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Analysis of India's Population Policy: An Experience of Five Decades

T.K. Roy

The demographic transition in the developed countries occurred without a government sponsored family planning programme. The transition took place in a synchronized manner along with socio-economic development. The rate of growth of their population was never very high. The experience of the developing countries, in this respect, was rather skewed. After the second world war, these countries experienced a sudden decline in mortality which was devoid of, in most cases, any perceptible improvement in socioeconomic development. Before the level of fertility started declining, they attained a low level of mortality, which was comparable to that existing in developed countries when they were completing the transition. For the developing countries, the growth rates have sometimes crossed the 3 percent mark.

India, along with other South and South-East Asian countries, faced a similar demographic situation at the initial stage of transition. A woman had, on an average, six children and average life expectancy was 40 years at the beginning of 1950. India pioneered the effort to control population in the early fifties. The other countries in the reason like China, Korea, Thailand, Indonesia and Sri Lanka, though introduced government sponsored family planning programmes much later, have progressed far ahead of India in achieving their goal of fertility reduction.

The programme in India is geared by increasing allocation of resources in each successive plan. Many innovative strategies and programmes have been introduced from time to time to give it a new direction. No doubt the level of fertility has declined, but it has been too slow. There is a need to have a comprehensive review of the birth control policy in India as it has developed over the fast five decades. Such an assessment can provide insights to shape the future policy in the country.

A Framework for Policy Analysis

Policy is a process which evolves over time, and its analysis requires examination in of its different components. A convenient framework for analysing birth control policy in a holistic manner is presented in figure 1 (figure 1 is missing). Three broad components relevant in the context of analysing the policy of an area are:

(i) sociocultural characteristics of population,

(ii) nature of the policy, and

(iii) process of implementation of the policy.

The socio-cultural, economic, demographic and political environment prevailing in a country stimulates the process of policy formulation and, to a large extent, determines the nature and strength of the policy. Greater the strength of a policy, the more effective mode of implementation can be adopted and the programmes can be pursued with greater vigour. The various socio-cultural factors may also have a direct influence on the process of implementation. The implementation process may not be commensurate with the strength of the policy if government's goal is not in harmony with the individual goal. Also, the existing work culture in society and the extent of seriousness with which tile government sponsored programmes are received in society will be important in determining the process of implementation. The outcome of a policy, in terms of achieving reduction in the level of fertility, depends, to a large extent, on the existing demand for children in a given society. The entire gamut of socioeconomic and cultural factors, including demand for child labour, the cost of bearing and rearing children, women's employment, level of infant and child mortality etc., tend to affect the demand for children which can be independent of either the strength or the process of implementation of the policy. Caldwell and Caldwell (1987) have emphasised the importance of indigenlus values and mentioned that this can be a reason for greater resistance of fertility decline in Sub-Saharan Africa compared to that in any other region. The deep-rooted beliefs place particular importance on having many children in this region. The socioeconomic factors can also exert influence on fertility through a change in supply of children.

The social, cultural and economic factors can have an all-pervading effect on the success of the policy in a country. One factor which can have particular significance in this context is the existing political situation. The form of government its strength and its

credibility among the masses can have a profound impact on the progress of the programme. It is much more likely that a strong, energetic and popular government would be able to carry on with its policy in a decisive manner. One of the important factors that contributed towards a successful family planning programme in Indonesia has been the continutiy and stability of its national government.

The second component, the nature and strength of a policy can be assessed by considering: (a) policy contents (b) the process of policy evolution, and (c) supporting environment.

The content of a policy entails examination of: (i) whether a policy document exists (ii) tile objectives envisaged in the policy, (iii) whether any constitutional or legislative provisions are made, (iv) whether any explicit reference has been made about the strategies and programmes to be adopted to facilitate attaining the objectives, (v) the budget provisions made available, and (vi) the range of contraceptive methods to be offered by the programme. Policy and laws are related practices. Constitutional or legislative provisions give a sense of direction to the policy and mandate the activities and can thereby strengthen it. There can be some inherent contradictions in carrying out a birth control policy. For example, there can be ethnic competition present in a society, and to achieve political dominance there may be an implicit urge to increase the population. In such a situation, it may be difficult for the overall policy of reducing fertility to succeed (Kokole, 1994). It is therefore, necessary, to screen the policy to understand how important the issue is and whether any step is taken in it to overcome such a discrepancy.

