a woman's menstrual cycle to change, it cannot be relied to the extent it is difficult to determine the exact time a woman is fertile.
- The rhythm method doesn't provide any protection against sexually transmitted infections including HIV.

10.4.2.2 Chemical Contraceptives: Spermicides

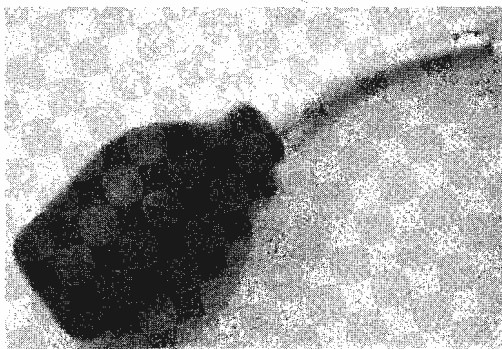
The chemical contraceptives are used either after the sexual intercourse or before it.

i) **Chemical contraceptives used after sexual intercourse:** Douche is the oldest method that was used mostly in the past after intercourse, and it is discussed below.

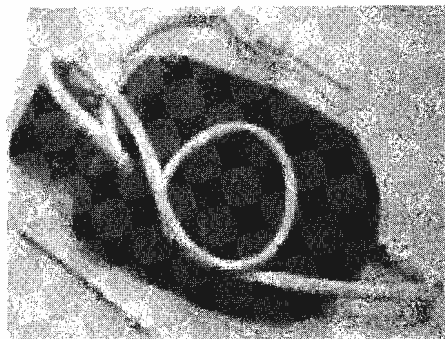
- **Douche:** It is a widely used chemical method. It is designed to remove the seminal fluid from the vagina after intercourse. Conception will not occur if all the sperms can be removed or destroyed by the douche before they have a chance of getting into the uterus. The addition of antiseptics to the douche presumably enhances its protective value by destroying the spermatozoa, but plain or soapy water is probably as effective for this purpose as any of the commercially advertised antiseptics.

The practice of douching is now largely restricted to the United States, where douching equipment is often available in pharmacies. A 1995 survey, quoted in the University of Rochester study, found that 27% of the U.S. women aged 15 to 44 douched regularly, but that douching was more common among African-American women (over 50%) than among white women (21%) (<http://en.wikipedia.org/wiki/Douche>).

Vaginal douches may consist of water, water mixed with vinegar, or even antiseptic chemicals. Douching has been touted as having a number of supposed but unproven benefits. In addition to promising to clean the vagina of unwanted odors, it can also be used by women who wish to avoid smearing a sexual partner's penis with menstrual blood while having intercourse during menstruation. Many health care professionals state that douching is dangerous, as it interferes with both the vagina's normal self-cleaning and with the natural bacterial culture of the vagina, and it might spread or introduce infections. For example, the U.S. Department of Health and Human Services strongly discourages douching, warning that it can lead to irritation, bacterial vaginosis, and pelvic inflammatory disease (PID). Frequent douching with water may result in an imbalance of the pH of the vagina, and thus may put women at risk for possible vaginal infections, especially yeast infections. Antiseptics may also result in an imbalance of the natural bacteria in the vagina, also resulting in an increased likelihood of infection. Furthermore, unclean douching equipment may also introduce undesirable foreign bodies into the vagina. For these reasons, the practice of douching is now strongly discouraged except when ordered by a physician for specific medical reasons. Douching may also wash bacteria into the uterus and Fallopian tubes, causing fertility problems. Douching after intercourse is estimated to reduce the chances of conception by only 15-25%. In some cases douching may force the ejaculate further into the vagina, increasing the chance of pregnancy. A review of studies by researchers at the University of Rochester Medical Center (N.Y.) showed that women who douched regularly and later became pregnant had higher rates of ectopic pregnancy, infections, and low birth-weight infants than those of women who only douched occasionally or who never douched (<http://en.wikipedia.org/wiki/Douche>).



A vaginal bulb syringe with lateral holes near the tip of the nozzle about 1 cm, or ½ inch, thick
ICD-9-CM 96.44
MeSH D044364



This "fountain syringe" should only be used for douching, by replacing the attached enema nozzle with the vaginal nozzle (shown bottom left). The vaginal nozzle is longer and thicker and has lateral holes.

Source: <http://en.wikipedia.org/wiki/Douche>

There is one major disadvantage with douche. If a chemical contraceptive is to be relied upon, it should be of the type that is to be placed in the vagina prior to, rather than after, the sex act. This is so because, it is possible for the spermatozoa to enter the uterus very soon after the ejaculation. Further, it is even maintained by some that by the end of the sexual act the uterus exerts an actual suction so that a certain amount of seminal fluid is drawn into it directly, although this has not been definitely proven.

ii) **Chemical contraceptives used prior to sexual intercourse:** Chemical contraceptives placed in the vagina prior to the sex act are made up in the following forms (Hannah and Abraham Stone, 1976, pp.147-150):

- Suppositories,
- Tablets and powders
- Jellies and creams
- Foam powder

They consist of various bases into which certain chemical ingredients are incorporated. In the vaginal canal, these preparations are supposed to dissolve or spread along the vaginal walls and cover the uterine opening, forming a mechanical barrier to the passage of the sperms. At the same time, the liberated chemical ingredients are intended to immobilize the sperms and render them inactive.

- **Suppositories:** These are made by incorporating one or more chemical ingredients in a cocoa, gelatin, or some other base which is solid under normal temperature, but when introduced into the vagina it is supposed to dissolve/melt at body heat and liberate its chemical contents. It is assumed that the base, after melting will form an oily or gelatinous layer over the mouth of the uterus, producing a mechanical barrier to the entrance of the spermatozoa while the chemicals will serve to immobilize the sperms. Therefore, to be effective, the suppository must melt readily, but this is often not the case. Even if the suppository does melt, it may not cover the uterine opening and it is possible for the sperms to enter the uterus very soon after coitus. It is thus obvious that the suppositories will have no effect under such circumstances. On the other hand, many people object to them because of the excessive oiliness or greasiness which is produced when they melt.
- **Tablets and powders:** The tablets on dissolving are supposed to liberate gas which in turn forms a foamy mass in the vagina and acts both as a chemical and mechanical contraceptive. In order for the tablet to dissolve, a certain amount of moisture is required and sometimes the moisture normally present in the vagina is insufficient. Powders too often fail to dissolve and, in addition, they have drying effect upon the vaginal walls which may sometimes become rather uncomfortable.
- **Jellies and creams:** Because the jellies and creams are already in a semisolid, gelatinous or creamy state, they spread much more readily along the vaginal canal and across the uterine opening. They are put up in collapsible tubes to which a special nozzle can be attached. The nozzle is inserted into the vagina and by compressing the tube some of the jelly is expressed into the vaginal canal. No jelly or cream is entirely reliable as a contraceptive by itself, although newer products are being

developed holding the promise of being highly effective. Jellies and creams, sometimes, cause over lubrication or leakage from the vagina and this is an aesthetic drawback to their use.

- **Foam powder:** This consists of a foam producing powder used in conjunction with a small sponge. The powder contains a non-soapy, lathering agent which, in the presence of moisture and friction, produces a foamy mass. The sponge is moistened and a little of the powder sprinkled on it, it is then kneaded between the fingers until a good foam is produced and inserted into the vagina. The foam is supposed to act as a chemical and mechanical barrier to the progress of the spermatozoa. This method has the advantage of simplicity as well as low cost, but it has not proven to be sufficiently reliable and, in some cases, cause irritation to the tissues.

10.4.2.3 Mechanical Contraceptives (Vaginal and Intra-Uterine Devices)

The most reliable methods available at present are the mechanical devices which actually cover up the entrance to the uterus and, thus, form a mechanical barrier to the passage of the sperms from the vagina into the cervix. These are made in several shapes and sizes.

- i) **Diaphragms:** Diaphragms are 'domes' made of thin, soft rubber or silicone. They form an excellent physical 'barrier' to sperms – though a spermicide (chemical) is used with them as well. Diaphragms and caps were extremely popular methods of family planning during the 20th century. But, their use has waned in recent years because new methods of contraception have become available. Diaphragms are a good deal bigger than cervical caps – they're about as wide as the palm of our hand. Diaphragm is put into vagina before sex, positioning it so that it keeps sperms from getting anywhere near cervix (http://www.netdoctor.co.uk/sex_relationships/facts_diaphragms.htm).

Diaphragms, also called pessaries, are designed to lie diagonally across the vaginal canal. They are made of soft rubber with a flexible metal spring around the circumference, are hemispherical in shape, and range from two to four inches in diameter. There are over twenty different sizes of diaphragms and it is not possible to tell the size that a woman requires without an individual gynecological examination. Since considerable variation exists in pelvic anatomy, a woman should no more use a diaphragm which has not been fitted for her individually. It is usually very simple for the woman to learn the technique of its insertion and removal. Before insertion, she smears the pessary with about half a teaspoonful of a contraceptive jelly or cream, which acts as a lubricant to make insertion easier and as an additional chemical safeguard. She then introduces the diaphragm into the vagina either manually or with the aid of a special inserter either before retiring or immediately before the sexual relation. If she wishes, she may remove it immediately after coitus, or she may leave it in until the next morning or even for twenty-four hours. However, if she does remove it soon after coitus, she should douche both before and after removal in order to wash out the seminal fluid from the canal. Diaphragm is both reliable and satisfactory method. It acts as a veil over the opening of the uterus and prevents the entry of the seminal fluid and, at the same time, it permits direct contact

between the male organ and the vaginal wall so that sensation is little affected. If the correct size is chosen neither the woman nor the man should be conscious of its presence. However, the diaphragm cannot be prescribed while the hymen is still in tact. Therefore, for the first two or three weeks of marriage, it is the man who must employ preventive measures, if a conception is to be avoided (Hannah and Abraham Stone, 1976, pp.151-153).

- ii) **Cervical Caps:** When a diaphragm cannot be used, a cervical cap is sometimes prescribed. The cap is designed to be placed directly over the neck of the uterus, the *cervix*, which it fits snugly. Cervical caps are usually made of rubber and they come in several sizes. After the physician has chosen the correct size, the woman is taught how to insert and remove the cap herself. She uses it just as she would a diaphragm, inserting it when she needed and leaving it in place until the next morning.
- iii) **Female Condom:** The female condom is a thin sheath or pouch worn by a woman during sex. It entirely lines the vagina and helps to prevent pregnancy and sexually transmitted diseases (STDs) including HIV. It typically comes in various sizes. Size should be carefully selected as not to cause any user discomfort, as well as to prevent errant sperm from bypassing the condom. The inner ring at the closed end of the sheath is used to insert the condom inside the vagina and to hold it in place during intercourse. The rolled outer ring at the open end of the sheath remains outside the vagina and covers part of the external genitalia.

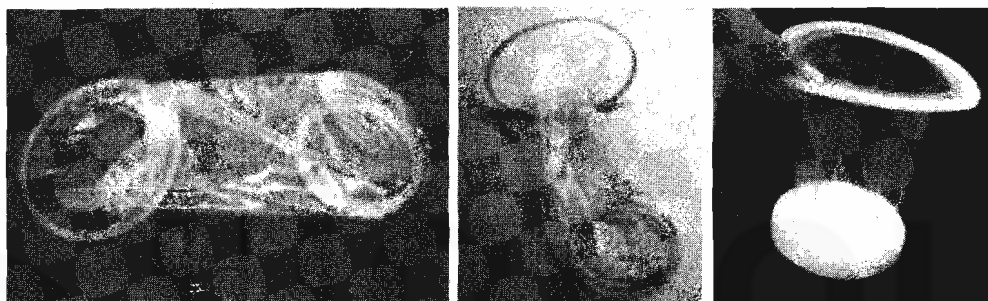
The FC and FC2 female condoms: The FC2 female condom is a nitrile sheath or pouch 17 cm (6.5 inches) in length. At each end there is a flexible ring. At the closed end of the sheath, the flexible ring is inserted into the vagina to hold the female condom in place. The other end of the sheath stays outside the vulva at the entrance to the vagina. This ring acts as a guide during penetration and it also stops the sheath from moving up inside the vagina. There is a silicone-based lubricant on the inside of the condom, but additional lubrication can be used. The condom does not contain spermicide (<http://www.avert.org/female-condom.htm>).

The original version of the FC female condom (brand names included Reality, Femy and Femidom), was made of polyurethane. As this was a relatively expensive material to use, the makers of the FC female condom released the FC2 version, using the cheaper nitrile material. Large-scale production of the FC2 began in 2007. Production of the original FC condom has now stopped. The FC2 female condom received United States Food and Drug Administration (FDA) approval in March 2009 (Ibid).

Other types of female condom: The VA w.o.w Condom Feminine (or VA for short) is made of latex. At around 9 cm (3.5 inches) it is shorter than the FC2. It has a rounded triangular frame at the open end and a sponge inside the closed end, which helps to anchor it inside the vagina. The VA is lubricated and does not contain spermicide. Oil-based lubricants should not be used with this female condom as they can damage latex. The VA has received the CE mark for distribution in the European Union, but has not received The United States Food and Drug Administration (FDA) approval. The World Health Organization is due to review the product following the

results from a 2011 clinical trial. Other female condoms include Cupid female condom (produced and distributed in India) and the Phonenurse female condom (produced and distributed in China) (Ibid).

The FC2 has several *advantages*: It provides an opportunity for women to share the responsibility for condoms with their partners; a woman may be able to use the female condom if her partner refuses to use a male condom; the female condom will protect against most STDs and pregnancy if used correctly; female condom can be inserted in advance of sexual intercourse so as not to interfere with the moment. No special storage requirements are needed because nitrile is not affected by changes in temperature and dampness. In addition, nitrile conducts heat well, so sensation is preserved. It can be specially beneficial for the sex workers who sometimes are not able to negotiate or convince their male partner to use male condom (Ibid).



1. An FC Female Condom

2. FC2 Female Condom

3. VA w.o.w Condom
Feminine

Sources: 1. <http://www.avert.org/female-condom.htm>
2. <http://www.fc2.us.com/>
3. <http://www.avert.org/female-condom.htm>

However, it has some *disadvantages* such as the following: a) The outer ring or frame is visible outside the vagina, which can make some women feel self-conscious; b) The FC2 female condom can make noises during intercourse (adding more lubricant can lessen this problem); c) Some women find the female condom hard to insert and remove; d) It has a higher failure rate in preventing pregnancy than non-barrier methods such as the pill; e) In some countries, it can be relatively expensive and limited in availability (Ibid).

- iv) **Intra-Uterine Devices (IUDs):** Initially the IUDs were called 'buttons' or 'stems', made of metal or rubber and often caused varying types of complications and harmful effects. Further, they had not proved to be very satisfactory and reliable, though they may cause pain, bleeding, etc. (Hannah and Abraham Stone, 1976, pp.154-155). Of course, currently the improved versions have proved very effective, cheap and highly satisfactory without any side effects or harmful effects. Once the IUD is removed, the fertility returns fast.

IUDs are of different types. The T-shaped copper IUD (CuT-200 mm²) is a popular device in India. The earlier popular brand was Lippes loop. Now, newer generations of copper, silver, gold and hormonal and plastic IUDs with tails or threads are available. The IUD is inserted into the uterus by the doctor or the trained paramedical personnel. It remains in the uterus for a

few years until automatically expelled or deliberately removed. It helps avoid conception and also prevents implantation of the fertilized ovum on the uterine wall (Seshadri and Pandey, 1991, p.271).

Types of IUDs: Following are the types of IUDs (http://www.ippf.org/nr/rdonlyres/20f550fd-ca6f-41bd-bd66-b155dd30bc08/0/37_2_apr03.pdf).

- **Inert IUDs:** Inert devices such as the Lippes loop should no longer be inserted, but women who have an inert device in situ, and are content with it, can continue to use it up to the menopause.
- **Copper-bearing IUDs:** The most widely used copper-bearing IUD, and the one for which there is greatest information on safety and effectiveness, is the TCu380A. Other current devices are the TCu220C, the Multiload Cu375, and the Nova T. Older copper-bearing IUDs such as TCu 200 and the Copper 7 should no longer be used.
- **Hormone-releasing IUDs:** The progestogen-releasing IUD (Mirena, Levonova) releases 20 micrograms of levonorgestrel per day. It is available in more than 60 countries but costs more than the copper-bearing IUDs – a disadvantage particularly in developing countries.

Tcu-380A IUD lasts at least 10 years. Failure rates are usually less than 1 per 100 women in the first year of use. The menstrual periods, especially at first, may be heavier and longer. There is no effect on breastfeeding (http://www.ippf.org/nr/rdonlyres/20f550fd-ca6f-41bd-bd66-b155dd30bc08/0/37_2_apr03.pdf).

Advantages: Many women choose an IUD as their method of contraception for reasons of efficacy, safety, and the convenience of not requiring action daily or precautions with every act of sexual intercourse. Copper-bearing devices have no systemic side-effects, and in long-term users these are less costly than other contraceptive methods. They can be used by breastfeeding women without affecting lactation or posing a risk to the infant, though in such women a levonorgestrel-releasing IUD should not be inserted until 6 weeks post-partum (Ibid).

Adverse effects: These include the following (Ibid).

- **Infection:** It is not a good method for a woman likely to get STDs. (For example, if she has more than one sex partner, or her sex partner has other partners). In such cases, STDs could lead to pelvic inflammatory disease (PID).
- **Bleeding:** In the first three to six months after insertion of a copper bearing IUD, women commonly report that menstrual bleeding has become heavier or longer. Usually this does no harm, and it tends to improve with time. In some women, however, the bleeding causes iron-deficiency anaemia.
- **Pain:** When pelvic pain other than dysmenorrhoea develops at any time after IUD insertion, the woman should be investigated for possible incorrect placement of the device or infection.
- **Perforation:** Perforation is a rare event which almost always occurs at the time of insertion, when it may be accompanied by sudden pain and/or bleeding. If perforation occurs, the device should be removed unless the risk of surgery is believed to exceed that of non-intervention.

- **Expulsion:** Spontaneous expulsion may occur, particularly during menstruation and within the first three months of use. After childbirth, expulsion is less likely with interval insertions than with insertions done within 24 hours post-partum.

Removal: IUD is removed under the following conditions (Ibid).

- At whatever time a woman seeks removal of her IUD, this request must be granted. Removal may be required for both medical or other reasons. The medical indications are:
 - Pregnancy;
 - Treatment required for endometrial or cervical malignancy;
 - Partial expulsion of the IUD;
 - Excessive bleeding affecting health or considered unacceptable by the woman.
- Other indications are:
 - Menopause – one year after last period;
 - Expiry of the effective lifespan of the IUD (no such time limit applies to non-medicated IUDs);

Replacement: If a woman wishes to continue using an IUD after expiry of the effective lifespan of her IUD, a new IUD may be inserted immediately after removal of the old one. The recommendations regarding reinsertion, including the screening process, are the same as those for first insertion.

10.4.2.4 Immunization against Conception: Spermatoxins and Hormones

Spermatoxins and hormones are used for immunization against conception. Such immunisation is done in the following ways.

- 1) **Birth Control Pills (Oral Contraceptive Pills):** Birth control pills are medications that prevent pregnancy. These may be *hormonal* or *non-hormonal*.
 - a) **Hormonal Contraceptive Pills:** Oral contraceptives are hormonal preparations that may contain progestin-hormone alone or combination of the hormones, estrogen and progestin.
 - **Minipill:** Minipills contain only a low dose of progesterone. They are not as effective as a combined pill. An example of a minipill is Ovrette.
 - **Combination Contraceptive Pills:** Combinations of estrogen and progestin prevent pregnancy by inhibiting the release of the hormones – luteinizing hormone (LH) and follicle stimulating hormone (FSH) – from the pituitary gland in the brain. LH and FSH play key roles in the development of the egg and preparation of the lining of the uterus for implantation of the embryo. Progestin also makes the uterine mucus (that surrounds the egg), thicker and difficult for sperm to penetrate and, therefore, difficult for fertilization to take place. In some women, progestin inhibits ovulation (release of the egg) (http://www.medicinenet.com/oral_contraceptives_birth_control_pills/article.htm).

Estrogen is usually in the form of ethinyl estradiol while the progestin may be in different forms such as levonorgestrel, desogestrel, norgestimate or gestodene. Combined pills are available in 2 different packs, the 21-day pack and the 28-day pack. The 28-day pack contains both the hormones in the first 21 pills and the last 7 pills have no hormones and are referred to as the spacer pills. In some packs, these spacer tablets contain iron. The pills are to be consumed daily at the same time. The common brands available in the US market are Levlite, Alesse, Mircette and LoEstrin, while those in the Indian market are Mala D, Ovral, Novelon and Femilon (<http://www.medindia.net/patients/patientinfo/birthcontrolpills.htm>).

In National Family Welfare Programme of India, Mala-N (Norethisterone acetate 1.0 mg and ethinyl 0.03 mg) and Mala-D (Levonorgestrel 0.5 mg and ethinyl oestradiol 0.03 mg) are available in packets of 28 tablets (21 contraceptive pills + 7 iron tablets). The pills are to be taken regularly by month. The success rate of contraceptive pills is high if used regularly. Its other merits include: it is a self-administered method of contraception; and it is a reversible method (Seshadri and Pandey, 1991, pp.271).

Types of combination contraceptive pills: There are different types of *combination contraceptive pills* that contain estrogen and progestin that are referred to as “monophasic,” “biphasic,” or “triphasic.” (http://www.medicinenet.com/oral_contraceptives_birth_control_pills/article.htm).

- *Monophasic birth control pills* deliver the same amount of estrogen and progestin every day.
- *Biphasic birth control pills* deliver the same amount of estrogen every day for the first 21 days of the cycle. During the first half of the cycle, the progestin/estrogen ratio is lower to allow the lining of the uterus (endometrium) to thicken as it normally does during the menstrual cycle. During the second half of the cycle, the progestin/estrogen ratio is higher to allow the normal shedding of the lining of the uterus to occur.
- *Triphasic birth control pills* have constant or changing estrogen concentrations and varying progestin concentrations throughout the cycle. There is no evidence that bi- or triphasic oral contraceptives are safer or superior to monophasic oral contraceptives, or vice versa, in their effectiveness for the prevention of pregnancy.

Thus, the phased pills may be either biphasic or triphasic. In these pills, the estrogen dose is kept more or less constant while the progestin dose is progressively increased in the later stages of the cycle. Common triphasic pills are Triquilar and 3-Phase (<http://www.medindia.net/patients/patientinfo/birthcontrolpills.htm>).

Emergency contraception – Morning After Pill (Emergency contraceptive pills: Emergency contraception is the birth control done through the pill that prevents pregnancy after sex, which is why it is sometimes called “*the morning after pill*,” “*the day after pill*,” or “*morning after contraception*”. Morning after pill or the emergency contraceptive pill is used after sexual intercourse to prevent pregnancy.

It contains a progestin either as 1 or 2 tablets. It is available in brands such as I-pill, Oops and Pill 72.

The women can use emergency contraception right away or up to five days after sex, if she thinks that the birth control she used has failed or she didn't use contraception or she was forced to have sex. Emergency contraception makes it much less likely for a women to get pregnant. But, emergency contraceptives are not as effective as birth control that's used before or during sex, like the pill or condoms. So, it is advisable for a sexually active woman not to use emergency contraception as the only protection against pregnancy or as a regular means to avoid pregnancy (<http://www.drew.edu/health/emergency-contraception>).

Thus, the pill is the most reliable and effective contraceptive available today, if it is taken regularly every day for best protection. It contains synthetic ovarian hormone like substances and has three definite effects: a) The pill inhibits ovulation and completely rules out the possibility of conception, since there is no release of ovum which can be fertilized by the sperm; b) The cervical mucus becomes thick and hostile to penetration by sperms; and c) The development of endometrium is impaired, making it unsuitable for embedding of the fertilized ovum.

The reasons for high acceptability of pills are that they are easy to take and reversible. Some users have side effects such as upset stomach, bleeding between periods or spotting, weight gain, or mild headache especially in first few months. It is safe for almost all women. Serious side effects are very rare. It can be used by any woman of any age, whether or not she has children. It helps to prevent certain cancers, anemia (low iron), menstrual cramps, and other medical conditions. It is not a good choice for nursing mothers; it can reduce milk supply.

b) *Non-hormonal Contraceptive Pills:* *Centchroman* is a non-hormonal oral birth control pill developed and available in India. It does not have the side effects of hormonal contraceptives.

2) *Injectable Contraceptives:* It was shown that the injection of sperms into the tissues of a female produces in the latter a temporary immunity to conception. The same, it seems, can be accomplished by the use of certain hormones. Experimental work along these lines has been conducted on animals for many years, and it was proven quite conclusively that animals can be rendered infertile for varying periods of time by the use of such injections (Hannah and Abraham Stone, 1976, p.156).

DMPA (Depot-medroxyprogesterone acetate): It is an injectable progestin – only contraceptive that provides highly effective, private, safe, long-acting, reversible contraception and avoids both the need for user action daily or near the time of sexual intercourse and the need for partner cooperation. There is a need to have one injection every 3 months. The bleeding changes are normal spotting, light bleeding between periods, and, after one year, often no periods. Some weight gain is common. It can be used by any women of any age, whether or not they have children. DMPA is often used by the following groups of women (<http://www.uptodate.com/contents/depot-medroxyprogesterone-acetate-for-contraception>):

- Women who do not want to take a hormone pill daily;
- Women who have a contraindication to, or wish to avoid, an estrogen-containing contraceptive;
- Women who would like to avoid regular menses;
- Adolescents who may not consistently remember to use types of contraception that require frequent administration;
- Institutionalized girls and women who have difficulty using other forms of contraception.

DMPA is available in two formulations: a) 150 mg/1 mL for intramuscular injection (IM), and b) 104 mg/0.65 mL for subcutaneous (SC) injection. The drug is given every three months because low solubility of the microcrystals at the injection site allows pharmacologically active drug levels to persist and remain effective for several months. The women who stop using DMPA take an average of 4 months longer than usual to get pregnant. It is safe during breastfeeding, beginning at 6 weeks after childbirth (Ibid).