In this context, it is also necessary to understand the proposed organizational structure of the family planning programme. Location of the programme and the extent of decentralization of authority and responsibility in the structure can be important to understand its strength. The particular ministry in which the programme is located status of the person who leads the programme and whether it is under the head of the executive will have relevance for its success. It is also relevant to see the extent to which there exists coordination between family planning programme with the other related departments in government. The issue of population depends on a large number of factors and hence success of a population programme depends on how the other programmes are run such as programmes on human resource development, women and child development, rural development etc. The population programme will be more effective if there exists effective inter-sectoral coordination. Another aspect, which can be crucial, is the extent of community participation envisaged in the policy. This can make the programme a people's programme. In Indonesia the traditional village community organizations were effectively and successfully involved in the programme,

they assisted in promoting and identifying new acceptors and providing follow up services.

Not only it is necessary to examine the content of a policy and the provisions made, it is also pertinent to understand how it has been evolved. The amount of planning that has gone into the development of a policy, and the degree to which the relevant information on existing socio-cultural, economic, political and ethical issues have been utilized in formulating the policy can have an immense bearing on its outcome. Another extremely important aspect is whether there exists a consensus about the policy. That is, whether it incorporates the views of different interest groups. In a situation where there exists a convergence of opinion on the issues and the policy has been evolved taking into account the opinion of the important sections of society and is kept beyond political manipulation, it can be implemented more effectively. In this context it is also important to examine whether views of religious leaders have been incorporated. The family planning programme in countries such as Malaysia and Indonesia has benefited considerable by the fact that religious bodies are officially represented on the governing councils of the national family, planning programme. To judge the success of a policy, it is important to examine who are tile interest groups, how important they are and whether their views have been sought in the policy.

The supporting environment relates mainly to the political commitment of the leaders in pursuing the policy. The dividend that accrues from a family planning programme is not that conspicuous and it begins only after a lapse of few years. Again, family planning deals, with the sensitive area of sexual behavior and reproduction, which is widely regarded as a personal matter. It is therefore the experience that necessary political will to vigorously pursue a family planning programme will be less forthcoming. However, a strong political commitment can be crucial in engineering a successful family planning programme. The family, planning programme in both China and Indonesia has gained immensely from the favorable disposition of their leaders towards such a programme. The commitment gets reflected, for example, in the assortments made by important politicians in favour of the policy, whether election manifestos of different political parties show a commitment towards fertility control, etc.

It is also necessary, in the context, to understand the role of donor agencies in the policy. The extent of support received from international donors can have an important bearing in shaping as well as carrying out the programme. Apart from the resources received, a donor driven programme, because of their emphasis on achieving results, often tend to lay greater emphasis on output, which may have either beneficial or

adverse effects. A donor driven programme may also suffer if broad political issues such as genocide and neocolonialism exist.

The third component in the framework is the process of implementation. The policy as such may be strong, but if not implemented properly will not produce the desired result. The different components in the appraisal of the process of implementation can be broadly classified as:

a. Availability of inputs,

b. Activities undertaken and

c. Management of the programme.

The strength of a programme, in terms of its implementation, will depend on the amount of inputs available. This refers mainly to the actual availability of institutions (like community health centers, primary health centers etc.), personnel (like doctors, nurses, health workers etc.) and other physical facilities (like building, equipment, medicines, contraceptives etc.) Greater the magnitude of resources available, better is likely to be the availability of services and the programme. Deployment of resources over different geographic areas can also be important in affecting the process of implementation of the programmes.

The next element is the type of activities that a programme undertakes. The important aspect is to understand the quality of care and services it provides which determines its strength. The type of interaction and exchanges that the providers have with the clients is one such element. More than the educative aspect, this relates to the behavioural dimensions namely, how much care they (providers) take in delivering the services and the extent to which they are able to generate confidence among the clients. The next element is the type of information given to the clients by the providers during their contact with them. This includes, inter alia, providing information about the range of methods available, their contra-indications, the possible side effects of the contraception and how to handle them, and the other services being available and provided by the personnel. Another very important element in the service delivery is the type of follow-up services provided to those who utilize such services. A good follow up care will enhance the satisfaction of the clients and hence will have a salutary effect on the programme, The type of information, education and communication (IEC) activities

undertaken in a programme to popularize the various aspects of child survival and safe motherhood will also be important in creating necessary demand for such services.

Once the resources are allocated, the success of a programme depends on how they are being managed. Under this broad umbrella, all the aspects which tend to measure how well the quantitative inputs are geared up to provide the services can be included. It will be important to examine the technical competence of the personnel and the mechanisms of enabling them to provide services. The nature in which the inputs are deployed in different areas, whether such distribution takes into account the specific needs of the areas and whether the inputs are provided as a package can have relevance in enhancing the programme performance (Srinivasan, et al., 1991). In order to improve the efficiency of the programme, there is a need to subject it to systematic monitoring and evaluation. To institutionalize such an effort, it is important to have a viable information system. It needs to be examined as to whether such a system exists and the reliability and efficiency with which it is being utilized for supervision, monitoring and evaluation of the programme. All these are linked to the quality of services and hence reflect the effectiveness of the process of implementation.