- 3) **Contraceptive Implants:** The contraceptive implant is a small flexible tube that's inserted under the skin of upper arm by a trained professional, such as a doctor. It prevents pregnancy by stopping the release of an egg from the ovary by slowly releasing progestogen into the body. It thickens the cervical mucus, makes it harder for sperm to move through cervix, and thins the womb lining which makes it less likely to accept a fertilised egg. It lasts for three years. If implanted correctly, it's more than 99% effective. Fewer than one woman in 1,000 will get pregnant in one year (<http://www.nhs.uk/Livewell/Contraception/Pages/Contraceptiveimplant.aspx>).

Contraceptive implants were first used on a wide scale way back in the 1990s. They received rather a bad press, partly because they so often caused menstrual problems, and partly because some of them were put in by doctors who had no real idea what they were doing. As a result, some women developed pain or infection at the insertion site. So, one should absolutely be sure that a doctor who offers to give a contraceptive implant has been fully trained in the insertion technique. In Britain, only a small minority of medics have this particular skill. In the early 2000s, there were even stories that implants could 'move around' inside the body. These put some women off. The implant which was used in Britain throughout the early years of this century was called Implanon (etonogestrel). It consists of a single rod, which was inserted under the skin, a few inches above the elbow. The rod contains the hormone etonogestrel. In December 2010, Implanon was withdrawn in Britain by the manufacturers, who replaced it with a new brand called Nexplanon (etonogestrel). This is very similar, but it contains an ingredient which makes it visible on an X-ray. For the moment, most implant-using women in the UK still have an Implanon rod in their arms. But, as the implant only lasts for three years, it's probable that most of these rods will eventually be replaced by a Nexplanon one (David Delvin at http://www.netdoctor.co.uk/sex_relationships/facts_contraceptive_implant.htm).

- **Norplant implants:** These are a long-acting contraceptive method. They consist of six matchstick-sized plastic capsules. A trained doctor or nurse places Norplant implants under the skin of upper arm by making a very small cut. The capsules may remain in arm for up to five years. They have

to be removed at the end of five years, but they can be taken out before that if one wishes. The procedure takes less than half an hour. After local anesthetic, the doctor or nurse will make a small cut on the inside of upper arm and insert the implants (<http://www.affection.org/sante/asvc/www.igc.apc.org/avsc/contraception/cnor2.html>).

Norplant is a form of birth control developed by the Population Council that was first approved in 1983 in Finland, where it was manufactured by Leiras Oy Pharmaceuticals. The original *Norplant* consisted of a set of six small (2.4 mm × 34 mm) silicone capsules, each filled with 36 mg of levonorgestrel (a progestin used in many birth control pills) implanted subdermally (below the skin) in the upper arm and effective for five years. *Norplant II* (*Norplant-2*, *Jadelle*), also developed by the Population Council and manufactured by Schering Oy, consists of two small (2.5 mm × 43 mm) silicone rods each containing 75 mg of levonorgestrel in a polymer matrix, instead of six capsules, also being effective for five years (<http://en.wikipedia.org/wiki/Norplant>).

Some advantages include the following (Ibid).

- It's very useful for women who know they don't want to get pregnant for up to three years.
- It can be useful for women who can't use contraception that contains oestrogen.
- It's very useful for women who find it difficult to take a pill at the same time every day.
- It is not affected by antibiotics.
- If there are side effects, the implant can be taken out.

Some side effects include the following (Ibid).

- When it's first put in, there may be some bruising, tenderness or swelling around the implant.
- In the first year, after the implant is fitted, periods may become irregular, lighter, heavier or longer. This usually settles down after the first year.
- A common side effect of the implant is that the periods may stop (amenorrhoea). It's not harmful, but it needs to be considered before deciding to have an implant.
- Some medicines, such as medication for HIV or epilepsy, or homeopathic remedies, such as St John's Wort, may reduce the implant's effectiveness.

10.4.2.5 Female Sterilization (Permanent Methods)

Female sterilization involves application of methods that make female permanently sterile. Like in the case of males, by means of application of X-rays to the sex glands or through surgical operation it is possible to make a woman permanently incapable of reproduction.

- Exposure of sex glands to heat or X-rays:*** Exposure of ovaries to heat or X-rays can arrest their capacity to produce ova either temporarily or permanently, depending upon the dose of the X-rays and the length of the

treatment. The use of X-rays for contraceptive purposes, however, carries certain potential dangers. There is the possibility that the effect of the rays may be too lasting and that the woman may become permanently sterile or the eggs produced later on may not be normal in quality and that as a result the future offspring may show certain defects in development (Hannah and Abraham Stone, 1976, pp.155-156).

- ii) **Surgical method:** Like male sterilization, female sterilization can also be done by means of surgical operation. In female sterilization through surgical operation, the fallopian tubes are cut or tied, and hence the eggs from the ovaries cannot reach uterus nor the sperm can gain access to the egg. An operation of this kind requires an abdominal incision and hospitalization for a week or two, and is, therefore, a more involved undertaking than sterilization of man. It is safe, simple surgery, usually done without putting the woman to sleep. Local anesthetic blocks pain. It is very effective and it does not have long-term side effects, though surgery may cause some short-term complications. It does not have effect on sexual ability or feelings. Of course, there are simple and advanced methods of sterilization.

Female sterilization is a form of birth control and all the sterilization procedures are meant to be permanent. During a sterilization procedure, a health care provider closes or blocks a woman's fallopian tubes. Closing the tubes can be done in several ways. One way is by tying and cutting the tubes — this is called *tubal ligation*. The fallopian tubes can also be sealed using an instrument with an electrical current. They can even be closed with clips, clamps or rings. Sometimes, a small piece of the tube is removed or tiny inserts are put in the tubes. Tissue grows around them and blocks the tubes. The brand names for these types of sterilization are Adiana and Essure (<http://www.plannedparenthood.org/health-topics/birth-control/sterilization-women-4248.htm>).

Female sterilization provides permanent contraception for women who do not want any more children. It is a safe and simple surgical procedure and can usually be done with local anesthesia and light sedation. A small incision is made by the doctor in the woman's abdomen and the two fallopian tubes are blocked off or cut. With the tubes blocked, the woman's egg cannot meet the man's sperm (<http://health.indiamart.com/familyplanning/female-sterilization.html>).

The effectiveness of this method depends partially on how the tubes are blocked, but all pregnancy rates are low. Only 0.5 pregnancies per 100 women (1 in 200) have been recorded in the first year after the procedure and in 10 years 1.8 pregnancies recorded per 100 women (1 in 55) (Ibid).

Postpartum tubal ligation (immediately after the childbirth) is one of the most effective female sterilization techniques. In the first year after the procedure only, 0.05 pregnancies per 100 women (1 in 2000) has been recorded (Ibid).

Advantages: These include the following.

- A single procedure leads to lifelong, safe and very effective family planning.
- Nothing to remember, no supplies needed and no repeated clinic visits required.
- No interference with sex. Does not affect a woman's ability to have sex.
- No known long-term side effects or health risks (Ibid).

Disadvantages: These include the following.

- It is usually painful for several days after the operation.
- Certain uncommon complications of the surgery can occur.
- Infection or bleeding at the incision.
- Internal infection or bleeding.
- Injury to internal organs.
- *Anesthetic risk:* With local anesthesia alone or with sedation, rare risks of allergic reaction or overdose. With general anesthesia, occasional delayed recovery and side effects. Complications are more severe than with local anesthesia. There is also a risk of overdose.

The right time to undergo female sterilization: A woman can have female sterilization procedure anytime that (Ibid):

- She decides that she will never want children in future.
- It is reasonably certain that she is not pregnant. These times can include:
 - Immediately after childbirth or within 7 days, if she has made a voluntary informed choice in advance;
 - Six weeks or more after childbirth; or
 - Immediately after abortion (within 48 hours), if she has not decided voluntarily in advance; and
 - Any other, but NOT between 7 days and 6 weeks postpartum.

Reversal: Reversal surgery is difficult, expensive and not available in most areas. Successful reversal too is not guaranteed. Women who may want to become pregnant in the future should choose a different method.

10.4.3 Ideal Contraceptive: Characteristics

The ideal contraceptive should first of all be harmless, without the likelihood of any injury to wife or husband or future offspring; it should be reliable and provide adequate protection; and it should be acceptable – that is, it should satisfy the individual needs of those who are to use it in particular culture of a society.

The ideal birth control or effective planned parenthood is possible only through perfect contraceptive. The ideal or perfect contraceptive should thus be:

- simple, practical, inexpensive and aesthetically satisfying;
- acceptable from the user's personal and cultural point of view;
- effective immediately and guaranteed to protect against pregnancy;
- without danger of nuisance or side effects and, more so of serious side effects; and
- quickly reversible.

From the range of the methods and techniques of contraception that we discussed above, it is clear that there are methods which carry the least risks but, at the same time, least effective whereas the most effective methods also carry greater risks of side effects. In view of the above, it can be concluded that none of the

methods in use today meets all the above requirements, and the ideal contraceptive still remains to be developed. So, while looking forward to the arrival of an ideal or perfect method, the individual or couples must be aware of available methods and techniques and assess all the associated factors before deciding on the method that seems best for an individual or couple in their context/background, so as to have effective control over some of the most important aspects of life. Always, for spacing the births, a combination of temporary contraceptives is more promising than any single contraceptive adopted by the individual or couple concerned. Similarly, after a couple decided not to have any more children, it is better if the husband and wife undergo vasectomy and tubectomy respectively if their collective health allows them accordingly, or by any one of the spouses as the health permits.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 4) List out different contraceptive birth-spacing methods and techniques available for females as part of their family planning efforts.

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- 5) What are the methods of female sterilization?

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10.5 LET US SUM UP

Individual plays an important role in population control both prior to and after his/her marriage. However, the role (s)he plays prior to marriage is significantly different from that after marriage. Keeping this in view, in Unit-10 we have highlighted different measures that an individual, be it male or female, can take to control population change in his family, community and the nation by way of adopting specific measure(s) of his/her choice prior to and after marriage.

We believe that the knowledge and understanding of these individual measures will enable you to contribute to population control/change or regulation in a manner befitting to enhancement of quality of life of the individual, family and community as a whole at the micro level which has its positive implications for development at macro level — at national and international levels.

10.6 ANSWERS TO 'CHECK YOUR PROGRESS' QUESTIONS

- 1) Pre-marriage measures of population control are limited and include the following: i) adhering to the legal age of marriage, and ii) delaying marriage beyond the legal age of marriage up to an ideal age of marriage. The legal marriageable age for men and women in India is 21 and 18 years respectively. The legal age of marriage is aimed at ensuring minimum maturity on the part of an individual so as to enable him/her to cope up with and physically able to sustain the married life and to reduce the mean duration of marriage in the life of an individual. But, delaying the marriage to an ideal age of marriage implies consideration of different facts and circumstances of particular individual or would be couples which may vary from case to case.

Nevertheless, in general, girls in rural areas are married early and hence their age at consummation of marriage in case of many of them is below 18 years (i.e. in violation of legal age of marriage) and the mean duration of marriage in such cases is more and they are more likely to beget more children in their lifetime, if no contraceptive or family planning method is adopted by the couple. There is strong need to prevent marriages in violation of legal age of marriage so as to make them law-abiding and to ensure their contribution to population control. As Agarwala (1972) mentions that if the age at marriage for girls in India is increased to 19 years or more, the birth rate may decline by 25% to 30% by 1991-1992. While such initiatives may take long time in the country like India, all the responsible citizens, and more so the persons with higher educational qualifications need to behave rationally by delaying their marriage at least up to 21 years of age if they are females and up to 24 years if they are males and also by promoting such practice among other concerned citizens. Such individual measures and efforts would have significant effect in controlling population change to make positive impact on the quality of life at individual, familial and national levels.

- 2) There are limited options available for males to adopt birth-spacing or temporary family planning methods. These methods are basically aimed at prevention of deposition of semen (sperms) in the vagina. While the

abstinence or continence is the best option that the male can exercise, it requires the mutual understanding of the partners including physical, psychological and emotional support, cooperation and adjustments. Other behavioural methods that are available to him are: coitus interruptus (withdrawal of penis from the the contact of vagina just before his semen is ejaculated); and coitus reservatus (withholding ejaculation or abstaining completely from an ejaculation while penis remains well in contact with the vagina during sexual contact). But, these methods have their limitations as well. The relatively better and more reliable option is Condom/Nirodh which is worn by him over the erected penis before sexual intercourse. The ejected semen remains within the condom and, thus, it prevents entry of semen into the vagina.

- 3) Male sterilization involves application of methods that make him permanently sterile. By means of application of X-rays to the sex glands or through surgical operation it is possible to make him permanently incapable of reproduction. There are simple but variety of methods of male sterilization – traditional vasectomy (which uses scalpel), no-scalpel vasectomy, and occlusion techniques (ligation/tying with suture material, cautery – electrosurgical or thermal coagulation, clipping, facial interposition – placing tissue barrier between two cut ends), and open-ended vasectomy or a combination of more than one of these methods/techniques.
- 4) There are many methods and techniques of contraception or birth-spacing available for woman. The sole objective of the female methods and techniques of family planning is to prevent spermatozoa from entering into the uterus or to prevent fertilization of the egg, or to prevent the fertilized egg (zygote) from implanting or developing in the uterus. These methods falling under different categories include the following.
 - i) Biological Contraceptives (Natural Family Planning methods)
 - a) Lactation or breast-feeding
 - b) Safe period or rhythm method
 - Ovulation calendar method.
 - Basal body temperature method.
 - Cervical mucus method
 - c) Sympto-thermal method
 - ii) Chemical Contraceptives and Spermicides
 - Douche
 - Suppositories
 - Tablets and powders
 - Jellies and creams
 - Foam powder
 - iii) Mechanical Contraceptives (Vaginal and Intra-Uterine Devices)
 - Diaphragms
 - Cervical Caps
 - Female condom
 - Intra-uterine devices: *Inert IUDs, Copper-bearing IUDs, Hormone-releasing IUDs.*

- iv) Immunization against Conception: Spermatoxins and hormones
 - a) Birth Control Pills (Oral Contraceptive Pills)
 - b) Injectable Contraceptives (Depot-medroxyprogesterone acetate - DMPA)
 - c) Contraceptive Implants.
- 5) Female sterilization involves application of methods that make female permanently sterile. By means of application of X-rays to the ovaries or through surgical operation or sealing of fallopian tubes it is possible to make her permanently incapable of reproduction.

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UNIT 11 NATIONAL MEASURES OF POPULATION CONTROL

Structure

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- 11.1 Objectives
- 11.2 Population Policies and Programmes of India
 - 11.2.1 Need for State Intervention in Population Control
 - 11.2.2 Shifts and Trends in Population Policy and Programmes
 - 11.2.2.1 Milestones in the Evolution of Population Policy
 - 11.2.2.2 Population Policy since the Beginning of the Planning Era
 - 11.2.2.3 National Population Policies – 1951, 1976/1977 and 2000
- 11.3 Institutionalisation of Population (and Development) Education: A Rationale
 - 11.3.1 Relevance of Conceptual Framework of Population (and Development) Education to its Institutionalisation: A Historical Perspective
 - 11.3.2 Rationale for Institutionalisation of Population (and Development) Education at Different Levels of Education: A Rationale
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- 11.5 Answers to 'Check Your Progress' Questions
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11.0 INTRODUCTION

In the preceding Unit, we discussed different measures that the individuals can take to control population change. But, the individual measures alone cannot be adequate and effective, given the cultural diversity and dynamics of a democratic country like India. It is, in fact, the State which can effectively intervene in bringing changes in the population situation both at macro and micro levels. It can decide upon the necessity in the given context, and direct the policy changes as per the constitutional and public mandates at national and state levels. Therefore, in this Unit, we attempt to present you the holistic picture of national measures of population control in India.

11.1 OBJECTIVES

After going through this unit, we expect you to be able to:

- Explain the need for state intervention in controlling the population change;
- Discuss the shifts and trends in national population policy and programmes in India; and
- Describe the efforts of institutionalisation of population and development education in India.

11.2 POPULATION POLICIES AND PROGRAMMES OF INDIA

The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>). While individual efforts in this regard can play effective role at micro level such as family and local community level, at national level realization of such objective is possible only with effective state intervention aimed at controlling the population change in the desired direction.

The population policy of a nation can no longer confine itself to the reduction of birth rate alone; instead, it must be all encompassing and comprehensive strategy for overall improvement of social, economic and demographic fabric of a nation. There are two distinct approaches to the family welfare/planning programmes. *One*, advocating long-term measures with a view to improving overall social, economic and demographic structure of a country, and *two*, short-term measures with a view to reaping immediate results by way of averting the number of births.

The long-term measures include: promoting well-conceived population education, increasing the marriage-age, preventing child labour, compulsory education and adult literacy campaigns, restricting the maternity benefits to small families, providing old-age security, introduction of new life insurance policies carrying special benefits for the small families, developing intense network of small-scale industries based upon agro-livestock raw material, utilising scheduled castes and schedule tribes manpower, diversifying economy by way of rapid urban industrial development, and better health, and enhancing education and employment facilities in general and for females in particular. On the other hand, short-term measures include: temporary and permanent methods of preventing child birth such as contraception, voluntary sterilisation, compulsory abortion after the birth of second/third child in the family, and social and economic benefits for small families and penalties for large families. All such measures need people's approval and participation.

11.2.1 Need for State Intervention in Population Control

In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy". After 1952, sharp declines in death rates were, however, not accompanied by a similar drop in birth rates. The National Health Policy, 1983 stated that replacement levels of total fertility rate (TFR) should be achieved by the year 2000 (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).

Nevertheless, India's population has been growing at an alarming rate. The significance of the population growth can be judged from the fact that during the decade 1981-91, there has been an increase of 162.97 million. By May 2000, India's population had already reached 1000 million (1027 million in 2001). While the global population has increased only three-fold during the last century, from 2 billion to 6 billion, India's population has increased nearly five times,

from 238 million to one billion in the same period. Its current annual increase (15.5 million) is large enough not only to neutralise any efforts to conserve the resource endowment and environment but also to make it the most populous country of the world, overtaking China by 2045 (Raja, 2012). Currently, Indian population is second only to China. The comparison with China, however, is misleading since China has about 20% of the world population and 7% of total land area. In contrast, India has about 16% of the world population but has only about 2.4% of the total land area.

Population and reproductive health facts of India, recently released by the United Nations Population Fund says that 'the country was not a role model in terms of population control'. The Report also comes down heavily on sex ratios which are among the 'worst in the world.' The adverse ratio of 960 females to 1000 males is due to 'sex preference for sons' and prevalent practices of female foeticide and infanticide.

India's population in 1991 and projections to 2016 are as follows:

Table 11.1: Population Projections for India (in millions)

March 1991	March 2001	March 2011	March 2016
846.3	1012.4	1178.9	1263.5

Source: Technical Group on Population Projections, Planning Commission (See <http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).

Population growth in India continues to be high on account of the following (http://population.commission.nic.in/npp_obj.htm).

- The size of the population in the reproductive age-group (estimated contribution 58 percent) is very large. An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reductions in family size in several states, including those which have already achieved replacement levels of TFR. This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the population being currently in their reproductive years. It is imperative that the couples in the reproductive age-group adopts, without further delay or exception, the "small family norm" for the reason that about 45 percent of population increase is contributed by births above two children per family.
- Higher fertility is due to unmet need for contraception (estimated contribution 20 percent). India has 168 million eligible couples of which just 44 percent are currently effectively protected. Urgent steps are currently required to make contraception more widely available, accessible and affordable. Around 74 percent of the population lives in rural areas, in about 5.5 lakh villages, many with poor communications and transport facilities. Reproductive health and basic health infrastructure and services often do not reach the villages and, as a result, vast numbers of people cannot avail of these services.
- High wanted fertility is due to the high infant mortality rate (IMR) (estimated contribution about 20 percent). Repeated child births are seen as an insurance against multiple infant (and child) deaths and, accordingly, high infant mortality stymies all efforts at reducing TFR.

- About 50 percent of girls marry below the age of 18, the minimum legal age of marriage, thus, resulting in a typical reproductive pattern of “too early, too frequent, too many”. Around 33 percent births occur at intervals (gap between two births) of less than 24 months, which also results in high IMR.

The Government of India, therefore, formulated and implemented a population policy to curb the rapid growth of population so as to ensure better quality of life to the people. As mentioned elsewhere above, it was the first developing country to adopt a positive population policy in 1951-52 ‘to stabilise population at a level the national economy could absorb’.

11.2.2 Shifts and Trends in Population Policy and Programmes

There have been many shifts and trends in population policy and programmes of India. These can be noticed by looking at some milestones in the evolution of population policy of India.

11.2.2.1 Milestones in the Evolution of Population Policy

Important of the milestones in the evolution of population policy of India include the following (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf> -- Appendix II).

- **1946:** Bhore Committee (also known as Health Survey and Development Committee) was set up by the government of India in 1943 to investigate and recommend improvements to the Indian Public Health system. It made many landmark recommendations in its report.
- **1952:** India became the first developing country to adopt positive population policy, marked by launching of National Family Planning Programme.
- **1976:** Statement of National Population Policy.
- **1977:** Policy Statement on Family Welfare Programme.
- **1983:** Both the above statements were laid on the Table of the House in Parliament, but never discussed or adopted. The National Health Policy of 1983 emphasized the need for “securing the small family norm, through voluntary efforts and moving towards the goal of population stabilisation”. While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy.
- **1991:** The National Development Council (NDC) appointed a Committee on Population with Shri Karunakaran as its Chairman. The Karunakaran Report (Report of the National Development Council Committee on Population) endorsed by NDC in 1993 proposed the formulation of a National Population Policy to take a “long-term, holistic view of development, population growth and environmental protection” and to “suggest policies and guidelines for formulation of programs” and “a monitoring mechanism with short, medium and long-term perspectives and goals” (Planning Commission, 1992). It was argued that the earlier policy statements of 1976 and 1977 were placed on the table. However, Parliament never really discussed or adopted them. Specifically, it was recommended that “a National Policy of Population should be formulated by the Government and adopted by Parliament”.

- **1993:** An Expert Group headed by Dr. M. S. Swaminathan was asked to prepare a draft of a national population policy that would be discussed by the Cabinet and then by Parliament.
- **1994:** Expert Group headed by Dr. Swaminathan prepared a Report on a National Population Policy. This report was circulated among Members of Parliament, and comments requested from central and state agencies. It was anticipated that a national population policy approved by the National Development Council and the Parliament would help produce a broad political consensus.
- **1997:** On the 50th anniversary of India's Independence, Prime Minister Gujral promised to announce a National Population Policy in the near future. Cabinet approved the draft National Population Policy with the direction that this be placed before Parliament. However, this document could not be placed in either House of Parliament as the respective Houses stood adjourned followed by dissolution of the Lok Sabha.
- **1999:** Another round of consultations was held during 1998, and another draft National Population Policy was finalised and placed before the Cabinet in March 1999. Cabinet appointed a Group of Ministers (headed by Dy. Chairman, Planning Commission) to examine the draft Policy. The GOM met several times and deliberated over the nuances of the Population Policy. In order to finalise a view about inclusion/exclusion of incentives and disincentives, the Group of Ministers invited a cross-section of experts from among academia, public health professionals, demographers, social scientists, and women's representatives. The GOM finalised a draft population policy, and placed the same before Cabinet. This was discussed in Cabinet on 19 November 1999. Several suggestions were made during the deliberations.
- **2000:** On the basis of suggestions, a fresh draft was submitted to Cabinet which formed the basis for National Population Policy, 2000. It is under implementation till date.

The milestones, listed above, have provided us a glance of national population policy. In the sub-sub-section 11.2.2.2 below, we will attempt to present more details of the population policy since the beginning of the planning era.

11.2.2.2 Population Policy since the Beginning of the Planning Era

Population policy began with the beginning of five year plans. Although India was the first developing country to adopt a positive population policy in 1951-52 'to stabilise population at a level the national economy could absorb', yet its achievements in controlling its numbers have been far from satisfactory. A brief review of population policy since the beginning of the planning era is presented below (<http://www.preservearticles.com/2012013022137/short-essay-on-indias-population-policy.html>).

- i) The First Five Year Plan (1951-56) enunciated that the programme for family limitation and population control should: a) present an accurate picture of the factors contributing to the rapid population increase in India; b) discover suitable techniques of family planning and devise methods by which

knowledge of these techniques could be widely disseminated; and c) give advice on family planning as an integral part of the service of government hospitals and public agencies, with the focus in the beginning remained on promoting the safe period method and a gradual popularisation of mechanical and chemical contraceptives.

- ii) The population policy of the First Plan continued unaltered during the Second Five Year Plan (1956-61) except that the voluntary sterilization scheme was introduced in 1956.
- iii) Due to unexpected high population growth rate in 1961 Census, the 'clinical approach' of the population policy was replaced by an 'extension education approach' during the Third Plan (1961-66). Thus, creation of social climate in favour of small family norms, provision of readily accessible services, adoption of effective family planning methods by all eligible couples (about 90 million), stimulating social changes such as increasing marriage-age, education and employment of women, acceleration of overall economic development, and continuous research and evaluation became the guiding principles of population policy of this plan.

There were no changes during 1966-69 when there were only annual plans, due to delay in formulation of the fourth five-year plan.

- iv) The population policy became more positive during the Fourth Five Year Plan (1969-74) which considered family planning as 'the kingpin of plan' and small family as 'an essential and inseparable ingredient of development'. The Plan also set up a time-bound target of reducing the birth rate from 39 per thousand to 23 per thousand by 1978-79. An organisational set-up from central to peripheral level was established as a part of the existing medical and health services to reach each couple in reproductive age-group all over the country. This plan achieved the target of the sterilisation of about 61 million couples, averting about 6.9 million births.
- v) The Fifth Five Year Plan (1974-79) introduced basic change in the population policy by integrating family planning services with welfare services covered under the minimum needs programme. The programme sought to integrate most of the basic social services like education and public health services with family planning and nutrition for children, and expectant and nursing mothers. Similarly, the introduction of the element of compulsion, monetary incentives and penalties, and legislation of abortions during the plan added new dimension to the population policy of the country.
- vi) During the Sixth Five Year Plan (1980-85) the family welfare continued to be accorded a high priority. The plan adopted a strategy to integrate health, family welfare and nutrition services at all levels. Enhanced cash-compensation for voluntary sterilisation and full rebate in income tax for specified donations for welfare purposes were some of the incentives popularised during the plan. The plan targeted 36 per cent of the couples in the reproductive age-group to bring down the birth rate to 30 per thousand by the end of the plan.
- vii) The population policy during the Seventh Plan (1985-90) took a significant turn to make family planning programme more effective. Its major objectives included: a) increasing the mean age at marriage for females to over 20

years; b) promoting 'two-child family' norm; c) protecting over 42 per cent eligible couples by way of variety of contraceptives; d) enhancing child-survival rate by reducing the infant mortality rate to 90 per thousand live births through universal immunization of infants and of prospecting mothers; e) bringing down the crude birth rate to 29.1 per thousand and the crude death rate to 10.4 per thousand; f) generating environment for fertility decline through relevant socioeconomic interventions; g) promoting female literacy and employment programmes; and h) providing population education to all children in 11-15 age-group and also to those out of educational institutions through Adult Education and Non-formal Education programmes. All this was to be achieved by effectively involving the people in general. The Plan stipulated a target of 31 million sterilisations, 21.25 million IUD insertions and 14.5 million CC users. It also advanced the target of achieving a net reproduction rate of 1 from 2000 to the period of 2006-2011.

viii) *NDC Sub-Committee on Population*: In order to ensure that the country makes the best use of the opportunity-window in the demographic transition, NDC in 1991 constituted a Sub-committee on population. The committee made several recommendations not only to give a new thrust and dynamism to the ongoing Family Welfare Programme but also to address the larger issue of population and development so that the country will speedily attain replacement level of fertility and higher quality of life. Major recommendations pertaining to the Family Welfare programme include:

- Decentralised area-specific planning based on the need assessment.
- Emphasis on improved access and quality of services to women and children.
- Providing special assistance to poorly performing states/districts to minimise the inter and intra-state differences in performance.
- Creation of district level databases on quality and coverage and impact indicators for monitoring the programme.
- Involvement of the people's organizations, people themselves in the movement.
- Formulation of a National Population Policy to be discussed and adopted by the Parliament and NDC so that there is a broad political consensus on the policy and strategies.

These recommendations were endorsed by the NDC in 1993.

- ix) The Eighth Plan (1992-97) fixed up the target of achieving the crude birth rate of 26 per thousand, infant mortality rate of 70 per 1000 live births and the couple protection rate of 56 per cent. The plan initiated an Action Programme with main features of: a) improving the quality and out-reach of family welfare services in the field; b) introducing new package of compensation/incentives giving more flexibility to State governments; c) initiating innovative programmes in urban slums for propagating family welfare activities; d) adopting a differential strategy for focusing attention on 90 districts of the country where the crude birth rate is above 39 per 1000; e) increasing the involvement of voluntary agencies and non-

governmental organisations in family welfare programmes; f) linking the rural development and poverty-alleviation grants to districts and panchayats on the basis of their performance in the control of birth rate; and g) reducing the strong son-preference in many parts of the country. The Eighth Plan again advanced the Net Reproduction Rate of unity to the period of 2011-16.

International Conference on Population and Development (Cairo 1994) advocated a similar approach. Concordance between National (NDC Committee) and International (ICPD) recommendations enabled flow of national and international funding and accelerated the pace of implementation of the family welfare programme.

Action taken on the recommendations of the NDC Committee on Population:

Dept of Family Welfare initiated several steps to implement the recommendations of the NDC Sub- Committee. These include:

- Abolition of centrally defined method-specific targets for family planning and changing over to PHC-based community-need assessment, planning and implementation of Family Welfare Programme in April 1996.
- Initiation of the Reproductive and Child Health care programme providing comprehensive health care to women and children in 1997.
- Provision of additional assistance to the poorly performing states such as Social Safety Net, United States Agency for International Development (USAID) assisted State Innovations in Family Planning Services Agency (SIFPSA) project in UP.
- Formulation of the National Population Policy, 2000.

Here, it is important for us to focus on National Population Policies – 1951, 1997 and 2000 for better understanding of the same.

11.2.2.3 National Population Policies – 1951, 1976/1977 and 2000

It was even long before procuring our independence that several discussion benches saw the onset of population policy. Much before Independence; in the year 1938 only, a Sub-Committee on population was set up by the National Planning Committee appointed by the then Interim Government. The National Planning Committee passed a resolution in 1940 that stated the need for the State to adopt family planning and welfare policies in order to bring about a harmonious order of social economy. The resolution also stressed the need for limitation of children. (<http://socioeconomyataglance.blogspot.in/search/label/CENSUS>). Further developments took place after independence in the wake of formation of the First Five Year Plan.

- I) National Population Policy – 1951:** April 1951 recorded further enhancements in this policy formulation as the First Five Year Plan labeled for an overt population policy and adjudged family planning as a pragmatic and essential step towards improvement in health of mothers and children. The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society. It was because, in the Plan, family planning was treated as a part

of the health programme and received a 100% funding from the central government. India was the first country in the world to launch a national programme in 1952, emphasizing family planning to the extent necessary for reducing birth rates “to stabilize the population at a level consistent with the requirement of national economy”.

The National Family Planning Programme, initiated in 1952 during the First Five Year Plan (1951-56), adopted a “clinical’ approach to family planning and opened a number of clinics with the expectation that the people would take advantage of the facilities. This approach was modified thereafter. The ‘community extension’ and ‘cafeteria’ approaches were followed during the Third Five Year Plan (1961-66) with an emphasis on creation of motivation among the people to respond to the family planning message and to utilise the services offered by changing popular attitudes and values to family planning. The ‘cafeteria approach’ in which various alternative means of family limitation (temporary and permanent) were propagated from the middle of 1960s, did not make much headway as the official emphasis remained on terminal methods alone. Later, many legislations were brought out, including on abortion (medical termination of pregnancy) and the age of marriage. An ‘incentives and disincentives’ scheme was introduced. Women’s education, population education, child nutrition, etc and their integration with the family planning programme was thought of.

After 1952, though there was sharp decline in death rates, it was, however, not accompanied by a similar drop in birth rates. As a result, with each passing year, the amount of these funds has increased. The success of this family planning agenda was so dear to the heart of the government that even a separate department coined as Department of Family Planning was carved out in the Ministry of Health in the year 1966. Further efforts in the policy front were undertaken by the this Department. This was done with an objective to reinforce the population control programme.

Consequently, a comprehensive National Population Policy, integrated with the overall strategy of socio-economic development, was evolved in April 1976 with a view to promoting family planning at a faster pace by involving in the programme the other development departments of the Government, both at the Centre and in the States. Also, all the organisations which commanded credibility and influence with the people and were interested in the public welfare were given importance in the task of promoting family planning.

II) National Population Policy – 1976/1977: Let us look at National Population Policy 1976, as it is this policy which was revised in 1977.

Some of the important features of the National Population Policy of 1976 are (Sreedhara Swamy, 1984, pp.154-155):

- i) increase in the age of marriage from 15 to 18 years for girls and from 18 to 21 for boys;
- ii) freezing of the population figures at the 1971 level until the year 2001 for the purpose of representation in the National Parliament as well as for allocation of Central assistance, devolution of taxes, etc, to the States;

- iii) linking of a part of Central assistance to the States for their development with their performance in family planning;
- iv) greater attention to girls' education;
- v) proper place for population education in the total system of education;
- vi) involvement of all Ministries/Departments of the government in the family planning programmes;
- vii) increase in monetary compensation for sterilisation;
- viii) institution of group awards as incentives for various organisations and bodies representing the people at local levels, including Zilla Parishads and Panchayat Samitis;
- ix) intimate association of voluntary organisations particularly those representing women, with the implementation of the programme;
- x) greater attention to research; and
- xi) greater use of motivational media, particularly in rural areas, for increasing acceptance of family planning.

The National Population Policy was further modified and re-announced in 1977. In this new policy, what was reinforced was education and health. The latter component of the reformulated policy included both the general as well as the maternal and child health. A voluntary family planning was also introduced here on. This also saw the change of the phrase from Family Planning to Family Welfare programme that is maintained till date (<http://socioeconomyataglance.blogspot.in/earch/label/CENSUS>).

The revised Population Policy stressed the importance of limiting population growth and emphasised the voluntary nature of the family planning programme. Simultaneously, the 'family planning programmes' were re-designated as 'family welfare programmes'. In addition to the items of the 1976 policy, this policy statement advocated a greater role for maternity and child health services, an expansion of the immunisation programme, improvement of women's education and population education, and the involvement of voluntary, youth and women's organisations. The major feature is the 'educational and voluntary approach' to family welfare. Population education as a part of normal courses of study was stressed for youth. Special attention was given to encourage necessary research inputs in the field, alongside education. Thus, a multi-pronged strategy was evolved to attain the envisaged demographic goals and the family planning (welfare) programme has been adopting increasingly effective approaches from time to time, i.e. from 'clinical' approach to 'cafeteria' approach to 'community extension' approach coupled with 'incentives and disincentives' to promote family planning. The educational approach is rather imminent as population and development are closely interrelated and embrace a number of complex factors that require thorough and rational consideration by the individuals, families and communities.

"On 11 May 2000 India is projected to have 1 billion (100 crore) people, i.e. 16 percent of the world's population on 2.4 percent of the globe's land area. If current trends continue, India may overtake China in 2045, to become the most populous country in the world. While global population has increased

three-fold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India's current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resource endowment and environment" (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).

Box 11.1: India's Demographic Achievement

Half a century after formulating the national family welfare programme, India has:

- reduced crude birth rate (CBR) from 40.8 (1951) to 26.4 (1998, SRS);
- halved the infant mortality rate (IMR) from 146 per 1000 live births (1951) to 72 per 1000 live births (1998, SRS);
- quadrupled the couple protection rate (CPR) from 10.4 percent (1971) to 44 percent (1999);
- reduced crude death rate (CDR) from 25 (1951) to 9.0 (1998, SRS);
- added 25 years to life expectancy from 37 years to 62 years;
- achieved nearly universal awareness of the need for and methods of family planning, and
- reduced total fertility rate from 6.0 (1951) to 3.3 (1997, SRS).

Source: <http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>.

Stabilising population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).

We will deal with these in greater details in National Population Policy 2000, since it is the latest one that continues till date.

III) National Population Policy – 2000: The New Population Policy was announced in 2000. It has special focus on health and education, and envisages the target of stable population by 2045 (instead of by 2016). This National Population Policy, 2000 (shortly, NPP 2000) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target-free approach in administering family planning services. The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies during the next decade to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child health services by government, industry and the voluntary non-government sectors, working in partnership (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).

Important features of national population policy 2000 are as follows (http://population.commission.nic.in/npp_obj.htm).

A) Objectives and goals

- 1) The immediate objective of the NPP 2000 is 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 is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.
- 2) In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated (See Box 11.2).

Box 11.2: National Socio-Demographic Goals for 2010

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 and attaining two-child norm.
- Universal access to information on birth-limitation methods and availability of totally free choice to citizens for planning their families.
- Make school education up to age 14 free and compulsory, and reduce drop-outs at primary and secondary school levels to below 20 percent for both boys and girls.
- Reduce infant mortality rate to below 30 per 1000 live births and the incidence of low birth-weight (below 2.5 kg.) babies.
- Reduce maternal mortality ratio to below 100 per 100,000 live births.
- Achieve universal immunization of children against all vaccine-preventable diseases, elimination of Polio by 2000 and near elimination of Tetanus and Measles.
- Reduce the incidence of marriage of girls below the age of 18 to zero and promote delayed marriage for girls, preferably after 20 years of age.
- Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- Contain the spread of Acquired Immuno-deficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organisation.
- Prevent and control communicable diseases.

- Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- Promote vigorously the small family norm to achieve replacement levels of TFR.
- Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people-centred programme.

- 3) If the NPP 2000 is fully implemented, we anticipate a population of 1107 million (110 crores) in 2010, instead of 1162 million (116 crores) as projected by the Technical Group on Population Projections.

Realising such goals calls for focus on strategic themes with effective operational strategies as articulated in the policy, and these are as presented below.

- B) Strategic Themes and Operational Strategies:** Twelve strategic themes have been identified which must be pursued simultaneously in “stand alone” or “inter-sectoral” programmes in order to achieve the national socio-demographic goals for 2010. These are presented below (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).

- 1) Decentralised Planning and Programme Implementation:** The 73rd and 74th Constitutional Amendments Act, 1992 made health, family welfare and education a responsibility of village panchayats. The panchayati raj institutions are an important means of furthering decentralised planning and programme implementation in the context of the NPP 2000. However, in order to realize their potential, they need strengthening by further delegation of administrative and financial powers, including powers of resource mobilization.

Further, since 33 percent of elected panchayat seats are reserved for women, representative committees of the panchayats (headed by an elected woman panchayat member) should be formed to promote a gender-sensitive, multi-sectoral agenda for population stabilisation, that will “think, plan and act locally, and support nationally”. These committees may identify area-specific unmet needs for reproductive health services, and prepare need-based, demand-driven, socio-demographic plans at the village level, aimed at identifying and providing responsive, people-centred and integrated basic reproductive and child health care. Panchayats demonstrating exemplary performance in the compulsory registration of births, deaths, marriages, and pregnancies, universalizing the small family norm, increasing safe deliveries, bringing about reductions in infant and maternal mortality, and promoting compulsory education up to age 14 will be nationally recognized and honored.

To be operationally strategic, meaningful decentralization will result only if the convergence of the national family welfare programme with the ICDS programme is strengthened. The focus of the ICDS programme on nutrition

improvement at village levels and on pre-school activities must be widened to include maternal and child health care services.

- Convergence of several related activities at service delivery levels with the ICDS programme in particular is critical for extending outreach and increasing access to services.
- Inter-sectoral coordination with appropriate training and sensitisation among field functionaries will facilitate dissemination of integrated reproductive and child health services to village and household levels.
- People will willingly cooperate in the registration of births, deaths, marriages and pregnancies if they perceive some benefit.
- At the village level, the community meeting every fortnight, may become their most convenient access to basic health care, both for maternal and child health, as well as for common ailments.
- Households may participate to receive integrated service delivery, along with information about ongoing micro-credit and thrift schemes.
- Government and non-government functionaries will be expected to function in harmony to ensure integrated service delivery. The panchayat will promote this coordination and exercise effective supervision.

- 2) ***Convergence of Service Delivery at Village Levels:*** Efforts at population stabilisation will be effective only if we direct an integrated package of essential services at village and household levels. Below district levels, current health infrastructure includes 2,500 community health centres, 25,000 primary health centres (each covering a population of 30,000), and 1.36 lakh subcentres (each covering a population of 5,000 in the plains and 3,000 in hilly regions) (http://populationcommission.nic.in/npp_strat.htm). Inadequacies in the existing health infrastructure have led to an unmet need of 28 percent for contraception services, and obvious gaps in coverage and outreach. Health care centres are over-burdened and struggling to provide services with limited personnel and equipment. Absence of supportive supervision, lack of training in inter-personal communication, and lack of motivation to work in rural areas, together impede citizens' access to reproductive and child health services, and contribute to poor quality of services and an apparent insensitivity to client's needs. The last 50 years have demonstrated the unsuitability of these yardsticks for provision of health care infrastructure, particularly for remote, inaccessible, or sparsely populated regions in the country like hilly and forested areas, desert regions and tribal areas. In order to resolve unmet needs and extend coverage, we need to promote a more flexible approach, by extending basic reproductive and child health care through mobile clinics and counseling services. Further, recognizing that government alone cannot make up for the inadequacies in health care infrastructure and services, the involvement of the voluntary sector and the non-government sector in partnership with the government is essential.

Since the management, funding and implementation of health and education programmes have been decentralised to panchayats, in order to reach household levels, a one-stop, integrated and coordinated service delivery

should be provided for basic reproductive and child health services at village levels. A vast increase in the number of trained birth attendants, at least two per village, is necessary to universalise coverage and outreach of ante-natal, natal and post-natal health care.

The operational strategy, in this regard, can be as follows.

- Utilize village self-help groups to organize and provide basic services for reproductive and child health care combined with the ongoing Integrated Child Development Scheme (ICDS). Village self-help groups are in existence through centrally sponsored schemes of: a) Department of Women and Child Development, Ministry of HRD, b) Ministry of Rural Development, and c) Ministry of Environment and Forests.
- Organize neighborhood acceptor-groups, and provide them with a revolving fund that may be accessed for income generation activities. The groups may establish rules of eligibility, interest rates, and accountability for which capital may be advanced, usually to be repaid in installments within two years. The repayments may be used to fund another acceptor-group in a nearby community, who would exert pressure to ensure timely repayments. Two trained birth attendants and the aanganwadi worker (AWW) should be members of this group.
- Implement at village levels a one-stop integrated and coordinated service delivery package for basic health care, family planning and maternal and child health related services, provided by the community and for the community.
- Train and motivate the village self-help acceptor-groups to become the primary contact at household levels. Once every fortnight, these acceptor-groups will meet, and provide at one place 6 different services for: i) registration of births, deaths, marriage and pregnancy; ii) weighing of children under 5 years, and recording the weight on a standard growth-chart; iii) counseling and advocacy for contraception, plus free supply of contraceptives; iv) preventive care, with availability of basic medicines for common ailments such as antipyretics for fevers, antibiotic ointments for infections, ORT IORS' for childhood diarrheas, together with standardized indigenous medication and homeopathic cures; v) nutrition supplements; and vi) advocacy and encouragement for the continued enrolment of children in school up to age 14. One health staff, appointed by the panchayat, will be suitably trained to provide guidance. Clustering services for women and children at one place and time at village levels will promote positive interactions in health benefits and reduce service delivery costs.
- Wherever these village self-help groups have not developed for any reason, community midwives, practitioners of ISMH, retired school teachers and ex-defense personnel may be organized into neighborhood groups to perform similar functions.
- At village levels, the aanganwadi center may become the pivot of basic health care activities, contraceptive counseling and supply, nutrition education and supplementation as well as pre-school activities. The aanganwadi centers can also function as depots for ORS/basic medicines and contraceptives.

- A maternity hut should be established in each village to be used as the village delivery room, with storage space for supplies and medicines. It should be adequately equipped with kits for midwifery, ante-natal care, and delivery; basic medication for obstetric emergency aid; contraceptives, drugs and medicines for common ailments; and indigenous medicines/supplies for maternal and new-born care. The panchayat may appoint a competent and mature mid- wife, to look after this village maternity hut. She may be assisted by volunteers.
 - Trained birth attendants as well as the vast pool of traditional dais should be made familiar with emergency and referral procedures. This will greatly assist the Auxiliary Nurse Midwife (ANM) at the sub-centers to monitor and respond to maternal morbidity/ emergencies at village levels.
 - Each village may maintain a list of community mid-wives, village health guides, panchayat sewa sahayaks, trained birth attendants, practitioners of indigenous systems of medicine, primary school teachers and other relevant persons, as well as the nearest institutional health care facilities that may be accessed for integrated service delivery. These persons may also be helpful: in involving civil society in monitoring availability, quality and accessibility of reproductive and child health services; in disseminating education and communication on the benefits of smaller and healthier families, with emphasis on education of the girl child; and in promoting female participation in the work force.
 - Provide a wider basket of choices in contraception, through innovative social marketing schemes to reach household levels.
- 3) ***Empowering Women for Improved Health and Nutrition:*** The complex socio-cultural determinants of women's health and nutrition have cumulative effects over a lifetime. Discriminatory childcare leads to malnutrition and impaired physical development of the girl child. Under-nutrition and micronutrient deficiency in early adolescence goes beyond mere food entitlements to those nutrition related capabilities that become crucial to a woman's well-being, and through her to the well-being of children. The positive effects of good health and nutrition on the labour productivity of the poor is well documented. To the extent that women are over-represented among the poor, interventions for improving women's health and nutrition are critical for poverty reduction.

Impaired health and nutrition is compounded by early child-bearing, and consequent risk of serious pregnancy related complications. Women's risk of premature death and disability is highest during their reproductive years. Malnutrition, frequent pregnancies, unsafe abortions, RTI and STI, all combine to keep the maternal mortality ratio in India among the highest globally. Maternal mortality is not merely a matter of health disadvantage, it is also a matter of social injustice. Low social and economic status of girls and women limits their access to education, good nutrition, as well as money to pay for health care and family planning services.

Programmes for Safe Motherhood, Universal Immunisation, Child Survival and Oral Rehydration have been combined into an Integrated Reproductive

and Child Health (IRCH) Programme, which also includes promoting management of STIs and RTIs. Women's health and nutrition problems can be largely prevented or mitigated through low cost interventions designed for low income settings.

The voluntary non-government sector and the private corporate sector should actively collaborate with the community and government through specific commitments in the areas of basic reproductive and child health care, basic education, and in securing higher levels of participation in the paid work force for women.

The action strategy can include the following.

- Improve the accessibility and quality of maternal and child health services through deployment of community mid-wives and additional health providers at village levels; cluster services for women and children at the same place and time, from village level upwards, e.g. ante-natal and post-partum care, monitoring infant growth, availability of contraceptives and medicine kits; and routinised immunizations at sub-centre levels. This promotes positive interactions in health benefits and reduces service delivery costs.
- As a measure to empower women, open more child-care centers in rural areas and in urban slums, where a woman worker may leave her children in responsible hands. This will encourage female participation in paid employment, reduce school drop-out rates, particularly for the girl-child, and promote school enrolment as well. The aanganwadis provide a partial solution.
- To empower women, pursue programmes of social afforestation to facilitate access to fuel wood and fodder. Similarly, pursue drinking water schemes for increasing access to potable water. This will reduce long absences from home, and the need for large numbers of children to perform such tasks.
- In any reward scheme intended for household levels, priority may be given to energy-saving devices such as solar cookers, or provision of sanitation facilities, or extension of telephone lines. This will empower households, and women in particular.
- Improve district, sub-district and panchayat-level health management with coordination and collaboration between district health officer, sub-district health officer and the panchayat for planning and implementation activities.
- Strengthen the referral network between the district health office, district hospital, community health centers (CHCs), the primary health centers (PHCs) and sub-centers in management of obstetric and neo-natal care and complications.
- Strengthen CHCs, PHCs and sub-centers to provide a comprehensive range of services, with delivery rooms, counseling for contraception, supplies of free contraceptives, ORS and basic medicines, together with facilities for immunization.

- Establish rigorous problem identification mechanisms through maternal and peri-natal audit, from village level upwards.
- Ensure adequate transportation at village level, sub-centre levels, zila parishads, primary health centers and at community health centers. Identifying women at risk is meaningful only if women with complications can reach emergency care in time.
- Involve professional agencies in developing and disseminating training modules for standard procedures in the management of obstetric and neo-natal cases. The aim should be to routinise these procedures at all appropriate levels.
- Improve supervision by developing guidance and supervision checklists.
- Monitor performance of maternal and child health services at each level by using the maternal and child health local area monitoring system, which includes monitoring the incidence and coverage of ante-natal visits, deliveries assisted by trained health care personnel and post-natal visits, among other indicators. The ANM at the sub-centre should be responsible and accountable for registering every pregnancy and child birth in her jurisdiction, and for providing universal ante-natal and post-natal services.
- Improve technical skills of maternal and child health care providers by:
a) strengthening skills of health personnel and health providers through classroom and on-the-job training in the management of obstetric and neo-natal emergencies. This should include training of birth attendants and community midwives at district-level hospitals in life-saving skills such as management of asphyxia and hypothermia; b) Training on integrated management of childhood illnesses for infants (1 week-2 months);
- Support community activities such as dissemination of IEC material, including leaflets and posters, and promotion of folk jatras, songs and dances to promote healthy mother and healthy baby messages, along with good management practices to ensure safe motherhood, including early recognition of danger signs.
- Convergence, strengthening, and universalisation of the nutritional programmes of the Department of Family Welfare and the ICDS run by the Department of Women and Child Development, ensuring training and timely supply of food supplements and medicines.
- Include STD/RTI and HIV/AIDS prevention, screening and management, in maternal and child health services.
- Provide quality care in family planning, including information, increased contraceptive choices for both spacing and terminal methods, increase access to good quality and affordable contraceptive supplies and services at diverse delivery points, counseling about the safety, efficacy and possible side effects of each method, and appropriate follow-up. Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing as well as commercial sales.

- Develop a health package for adolescents.
- Expand the availability of safe abortion care. Abortion is legal, but there are barriers limiting women's access to safe abortion services. Some operational strategies, are: Community-level education campaigns should target women, household decision-makers and adolescents about the availability of safe abortion services and the dangers of unsafe abortion.
- Ensure services for termination of pregnancy at primary health centers and at community health centers.
- Provide competent post-abortion care, including management of complications and identification of other health needs of post-abortion patients, and linking with appropriate services. As part of post-abortion care, physicians may be trained to provide family planning counseling and services such as sterilization, and reversible modern methods such as IUDs as well as oral contraceptives and condoms.
- Modify syllabus and curricula for medical graduates, as well as for continuing education and in-house learning, to provide for practical training in the newer procedures.
- Develop maternity hospitals at sub-district levels and at community health centers to function as First Referral Units (FRUs) for complicated and life-threatening deliveries.
- Formulate and enforce standards for clinical services in the public, private and NGO sectors.
- Create a national network consisting of public, private and NGO centers, identified by a common logo, for delivering reproductive and child health services free to any client. The provider will be compensated for the service provided, on the basis of a coupon, duly counter-signed by the beneficiary, and paid for by a system to be devised. The compensation will be identical to providers across all sectors. The end-user will choose the providers of the service. A group of management experts will devise checks and balances to prevent misuse.

- 4) ***Child Health and Survival:*** Infant mortality is a sensitive indicator of human development. High mortality and morbidity among infants and children below 5 years occurs on account of inadequate care, asphyxia during birth, premature birth, low birth-weight, acute respiratory infections, diarrhea, vaccine-preventable diseases, malnutrition and deficiencies of nutrients, including Vitamin A.

Implementation at the grass-roots must benefit from current developments in the fields of perinatology and neonatology. The baby-friendly hospital initiative (BFHI) should be extended to all hospitals and clinics, up to sub-centre levels. Additionally, besides promoting breast-feeding and complementary feeds, the BFHI should include updating of skills of trained birth attendants to improve new born care practices to reduce the risks of hypothermia and infection. Essential equipment for the new born must be provided at sub-centre levels.

Child survival interventions, i.e. universal immunisation, control of childhood diarrheas with oral rehydration therapies, management of acute respiratory infections, and massive doses of Vitamin A and food supplements have all helped to reduce infant and child mortality and morbidity. With intensified efforts, the eradication of polio is within reach. However, the decline in standards, outreach and quality of routine immunisation is a matter of concern. Significant improvements need to be made in the quality and coverage of the routine immunisation programme.

Operational strategy can include the following.

- Support community activities from village level upwards to monitor early and adequate ante-natal, natal and post-natal care.
- Focus attention on neo-natal health care and nutrition. Set up a National Technical Committee on neo-natal care, to align programme and project interventions with newly emerging technologies in neo-natal and perinatal care.
- Pursue compulsory registration of births in coordination with the ICDS Programme.
- After the birth of a child, provide counseling and advocacy about contraception, to encourage adoption of a reversible or a terminal method. This will also contribute to the health and well-being of both mother and child.
- Improve capacities at health centers in basic midwifery services, essential neo-natal care, including the management of sick neo-nates outside the hospital.
- Sensitize and train health personnel in the integrated management of childhood illnesses.
- Standard case management of diarrhea and acute respiratory infections must be provided at sub-centers and primary health centers, with appropriate training, and adequate equipment. Besides, training in this sector may be imparted to health care providers at village levels, especially in indigenous systems.
- Strengthen critical interventions aimed at bringing about reductions in maternal malnutrition, morbidity and mortality, by ensuring availability of supplies and equipment at village levels and at sub-centers.
- Pursue rigorously the pulse polio campaign to eradicate polio.
- Ensure 100 percent routine immunization for all vaccine-preventable diseases, in particular tetanus and measles.
- As a child survival initiative, explore promotional and motivational measures for couples below the poverty line who marry after the legal age of marriage, to have the first child after the mother reaches the age of 21, and adopt a terminal method of contraception after the birth of the second child.
- Children form a vulnerable group and certain sub-groups merit focused attention and intervention, such as street children and child laborers.

Encourage voluntary groups as well as NGOs to formulate and implement special schemes for these groups of children.

- Explore the feasibility of a national health insurance covering hospitalization costs for children below 5 years, whose parents have adopted the small family norm, and opted for a terminal method of contraception after the birth of the second child.
- Expand the ICDS to include children between 6-9 years of age, specifically to promote and ensure 100 percent school enrolment, particularly for girls. Promote primary education with the help of aanganwadi workers, and encourage retention in school till age 14. Education promotes awareness, late marriages, small family size and higher child survival rates.
- Provide vocational training for girls. This will enhance perception of the immediate utility of educating girls, and gradually raise the average age of marriage. It will also increase enrolment and retention of girls at primary school, and likely also at secondary school levels. Involve NGOs, the voluntary sector and the private sector, as necessary, to target employment opportunities.

5) ***Meeting the Unmet Needs for Family Welfare Services:*** In both rural and urban areas there continue to be unmet needs for contraceptives, supplies and equipment for integrated service delivery, mobility of health providers and patients, and comprehensive information. It is important to strengthen, energise and make accountable the cutting edge of health infrastructure at the village, sub-centre and primary health centre levels, to improve facilities for referral transportation, to encourage and strengthen local initiatives for ambulance services at village and block levels, to increase innovative social marketing schemes for affordable products and services and to improve advocacy in locally relevant and acceptable dialects.

The *action strategy* should focus on the following.

- Address on priority the different unmet needs, and in particular, increase rural infrastructure, deployment of sanctioned and appropriately trained health personnel, and provisioning of essential equipment and drugs.
- Formulate and implement innovative social marketing schemes to provide subsidized products and services in areas where the existing coverage of the public, private and NGO sectors is insufficient in order to increase outreach and coverage.
- Improve facilities for referral transportation at panchayat, zilla parishad and primary health centre levels. At Sub-centers, provide ANMs with soft-loans for purchase of mopeds, to enhance their mobility. This will increase coverage of ante-natal and post natal check-ups, which, in turn, and will bring about reductions in maternal and infant mortality.
- Encourage local entrepreneurs at village and block levels to start ambulance services through special loan schemes, with appropriate vehicles to facilitate transportation of persons requiring emergency as well as essential medical attention.

- Provide special loan schemes and make site allotments at village levels to facilitate the starting of chemist shops for basic medicines and provision for medical first aid.
 - *Increased Participation of Men in Planned Parenthood:* In the past, population programmes have tended to exclude men-folk. Gender inequalities in patriarchal societies ensure that men play a critical role in determining the education and employment of family members, age at marriage, besides access to and utilisation of health, nutrition, and family welfare services for women and children. The active involvement of men is called for in planning families, supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoiding delays in seeking care, helping after the baby is born and, finally, in being a responsible father. In short, the active cooperation and participation of men is vital for ensuring programme acceptance. Further, currently, over 97 percent of sterilisations are tubectomies and this manifestation of gender imbalance needs to be corrected. The special needs of men include re-popularising vasectomies, in particular no-scalpel vasectomy as a safe and simple procedure, and focusing on men in the information and education campaigns to promote the small family norm.
 - Focus attention on men in the information and education campaigns to promote the small family norm, and to raise awareness by emphasizing the significant benefits of fewer children, better spacing, better health and nutrition, and better education.
 - In the continuing education and training at all levels, there is need to ensure that the no-scalpel vasectomy, and all such emerging techniques and skills are included in the syllabi, together with abundant practical training. Medical graduates, and all those participating in "in-service" continuing education and training, will be equipped to handle this intervention.
- 6) ***Under-Served Population Groups:*** Urban slums, Tribal communities, Hill area populations and Displaced migrants population and Adolescents are the major under-served population groups.
- a) ***Urban Slums:*** Nearly 100 million people live in urban slums, with little or no access to potable water, sanitation facilities, and health care services. This contributes to high infant and child mortality, which in turn perpetuate high TFR and maternal mortality. Basic and primary health care, including reproductive and child health care, needs to be provided. Coordination with municipal bodies for water, sanitation and waste disposal must be pursued, and targeted information, education and communication campaigns must spread awareness about the secondary and tertiary facilities available.

The action strategy can be as follows.

- Finalize a comprehensive urban health care strategy.
- Facilitate service delivery centers in urban slums to provide comprehensive basic health, reproductive and child health services by involving NGOs and private sector organizations, including corporate houses.

- Promote networks of retired government doctors and para-medical and non-medical personnel who may function as health care providers for clinical and non-clinical services on remunerative terms.
- Strengthen social marketing programmes for non-clinical family planning products and services in urban slums.
- Initiate specially targeted information, education and communication campaigns for urban slums on family planning, immunization, ante-natal, natal and post-natal check-ups and other reproductive health care services. Integrate aggressive health education programmes with health and medical care programmes, with emphasis on environmental health, personal hygiene and healthy habits, nutrition education and population education.
- Promote inter-sectoral coordination between departments/municipal bodies dealing with water and sanitation, industry and pollution, housing, transport, education and nutrition, and women and child development, to deal with unplanned and uncoordinated settlements.
- Streamline the referral systems and linkages between the primary, secondary and tertiary levels of health care in the urban areas.
- Link the provision of continued facilities to urban slum-dwellers with their observance of the small family norm.

b) *Tribal Communities, Hill Area Populations, and Displaced and Migrant Populations:* In general, populations in remote and low density areas do not have adequate access to affordable health care services. Tribal populations often have high levels of morbidity arising from poor nutrition, particularly in situations where they are involuntarily displaced or resettled. Frequently, they have low levels of literacy, coupled with high infant, child, and maternal mortality. They remain under-served in the coverage of reproductive and child health services. These communities need special attention in terms of basic health, and reproductive and child health services. The special needs of tribal groups which need to be addressed include the provision of mobile clinics that will be responsive to seasonal variations in the availability of work and income. Information and counseling on infertility, and regular supply of standardised medication will be included.

- Many tribal communities are dwindling in numbers, and may not need fertility regulation. Instead, they may need information and counseling in respect of infertility.
- The NGO sector may be encouraged to formulate and implement a system of preventive and curative health care that responds to seasonal variations in the availability of work, income and food for tribal and hill area communities and migrant and displaced populations. To begin with, mobile clinics may provide some degree of regular coverage and outreach.
- Many tribal communities are dependent upon indigenous systems of medicine which necessitates a regular supply of local flora, fauna and minerals, or of standardized medication derived from these. Husbandry of such local resources and of preparation and distribution of standardized formulations should be encouraged.

- Health care providers in the public, private and NGO sectors should be sensitized to adopt a “burden of disease” approach to meet the special needs of tribal and hill area communities.
- c) *Adolescents:* Adolescents represent about a fifth of India’s population. The needs of adolescents, including protection from unwanted pregnancies and sexually transmitted diseases (STD), have not been specifically addressed in the past. Programmes should encourage delayed marriage and child-bearing, and education of adolescents about the risks of unprotected sex. Reproductive health services for adolescent girls and boys is especially significant in rural India, where adolescent marriage and pregnancy are widely prevalent. Their special requirements comprise information, counseling, population education, and making contraceptive services accessible and affordable, providing food supplements and nutritional services through the ICDS, and enforcing the Child Marriage Restraint Act, 1976.

The action strategy can be as follows.

- Provide for adolescents the package of nutritional services available under the ICDS programme. Improvements in health status of adolescent girls has an inter-generational impact. It reduces the risk of low birth-weight and minimizes neo-natal mortality. Malnutrition is a problem that seriously impairs the health of adolescent and adult women and has its roots in early childhood. The causal linkages between anemia and low birth-weight, peri-natal mortality, and maternal mortality has been extensively studied and established.
 - Enforce the Child Marriage Restraint Act, 1976 to reduce the incidence of teenage pregnancies. Preventing the marriage of girls below the legally permissible age of 18 should become a national concern. It will promote higher retention of girls at schools, and is also likely to encourage their participation in the paid workforce.
 - Provide integrated intervention in pockets with unmet needs in the urban slums, remote rural areas, border districts and among tribal populations.
- 7) *Diverse Health Care Providers:* Given the large unmet need for reproductive and child health services, and inadequacies in health care infrastructure it is imperative to increase the numbers and diversify the categories of health care providers. Ways of doing this include accrediting private medical practitioners and assigning them to defined beneficiary groups to provide these services; revival of the system of licensed medical practitioner who, after appropriate certification from the Indian Medical Association (IMA), could provide specified clinical services.

The action strategy can be as follows.

- At district and sub-district levels, maintain block-wise database of private medical practitioners whose credentials may be certified by the Indian Medical Association (IMA). Explore the possibility of accrediting these private practitioners for a year at a time, and assign to each a satellite population, not exceeding 5,000 (depending upon distances and spread),

for whom they may provide reproductive and child health services. The private practitioners would be compensated for the services rendered through designated agencies. Renewal of contracts after one year may be guided by client satisfaction. This will serve as an incentive to expand the coverage and outreach of high quality health care. Appropriate checks and balances will safeguard misuse.

- Revive the earlier system of the licensed medical practitioners who, after appropriate certification from the IMA, may participate in the provision of clinical services.
- Involve the non-medical fraternity in counseling and advocacy so as to demystify the national family welfare effort, such as retired defense personnel, retired school teachers and other persons who are active and willing to get involved.
- Modify the under/post-graduate medical, nursing and paramedical professional course syllabi and curricula, in consultation with the Medical Council of India, the Councils of ISMH, and the Indian Nursing Council, in order to reflect the concepts and implementation strategies of the reproductive and child health programme and the national population policy. This will also be applied to all in-service training and educational curricula.
- Ensure the efficient functioning of the First Referral Units, i.e. 30 bed hospitals at block levels which provide emergency obstetric and child health care, to bring about reductions in Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR). In many states, these FRUs are not operational on account of an acute shortage of specialists, i.e. gynecologist/obstetrician, anesthetist and pediatrician. Augment the availability of specialists in these three disciplines, by increasing seats in medical institutions, and simultaneously enable and facilitate the acquisition of in-service post-graduate qualifications through the National Board of Medical Examination and open universities like IGNOU in larger numbers. As an incentive, seats will be reserved for those in-service medical graduates who are willing to abide by a bond to serve for 5 years at First Referral Units after completion of the course. States would need to sanction posts of Specialists at the FRUs. Further, these specialists should be provided with clear promotion channels.

- 8) ***Collaboration with and commitments from Non-Government Organisations and the Private Sector:*** A national effort to reach out to households cannot be sustained by government alone. We need to put in place a partnership of non-government voluntary organizations, the private corporate sector, government and the community. Triggered by rising incomes and institutional finance, private health care has grown significantly, with an impressive pool of expertise and management skills, and currently accounts for nearly 75 percent of health care expenditures. However, despite their obvious potential, mobilising the private (profit and non-profit) sector to serve public health goals raises governance issues of contracting, accreditation, regulation and referral, besides the appropriate division of labour between the public and private health providers, all of which need to

be addressed carefully. Where government interventions or capacities are insufficient, and the participation of the private sector unviable, focused service delivery by NGOs may effectively complement government efforts.

The action strategy must take care of the following.

- There remain innumerable hurdles that inhibit genuine long-term collaboration between the government and non-government sectors. A forum of representatives from government, the non-government organizations and the private sector may identify these hurdles and prepare guidelines that will facilitate and promote collaborative arrangements.
 - Collaboration with and commitments from NGOs to augment advocacy, counseling and clinical services, while accessing village levels, will require increased clinic-outlets as well as mobile clinics.
 - Collaboration between the voluntary sector and the NGOs will facilitate dissemination of efficient service delivery upto village levels. The guidelines could articulate the role and responsibility of each sector.
 - Encourage the voluntary sector to motivate village-level self-help groups to participate in community activity.
 - Specific collaboration with the non-government sector in the social marketing of contraceptives to reach village levels will be encouraged.
- 9) ***Mainstreaming Indian Systems of Medicine and Homeopathy (ISMH):*** India's community-supported ancient but living traditions of indigenous systems of medicine has sustained the population for centuries, with effective cures and remedies for numerous conditions, including those relating to women and children, with minimal side effects. Utilisation of ISMH in basic reproductive and child health care will expand the pool of effective health care providers, optimise utilisation of locally-based remedies and cures, and promote low cost health care. Guidelines need to be evolved to regulate and ensure standardisation, efficacy and safety of ISMH drugs for wider entry into national markets.

Particular challenges to be addressed in *action strategy* include: providing appropriate training, and raising awareness and skill development in reproductive and child health care to the institutionally-qualified ISMH medical practitioners. The feasibility of utilising their services to fill-in gaps in manpower at village levels, and at sub-centres and primary health centres may be explored. ISMH institutions, hospitals and dispensaries may be utilised for reproductive and child health care programmes. At village levels, the services of the ISMH "barefoot doctors", after appropriate training, may be utilised for advocacy and counseling, for distributing supplies and equipment, and as depot holders. ISMH practices may be applied at village maternity huts, and at household levels, for ante-natal, natal and post-natal care, and for nurture of the new born.

- 10) ***Contraceptive Technology and Research on Reproductive and Child Health:*** Government must constantly advance, encourage and support medical, social science, demographic and behavioural science research on

maternal, child and reproductive health care issues. This will improve medical techniques relevant to the country's needs, and strengthen programme and project design and implementation. Consultation and frequent dialogue by Government with the existing network of academic and research institutions in allopathy and ISMH, and with other relevant public and private research institutions engaged in social science, demography and behavioural research must continue. The International Institute of Population Sciences and the Population Research Centres, which have been set up to pursue applied research in population related matters, need to be revitalised and strengthened.

Applied research relies upon constant monitoring of performance at the programme and project levels. The National Health and Family Welfare Survey provides data on key health and family welfare indicators every five years. Data from the first National Family Health Survey (NFHS-1) 1992-93, has been updated by NFHS-2, 1998-99. Annual data is generated by the Sample Registration Survey, which, inter alia, maps at state levels the birth, death and infant mortality rates. Absence of regular feedback has been a weakness in the family welfare programme. For this reason, the Department of Family Welfare is strengthening its management information systems (MIS) and has commenced during 1998, a system of ascertaining impacts and outcomes through district surveys and facility surveys. The district surveys cover 50% districts every year, so that every 2 years there is an update on every district in the country. The facility surveys ascertain the availability of infrastructure and services up to primary health centre level, covering one district per month. The feedback from both these surveys enable remedial action at district and sub-district levels.

The *action strategy* can be as follows.

- Government will encourage, support and advance the pursuit of medical and social science research on reproductive and child health, in consultation with ICMR and the network of academic and research institutions.
- The International Institute of Population Sciences and the Population Research Centers will continue to review programme and monitoring indicators to ensure their continued relevance to strategic goals. Government will restructure the Population Research Centers, if necessary.
- Standards for clinical and non-clinical interventions will be issued and regularly reviewed.
- A constant review and evaluation of the community needs assessment approach will be pursued to align programme delivery with good management practices and with newly emerging technologies.
- A committee of international and Indian experts, voluntary and non-government organizations and government may be set up to regularly review and recommend specific incorporation of the advances in contraceptive technology and, in particular, the newly emerging techniques, into programme development.

- 11) *Providing for the Older Population:*** Improved life expectancy is leading to an increase in the absolute number and proportion of persons aged 60 years and above, and is anticipated to nearly double during 1996-2016, from 62.3 million to 112.9 million (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>). When viewed in the context of significant weakening of traditional support systems, the elderly are increasingly vulnerable, needing protection and care. Promoting old-age health care and support will, over time, also serve to reduce the incentive to have large families.

The Ministry of Social Justice and Empowerment has adopted in January 1999 a National Policy on Older Persons. It has become important to build in geriatric health concerns in the population policy. Ways of doing this include sensitising, training and equipping rural and urban health centres and hospitals for providing geriatric health care; encouraging NGOs to design and implement formal and informal schemes that make the elderly economically self-reliant; providing for and routinising screening for cancer, osteoporosis, and cardiovascular conditions in primary health centres, community health centres, and urban health care centres at primary, secondary and tertiary levels; and exploring tax incentives to encourage grown-up children to look after their aged parents.

- 12) *Information, Education and Communication:*** Information, education and communication (IEC) of family welfare messages must be clear, focused and disseminated everywhere, including the remote corners of the country, and in local dialects. This will ensure that the messages are effectively conveyed. These need to be strengthened and their outreach widened, with locally-relevant, and locally-comprehensible media and messages. On the model of the total literacy campaigns which have successfully mobilised local populations, there is need to undertake a massive national campaign on population related issues, via artists, popular film stars, doctors, vaidyas, hakims, nurses, local midwives, women's organizations, and youth organizations.

- Converge IEC efforts across the social sectors. The two sectors of Family Welfare and Education have coordinated a mutually supportive IEC strategy. The Zila Saksharta Samitis design and deliver joint IEC campaigns in the local idiom, promoting the cause of literacy as well as family welfare. Optimal use of folk media has proven effect in successfully mobilizing local populations.
- Involve departments of rural development, social welfare, transport, cooperatives, education with special reference to schools, to improve clarity and focus of the IEC effort, and to extend coverage and outreach. Health and population education must be inculcated from the school levels.
- Fund the nagar palikas, panchayats, NGOs and community organizations for interactive and participatory IEC activities.
- Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behavior and response patterns

of individuals and communities. This serves to enthuse communities to be attentive towards the quality and coverage of maternal and child health services, including referral care. Public leaders and film stars could spread widely the messages of the small family norm, female literacy, delayed marriages for women, fewer babies, healthier babies, child immunization and so on. The involvement and enthusiastic participation of elected leaders will ensure dedicated involvement of administrators at district and sub-district levels. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional, and religious leaders, media and film stars, sports personalities and other opinion makers will enhance its acceptance throughout society.

- Utilize radio and television as the most powerful media for disseminating relevant socio-demographic messages. Government could explore the feasibility of appropriate regulations, and even legislation, if necessary, to mandate the broadcast of social messages during prime time.
- Utilize dairy cooperatives, the public distribution systems, and other established networks for distribution of contraceptives and basic medicines to target infant/childhood diarrheas, and anemia and malnutrition among adolescent girls and pregnant mothers. This will widen outreach and coverage.
- Sensitize the field level functionaries across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, cooperatives) to the strategies, goals and objectives of the population stabilization programmes.
- Involve civil society for disseminating information, counseling and spreading education about the small family norm, the need for fewer but healthier babies, higher female literacy and late marriages for women. Civil society could also be of assistance in monitoring the availability of contraceptives, vaccines and drugs in rural areas and in urban slums.

C) Legislation, Public Support and New Structures: Here, we touch upon the legislation, public support and new structures in respect of national population policy 2000.

- 1) **Legislation:** As a motivational measure, in order to enable state governments to fearlessly and effectively pursue the agenda for population stabilisation contained in the National Population Policy 2000, one legislation is considered necessary. It is recommended that the 42nd Constitutional Amendment that freezes till 2001 the number of seats to the Lok Sabha and the Rajya Sabha based on the 1971 Census be extended up to 2026.
- 2) **Public support:** Demonstration of strong support to the small family norm as well as personal example by political, community, business, professional and religious leaders, media and film stars, sports personalities, and other opinion makers will enhance its acceptance throughout society. The government will actively enlist their support in concrete ways.
- 3) **New structures:** The NPP 2000 is to be largely implemented and managed at panchayat and nagar palika levels, in coordination with the concerned

State/Union Territory administrations. Accordingly, the specific situation in each State/UT must be kept in mind. This will require comprehensive and multi-sectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes for education, nutrition, women and child development, safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection, and urban development. Accordingly, the following structures are recommended:

- i) *National Commission on Population:* A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all States and UTs, and the Central Ministers in charge of the Department of Family Welfare and other concerned Central Ministries and Departments such as Department of Woman and Child Development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, including reputed demographers, public health professionals and NGOs as members. This Commission will oversee and review implementation of policy. The Commission Secretariat will be provided by the Department of Family Welfare. The Commission has the following mandate.
 - To review, monitor and give directions for implementation of the National Population Policy with the view to achieve the goals set in the Policy.
 - To promote synergy between health, educational, environmental and developmental programmes so as to hasten population stabilization.
 - To promote inter-sectoral coordination in planning and implementation of the programmes through different sectors and agencies in center and the States.
 - To develop a vigorous people's programme to support this national effort.
- ii) *State / UT Commissions on Population:* Each State and UT may consider having a State / UT Commission on Population, presided over by the Chief Minister, on the analogy of the National Commission to likewise oversee and review implementation of the NPP 2000 in the State / UT.
- iii) *Coordination Cell in the Planning Commission:* The Planning Commission will have a Coordination Cell for inter-sectoral coordination between Ministries for enhancing performance, particularly in States/UTs needing special attention on account of adverse demographic and human development indicators.
- iv) *Technology Mission in the Department of Family Welfare:* To enhance performance, particularly in States with currently below average socio-demographic indices that need focused attention, a Technology Mission in the Department of Family Welfare will be established to provide technology support in respect of design and monitoring of projects and programmes for reproductive and child health, as well as for IEC campaigns.

D) Funding, Promotional and Motivational Measures for Adoption of the Small Family Norm: The details in this regard are as follows.

- a) **Funding:** The programmes, projects and schemes premised on the goals and objectives of the NPP 2000, and indeed all efforts at population stabilisation, will be adequately funded in view of their critical importance to national development. Preventive and promotive services such as ante-natal and post-natal care for women, immunisation for children, and contraception will continue to be subsidised for all those who need the services. Priority in allocation of funds will be given to improving health care infrastructure at the community and primary health centres, subcentre and village levels. Critical gaps in manpower will be remedied through redeployment, particularly in under-served and inaccessible areas, and referral linkages will be improved. In order to implement immediately the Action Plan, it would be necessary to double the annual budget of the Department of Family Welfare to enable government to address the shortfall in unmet needs for health care infrastructure, services and supplies (<http://archive.k4health.org/system/files/India%20Population%20Policy.pdf>).
- b) **Promotional and motivational measures for adoption of the small family norm:** The following promotional and motivational measures will be undertaken.
- i) Panchayats and Zilla Parishads will be rewarded and honoured for exemplary performance in universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.
 - ii) The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs.500 is awarded at the birth of the girl child of birth order 1 or 2.
 - iii) Maternity Benefit Scheme run by the Department of Rural Development will continue. A cash incentive of Rs.500 is awarded to mothers who have their first child after 19 years of age, for birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth and BCG immunisation.
 - iv) A Family Welfare-linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible (along with children) for health insurance (for hospitalisation) not exceeding Rs.5000, and a personal accident insurance cover for the spouse undergoing sterilisation.
 - v) Couples below the poverty line, who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded.
 - vi) A revolving fund will be set up for income-generating activities by village-level self-help groups, who provide community-level health care services.

- vii) Crèches and child care centres will be opened in rural areas and urban slums. This will facilitate and promote participation of women in paid employment.
- viii) A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent.
- ix) Facilities for safe abortion will be strengthened and expanded.
- x) Products and services will be made affordable through innovative social marketing schemes.
- xi) Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.
- xii) Increased vocational training schemes for girls, leading to self-employment will be encouraged.
- xiii) Strict enforcement of Child Marriage Restraint Act, 1976.
- xiv) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994.
- xv) Soft loans to ensure mobility of the ANMs will be increased.
- xvi) The 42nd Constitutional Amendment that freezes the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels which is currently valid until 2001 needs to be extended until 2026 so as to serve as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation.

Even though the annual budget for population stabilisation activities assigned to the Department of Family Welfare has increased over the years, at least 50 percent of the budgetary outlay is deployed towards non-plan activities (recurring expenditures for maintenance of health care infrastructure in the States and UTs, and towards salaries). To illustrate, of the annual budget of Rs.2920 crores for 1999-2000, nearly Rs.1500 crores is allocated towards non-plan activities. Only the remaining 50 percent becomes available for genuine plan activities, including procurement of supplies and equipment. For these reasons, since 1980 the Department of Family Welfare has been unable to revise norms of operational costs of health infrastructure, which in turn has impacted directly the quality of care and outreach of services provided.

The policy includes freezing of Lok Sabha seats at current level of 543 till 2026, compulsory registration of marriage and pregnancy, along with birth and death, cash incentives for compliance with requirements regarding antenatal check-up, institutional delivery by a trained birth attendant, increasing the number of health workers, improving the availability of contraceptives and strengthening the health and family welfare services.

The medium-term objectives of the policy included bringing down the total fertility rate to replacement level by 2010 through vigorous implementation of inter-sectoral operational strategies like free school education to children up to the age of 14, 20 per cent reduction in the drop-outs of children in schools at primary and secondary levels, bringing down the child mortality rate to the level

of 30 per 1000, universal immunization for prevention of communicable diseases, containing the spread of AIDS, and fixing the minimum marriage age limit of 18 years for girls.

Under the policy, the Government of India has offered an incentive package to model small families. It includes improvement in the facilities for safe abortion, prize to village panchayats and district boards fulfilling the target of model small families in respect of reducing infant mortality rate and improving literacy, an incentive of Rs.500 for the upbringing of female children up to the limit of two, an incentive of Rs.500 to the couple aged 19 years on the birth of first child to the birth of second child, insurance up to Rs.5,000 for the couple below the poverty line who has two living children, incentive to the couple marrying after the fixed age, producing first child after 21 years of age and adopting permanent family planning measures after the birth of second child.

In the new millennium, nations are judged by the well-being of their peoples; by levels of health, nutrition and education; by the civil and political liberties enjoyed by their citizens; by the protection guaranteed to children and by provisions made for the vulnerable and the disadvantaged. The vast number of people in India can be its greatest asset if they are provided with the means to lead healthy and economically productive lives. Population stabilisation is a multi-sectoral endeavour requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a steady, equitable improvement in family incomes will facilitate early achievement of the socio-demographic goals. Success will be achieved if the Action Plan contained in the NPP 2000 is pursued as a national movement. At this cornerstone, population and development education is an effective strategy to control population growth.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 1) Elucidate the reasons as to why population growth in India continues to be high.

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2) What are the milestones in the evolution of population policy in India?

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3) What are the goals of National Population Policy 2000?

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11.3 INSTITUTIONALISATION OF POPULATION (AND DEVELOPMENT) EDUCATION: A RATIONALE

You can recall our discussion on origin, growth and status of population education under Section 1.4 of Unit-1 of Block-1 of this Course, i.e, MAE-005. It must have given you clear picture of the status of institutionalization of population and development education. Here, in Section 11.3, we attempt to highlight the relevance of conceptual framework and rationale for institutionalization of population and development education at different levels.

11.3.1 Relevance of Conceptual Framework of Population (and Development) Education to its Institutionalisation: A Historical Perspective

One important aspect that needs thorough consideration for institutionalization of population and development education is its conceptual framework that forms basis for its curriculum development. As you have noticed in Unit-1, the concept of Population Education (now popularly, population and development education) has relatively a short history. Ever since its inception, it has been changing and evolving at relatively faster pace. This has been so primarily because its central subject – the population phenomenon – has been unfolding itself in quick succession, and enlarging the scope for identifying new dimensions of its interrelationships with many facets of human development. Thus, it has been a difficult task due to ever changing dimensions.

Alva Myrdal was, perhaps, the first to raise voice for the need of education in respect to the then population situation of western societies in 1941. Later, in 1960, the noted teacher educators like Sloan R. Wayland, Warren S. Thompson and Philip M. Hauser conceptualized it as an education for making students aware of the demographic concerns focused on population growth.

In India also, Population Education was first conceptualized during the later half of nineteen sixties only. The National Seminar on Population Education held in 1969 defined it as an education to make learner aware of the causes and effects of population changes. Initially, Population Education emerged as a *demography-laden* concept. In early seventies, the Conceptual Framework of Population Education was built around the following *six major areas*.

- 1) The population growth.
- 2) Economic development and population.
- 3) Social development and population.
- 4) Health, nutrition and population.
- 5) Biological factors — family life and population.
- 6) Environment and Population.

The first *re-conceptualization* occurred during late 1980s, when the Population Education Conceptual Framework focused on *six major themes*, viz. i) Family Size and Family Welfare; ii) Delayed Marriage; iii) Responsible Parenthood; iv) Population Change and Resource Development; v) Population Related Values and Beliefs; and vi) Status of Women. The content focusing on these themes were drawn from the following *six content areas*.

- 1) Population and Economic Development.
- 2) Population and Social Development.
- 3) Population and Family Life.
- 4) Population and Health and Nutrition.
- 5) Population and Environmental Resources.
- 6) Population Dynamics.

But, with the passage of time, it was realized that it should be oriented toward values and, therefore, a need was felt to re-conceptualize it. The concept of Population Education was reoriented to make it value-laden, as population issues are predominantly value-laden. Thus, by early 1990, again a need was felt to re-conceptualize Population Education. The feedback received through in-built monitoring and findings of evaluation studies identified two basic limitations. These were:

- i) Population Education Framework did not provide comprehensive treatment to the unfolding dimensions of relationship between population and development; and
- ii) Its theoretical framework was not in tune with the existing National Curriculum Framework of School Education in India.

The Core Curricular areas emphasized in the National Policy of Education, 1986, such as Observance of Small Family Norm, Equality of Sexes, Protection of Environment, Removal of Social Barriers and Inculcation of Scientific Temper were also to be reflected.

At the global level, UNESCO Regional Office for Education in Asia in 1970 defined Population Education “as an educational programme which provides

for a study of the population situation in the family, the community, nation and the world with the purpose of developing in the students rational and responsible attitudes and behaviour toward that situation". In view of the ICPD Programme of Action, in the Re-conceptualized Framework of Population Education, it has been elaborated and defined "as an educational process to develop in learners an understanding of inter-relationships between population and development, causes and consequences of population change and the criticality of the conditions for population stabilization. It inculcates among them rational attitude and responsible behaviour towards population and development issues, so that they may make informed decisions". The basic change in the perception of inter-relationship between population and development reflected in the ICPD Programme of Action registered a Paradigm Shift and put forth a fresh population agenda for the nations. Meanwhile, the experiences gained during the implementation of NPEP in India also highlighted the gap regarding some crucial areas concerning sex-related matters, HIV/AIDS and Drug Abuse.

The process of curriculum development should take into consideration the following objectives of population education:

- Making learners aware of the inter-relationships between population and sustainable development.
- Developing in them an understanding of the criticality of essential conditions of population stabilization for better quality of life of present and future generations.
- Inculcating in them rational attitude and responsible behaviour towards population and development issues.
- Making them understand the crucial aspects of adolescent reproductive health, focusing on the elements of process of growing-up, and implication of HIV/AIDS and Drug Abuse.
- Inculcating in them rational attitude towards sex and drugs and promoting respect for the opposite sex; and
- Empowering them to take informed decisions on issues of population and development including reproductive health.

In view of the above, the existing framework of population education was re-conceptualized with the following highlights:

- a) The focus of population education will shift from number to essential conditions for population stabilization. These conditions are: Gender Equity and Equality; Reproductive Health and Reproductive Rights; Family - Its Structure and Role; Sustainable Development; and so on. It will highlight the individual needs instead of demographic targets and reflect the shift from purely population control to broader sustainable development approach.
- b) It will highlight education as an essential condition for population stabilization. Population Education will, thus, be conceptualized as a truly educational approach.
- c) The new framework will incorporate the elements of Adolescence Education (Process of Growing up, HIV/AIDS and Drug Abuse) as one of its major components.

- d) The policy directions of Revised NPE 1992 will also be reflected in the Re-conceptualised Framework of Population Education.

Identification of Population Education Contents: Population Education is a value-laden concept. Its content is culture and region-specific and interdisciplinary in nature. The desirability of having need-based as well as a demand-based curriculum calls for a serious exercise in respect of selecting appropriate and relevant contents. The Re-conceptualized Framework of Population Education has been built around the following *six major themes*:

- 1) Population and Sustainable Development.
- 2) Gender Equality and Empowerment of Women.
- 3) Adolescents' Reproductive Health.
- 4) Family: Socio-Economic Factors and Quality of Life.
- 5) Health and Education.
- 6) Population Distribution: Urbanization and Migration.

The broad contents of school education, theme-wise and stage-wise have been identified along with subjects with which these could be integrated. These are given below in tabular form.

Table 11.1: Broad Contents of Population Education

Sl. No	Themes	Broad content areas	School stages	Subjects
1.	Population and Sustainable Development	Population Situation	Upper Primary	Social Sciences
		Implications for Population Stabilization	Secondary	Co-Curricular Activities
		Population and Sustained Economic Growth, Population and Poverty	Secondary, Higher Secondary	Social Sciences, Economics, Geography, Political Science, Sociology
		Consumption and Utilization of Resources, Avoidance of wastage	Primary, Upper Primary	EVS / Social Science
		Sustainable Patterns and Levels of Resource Utilization, Production and Consumption	Secondary, Higher Secondary	Social Sciences, Sociology, Economics, Geography
		Population Resource and Technology	-do-	-do-
		Environment, Development and Population inter-relationship	-do-	Economics, Geography, Sociology

2.	Gender Equality and Empowerment of Women	The Girl-child, Equal treatment of boys and girls;	Primary	Language, EVS, Co-curricular Activities
		Elimination of discrimination	Upper Primary	Language, Social Sciences, Co-curricular Activities
		Equity and equality between man and woman in different aspects of life	Secondary, Higher Secondary	Social Sciences Sociology, Co-curricular Activities
		Promoting the Fulfillment of Women's Potential	-do-	Social Sciences Sociology
		Empowerment of women	-do-	-do-
		Participation of women in all aspects of life	-do-	-do-
		Reproductive health and Reproductive right	-do-	-do-
		Male responsibility in all areas of family and household activity	-do-	-do-
		Reproductive rights	-do-	-do-
3.	Adolescents Reproductive Health	Physical growth in human body, Genital hygiene	Primary	EVS, Co-Curricular Activities
		Physical, emotional changes during adolescence, inter-personal relationships, sexual health and hygiene, myths and misconceptions, physical, physiological and psychological development during adolescence	Upper Primary, Secondary, Higher Secondary	Sciences, Social Sciences, Biology, Psychological Health, Physical Education, Co-curricular Activities
		Conception and pregnancy, Contraceptive methods, Adolescent pregnancy and its consequences	-do-	-do-
		Interpersonal relationships between adolescents and members of the opposite sex, parents, peer group and gender roles.	-do-	-do-
		Meaning of HIV/AIDS, Modes of Transmission	-do-	Sciences, Social Sciences, Biology, Health and Physical Education
		Ways of preventing HIV transmission	Secondary	Co-Curricular Activities

		Drug Abuse, and its Implication, Prevention & Rehabilitation of Drug Abuse, Myths and Misconceptions	Secondary, Higher Secondary	Science, Biology, Social Sciences, Sociology, Co-Curricular Activities
4.	Family, Socio-Economic Factors and Quality of Life	Family as a basic unit of society, Family and basic needs of family members	Primary, Upper Primary	Language, Environmental Studies, Civics, Co-curricular Activities
		Shared roles and responsibilities of all the members in the family	-do-	-do-
		Marriage and family, Socio-economic development and their impact on patterns of family composition	-do-	-do-
		Shared roles and responsibilities of the members particularly the participation of women in decision-making	Secondary, Higher Secondary	Political Science, Sociology
		Elimination of discrimination against girl child, elimination of all types of violence against girls and women	-do-	-do-
		Equal opportunities for male and female members for education, employment, responsible parenthood	-do-	-do-
5.	Health & Education	Health, Cleanliness of surrounding, Safe drinking water, Importance of Immunization, Primary Health Care	Primary, Upper Primary	EVS, Science, Language
		Child survival, Spacing, Reproductive health of mother, Child care, Health of women and safe motherhood, Improvement in nutritional status especially of pregnant and lactating mother, Pre and Post-natal care	Secondary, Higher Secondary	Science, Biology Sociology
6.	Population Distribution, Urbanization and Migration	Population Distribution, Concept of Urbanization, Population growth in urban areas, socio-economic, civic and environmental challenges, problems of urban agglomeration	Secondary, Higher Secondary	Social Science, Economics, Geography, Sociology, Economics
		Need for sustainable regional development strategies	-do-	-do-
		Migration -- Causes and impact	Upper Primary, Secondary, Higher Secondary	Social Sciences

11.3.2 Rationale for Institutionalisation of Population (and Development) Education at Different Levels of Education: A Rationale

Curriculum development is the most important, rather essential, component of an educational innovation such as population and development education. This innovation can have an impact on curriculum design and instruction in education and make it possible to assert that population education can become both a stimulus to and a support for wide-spread educational reform. It calls for introduction of population issues in the curriculum at school, college and university levels, the explanation of the inter-relationships between a wide-range of social phenomena both at the micro and the macro levels, the explicit attention to the preparation of students for their future role as adult decision-makers in their families, the community and the nation. It aims at the development of awareness and attitudes that will make learners at different levels to develop responsible behaviour in the context of population issues.

Rationale for Introduction of Population and Development Education at School Level: The onus of meeting the challenge of population growth rests on the young people who will constitute the adult population in the coming two to three decades. It is their reproductive behavior, when they become adults, which is going to affect considerably the population situation in future. In order to achieve population stabilization, the future parents, who are most important segment of society, must be involved in the process. Their changed attitude towards family size is vital. Population education through the school system could be a potent instrument for developing these attitudes and competencies among this group and help them take rational decisions. It is through the curricular materials that the future citizens receive population education messages. However, the rationale for introduction of population education at different grade-levels has been different.

Some of the arguments given for the introduction of population education at the elementary stage in India are as follows.

- i) Elementary stage has the highest enrolment. Children drop-out as they go up higher in the educational ladder. Introducing population education at this stage will benefit larger number of children.
- ii) Elementary school curriculum generally provides flexibility for introducing new concerns. Since there is no public examination at this stage, a greater number of opportunities for the use of experimental materials are available.
- iii) A number of research studies have indicated that it is easy to bring about change in attitudes at this formative stage.
- iv) Primary school teachers still play an important role in the rural areas. Their exposure to population related issues will help both the students and the community at large in changing their attitude and behaviour in a right direction.

Those who argue for the introduction of population education at the secondary level give the following reasons.

- i) Students at this stage are in the process of growing-up. These are the students who are already or will be taking decisions regarding marriage and reproductive behaviour very shortly. Education in matters related to

adolescent reproductive health and other population related issues is of immediate relevance.

- ii) Students at this stage can grasp and understand population issues in greater depth.
- iii) The number of teachers to be trained in population education is comparatively smaller.

It would be better if population education is introduced at all the stages of school education. Similarly, efforts should be made to reach even those who are out of school by introducing it in non-formal education as well.

Introduction of population education into the school system gained importance in 1969, when the First National Seminar on Population Education recommended introduction of population related content into the existing curriculum of schools and colleges. Following the seminar, the National Council of Educational Research and Training (NCERT) set up a Population Education Cell in its Department of Education in Social Sciences and Humanities. The Cell developed curricula and instructional materials and worked out a model syllabus for population education for teacher training institutions. Promotional activities were later undertaken when it became apparent that the Population Education Cell's efforts were not reaching the local schools. 4 regional workshops were organized in 1979, and a 3-year national population education project was designed to institutionalize population education in the formal educational system and to encourage rational family size decisions by students and the community at large. 2 workshops were held for preparation of detailed state project proposals. The State Councils of Educational Research and Training (SCERTs) or their equivalents were assigned the tasks of preparing the population education curricula, developing instructional materials, developing and implementing training programmes for teachers and administrators, and monitoring the programme. Workshops for curriculum and materials development were held in July 1980, and the NCERT Population Education Unit has published curriculum guidelines, draft syllabuses and reference materials. Several intensive workshops have been held for full-time population education personnel (Pandey, 2005).

Rationale for Introduction of Population and Development Education at College and University Level: Population explosion is the undermining factor affecting the social and economic growth and development. It is the single most pressing problem being faced by the country. The impact of population growth is bound to damage the environment, bring ecological crisis and create unmanageable shortage in basic necessities of life. Though the effects of family welfare programme over the last five decades with holistic approach towards population control, together with other social factors like female literacy, age at marriage, status of women, spacing of children, immunization, health care, infant mortality, etc. have made significant contributions in the desired direction, there is the necessity for educational intervention at higher level to bring appropriate social transformations so as to promote population stabilization and ensure quality of life. In this regard, the Universities and other Higher Education Institutions can play a vital role by providing adequate knowledge and necessary awareness in relevant areas among their students and through them among the communities around their campuses.

The National Population Policy (2000) provided a framework for the next decade in several sectors for population development, with the objective to improve the quality of life of the people, to enhance their well-being and to provide them with opportunities and choices to become productive assets in society. Its aim is to achieve a stable population by 2045 at a level consistent with the requirements of sustainable economic growth, social development and environment protection. Among the many socio-demographic goals to be achieved by 2010 under this policy, several can be achieved at accelerated pace through population education activities and programmes at the university level. Training and sensitization of the university youth to the socio-demographic goals and through the youth, a reach-out to the community through extension education is likely to enable us to achieve the National Population Policy (2000) goals sooner than projected.

Population education has, thus, been recognized as a critical input and support for several other policy thrusts to promote extension education as the third dimension. In 1983, the concept of Population Education through Higher Education with the main objective to provide opportunities to the University/ College youth and there from to the community for creating awareness of relationship between the population and quality of life through access of information and transmission of knowledge was introduced in some Universities by setting up Population Education Clubs (PE Clubs) as co-curricular activities.

The UGC-UNFPA joint project on Population Education (PE) in higher education was launched in 1986. The financial support of the UNFPA and technical assistance of UNESCO Provided further impetus to the program for development of contents for the courses at UG and PG levels, research and extension education. The third phase of the UGC-UNFPA on population and development education in higher education system was commenced in 1997 emphasizing on national capacity-building, adolescence education and improved management system. The major focus was both academic and social for the effective implementation of the programme by the Population Education Resource Centres (PERCs) established in the Departments of Adult, Continuing Education and Extension (ACEE) which also came to be known as Departments of Adult, Continuing Education and Extension and Field Outreach (ACEE&FO) in various universities of the country with major focus at both academic and social aspects.

We have already covered other relevant details of institutionalisation of population education at different levels in section 1.4 of Unit-1 of Block-1 of this course, which you can revisit for comprehensive view of the same.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 4) What are the arguments given for introduction of population education at the elementary stage?

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- 5) Give, in brief, the rationale for introduction of population education at College and University level.

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11.4 LET US SUM UP

There have been undaunted endeavours to accelerate the pace of socio-economic development through the instrumentalities of science and technology and to secure distributive justice for the people through different institutional mechanisms. But, those are confronted with some basic population related questions of how many people are going to inhabit the earth, how they are to be supported and enabled to make their contributions to development efforts, what they are going to bequeath to posterity and how long they are going to be sustained by the natural and human resource base. The rapid population growth and the concomitant problems of poverty, lack of adequate health and educational facilities, malnutrition, non-fulfillment of even the basic needs of a vast majority of the populace, paucity of employment opportunities, dwindling natural resources and consequent environmental degradation constitute critical dimensions of the present population and development phenomena. It is also pertinent to note that the population phenomenon today embraces issues beyond development. While the size, growth, composition and distribution of population have a close bearing on socio-economic development, the population related issues also bring forth concerns for the "carrying capacity" of biological and ecological system and the future of mankind.

It has been gradually realized that since the interrelationship between population and development is highly complex and population problems are multidimensional, it will not yield to any single solution. It is basically related to the developmental needs of a nation and its people. Demographic trends influence, and are influenced by, the level of development and the quality of life of the people. The population situation of any nation largely depends on the demographic behaviour of its people. Changes in the demographic profile of a nation depend largely on attitudes and behaviours of individuals in respect of population and development issues. The demographic behaviour is to a great extent informed by population socialization, a process by which people acquire norms, values, attitudes and belief systems in respect of population related issues embedded within the larger complex social practices reflecting the society's internal logical system. This process is greatly influenced by education which enables the individual to know the phenomenon of population change and its consequences. It is commonly observed in many countries that the knowledge of the simple

facts of population change, let alone the complex interrelationships with other parameters, is very low even among educated people. It is precisely because of these complexities that population education has emerged as an integral part of the national population policy and multi-pronged strategy employed to solve contemporary population problems at national level.

Population education as a strategic innovation emerged in the context of population and development — the two most pressing issues before humankind today. Both are closely interrelated and both encompass a number of complex factors. Viewed as an important phenomenon of the process of development, population issues have aroused widespread concern among almost all the members of the comity of nations. Population education which emerged as an educational innovation in response to population problems only about five decades ago is now being experimented in over a hundred countries of the world; but in not-too-uniform a manner. It has been introduced in the education systems of different countries as an important component of the multi-pronged strategy employed to help nations attain the goals of population stabilisation and sustainable development. Very few educational programmes in India have matched its pace of expansion and adopted such varied conceptual frameworks and strategies of curriculum transaction at different levels of education. Perhaps, no other educational innovation has experienced such frequent changes in its framework as have been discussed above. This has been so because of not only the nature of the context in which it emerged but also its newness and its complex characteristics.

11.5 ANSWERS TO ‘CHECK YOUR PROGRESS’ QUESTIONS

- 1) Population growth in India continues to be high on account of:
 - The large size of the population is in the reproductive age-group (estimated contribution 58 percent). An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reductions in family size in several states, including those which have already achieved replacement levels of TFR. This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the population being currently in their reproductive years. It is imperative that the couples in the reproductive age-group adopts without further delay or exception the “small family norm”, for the reason that about 45 percent of population increase is contributed by births above two children per family.
 - There is higher fertility due to unmet need for contraception (estimated contribution 20 percent). India has 168 million eligible couples of which just 44 percent are currently effectively protected. Urgent steps are currently required to make contraception more widely available, accessible and affordable. Around 74 percent of the population lives in rural areas, in about 5.5 lakh villages, many with poor communications and transport. Reproductive health and basic health infrastructure and services often do not reach the villages and, as a result, vast numbers of people cannot avail of these services.

- High wanted fertility due to the high infant mortality rate (IMR) (estimated contribution about 20 percent). Repeated child births are seen as an insurance against multiple infant (and child) deaths and, accordingly, high infant mortality stymies all efforts at reducing TFR.
- Over 50 percent of girls marry below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of “too early, too frequent, too many”. Around 33 percent births occur at intervals (i.e. space between two successive births) of less than 24 months, which also results in high IMR.

2) Following are the milestones in the evolution of population policy in India.

- 1946: Bhore Committee, also known as Health Survey and Development Committee, was set up by the government of India in 1943 to investigate and recommend improvements to the Indian Public Health system. It made many landmark recommendations in its report.
- 1952: India became the first developing country to adopt positive population policy, marked by launching of National Family Planning Programme.
- 1976 and 1977: Statement of National Population Policy was prepared in 1976. In 1977 the Policy Statement redesignated family planning programme as Family Welfare programme. Both the statements were laid on the Table of the House in Parliament, but never discussed or adopted.
- 1983: The National Health Policy of 1983 emphasized the need for “securing the small family norm, through voluntary efforts and moving towards the goal of population stabilisation”. While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy.
- 1991: The National Development Council (NDC) appointed a Committee on Population with Shri Karunakaran as its Chairman, the Committee’s Report endorsed by NDC in 1993 proposed the formulation of a National Population Policy to take a “long-term, holistic view of development, population growth and environmental protection” and to “suggest policies and guidelines for formulation of programmes” and “a monitoring mechanism with short, medium and long-term perspectives and goals” (Planning Commission, 1992). Specifically, it was recommended that “a National Policy of Population should be formulated by the Government and adopted by Parliament”.
- 1993: An Expert Group headed by Dr. M. S. Swaminathan was asked to prepare a draft of a national population policy that would be discussed by the Cabinet and then by Parliament.
- 1994: Expert Group headed by Dr. Swaminathan prepared a Report on a National Population Policy. This report was circulated among Members of Parliament, and comments requested from central and state agencies. It was anticipated that a national population policy approved by the National Development Council and the Parliament would help produce a broad political consensus.

- 1997: On the 50th anniversary of India's Independence, Prime Minister Gujral promised to announce a National Population Policy in the near future. Cabinet approved the draft National Population Policy with the direction that this be placed before Parliament. However, this document could not be placed in either House of Parliament as the respective Houses stood adjourned followed by dissolution of the Lok Sabha.
- 1999: Another round of consultations was held during 1998, and another draft National Population Policy was finalised and placed before the Cabinet in March 1999. Cabinet appointed a Group of Ministers (headed by Dy Chairman, Planning Commission) to examine the draft Policy. The GOM met several times and deliberated over the nuances of the Population Policy. In order to finalise a view about inclusion/exclusion of incentives and disincentives, the GOM invited a cross-section of experts from among academia, public health professionals, demographers, social scientists, and women's representatives. The GOM finalised a draft population policy, and placed the same before Cabinet. This was discussed in Cabinet on 19 November 1999. Several suggestions were made during the deliberations.
- 2000: On the basis of the suggestions, a fresh draft was submitted to Cabinet which formed the basis for National Population Policy, 2000. It is under implementation till date.

3) The National Population Policy 2000 has set the following goals:

- Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 and attaining two-child norm.
- Full coverage of registration of births, deaths and marriages.
- Universal access to information of birth-limitation methods and availability of totally free choice to citizens for planning their families.
- To reduce Infant Mortality Rate below 30 per thousand live births and bring in sharp reduction in the incidence of low birth-weight (below 2.5 kg.) babies.
- Universal immunisation of children against vaccine-preventable diseases, elimination of Polio by 2000 and near elimination of Tetanus and Measles.
- Reduction in the incidence of marriage of girls below the age of 18 to zero.
- Increase in the percentage of deliveries conducted by trained persons to 100%.
- Containing of Sexually Transmitted Diseases.
- Reduction in Maternal Mortality Rate to less than 100 per one lakh live births.
- Universalisation of primary education and reduction in the drop-out rates at primary and secondary levels to below 20% both for boys and girls.

- 4) Some of the arguments given for the introduction of population education at the elementary stage in India are as follows:
- i) Elementary stage has the highest enrolment. Children drop-out as they go up higher in the educational ladder. Introducing population education at this stage will benefit larger number of children.
 - ii) Elementary school curriculum generally provides flexibility for introducing new concerns. Since there is no public examination at this stage, a greater number of opportunities for the use of experimental materials are available.
 - iii) A number of research studies have indicated that it is easy to bring about change in attitudes at this formative stage.
 - iv) Primary school teachers still play an important role in the rural areas. Their exposure to population related issues will help both students and the community at large in changing their attitude and behaviour in a right direction.
- 5) Rationale for Introduction of Population Education at College and University Level: Population explosion is the undermining factor affecting the social and economic growth and development. It is the single most pressing problem being faced by the country. The impact of population growth is bound to damage the environment, bring ecological crisis and create unmanageable shortage in basic necessities of life. Though the effects of family welfare programme over the last five decades with holistic approach towards population control, together with other social factors like female literacy, age at marriage, status of women, spacing of children, immunization, health care, infant mortality, etc. have made significant contributions in the desired direction, there is the necessity for educational intervention at higher level to bring appropriate social transformations so as to promote population stabilization and ensure quality of life. In this regard, the Universities and other Higher Education Institutions can play a vital role by providing adequate knowledge and necessary awareness in relevant areas among the students and through them in the communities around their campuses.

The National Population Policy (2000) provided a framework for the next decade in several sectors for population development, with the objective to improve the quality of life of the people, to enhance their well-being and to provide them with opportunities and choices to become productive assets in society. Its aim is to achieve a stable population by 2045 at a level consistent with the requirements of sustainable economic growth, social development and environment protection. Among the many socio-demographic goals to be achieved by 2010 under this policy, several can be achieved at accelerated pace through population education activities and programmes at the university level. Training and sensitization of the university youth to the socio-demographic goals and through the youth, a reach-out to the community through extension education is likely to enable us to achieve the National Population Policy (2000) goals sooner than projected.

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UNIT 12 INTERNATIONAL MEASURES OF POPULATION CONTROL

Structure

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12.0 INTRODUCTION

You have studied individual measures and national measures of population control in Units 10 and 11 respectively. In this Unit, i.e. Unit 12, which is the last unit of course MAE-005, we will focus on international measures with an emphasis on the global projection on population matters, NGO relations and international efforts on population control including the roles played by the United Nations and other international agencies.

12.1 OBJECTIVES

After going through this unit, we expect you to be able to:

- Explain the significance of international projections related to population matters;
- Describe the international efforts in population control; and
- Appreciate the role played by the United Nations and other concerned international agencies.

12.2 POPULATION CONTROL MEASURES AT GLOBAL LEVEL: UNITED NATIONS INITIATIVES

Every two years the Population Division of the United Nations Department of Economic and Social Affairs publishes its *World Population Prospects*, essentially a “revision” of previous projections. Based on the latest national census results and other surveys, this is the acknowledged source of global population data (<http://uk.oneworld.net/guides/population>).

12.2.1 United Nations’ Efforts on Global Data/Information Production

The following aspects covered under World Population Guide (See <http://uk.oneworld.net/guides/population>) provide us an understanding of the efforts of the United Nations regarding production of global data/information on population and development related matters that serve as the basis for policies and strategies for population control, among other things, at global level.

- i) **Census Data Collection:** Accurate population data is a vital ingredient of social and economic policy. Governments cannot deliver efficient services and infrastructure without knowledge of the national demographic profile – the size of the population, where people live, how old they are, and the net effect of births, deaths and migration.

Compiling this essential information is far from straightforward. The conduct of a census requires professional management, a very large number of enumerators, the application of new technologies and skilled interpretation of the results.

The UN strives to ensure that data has value in the global as well as national domain. Its 2010 World Population and Housing Census Programme has sought out the cooperation of every country to complete at least one census between 2005 and 2014. This agenda peaked in 2011 with censuses conducted in 70 countries.

- ii) **Demographic Transition:** To stereotype the poorest countries with the custom of large family sizes is to turn a blind eye to history. Most people now living in richer countries will discover similar fecundity in their own families by tracing back just a few generations. The circumstances were much in common with contemporary Africa – poverty and high child mortality, dependence on surviving children for economic support, lack of education or job opportunities for women and the unavailability of any form of contraception

The evolution to lower fertility rates and longer life expectancy experienced in developed countries correlates with their improving economic circumstances. This demographic transition reflects how access to modern medicine combines with greater choice in work, education and lifestyle to lessen the appeal of large families. In this transition from high to low fertility and mortality rates, the latter has invariably outpaced the former. The consequence is a “baby boom” and a rapid rise in national population. When

the birth rate finally stabilises at its lower level, a country's population profile will progressively age as the "baby boom" generation matures.

Countries around the world find themselves at very different points within the demographic transition. The 48 Least Developed Countries are at an early stage where improvements in health services are just beginning to take effect. The fertility rate remains high at 4.4, people aged under 25 are 60% and the combined populations are projected to double to 1.7 billion by 2050. The contrast with richer countries is dramatic. In no fewer than 75 countries, including Brazil, Iran and Thailand, the fertility rate has fallen below 2.1, the threshold for natural population replacement. Almost half of the world's population is, therefore, stable or falling.

The dependency ratio is causing considerable concern in mature economies, where funding of health and pension provision is inadequate to support ballooning numbers of older people, living ever longer. The rush towards a world population of 10 billion, therefore, masks a complex mix of underlying trends.

- ii) **Population and Development:** The UN's population projections assume not only that the demographic transition will be reproduced in the poorest countries but also that it happens relatively quickly, with fertility rates falling as low as 2.2 by 2050.

These assumptions are far from certain and are required to be closely monitored. Even if they prove accurate, the outcome will not in itself relieve the challenge of sustaining a world population of 9-10 billion but it will create the conditions necessary for long-term stability, or may be reduction. As the projected increase will occur entirely in developing countries, the task of stabilising world population must be captured within the international development agenda including poverty reduction which is critical to bringing population growth under control.

- iii) **Demographic Dividend:** The prospective contribution of growth to this strategy for stabilising population is bolstered by an economic theory of demographics. Poor countries enjoy favourable dependency ratios, their populations dominated by potentially productive young people. This is often described as the "demographic dividend" and has been associated with the tiger economies of East Asia. Others fear that poor infrastructure, governance and education will stifle the potential. Very high rates of youth unemployment do indeed persist in most developing countries. The demographic dividend is a fleeting opportunity which can quickly overturn into social unrest, as illustrated by recent dramatic events in several Arab countries.

There is further concern that a hard core of about 25 of the very poorest countries cannot possibly benefit from the demographic dividend. They show signs of being trapped in a demographic vortex, where low resilience to the impact of climate change on food and water scarcity offers no escape from exceptionally high fertility rates of around 8 children per woman.

Whilst there is some truth in the adage that "development is the best contraceptive," it is wise to award at least equal status to the view that "contraception is the best development."

iv) **Reproductive Health:** A target of universal access to reproductive health services by 2015 was included in the Millennium Development Goals. Progress is disappointing, especially for the family planning component. Neglect of sexual and reproductive health results in an estimated 80 million unintended pregnancies, 22 million unsafe abortions and 358,000 deaths from maternal causes. Dr. Hania Zlotnik, Director of the UN Population Division, has said that: "in most high fertility countries, contraceptive prevalence is increasing by less than 1% per year." As a result, 215 million women in developing countries have an unfulfilled wish for family planning services. A 2010 report by the Guttmacher Institute estimates that the cost of meeting this need would be \$3.6 billion per annum. Such an investment would bring an immediate return through the savings in maternal health support for the pregnancies avoided, quite apart from the long-term benefits of smaller family sizes.

Obstacles to Family Planning: Campaigners for universal access to reproductive health must contend with some of the most sensitive issues in international development.

- The first obstacle has been the narrow dividing-line between voluntary family planning and coercion. Fears have stemmed largely from the history of over-enthusiastic birth control policy in India in the 1970s/80s and the one-child policy imposed by China since 1979.
- China's policy is explicitly coercive but claims to have averted 400 million births. However, a high price has been paid in the denial of human rights in family life and in the unspoken tolerance of sex-selective abortion. The Chinese authorities themselves estimate that, by 2020, there will be 24 million more men of marriageable age than women. Similar distortion is found in India.
- Although the Cairo Consensus has provided reassurance about coercion, it has been unable to overcome the further obstacle of religious conservatism. The Catholic Church, which claims over 1.1 billion followers, opposes all forms of contraception, despite evidence of the consequent human distress.
- Islamic teachings generally adopt a pragmatic interpretation of the Koran, supporting the right of women to space their children through use of family planning within marriage. Government programmes in Bangladesh and Indonesia have been praised for their success in reducing high fertility rates.
- Answerable to the religious right in the US, the House seeks to deny funding for UNFPA and to reinstate legislation known as the Global Gag rule. This blocked US funds from supporting any developing country organisation whose programmes implied tolerance of abortion.
- Wary of religious and racial sensitivities, aid agencies and environmental groups have tended to suppress their views about population issues. Their silence may have contributed to the long-term downward trend in funding for overall population assistance.
- The Roman Catholic church in the Philippines opposes new legislation which would provide modern family planning services from UNFPA Asia.

- v) **Overpopulation or Over-consumption?** In the animal world, species move through demographic cycles which typically follow a pattern of “boom and bust.” Rampant reproduction encounters a threshold known as “carrying capacity” beyond which the environmental resources essential to that species deteriorate, leading to a sharp decline in its population.

Humans possess the unique power to determine their own carrying capacity. They know the factors that will dictate its level – the global population, the economic means of individuals to consume resources, the technology available and the choice of lifestyle. Exercising wisdom in mixing this cocktail is proving highly problematic, largely because of the extreme inequality in our current consumption.

According to the *Global Footprint Network*, if all countries adopted the American lifestyle, it would require five planets to supply the necessary resources. Yet, that is the aspiration of poorer countries. Fact is, almost a third of the world’s population lives on less than \$2.00 per day. Such are these extremes that, even if the population of developing countries was stabilised tomorrow, the roll-call of environmental threats – climate change, loss of biodiversity, water scarcity – would remain barely diminished. The 2009 scientific study published by the Stockholm Resilience Centre suggests that three out of nine environmental boundaries critical to a sustainable planet have already been crossed.

The immediate priority is to find a narrower and less damaging range of consumption in which the less fortunate can live in dignity but which in aggregate remains within our planetary boundaries. The obstacle is global addiction to a measure of economic success which rewards consumption of resources rather than efficiency of their use.

Food, Water and Energy: Prospects for the three essential household-needs illustrate how global population can be sustained if rich and poor can be persuaded to meet halfway.

- A 2009 UN conference billed as “how to feed the world in 2050” generated much public anxiety. In the event, the UN Food and Agriculture Organization (FAO) declared itself to be “cautiously optimistic” whilst stressing the “need for a proper socio-economic framework to address imbalances and inequalities.”
- Water scarcity is another subject for water wars. But, the 2006 UN Human Development Report observed that “there is more than enough water in the world for domestic purposes, for agriculture and for industry ... scarcity is manufactured through political processes and institutions that disadvantage the poor.”
- Likewise, the exponential future demand for energy that converts into projections of runaway climate-change is caused by the extremes of personal consumption. The World Watch Institute’s *State of the World 2010* records that “the world’s richest 500 million people (roughly 7 percent of the world’s population) are currently responsible for 50 percent of the world’s carbon dioxide emissions, while the poorest 3 billion are responsible for just 6 percent.”

Such appeals to the principle of equity in distribution of resources do not deny the awesome challenge of overcoming scarcity as population numbers rise. Food production must increase by 70% by 2050 and freshwater demand will rise by 53% by 2030. Energy security is not just about incremental demand but also the basic needs of 1.3 billion people who have no access to electricity at all.

vi) Global Projections: The following population projections, just to cite a few, are enough to throw light on the seriousness of the emerging concerns at the global level.

- Each day the world population increases by over 200,000 demanding the equivalent of a new city for more than a million inhabitants every week. The total passed seven billion in October 2011 and will almost certainly reach eight billion in 2025. The median projection for 2050 is 9.3 billion.
- The whole of the increase of 2.3 billion between now and 2050 is predicted to occur in developing countries. India's population of 1.25 billion will shortly overtake China, rising to 1.7 billion in 2050. Together these two countries may account for almost a third of the global population.
- The 2010 revision concedes that the two key variables in population projections – life expectancy and fertility – are fraught with uncertainty over such a long period. Even a modest error of 0.5 in the assumed total fertility rate (TFR is the average number of children born per woman) is sufficient to generate lower and upper estimates of 8.1 and 10.6 billion for the 2050 population projection.

12.2.2 United Nations' Conferences and Reviews on Population (and Development)

At the global level, an international body like UN only can facilitate efforts for strategies to stabilise the world population. In this sub-section, we will have a glance through such efforts by United Nations directly focused on population control.

Every ten years since 1954, United Nations has been organizing world/international conferences on population and development issues with a view to work out positive initiatives for controlling and reducing population growth. Each conference brought forth issues relevant to that decade for discussion. The first two United Nations Population Conferences held in 1954 in Rome, and 1965 in Belgrade were purely technical conferences aimed at expanding scientific knowledge and understanding on population issues. These two conferences were held in collaboration with the International Union on the Scientific Study of Population (IUSSP) and comprised of technical experts. The subsequent two conferences held in 1974 in Bucharest and 1984 in Mexico City, were organized by the United Nations alone and composed of government representatives. These conferences benefited from extensive preparations, scientific symposia, regional meetings, and meetings of preparatory committees involving technical experts and focused on development of policies. Later, International Conference on Population and Development held in 1994 in Cairo followed by 5 year review of it have made significant contribution to formulation of Millennium Development Goals. We will discuss all these in greater detail below.

12.2.2.1 World Population Conferences

The First World Population Conference was organized by the United Nations in Rome from 30 August to 10 September in 1954 to exchange scientific information on population variables, their determinants and their consequences. This eminently was academic conference resolved basically to generate fuller information on the demographic situation of the developing countries and to promote the creation of regional training centres which would help to address population issues and to prepare specialists in demographic analysis (UNFPA, See <http://www.un.org/esa/devagenda/population.html>; and http://www.wya.net/i/un_advocacy_cpd39_reading%20packet.pdf).

The Second World Population Conference was organized in 1965 from 30 August to 10 September by the International Union for the Scientific Study of Population (IUSSP) and the United Nations; most of the participants were experts in the field. The focus at this international meeting was on the analysis of fertility as part of a policy for development planning. This Conference was held at a time when expert studies on the population aspects of development coincided with the start-up of population programmes subsidized by the United States Agency for International Development (USAID) (Ibid).

The Third World Population Conference organized by the United Nations was held in Bucharest, Romania, from 19 to 30 August 1974. This Conference, the first of an intergovernmental nature, was attended by representatives of 135 countries. The debate focused on the relationship between population issues and development. The outcome of the Conference, the World Population Plan of Action, states, among other principles, that the essential aim is the social, economic and cultural development of countries, that population variables and development are interdependent and that population policies and objectives are an integral part (constituent elements) of socio-economic development policies (Ibid).

12.2.2.2 International Conference on Population

This international conference on population held from 6-14 August 1984, reviewed and endorsed most aspects of the agreements of the 1974 Bucharest Conference and expanded the World Population Plan of Action in order to incorporate the results of the latest research and data provided by Governments. The human rights of individuals and families, conditions of health and well-being, employment and education were some of the issues highlighted in the Declaration signed at the Conference. Other significant issues were the intensification of international cooperation and the pursuit of greater efficiency in adopting policy decisions relating to population (Ibid).

12.2.2.3 International Conference on Population and Development (ICPD)

The 1994 International Conference on Population and Development held from September 5-13, 1994 in Cairo was a landmark conference in population policy and politics. It is at this conference that the concepts of reproductive rights, sexual health, and reproductive health were officially incorporated in the Programme of Action. This "rights-based" approach agreed at the ICPD holds that if people's needs for family planning and reproductive health care are met, along with other basic health and education needs, then population stabilization

will be achieved naturally, not as a matter of coercion or control. This conference witnessed more than 4000 delegates from 180 national governments and produced a Programme of Action. The ICPD held in 1994 is undoubtedly a landmark conference, particularly in terms of the shift from population control to a reproductive rights framework. Its accomplishments include the ICPD Programme of Action that represents a “quantum leap” for population and development policies. These include (<http://www.iisd.ca/vol06/0639028e.html>):

- a shift from the previous emphasis on demography and population control to sustainable development and the recognition of the need for comprehensive reproductive health care and reproductive rights;
 - strong focus on the empowerment of women;
 - reflection of different values and religious beliefs and reaffirmation of the central role of the family; and
 - recognition of the needs of adolescents.
- a) ***Reproductive health care and reproductive rights:*** The Programme of Action recognizes that population and development programmes should be based on reproductive health, including sexual health, and reproductive rights for women, men and children. The Programme of Action goes beyond the traditional concept of family planning. Experts and advocates have long argued that family planning in itself is not enough, but it should be part of a much wider range of reproductive health services. The objectives in the Programme of Action reflect this point of view and call for ensuring comprehensive and factual information and a full range of reproductive health-care services, including family planning to make them accessible, affordable, acceptable and convenient to all users.
- b) ***Empowerment of women:*** This includes the following.
- to achieve equality and equity based on a harmonious partnership between men and women and enable women to realize their full potential;
 - to ensure the enhancement of women’s contributions to sustainable development through their full involvement in policy and decision-making; and
 - to ensure that all women are provided with the education necessary for them to meet their basic human needs and to exercise their human rights.

All countries are urged to ensure the widest and earliest possible access by girls and women in fulfilling the goal of universal primary education before the year 2015. Encouraging the full participation of the girl-child and speaking out against patterns of gender discrimination is also highlighted. This focus finally meets the demands of those who have long argued that any sound population policy has to be implemented through those who are in a position to make a difference — women. Although some countries argued that the language on equal inheritance rights between men and women goes against Islamic Law, nonetheless, the progress made towards empowerment of women is considered remarkable.

- c) **Reflection of different values and religious beliefs:** The document reflects different moral, ethical, religious and cultural values that make it more implementable and legitimate in many countries. A key element in giving the document greater sensitivity was that the implementation of the Programme of Action will be carried out within the context of national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized human rights. This not only enabled those countries with strong religious fundamentalist communities to join the consensus but also undermined the claim by some protesters that the Programme of Action is yet another manifestation of Western imperialism, where the view of a select few on contraception would be imposed on the developing world.

Furthermore, this language served to neutralize some of the efforts undertaken by the Holy See, among others, to prevent consensus on certain issues, including abortion, contraception, fertility regulation and sexual and reproductive rights. Prior to the Conference, the majority of the media attention was on the so-called “un-holy alliance” between the Vatican and the fundamentalist Islamic countries. The media hype proved to be unfounded in the end, when even the Vatican admitted that it could join the consensus on Chapter II.

- d) **Reaffirmation of family as the basic unit in society:** While everyone agreed that the family is the basic unit in society, the flexible nature of the Programme of Action is apparent once again as several countries “qualified” their conception of the family along religious or cultural lines. There was some debate on the matter as the EU and other developed countries wanted to retain the reference to “other unions,” but this gave rise to such debate that eventually they “agreed to disagree.” As a result the text is less than clear and it will be up to the individual States to implement as they see fit.
- e) **Recognition of the needs of adolescents:** The fact that an entire section of Chapter VII is dedicated to the needs of adolescents is indicative of the realization of the importance of the issue. Although some delegations disagreed that adolescents should have access to reproductive health care, including family planning services, the text states the need “to address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, sexually transmitted diseases and HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group.”

What is the ICPD Programme of Action? The ICPD Programme of Action contains 16 Chapters of consensus recommendations and commitments agreed to by 179 governments at the International Conference on Population and Development held in Cairo in 1994. These recommendations and commitments, strengthened and updated at the ICPD five-year review (New York, 1999), range from basic principles that guide population and development efforts to concrete steps each nation should take to make such efforts successful by the year 2015 (http://www.iwhc.org/index.php?option=com_content&task=view&id=2485&Itemid=824).

- i) **Key goals embodied in the Programme of Action:** These include the following (Ibid).
- The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary enrolment ratio for children of both sexes should be at least 90 percent.
 - By 2005, 60 percent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted infections (STIs), and barrier methods to prevent infection; 80 percent of facilities should offer such services by 2010, and all should do so by 2015.
 - At least 40 percent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80 percent globally, by 2005; these figures should be 50 and 85 percent by 2010; and 60 and 90 percent by 2015.
 - The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75 percent by 2010, and by 100 percent by 2015.
 - To reduce vulnerability to HIV/AIDS infection, at least 90 percent of young men and women, aged 15-24, should have access by 2005 to preventive methods such as female and male condoms, voluntary testing, counseling, and follow-up, and at least 95 percent by 2010. HIV infection rates in persons of 15-24 years age-group should be reduced by 25 percent in the most affected countries by 2005 and by 25 percent globally by 2010.
 - By 2015 all countries should aim to achieve an infant mortality rate below 35 per 1000 live births and an under-5 mortality rate below 45 per 1000.
 - Countries should strive to reduce maternal mortality by 100 percent by 2015.

The goals and content of the ICPD Programme of Action are, thus, sweeping in scope.

- ii) **The Core Agenda:** The Programme of Action's "core agenda" revolves around four constituent parts: i) basic family planning, ii) expanded reproductive health, iii) information and education on sexually transmitted infections, and iv) data/research. The "core agenda" was reviewed exhaustively-enough to develop detailed resource estimates through the year 2015 in advance of the ICPD (Ibid).

- a) **Family planning:** As part of a comprehensive approach, the ICPD Programme of Action signaled the world's renewed commitment to launch high quality, voluntary family planning programmes with the aim of making them available to all who want them as early as possible. Currently, there are an estimated 350 million couples who lack access to the full range of family planning information and services. The components of the ICPD family planning package include:

- contraceptive commodities and service delivery;
- capacity-building for information, education and communication regarding family planning;
- infrastructure and upgrading of facilities;
- policy development and programme evaluation;
- information management systems;
- basic service statistics;
- efforts to improve quality of care.

Estimate of global resources required: \$11.5 billion in 2005; \$12.6 billion in 2010; \$13.8 billion in 2015.

b) *Reproductive Health:* In perhaps the most significant new development, the ICPD agreed that family planning should be placed in the context of a much broader approach to reproductive health for women and men of all ages. Quality reproductive health care goes beyond narrow family planning to encompass improving women's general health, promoting healthy pregnancies, reducing infant and maternal morbidity and mortality, and alleviating suffering and disease. The ICPD reproductive health package includes:

- routine services related to safe motherhood, including pre-natal care, normal and safe delivery, post-natal care, and breastfeeding;
- safe abortion services (where not against the law) and treatment for complications of unsafe abortion under any circumstances;
- information, education and communication about reproductive health, including sexually transmitted diseases (STDs), human sexuality, responsible parenthood and harmful practices;
- counseling;
- diagnosis and treatment for sexually transmitted diseases and other reproductive tract infections as feasible;
- infertility prevention and treatment where feasible;
- counseling and referrals for STDs, including HIV/AIDS and for pregnancy or delivery complications.

Estimate of global resources required: \$5.4 billion in 2005; \$5.7 billion in 2010; \$6.1 billion in 2015. (This 1994 estimate does not reflect the resources needed for HIV prevention services, given the extent of the pandemic).

c) *Education and Prevention Campaigns on Sexually Transmitted Infections:* While the medical aspects of STIs are addressed in the reproductive health package outlined above, the ICPD also embraced implementation of major STI prevention programmes through various information, education and communication efforts. The ICPD STI prevention programme includes:

- mass media and in-school education programmes;
- promotion of voluntary abstinence and responsible sexual behavior;
- expanded distribution of condoms;

Estimate of global resources required: \$1.4 billion in 2005; \$1.5 billion in 2010; \$1.5 billion in 2015.

- d) *Basic Research and Data:* Only with an in-depth understanding of population and development can international agencies and national governments respond with appropriate plans and motivate political will for action. Despite great improvement in data collection and analysis, even the basic demographic indicators provided by many countries are unreliable, incomplete, or difficult to obtain. This so-called “data barrier” is an obstacle for planners in many developing countries. The ICPD Programme of Action urges nations and the international community to support training programmes in statistics, demography, and population and development studies. It also identifies specific areas in need of further research:
- reproductive health and the socio-cultural context for sexual and reproductive behavior ;
 - development of new family planning methods, including more methods for men, and barrier and other methods (such as microbicides) for women, to help prevent the spread of STIs, including HIV/AIDS;
 - gender roles and relationships and belief systems to inform programmes to end violence and other abuses against women, and to eradicate harmful practices such as female genital mutilation (FGM);
 - gender-disaggregated data to provide a more accurate picture of women’s economic contributions to society, including their unpaid labor in the family and in the informal sector.

Estimate of global resources required: \$200 million in 2005; \$700 million in 2010 and \$300 million in 2015.

Additional Aspects of the ICPD Programme of Action: Beyond the core package, the ICPD articulated a broader group of investments that would need to be pursued to stabilize global population and promote development. This *broader package* included the following (Ibid).

- a) *Education:* The ICPD Programme of Action calls for universal primary education and closing the gender gap in secondary education (lack of secondary education for girls and women correlates with high fertility). Participants agreed on the wisdom of an ambitious agenda for education around the globe not only to advance development but also to reduce rapid population growth. The basic right to education was established in 1948 as part of the Universal Declaration of Human Rights. But, education remains a distant dream for millions, especially girls. There are 121 million children out of school around the world; 65 million of them are girls, and 83 percent of those girls live in sub-Saharan Africa (UNICEF, 2003). Roughly, two-thirds of the world’s 862 million illiterates are women (UNESCO, 2003). Global public spending on education was \$1.54 trillion in 2000, but 85 percent of that was spent in developed countries (World Bank, 2003).

Educating girls and women is closely associated with better health, lower infant mortality, lower fertility, higher economic growth, and environmental stewardship. In developing countries, each additional year of schooling is associated with a 5 to 10 percent decline in child deaths. Experts suggest that education is second only to family planning in lowering family size. And on the economic front, each 1 percent increase in female secondary schooling is estimated to result in a 0.3 percent increase in national economic growth (UNFPA, 1998 and 2000).

In other words, educated women are more likely to be a part of the productive labor force, to invest their earnings in their family, and to seek health care for themselves and their children. They are better at producing food and using resources in a sustainable manner. They are more likely to delay marriage, use family planning, raise healthy children, and live longer.

- b) Primary Health Care:** As per Family Care International Fact Sheet on Reproductive Health, an estimated 900 million people in developing countries do not have access to modern health services. The ICPD emphasized the importance of basic health needs, beyond those articulated in the core agenda. Here, too, several key components can be readily identified, priced, and pursued.

Strengthening the primary health-care delivery system: It involves:

- making primary health care universally available;
- enhancing the ability of developing countries to produce generic drugs for the domestic market or otherwise ensure availability of vaccines, antibiotics, and other commodities;
- providing emergency obstetrics; and
- addressing special needs in rural areas;

Promoting child survival: It involves:

- providing pre-natal care and counseling;
- offering adequate delivery assistance ;
- ensuring neo-natal care, including breast-feeding and information on proper breast-feeding practices;
- providing micronutrients and tetanus toxoid;
- reducing the number of low birth-weight babies and those with other nutritional deficiencies (such as anemia);
- reducing major childhood diseases, particularly infectious and parasitic diseases;
- preventing malnutrition;
- ensuring universal access to safe water and sanitation.

Promoting women's social and legal rights: The ICPD recognized the importance of promoting equity and equality in economic, social, and political life. It urged that special attention be given to the legal and civil rights of women of all ages, including laws related to marriage based on consent, land ownership and inheritance.

Reducing violence against women is also part of the agenda for strengthening women's social and legal rights. Of special concern is the continued practice of female genital mutilation (FGM) and sex slavery, forced prostitution, and trafficking in women and young girls. One in three women will be raped, beaten, coerced into sex, or otherwise abused in her lifetime (UNIFEM, 2003).

Creating economic opportunity for women: Women's economic integration is a powerful impetus for economic, social and environmental progress at the local and national levels. The ICPD agreed that involving women fully in policy and decision-making processes — including all aspects of economic, political and cultural life — is an important end in itself and is essential for achieving development. It also called for all women, as well as men, to receive the education required to meet their basic human needs including skill development and preparation for employment.

In urban and other non-agricultural settings, women face a host of barriers such as unequal pay for equal work, lack of access to credit, and other discriminatory practices. Traditional accounting usually understates women's economic contribution by ignoring informal-sector work and home-farm labor. Especially in rural areas, women's efforts to grow and prepare family food, and to collect water and fuel for cooking and fodder for domestic animals are largely unquantified and unrewarded. If unpaid household and agricultural labor is included, women are estimated to work 30 percent more than men (UNFPA, 2000).

Women in the informal sector have benefited from the advent of microcredit programmes, which provide seed loans for investing in income-generating enterprises.

- c) ***Environment:*** The ICPD agreed that integrated strategies for ensuring economic and environmental progress are essential for individual, national and global futures. Economic and environmental conditions link the world's people as never before. And, in turn these conditions affect demographic trends in powerful ways. Poverty, pollution and population are linked in effect, as in solution.
- d) ***Men's responsibility for their own behavior:*** The ICPD agreed that efforts should be undertaken to encourage and enable men to take responsibility for their sexual and reproductive behavior and play a more active role in family planning and child-rearing. The support, cooperation, and involvement of men can help end gender discrimination and violence against women and improve reproductive health. The empowerment of women relies on joint decision-making with men in families, communities and government. Men can advance gender equality and improve their family's welfare by:
 - protecting their partner's health and supporting her choice;
 - taking care of their own reproductive health;
 - taking a stand against gender violence;
 - practicing responsible fatherhood;
 - promoting women's education and participation in society.

- e) **Provision of family planning in emergency situations:** According to UN estimates, three quarters of the world's refugees and displaced persons in trouble spots around the world are women, the elderly, or children. About 25 percent of those displaced by war, famine, persecution or natural disaster are women of reproductive age; of these, one in five is likely to be pregnant. Displaced pregnant women are often at risk of malnourishment, violence and infectious diseases, and they face hazardous conditions when giving birth. Women and girls who have been forced to leave their homes in crisis situations face a heightened risk of rape and sexual violence. For example, estimates of the numbers of women from Bosnia and Herzegovina raped during the Bosnian conflict range from 10,000 to 60,000 (WHO, 2002).

The ICPD Programme of Action recognized the need to ensure reproductive rights and provide reproductive health care in emergency situations, particularly for women and adolescents. These efforts include:

- family planning, including contraception;
- ante-natal care, safe delivery and post-natal care;
- management of sexual violence and rape, including emergency contraception;
- treatment and prevention of STDs, including HIV/AIDS;
- management of complications from unsafe abortion (according to WHO, post-abortion complications account for some 25-50 percent of maternal deaths in refugee situations).

12.2.2.4 ICPD + 5 Review and Millennium Development Goals

In five years, progress has been made in advancing the Cairo goals. Many countries have embraced and strengthened the recognition of reproductive and sexual rights through policy changes; have taken steps to integrate population concerns into their development strategies; and have added new components to reproductive health services while improving their access. At the same time, the review revealed that much greater and urgent action is needed in areas such as prevention of the HIV/AIDS pandemic; adolescent sexual and reproductive health; reduction of maternal morbidity and mortality; and the provision of reproductive health care to women and adolescents in emergency situations. The review also revealed that the financial constraints on implementation of the Programme of Action are severe: developing countries and countries with economies in transition are having difficulty finding the necessary resources from their own budgets, and development cooperation has fallen short.

The five-year review in 1999 agreed on new benchmarks to measure implementation of ICPD key goals mentioned elsewhere above, and also added the following (United Nations, 1999, See <http://www.unfpa.org/swp/1999/chapter1d.htm>).

- Recognizing that the HIV/AIDS situation is worse than anticipated by the ICPD, the review agreed that to reduce vulnerability to HIV/AIDS infection at least 90% of young men and women aged 15 to 24 should have access by 2005 to preventive methods — such as female and male condoms, voluntary testing, counselling and follow-up — and at least 95% by 2010. HIV infection rates in persons of 15 to 24 years age-group should be reduced by 25% in the most-affected countries by 2005 and by 25% globally by 2010.

Commission on Population and Development: This Commission is one of the ten Functional Commissions of the United Nations Economic and Social Council. At its establishment by ECOSOC in October 1946 the Commission's name was "*Population Commission*", and in December 1994, it was changed to "*Commission on Population and Development*". The goal of the Commission on Population and Development is the follow-up to the implementation of the Programme of Action of the International Conference on Population and Development. The Commission would monitor, review and assess the implementation of the Programme of Action at the regional, national and international levels and advise the Economic and Social Council on issues such as population issues and trends, integrating population and development strategies, and on population and related development policies and programmes. It would also provide advice and assistance to the United Nations System, governments and other organizations on population and development related efforts. It met typically every two or three years until 1994, after which it has met once a year (http://en.wikipedia.org/wiki/Commission_on_Population_and_Development).

Millennium Development Goals: The Programme of Action agreed to at the International Conference on Population and Development along with benchmarks added at the ICPD+5 review formed basis for the eight Millennium Development Goals (derived from Millennium Summit, 2000). We have mentioned these eight goals in Unit-5 of Block-1 (See Sub-section 5.2.1: Population and Development Education). These mutually reinforcing development blueprints guide UNFPA in its efforts to improve lives, support reproductive health and rights, and advance gender equality, among others.

12.2.3 Efforts of Population Control by United Nations Population Fund (UNFPA)

The United Nations Population Fund (UNFPA) is the primary organization within the United Nations (UN) system tasked with addressing population issues. Created in 1967 as a trust fund, and then established as a subsidiary of the General Assembly in its own right in 1969, the UNFPA has since then been a major presence in the international population movement (<http://www.cgdev.org/doc/UNFPA-in-Context.pdf>). The name was changed in 1987 to United Nations Population Fund under the administration of the United Nations Development Fund and in 1971 it was placed under the authority of the United Nations General Assembly.

Brief details of UNFPA's origin, background, objectives, activities and NGO relations, among others, are given below (UNFPA, See <http://www.un-ngls.org/orf/documents/publications.en/ngls.handbook/a18unfpa.htm>).

12.2.3.1 Origin and Background

The United Nations Population Fund (UNFPA) is the largest internationally-funded source of population assistance, directly managing one quarter of the world's population assistance to developing countries. As mentioned above, the fund began operations in 1969 and is a subsidiary organ of the General Assembly. To date, 172 nations have pledged about US\$4.5 billion to UNFPA. In 1998, UNFPA carried out activities in some 155 countries.

UNFPA extends assistance to developing countries, countries with economies in transition and other countries at their request to help them address their reproductive health needs and population issues, and raises awareness of these issues in all countries. UNFPA is guided by, and promotes, the principles of the Programme of Action of the 1994 International Conference on Population and Development (ICPD), held in Cairo (Egypt). The ICPD marked a dramatic shift in approaches to viewing population and in implementing population programmes. As a process, it signaled inclusion, collaboration and international consensus on such policy goals and objectives as gender equality, equity and empowerment; human rights; quality of care; and partnership. The target-driven demographic approach was modified, and the life-cycle concept of reproductive and sexual health within a broader sustainable development approach was promoted. The focus shifted from sectoral to multi-sectoral approaches, from numbers to individuals and their needs; from the provision of family planning commodities and services to women in their reproductive period to the provision of quality reproductive and sexual health information and services to women, men and adolescents in a culturally sensitive manner.

UNFPA's *three main areas of work* are to:

- help ensure universal access to reproductive health, including family planning and sexual health, to all couples and individuals by the year 2015;
- support population and development strategies that enable capacity-building in population programming to promote awareness of population and development issues; and
- advocate for mobilization of the resources and political will necessary to accomplish its areas of work.

UNFPA is primarily a grant-providing agency; responsibility for implementing projects rests with recipient countries or with UN agencies and NGOs that execute projects in their areas of expertise. UNFPA is not supported by the United Nations regular budget, but entirely by voluntary contributions. In 1998, 89 countries made pledges, most of them developing countries. The total income (provisional) of UNFPA in 1998 was US\$309.3 million, compared to US\$322.7 million in 1997. Expenditures for reproductive health and family planning programmes, and closely associated information, education and communications activities accounted for almost 60% of UNFPA assistance; population and development strategies for roughly 24%; and advocacy for some 16%. Africa accounted for 32.7% of UNFPA programme expenditures, the Asia and Pacific region for 32.3%, the Latin America and Caribbean region for 11.4%, and the Arab states and Europe for 11.3%. Support for inter-regional and global programmes amounted to 12.4% of programme expenditures. The fund continued to concentrate more than 60% of its resources in countries in greatest need of assistance, notably in the poorest developing countries. UNFPA maintains a channel for bilateral population assistance to specific projects.

UNFPA works closely with the United Nations Development Programme (UNDP) and uses its field structure of resident representatives in helping to carry out its work. UNFPA representatives, in residence in more than 65 countries, are responsible for the formulation, coordination, monitoring and evaluation of the programmes and projects the Fund supports. Since 1991, UNFPA has also been

providing technical assistance through its country support teams, which are composed of experts in reproductive health and population issues and are located in eight centres throughout the world. UNFPA, as the lead United Nations organization for follow-up and implementation of the ICPD Programme of Action, is fully committed to working in partnership with governments, all parts of the United Nations system, development banks, bilateral aid agencies and civil society, including NGOs. The Fund is a member of the United Nations Development Group (UNDG) and its Executive Committee, and participates in all UNDG sub-groups and activities. It also participates in a number of other coordination mechanisms and the United Nations system-wide coordination bodies of the Administrative Committee on Coordination (ACC). UNFPA strongly supports the United Nations Resident Coordinator system and the implementation of all relevant United Nations decisions.

12.2.3.2 Objectives

The objectives of UNFPA are:

- To assist countries in providing reproductive health care, including family planning and sexual health, on the basis of individual choice; in formulating population strategies in support of sustainable development; and in advocacy for issues related to population, reproductive health and the autonomy and equality of women.
- To advance the strategy endorsed by the ICPD, which emphasized the interdependence of population and development and focused on meeting individuals' needs rather than demographic targets. The key to this new approach is empowering women and expanding access to education, health services and employment opportunities.
- To promote cooperation and coordination among UN system organizations, bilateral agencies, governments, non-governmental organizations and the private sector in addressing issues of population and development, reproductive health, gender equality and women's empowerment.

The ICPD endorsed a set of interdependent population and development objectives including sustained economic growth in the context of sustainable development, and gender equity and equality. Countries were urged to include population factors in all development strategies, and to act to eliminate gender-based violence and harmful traditional practices including female genital mutilation. Quantitative goals were adopted in *three areas*:

- *Universal education* — Elimination of the gender gap in primary and secondary education by 2005, and complete access to primary school or the equivalent by both girls and boys as quickly as possible and in any case before 2015;
- *Mortality reduction* — Reduction in infant and under-five mortality rates by at least one-third to no more than 50 and 70 per 1,000 live births respectively, by 2000, and to below 35 and 45 respectively by 2015; reduction in maternal mortality to half the 1990 levels by 2000 and by a further one-half by 2015 (specifically, in countries with the highest levels of mortality to below 60 per 100,000 live births);

- **Reproductive health** — Provision of universal access to a full range of safe and reliable family planning methods and to related reproductive and sexual health services by 2015.

The subsequent programmes of action endorsed at the 1995 World Summit for Social Development in Copenhagen; the 1995 Fourth World Conference on Women in Beijing; the Second United Nations Conference on Human Settlements (Habitat II) in Istanbul; and the 1996 World Food Summit in Rome all reinforced and sometimes expanded upon the objectives and goals of the ICPD.

12.2.3.3 Activities

UNFPA's work is guided by the Program of Action adopted by 179 governments at the International Conference on Population and Development in 1994 and the follow-up decisions taken by UN, which pertain to certain core areas.

Core areas: To help meet the goals laid out in the ICPD Programme of Action the UNDP/UNFPA Executive Board, in its decision 95/15, endorsed UNFPA's *three core programme areas*, which are described below.

- i) **Reproductive Health, Including Family Planning and Sexual Health:** UNFPA supports the provision of quality reproductive health care, including wider choice of family planning methods and related information. Among other reproductive health care services UNFPA supports are: safe motherhood, and maternal health care including assisted deliveries; counselling; sexual health; support for complications arising from unsafe abortion; and prevention of infertility, reproductive tract infections and sexually transmitted diseases, including HIV/AIDS. UNFPA provides support for HIV/AIDS prevention and control according to the global strategy of the Joint United Nations Programme on HIV/AIDS, and in line with national AIDS programmes and policies. The Fund pays special attention to the specific reproductive health needs of all age groups, especially adolescents and women in emergency situations such as natural disasters and armed conflicts. In addition, the fund supports technical assistance, training and research in all these areas.
- ii) **Population and Development Strategy:** UNFPA helps countries to formulate and implement comprehensive population policies as a central part of sustainable development strategies. This includes support for data collection and analysis, research, and activities intended to increase knowledge and awareness of some of the population challenges the world is facing in the new century, such as population ageing. The Fund has also made a significant step in its ability to monitor progress in achieving ICPD goals with the development of indicators for population and reproductive health programmes.
- iii) **Advocacy:** UNFPA advocacy efforts at the international level seek to ensure that the principles, goals and objectives of the ICPD are understood and accepted; secure commitment and funding for meeting these objectives; and build support for UNFPA's programme and resource development activities. Promoting support for the ICPD is the focus of much of the advocacy work that UNFPA undertakes at the country level as part of its country programmes. Such advocacy activities are necessarily intertwined

with the substantive activities being supported: for example, adolescent reproductive health and reduction of violence against women. Advocacy is, by its nature, public policy-oriented and oppositional at times and requires networking and coalition-building to broaden the base of support. To assist in this goal, UNFPA launched *World Population Day on 11 July 1987* — an observance that is now celebrated annually worldwide by governments and NGOs through a wide range of activities and events. The Fund's Face-to-Face campaign is one of the key activities used to achieve greater public awareness of population and reproductive health issues. The campaign, which uses celebrity Goodwill Ambassadors as spokespersons on a variety of issues, was expanded throughout 1998. Goodwill Ambassadors include Waris Dirie, UNFPA Special Ambassador for the Elimination of Female Genital Mutilation and Face-to-Face Campaign spokesperson; Nigerian author Chinua Achebe; Geri Halliwell of the United Kingdom, a singer and entertainment personality; Kattis Ahlstrom, a Swedish journalist and radio/television host and producer; and Keiko Kishi, a Japanese actress and television personality.

Informational publications issued by UNFPA in 1999 that are designed for international audiences include the *State of World Population 1999: Six Billion – A Time for Choices*; the *Annual Report*; a revision of the *Population Issues Briefing Kit*; ten issues of the news bulletin *Dispatches* and four issues of the UNFPA magazine *Populi*. In addition, UNFPA produced new booklets in its ongoing series of advocacy booklets related to the Fund's information mandate. An electronic version of *State of World Population 1998* was the most-visited document on UNFPA's popular website (www.unfpa.org). UNFPA also produces three major population reference volumes: *Inventory of Population Projects in Developing Countries Around the World* (annual), *Global Population Assistance Report* (annual), and *Guide to Sources of International Population Assistance* (triennial). In addition, the Fund produces audiovisual information materials, as well as technical and programme related publications.

The Internet site is a key source of information for the public on the Fund's work and on population and reproductive health issues generally. In 1998, the variety and volume of information on the site continued to expand. It has been redesigned to accommodate more information and has been made easier to navigate and use. The ICPD+5 section of UNFPA's website, created in 1998, was continuously updated to provide timely information on the full range of activities being undertaken in connection with the five-year review. UNFPA produced a great variety of posters, exhibits and multimedia materials in 1998 including a UNFPA CD-ROM containing 30 websites with more than 84,000 cross-links and 50 software applications. A UNFPA-organized seminar in Ankara (Turkey) in December 1999 examined the role that new communication technologies might have in promoting the goals of the ICPD Programme of Action. The seminar brought together experts and policy makers from the information and communication technologies sector and the population communications field. It focused on new concepts and the operational implications of new technologies for future advocacy strategies in support of the ICPD.

ICPD + 5 Review: In December 1997, the General Assembly considered the question of follow-up to the ICPD and decided to convene a special session from 30 June to 2 July 1999 to review and appraise implementation of the

Programme of Action. The special session marked the culmination of a comprehensive, five-year review of progress achieved and constraints faced in ICPD implementation, and saw the adoption by consensus of Key Actions for the Further Implementation of the Programme of Action of the ICPD (A/S-21/5/Add.1). The review showed that in five years, progress has been made in advancing the Cairo goals. Many countries have embraced and strengthened the recognition of reproductive and sexual rights through policy changes; have taken steps to integrate population concerns into their development strategies; and have added new components to reproductive health services while improving their access. At the same time, the review revealed that much greater and urgent action is needed in areas such as prevention of the HIV/AIDS pandemic; adolescent sexual and reproductive health; reduction of maternal morbidity and mortality; and the provision of reproductive health care to women and adolescents in emergency situations. The review also revealed that the financial constraints on implementation of the Programme of Action are severe: developing countries and countries with economies in transition are having difficulty in finding the necessary resources from their own budgets, and development cooperation has fallen short.

As part of the ICPD+5 process and during the course of 1998, the Fund organized three roundtables on major themes connected with implementing the Programme of Action: adolescent reproductive health; reproductive health and rights, including gender concerns; and partnerships with civil society. The Fund also sponsored a series of technical meetings and symposia on international migration, ageing, population change and economic development, and reproductive health in emergency situations. In addition, UNFPA conducted a global Field Inquiry that was sent to developing countries and countries with economies in transition to collect information in *four areas*:

- i) policies and programmes in population and development;
- ii) gender equality, equity and empowerment of women;
- iii) reproductive rights and reproductive health; and
- iv) government partnerships and collaboration with civil society.

The findings and outcomes from these activities, which focused on technical and operational assessments of the progress made and constraints faced by countries in implementing the Programme of Action, were discussed at an international forum in The Hague (Netherlands), from 8-12 February 1999. The Hague Forum was organized by UNFPA to contribute to the ICPD+5 review by focusing on key issues emerging from the appraisal process and by analysing achievements and challenges experienced in implementing the Programme of Action at the country level. Its *aims were four-fold*:

- a) to examine lessons learned, success stories, and obstacles and constraints encountered with a view to finding solutions to aid the further implementation of the Programme of Action;
- b) to allow for exchanges among programme countries facing similar experiences;
- c) to bring together a wide variety of partners to refocus their commitment on population and development; and
- d) to provide technical inputs to the General Assembly special session.

The Report of the International Forum for the Operational Review and Appraisal of the Implementation of the Programme of Action of the ICPD was submitted to the Commission on Population and Development, acting as the preparatory committee for the special session of the General Assembly, in March 1999. The Hague Forum was preceded by an International Parliamentarians' Forum on 4-6 February; and a Youth and NGO Forum on 6-7 February. These meetings, organized by UNFPA, included many stakeholders – government officials, parliamentarians, non-governmental organizations, youth and private foundations – and led to a sharing of lessons learned during nearly five years of experience in implementing the ICPD Programme of Action.

The Executive Director of UNFPA serves as the Secretary of the Committee for the *United Nations Population Award*, which is presented annually by the United Nations Secretary-General to individuals and/or institutions who have made an outstanding contribution to the understanding of population questions and to their solutions, especially at the level of the individual and the community.

12.2.3.4 NGO Relations

UNFPA has been working with civil society groups, especially NGOs since its inception, and has accepted hundreds of NGOs as executing agencies for UNFPA-supported projects. Following the ICPD, UNFPA undertook several initiatives to enhance NGO/civil society participation at headquarters and regional and national levels. These included: committing greater resources; designing and putting into effect new guidelines, procedures and policies; organizing meetings and consultations on a wide range of issues; facilitating dialogue, networking and coordination; and building NGO capacity. In 1998, NGOs accounted for around 16% of UNFPA's annual programme allocations. UNFPA worked with 275 NGOs – 186 were national NGOs, 30 were regional and 59 were international – executing projects in 124 countries for a total of some US\$34.4 million. These figures do not include many NGOs working directly under the country programmes.

The ICPD Programme of Action proposed broader and more effective partnerships among intergovernmental organizations, governments and NGOs, especially at the national and local levels, to “assist in the formulation, implementation, monitoring and evaluation of population and development objectives and activities.” Furthermore, it referred to involvement of the non-governmental sector, private sector and civil society in almost all aspects of the Programme of Action. The contribution of NGOs to the ICPD process proved to be significant, both procedurally by opening dialogue with civil society, and substantively by helping to shape a forward-looking and innovative Programme of Action. Since the ICPD, partnership has emerged as the basic process to advance implementation of the Programme of Action. The main goal of UNFPA's collaboration with NGOs is to supplement and strengthen national capacity to implement programmes in the sectoral areas within UNFPA's mandate. The Guidelines for UNFPA Collaboration with NGOs outline specific activities within the three areas of collaboration (reproductive health activities, including family planning and sexual health; population and development strategies; and advocacy) for which UNFPA may provide assistance to NGOs. UNFPA-NGO collaboration includes support for joint conferences, workshops or special events on population issues; regular interchange of information; and support for special publications and audiovisual

materials aimed at NGO constituencies. Other areas of collaboration include formulation and implementation of national population policies, access to reproductive health including family planning and sexual health, education and communication activities, research and surveys, adaptation and introduction of contraceptive technologies, training activities, technical advisory services and fundraising.

NGOs seeking assistance from UNFPA must satisfy the Fund that they have substantive knowledge and experience in population activities, and that they have the ability and capacity to execute projects on their own. Preference is given to NGOs that have sustained interest in population-related activities. It is UNFPA's long-term policy to encourage NGOs to include population components in their own ongoing programmes. The Fund may consider assisting such population components on an experimental basis. In general, no support is given for core staff or institutional support. NGOs are expected to be able to undertake population activities without such support. Funds are provided to NGOs for specific projects. UNFPA has guidelines on NGO project formulation and appraisal, in addition to guidelines on assistance to NGOs.

Proposals for NGO projects at the national level must be submitted to the UNFPA representative in the country concerned. While processing the proposal, the representative will make sure that the country's government has no objection to the project. In the case of inter-country projects, the request for assistance may be forwarded directly to UNFPA headquarters in New York. In these cases, UNFPA may require that each national project, as a component of the larger programme, be forwarded through the UNFPA representative in the individual country concerned. Strict financial monitoring and project evaluation procedures are also part of all cooperative agreements between UNFPA and NGOs.

- **NGO Advisory Committee:** In 1995 UNFPA established an NGO Advisory Committee at the international level to advise the Fund on policy and programming matters and to promote more active involvement of NGOs in the work of UNFPA, especially in advocacy activities. The committee meets annually and is composed of 25 to 30 representatives of NGOs: community-based, national, regional and international. UNFPA attaches great importance to the work of the committee and seeks to act upon its recommendations to the extent possible. In 1997, UNFPA succeeded in ensuring that the NGO Advisory Committee voice was included in deliberations of the UNFPA Executive Board, and in 1997 and 1998 a representative of the committee addressed the Executive Board and presented recommendations of the previous years.
- **Guidelines for UNFPA Collaboration with NGOs:** In November 1997, UNFPA revised its Guidelines for Collaboration with NGOs in order to further strengthen its interaction with the NGO community to facilitate implementation of the ICPD recommendations. Emphasis was placed on identifying and fostering new and innovative partnerships with the full range of NGOs worldwide.
- **Accreditation Processes:** UNFPA's cooperation with NGOs extends beyond the list of NGOs in consultative status with the Economic and Social Council to organizations working at the national and local levels. The certification of NGOs as possible executing agencies for UNFPA-funded projects is

conducted through an accreditation process based on criteria enumerated in the above-cited guidelines. The accreditation process for NGOs that may potentially execute international or regional level projects is conducted at headquarters by a committee chaired by the Deputy Executive Director (Administration and Policy). The accreditation process for NGOs that may potentially execute national level projects is conducted at the country level, under the guidance of the UNFPA representative.

- **NGO/Civil Society Theme Group:** A primary focus of the NGO/Civil Society Theme Group, established in January 1998, is to formulate, recommend and, as appropriate, implement strategies, procedures and activities that will promote, strengthen and facilitate UNFPA interaction and collaboration with civil society, particularly NGOs. Both UNFPA staff at headquarters and in the field participate in the work of the theme group.
- **Participation in UN Conferences:** UNFPA has actively supported participation of NGOs, particularly women's NGOs and youth groups, during the preparations for and at United Nations conferences and summits. UNFPA support in this area was notable in the preparations for and at the General Assembly special session on ICPD+5; and at the 1995 Fourth World Conference on Women and the ICPD.
- **Programme Review and Strategy Development:** The current Programme Review and Strategy Development (PRSD) Guidelines have a section under sectoral strategies that is devoted to NGOs.
- **Comparative Advantage:** UNFPA believes that NGOs can play a critical role in the area of advocacy. NGOs often engage in activities that might be considered sensitive, and that are taken up by governments once popular acceptance is guaranteed. NGOs are also particularly suited to deliver reproductive health, including family planning and sexual health services, at the community level; promote gender equality and equity; conduct innovative research; and organize cost-effective training and other activities.

UNFPA believes there are several areas where there is room for strengthening collaboration with NGOs, particularly in the areas of programme implementation, monitoring and evaluation. UNFPA is exploring ways to help NGOs increase their sustainability and self-reliance, while at the same time enhance their management skills, training, accountability and transparency.

12.2.3.5 Programme Frameworks and Progress

The United Nations Population Fund (UNFPA) is a leading international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect (UNFPA See http://www.unfpa.org/public/about/employment/docs/Role_Specification_UNFPA_TD_extended.pdf).

UNFPA works in partnership with governments, along with other United Nations agencies, communities, NGOs, foundations and the private sector to raise awareness and mobilize the support and resources needed to achieve its mission.

The *three core inter-related areas* of UNFPA's work are reproductive health, gender equality and population and development strategies. Population dynamics, including growth rates, age structure, fertility and mortality, migration and more, influence every aspect of human, social and economic development. Reproductive health and women's empowerment powerfully affect and are affected by population trends. *Two frameworks guide the organization's efforts:*

- The Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD).
- The Millennium Development Goals, a set of eight time-bound targets set at Millennium Summit 2000 to reduce extreme poverty by 2015.

In 2007, UNFPA began to decentralize its operations to become a more field-centred, efficient and strategic partner to the countries it serves. Towards this end, it established five regional and six sub-regional offices in the field that help coordinate work in about 150 countries, areas and territories through a network of 115 country offices. By strengthening the capacity of country offices and providing more effective and integrated support to them, this structure is designed to foster an environment more conducive to national ownership of programmes and to South-South cooperation.

Overall, the organization employs 2,700 staff. Donor contributions to UNFPA and other income in 2011 reached a record of nearly \$870 million, up from \$756 million in 2009. The twenty-five largest donors each made contributions exceeding \$1 million.

i) **Programme of Action of ICPD and UNFPA's Framework:** UNFPA's work is guided by the Programme of Action adopted by 179 governments at the International Conference on Population and Development in 1994. The conference agreed that meeting people's needs for education and health, including reproductive health, is a prerequisite of sustainable development. The *main goals* of the Program of Action are:

- Universal access to reproductive health services by 2015;
- Universal primary education and closing the gender gap in education by 2015;
- Reducing maternal mortality by seventy-five percent by 2015;
- Reducing infant mortality; and
- Increasing life expectancy.

These *goals were refined in 1999*. One of the most important additions concerned HIV:

- HIV infection rates in persons of 15–24 years age-group should be reduced by 25 percent in the most affected countries by 2005 and by 25 percent globally by 2010.

Approach to health care: The Fund promotes a *holistic approach* to reproductive health care that includes access to a range of safe and affordable contraceptive methods and to sensitive counseling; prenatal care, attended deliveries, emergency obstetric care and post-natal care; and prevention of

sexually transmitted infections by promoting safer sexual behavior (http://en.wikipedia.org/wiki/United_Nations_Population_Fund).

UNFPA looks to improve the lives and expand the choices of individuals and couples because, according to UNFPA, in time reproductive choices, multiplied across communities and countries, affect population construction and trends. The work of the agency revolves around improving reproductive health, making motherhood safer, supporting adolescence and youth, preventing HIV and AIDS, promoting gender equality, protecting human rights, and securing reproductive health supplies; throughout all this they use a *culturally-sensitive approach*. Their assistance is in developing countries which receive help in accordance with their priorities for development (Ibid).

UNFPA Programmes: Cross-Cutting Concerns: UNFPA's gender framework incorporates *four strategic linkages* that address critical factors underlying inequalities and rights' violations: girls' education, women's economic empowerment, women's political participation and the balancing of reproductive and productive roles.

The Fund brings gender issues to wider attention, and promotes legal and policy reforms and gender-sensitive data collection. It works to end gender-based violence, including traditional practices that harm women, such as child marriage and female genital mutilation. It also raises awareness of women's specific strengths, vulnerabilities and needs in relation to a variety of issues such as humanitarian emergencies, climate-change and migration. UNFPA also recognizes the rights perspectives and influence of men and boys, and seeks to involve them in efforts to promote gender equality and improve reproductive health.

Promoting and protecting fundamental human rights, including reproductive rights, are at the core of all UNFPA programming. This is one of the reasons the Fund places priority on reaching those in the greatest need, whether because of poverty, marginalization, emergencies, age, sex, ethnicity or health status.

- *Gender equality and women's empowerment:* The importance of gender equality and women's empowerment to development progress is underscored by the fact that this was selected as one of the eight Millennium Development Goals. Beyond being a goal in itself, gender equality is also a driver for all the MDGs, and is intimately linked and specifically connected to goals to improve maternal and newborn health and reduce the spread of HIV.
- *Culturally sensitive, human rights-based approaches:* A strong emphasis on the human rights, including reproductive rights, of individual women and men underpins all of UNFPA's work and its way of working. Promoting and protecting these rights require considerable cultural fluency, because UNFPA works in some of the most sensitive and intimate spheres of human existence, including sexuality, gender relations and population issues. Since 2002, UNFPA has emphasized the integration of culturally sensitive approaches into programming efforts. Toward this end, it has worked closely within communities and with local agents of change, including religious leaders and faith-based organizations (Ibid).

- *Supporting adolescents and youth:* More than a quarter of the world's population – some 1.8 billion people – are between the ages of 10 and 24. UNFPA promotes and protects the rights of this important generation of young people, and works towards a world in which girls and boys have optimal opportunities to develop their full potential, to freely express themselves and have their views respected, and to live free of poverty, discrimination and violence (Ibid).

UNFPA's 'four keys' to opening up opportunities for young people include: incorporating youth issues into national development and poverty reduction strategies; expanding access to gender-sensitive sexual and reproductive health education that encourages the development of life skills; promoting a core package of health services and commodities for young people; and encouraging youth leadership and participation (Ibid).

- *Responding to the AIDS epidemic:* The contribution of UNFPA to the global response to AIDS is shaped by its mandate to reduce poverty, eliminate gender inequality and ensure universal access to sexual and reproductive health. As a co-sponsor of UNAIDS and under the UNAIDS division of labour, UNFPA focuses its response on HIV prevention among young people, women and marginalized groups, including within the context of sex work. It supports comprehensive programming for male and female condoms and advocates for the linking and integration of sexual and reproductive health and HIV policies, programmes and services. It aims to make sure that family planning and maternal health services meet the needs of women living with HIV. This includes interventions to prevent mother-to-child transmission and support for confidential voluntary HIV testing and counseling (Ibid).

UNFPA also works in many contexts, including humanitarian and post-conflict situations, toward the elimination of gender-based violence and prevention of HIV.

- Sexual and Reproductive Health and HIV Linkages: Evidence Review and Recommendations.
- Global Guidance Briefs on HIV and Young People.
- Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages.
- Assisting in emergencies.

In times of upheaval, pregnancy related deaths and sexual violence soar. Reproductive health and obstetric services often become unavailable. Young people become more vulnerable to HIV infection and sexual exploitation. Within the coordinated, inter-agency response to disasters, UNFPA moves quickly when emergency strikes. The Fund takes the lead in providing supplies and services to protect reproductive health, with an emphasis on the special needs and vulnerabilities of women and young people.

UNFPA supports various data collection activities, including censuses to provide detailed information for planning and rapid health assessments to allow for appropriate, effective and efficient relief. It also assists stricken communities as they move beyond the acute crisis and enter the reconstruction phase.

- ✓ Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings.
- ✓ Women are the Fabric: Reproductive Health for Communities in Crisis.
- ✓ Will You Listen? Young Voices from Conflict Zones.

According to UNFPA these elements promote the right of “reproductive health”, that is physical, mental, and social health in matters related to reproduction and the reproductive system. The Fund raises awareness of and supports efforts to meet these needs in developing countries, advocates close attention to population concerns, and helps developing nations formulate policies and strategies in support of sustainable development.

Because the dates for achievement of these interconnected sets of goals and related targets are fast approaching, considerable work has been done in analyzing what has worked, and to galvanize support and a redoubling of efforts.

- ii) **Millennium Development Goals and UNFPA's Work:** At the Millennium Summit in 2000, 189 Member States agreed to help the world's poorest countries significantly by the year 2015. A framework for progress consisting of eight Millennium Development Goals was derived from the Millennium Declaration adopted by these world leaders. The Programme of Action agreed to at the International Conference on Population and Development, along with benchmarks added at the ICPD+5 review, formed basis for the eight Millennium Development Goals (derived from Millennium Summit, 2000). These mutually reinforcing development blueprints guide UNFPA in its efforts to improve lives, support reproductive health and rights, and advance gender equality.

The MDGs serve as a time-bound, achievable blueprint for reducing poverty and improving lives agreed to by all countries and all leading development institutions. They guide and focus development priorities for governments, donors and practitioner-agencies worldwide. The ICPD Programme of Action and MDGs have guided UNFPA in its efforts to deliver a world where every pregnancy is wanted, every child-birth is safe and the potential of every young person is achieved.

- **ICPD 1994 – 2004:** The 10-year anniversary of the International Conference on Population and Development in Cairo has provided the Caribbean Development and Cooperation Committee (CDCC) member states with an opportunity to report on the progress made, opportunities and constraints faced, and emerging issues in the further implementation of the ICPD Programme of Action and the Caribbean Plan of Action on Population and Development. As the ICPD goals map very closely to the Millennium Development Goals, poverty reduction through interventions in population and development as well as sexual and reproductive health and gender empowerment will remain of paramount concern in the analytical framework employed for this process.
- **ICPD and MDGs for the Next Generation:** As the 20th anniversary of the ICPD (2014) and the deadline for the MDGs (2015) approach, governments of the world have renewed their commitment to the ICPD Programme of Action and have tasked UNFPA to conduct a global review of achievements, gaps and challenges in delivering the promise of Cairo.

A review of progress towards MDGs is also being undertaken. The results of both reviews will lead to a new consensus on development for the next generation.

In response to the 2010 UN General Assembly resolution that called for a comprehensive review of the ICPD programme of action, UNFPA has established the *ICPD Beyond 2014* Secretariat. The Secretariat will co-ordinate a comprehensive review of the ICPD Programme of Action. A key outcome from the review will be a special report with recommendations for action from the UN Secretary General to be presented to the UN Conference on Population and Development in 2014. It is anticipated this report will also inform the next round of global development goals.

- **2012 International Parliamentarians' Conference on Implementation of the ICPD Programme of Action:** The Fifth International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action (IPCI/ICPD) took place in Istanbul, Turkey, on 24-25 May 2012. The conference was organized by the European Parliamentary Forum on Population and Development (EPF) and UNFPA in collaboration with the regional parliamentary forums and hosted by the Grand National Assembly of Turkey.

IPCI Istanbul came at a very significant time for the ICPD mandate. With only two years before the Cairo agenda was expected to be complete, the conference was an excellent opportunity for parliamentarians to recommit themselves to this unfinished agenda. While the international community undertakes the mandated United Nations General Assembly operational review at the national, regional and global levels, IPCI Istanbul provided the parliamentarians from around the world an opportunity to make their strategic contributions to this exercise, which will set forth the path for the ICPD agenda beyond 2014.

At the end of the two day event, the participants committed themselves to its unfinished plan by unanimously adopting the Istanbul Statement of Commitment. In it, and under the theme, *'Keeping Promises — Measuring Results'*, they determined to advocate for increased national and external funding for the entire implementation of the ICPD agenda in order to achieve access to sexual and reproductive health, including family planning. The parliamentarians pledged, among other actions, to:

- ✓ Attain at least 10 per cent of national development budgets and development assistance budgets for population and reproductive health programmes. That includes HIV prevention and reproductive health commodities;
- ✓ Re-commit to ensuring the target of 0.7 per cent of gross national product (GNP) for official development is met: and
- ✓ Pledge to support policies that give special attention to the specific concerns and needs of young people by promoting and protecting their right to "access good quality education at all levels, health, sexual and reproductive services, including comprehensive sexuality education," and to adopt measures to prevent all types of exploitation and abuse against them.

- Audit reports uncover that 75 percent of the programmes studied “failed to deliver all their planned outputs,” while 25 per cent, which accounts for \$24.9 million, “fell significantly short.” Audit reports also point to the frequent breaching of United Nations financial regulations, at both UNFPA headquarters and at numerous UNFPA country offices, and that this problem has grown worse over time. In 2000, less than half of the audited country offices were found to have satisfactory internal controls. Numerous cases of fraud were also reported (Ibid).

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3) Write in brief about IPCI/ICPD 2012.

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12.2.4 Efforts of Population Control by the United Nations Children's Fund (UNICEF)

United Nations International Children's Emergency Fund (UNICEF) is an international charity, headquartered in New York City, that provides long-term humanitarian and developmental assistance to children and mothers in developing countries. It is one of the members of the United Nations Development Group and its Executive Committee.

UNICEF was created by the United Nations General Assembly on December 11, 1946 to provide emergency food and healthcare to children in countries that had been devastated by World War II. In 1954, UNICEF became a permanent part of the United Nations System and its name was shortened from the original United Nations International Children's Emergency Fund to *United Nations Children's Fund*, but it has continued to be known by the popular acronym, UNICEF, based on its old name.

UNICEF relies on contributions from governments and private donors. Its total income for 2008 was \$3,372,540,239. Governments contribute two thirds of the organization's resources; private groups and some 6 million individuals contribute the rest through the National Committees. It is estimated that 91.8% of their revenue is distributed to Programme Services. UNICEF's programmes emphasize developing community-level services to promote the health and well-being of children. UNICEF was awarded the Nobel Peace Prize in 1965 and the Prince of Asturias Award of Concord in 2006.

Most of UNICEF's work is in the field, with staff in over 190 countries and territories. More than 200 country offices carry out UNICEF's mission through a programme developed with host governments. Seven regional offices provide technical assistance to country offices as needed. Overall management and administration of the organization takes place at its headquarters in New York. UNICEF's Supply Division is based in Copenhagen and serves as the primary point of distribution for such essential items as vaccines, anti-retroviral medicines for children and mothers with HIV, nutritional supplements, emergency shelters and educational supplies, among others. A 36-member Executive Board establishes policies, approves programmes and oversees administrative and financial plans. The Executive Board is made up of government representatives who are elected by the United Nations Economic and Social Council, usually for three-year terms.

UNICEF is an inter-governmental organization and, thus, is accountable to those governments. UNICEF's salary and benefits package is based on the United Nations Common System.

- **UNICEF National Committees – Promotion and fund-raising:** UNICEF is present in 190 countries and territories around the world. There are National Committees in 36 industrialized countries worldwide, each established as an independent local non-governmental organization. The National Committees raise funds from the private sector. Many people in developed countries first hear about UNICEF's work through the activities of these National Committees for UNICEF. These non-governmental organizations (NGO) are primarily responsible for fund-raising, selling UNICEF greeting cards and products, creating private and public partnerships, advocating for children's rights, and providing other invaluable support. The U. S. Fund for UNICEF is the oldest of the National Committees, founded in 1947.

UNICEF is funded exclusively by voluntary contributions, and the National Committee collectively raise around one-third of UNICEF's annual income. This comes through contributions from corporations, civil society organizations and more than 6 million individual donors worldwide. They also rally many different partners – including the media, national and local government officials, NGOs, specialists such as doctors and lawyers, corporations, schools, young people and the general public – on issues related to children's rights.

- **A Shift from its Mandate:** UNICEF has moved far from its mandate of protecting babies. Consider the 1959 UN Universal Declaration of the Rights of the Child: "Whereas the child, by reason of his physical and mental immaturity, needs special safeguards and care, including legal protection, before and as well as after birth ..." Then consider the UN creation from 1991, a revised Declaration of the Rights of the Child. This offers state protection to a child only after birth. By 1987, UNICEF "officially" endorsed abortion at the International Conference on Better Health for Women and Children in Nairobi, Kenya. UNICEF and six other agencies – all sponsored by UNICEF (the UNFPA, the World Bank, the WHO, UNDP, the Population Council, and the International Planned Parenthood Federation) – went on record as being openly pro-abortion. In a joint statement, they recommended that "legal, good quality abortion services should be made easily accessible to all women." In 1992, UNICEF increased support for China's one-child family programme, complete with involuntary sterilizations and forced, late-term abortions, from over \$2 million to almost \$5 million (<http://www.theinterim.com/1999/aug/20unicef.html>).

In addition to direct efforts by United Nations, there have been efforts by other agencies in addressing the population issues. However, we discuss, in brief, the efforts of IPPF below as it is the largest NGO involved in population control at global level.

12.2.5 Efforts of International Planned Parenthood Federation (IPPF)

International Planned Parenthood Federation (IPPF) was formed in 1952 at the Third International Conference on Planned Parenthood in Bombay, India. It was

the result of campaigning by a handful of brave and angry women, including Margaret Sanger from America, Elise Ottesen-Jensen from Sweden and Dhanvanthi Rama Rau from India, who were imprisoned for their assertion that women had the right to control their own fertility. They were determined to work with different cultures, traditions, laws and religious attitudes to improve lives for women around the world (<http://arabinfomall.bibalex.org/en/orgdata.aspx?orgid=950§ionid=3>).

IPPF is a global non-governmental organization with the broad aims of promoting sexual and reproductive health, and advocating the right of individuals to make their own choices in family planning. Formed in 1952 in Bombay, India, it now consists of more than 149 Member Associations working in more than 189 countries. IPPF is highly developed and organized into six regions around the world (http://en.wikipedia.org/wiki/International_Planned_Parenthood_Federation).

With its global headquarters located in London, UK, IPPF has the following six Regional Offices.

- Africa (Nairobi, Kenya).
- Arab World (Tunis, Tunisia).
- Europe (Brussels, Belgium).
- South Asia (New Delhi, India).
- East, South-East Asia and Oceania (Kuala Lumpur, Malaysia).
- Western Hemisphere (New York, USA).

National Family Planning Associations from eight countries formed the new Federation including (<http://arabinfomall.bibalex.org/en/orgdata.aspx?orgid=950§ionid=3>): Hong Kong (www.famplan.org.hk), India (<http://www.fpaIndia.org/>), Netherlands (www.rng.nl/), Singapore, Sweden (www.rfsu.se), United Kingdom (<http://www.fpa.org.uk/>), United States (www.plannedparenthood.org), and West Germany (www.profamilia.de).

Important events/achievements, in brief, of IPPF include the following (<http://arabinfomall.bibalex.org/en/orgdata.aspx?orgid=950§ionid=3>):

- **1952** – The fledgling organization operated on a tiny budget of \$5,000 and kept in touch with its supporters via a monthly *'Around the World News of Population & Birth Control'*. Circulation rapidly reached 12,000 copies to 30 different countries.
- **1956** – The IPPF had a directory listing in 43 countries in which family planning advice was obtainable.
- **1961** – The contraceptive pill went on sale. After receiving a research grant from the Planned Parenthood Federation of America (PPFA), the work of Gregory Pincus (Director of the Worcester Foundation for Experimental Biology) resulted in the development of an oral pill that prevented ovulation.
- **1966** – Sweden was the first country to provide a government grant to IPPF.
- **1981** – The 'Family Planning in the 80s' conference in Jakarta, Indonesia, was the first world conference on the subject to be jointly sponsored by the three major players – IPPF, UNFPA and the Population Council.

- **Today** – IPPF is still leading a ‘brave and angry’ stance with regard to people’s right to access to good sexual and reproductive health care and services. As these important choices and freedoms are seriously threatened, we are needed now more than ever.

Purpose: Member Associations provide non-profit family planning services, sexual health and abuse-prevention training and education. Their goals include: giving clients the information necessary to make informed sexual health decisions, promoting continuing sexual health, making available high quality sexual health services, improving the overall health of low income individuals, and using democratic organization and the leadership of volunteers to promote these goals (http://en.wikipedia.org/wiki/International_Planned_Parenthood_Federation).

The services provided by IPPF include the following (<http://arabinfomall.bibalex.org/en/orgdata.aspx?orgid=950§ionid=3>):

- counselling, gynaecological care, HIV-related services;
- diagnosis and treatment of sexually transmitted infections;
- infertility services, mother and child health, family planning;
- contraception, emergency contraception, abortion-related services.

Funding: The IPPF is financially supported by governments, trusts, and foundations including the European Commission and the United Nations Population Fund for special projects. Half of the balance of their funding comes from government official development assistance programmes. To achieve their goals as an organization, the IPPF often collaborates with the World Health Organization (WHO), the United Nations Development Program (UNDP), the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNPF), and the Organization for Economic Co-operation and Development (OECD) (http://en.wikipedia.org/wiki/International_Planned_Parenthood_Federation).

The IPPF is a prominent lobbyist in the European Union, specifically, for the European Council and the United Nations Economic and Social Council (ECOSOC). It is the only non-governmental organization (NGO) that focuses on sexual health and reproductive rights to qualify for Consultative Status with the Council of Europe. This allows the IPPF to sit in on the Parliamentary Assembly (Ibid).

- **Canadian funding:** In April 2011, it was revealed that IPPF, which had applied for an \$18 million grant more than a year previously, had been denied funding by the Conservative government due to lobbying efforts by pro-life groups. On Sept. 22, 2011 the Canadian International Development Agency (CIDA) granted IPPF \$6 million over three years. The money is for services yet to be rendered in Afghanistan, Bangladesh, Mali, Sudan and Tanzania. Many anti-abortion activists have been critical of the spending including conservative MP Brad Trost who criticized his own party for supporting the pro-choice group (Ibid).
- **United States funding:** IPPF is a pro-choice organization that advocates for access to contraception and safe abortion services. This has led IPPF into conflict with conservative social forces, including the Roman Catholic

- Income in 2010 of \$124.2 million.
- Expenditure in 2010 of \$126.8 million.

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In this Unit, we have highlighted international measures with an emphasis on the global population projection and control by United Nations and its associated organizations/agencies. We have broadly covered the efforts of United Nations in terms of organising population and development related conferences and taking follow-up efforts such as funding, enabling implementation of programmes by member nations, monitoring and reviewing progress, among others by involving United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and others. We have also covered the efforts of International Planned Parenthood Federation (IPPF), the largest and the only NGO that focuses on sexual health and reproductive rights at global level.

12.4 ANSWERS TO 'CHECK YOUR PROGRESS' QUESTIONS

- 1) The ICPD held in 1994 is undoubtedly a landmark conference particularly in terms of the shift from population control to a reproductive rights framework. Its accomplishments include the ICPD Programme of Action that represents a “quantum leap” for population and development policies. These include:
 - a shift from the previous emphasis on demography and population control to sustainable development and the recognition of the need for comprehensive reproductive health care and reproductive rights;
 - strong focus on the empowerment of women;
 - reflection of different values and religious beliefs and reaffirmation of the central role of the family; and
 - recognition of the needs of adolescents.
- 2) Key goals embodied in the Programme of Action of ICPD 1994 include the following.
 - The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary enrolment ratio for children of both sexes should be at least 90 percent.
 - By 2005, 60 percent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted infections (STIs), and barrier methods to prevent infection; 80 percent of facilities should offer such services by 2010, and all should do so by 2015.
 - At least 40 percent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80 percent globally, by 2005; these figures should be 50 and 85 percent by 2010; and 60 and 90 percent by 2015.
 - The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75 percent by 2010, and by 100 percent by 2015.
 - To reduce vulnerability to HIV/AIDS infection, at least 90 percent of young men and women, aged 15-24, should have access by 2005 to preventive methods such as female and male condoms, voluntary testing, counseling, and follow-up, and at least 95 percent by 2010. HIV infection rates in persons of 15-24 years age-group should be reduced by 25 percent in the most affected countries by 2005 and by 25 percent globally by 2010.
 - By 2015 all countries should aim to achieve an infant mortality rate below 35 per 1000 live births and an under-5 mortality rate below 45 per 1000.
 - Countries should strive to reduce maternal mortality by 100 percent by 2015.

- 3) The Fifth International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action, which is also called ICP, 2012, took place in Istanbul, Turkey on 24-25 May 2012. The conference was organized by the European Parliamentary Forum on Population and Development (EPF) and UNFPA in collaboration with the regional parliamentary forums and hosted by the Grand National Assembly of Turkey. IPCI Istanbul came at a very significant time for the ICPD mandate; with only two years before the Cairo agenda was expected to be complete, the conference was an excellent opportunity for parliamentarians to recommit themselves to this unfinished agenda, which set forth the path for the ICPD agenda beyond 2014. At the end of the two-day event, the participants committed themselves to its unfinished plan by unanimously adopting the Istanbul Statement of Commitment, under the theme, '*Keeping Promises — Measuring Results*'. Finally, the participants decided to build a global network of ICPD supporters, and to ensure that ICPD's continuing and emerging priorities and concerns are reflected in the 'ICPD Beyond 2014'. They also called upon the United Nations General Assembly "to play a key role in building support for the ICPD Programme of Action," and committed to holding themselves accountable for reporting on the follow-up to the IPCI commitments.
- 4) *Mission and Goals of UNFPA*: UNFPA's work is guided by the Program of Action adopted by 179 governments at the International Conference on Population and Development in 1994. Stated mission of UNFPA is to promote the right of every woman, man and child to enjoy a life of "health and equal opportunity." UNFPA supports countries in using population data for policies and programs to "reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS and sexually transmitted diseases, and every girl and woman is treated with dignity and respect."

The agency's *main goals* are:

- Universal access to reproductive health services by 2015.
- Universal primary education and closing the gender gap in education by 2015.
- Reducing maternal mortality by 75 per cent by 2015.
- Reducing infant mortality.
- Increasing life expectancy.
- Decreasing HIV infection rates.

These goals were refined in 1999. One of the most important additions concerned HIV:

- HIV infection rates in persons in the age-group of 15–24 years should be reduced by 25 percent in the most affected countries by 2005 and by 25 percent globally by 2010.

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