Evaluation of India's Policy

With the help of the above framework, an attempt is made to evaluate the population policy of India as it has evolved over the past five decades. India has lagged behind in its socio-economic development programmes. According to the latest available report, it is ranked 138 among 175 countries in terms of human development index (United Nations Development Program, 1997). The census of 1991 shows that only 39 percent of female (age 7 and over) in the country are literate. The level of infant mortality though has declined from a level of 139 in 1972 to 74 in 1995 is still high.

There is little doubt that the success or failure of the family welfare programme in the country has to be viewed in the context of its performance in the socioeconomic development. The emphasis is not so much on whether it is a success or a failure. More important is to understand how the policy has evolved in the given socioeconomic context what have been its weaknesses and what should be done to remove such weaknesses.

At the time when the programme was initiated in 1952, the concept of small family size norm was non existent in the country. In fact, the first all India's survey conducted in 1970 revealed that only 9 percent of tile women felt that a couple should ideally have two or less children (Operations Research Group, 1971). Clearly, the need at that time

was to make people aware about the importance of having a small family, how fertility can be regulated and various aspects of maternal and child health care. After independence there was enthusiasm all around, and with the strong and credible government it would not have been difficult to create a favorable atmosphere for the programme. Ignoring the ground realities, the programme was launched adopting a clinic-based approach. There was lack of support from the top and it meant only a nominal implementation of the programme. The extension approach was adopted sometimes in the 1960s and we lost about 10 precious years where we could have prepared the ground with a genuine awareness and at least a favorable disposition towards the programme. The 1961 census revealed an enormous increase in the population. It came as a big jolt, and a sense of urgency dawned. The situation reached a crisis level after the 1971 census was out. The country added 187 million persons to its population of 361 million in 1951 during the two decades. The sense of urgency engulfed the top echelons of the country who could influence the policy, and drastic measures to rectify the situation were being discussed. Somehow sterilization emerged as a possible solution. In fact, the tilt from rhythm method advocated initially to sterilization occurred in 1960s. From the programme point of view, two important events took place during 1960s which perhaps contributed towards favouring sterilization. The first is the failure of the IUCD programme which was introduced in 1965 with high expectations. The other is the sporadic experiments with mass vasectomy camps, some of which were successful in attracting a large number of people.

In the rush for a quick solution to the situation, which indeed became alarming, the strategies for strengthening the supply side of the programme got uppermost in the minds of the planners. That the demand is a fundamental and crucial component to have a sustainable programme was again relegated to the background. It may be mentioned that an official target was set in the Third Five Year Plan according to which the crude birth rate in the country was to have reached a level of 25 by 1972 in a period of about 10 years. We are still to attain that level of fertility. This again highlights the lack of concern to consider the existing conditions in shaping the policy. The socio-economic, cultural and political conditions in the country could not support the undue emphasis given to the sterilization programme and it collapsed after the emergency period in 1975-77. The programme got a severe set back. The much needed political commitment which was beginning to emerge before the emergency got demolished, and the programme has still not regained the loss. It needs to be mentioned that the first policy document appeared in 1976 and it had a number of features to strengthen the programme. For example, representation in Parliament from each state used to be decided on the basis of their population. There was an implicit political incentive for the state government in increasing its relative size (Srinivasan, 1988). A measure was taken in the policy to freeze the representation on the basis of 1971 population. Also, the

population control programme was placed on "concurrent list" in 1976, giving the central government more leverage in formulating the policy (Pai Panandikar and Umashankar, 1994).

The sterilization syndrome continued even after the emergency period but at a different plane. Although care was taken to transform it to a welfare programme, it largely remained in the content of the policy and did not get translated in the process of implementation. The emphasis gradually shifted towards achieving targets particularly the sterilization target. Neither any sincere effort was made to create the demand nor was the focus on maternal and child health services. Along with a variety of strategies to give incentives to acceptors, motivations and programme administrators, the performance, particularly of sterilization occupied the central place. The over-estimation of contraceptive prevalence concentrated on older and ineligible couples became apparent. In the pre-emergency period, we had rumours that young and unmarried males were also brought under the programme. Now it was that older couples or both husband and wife who were undergoing sterilization. During much of the 1980s, fertility level in the country stagnated, though the official statistics suggested a steady increase in the contraceptive prevalence rate. It is true that population momentum was such that it tended to increase fertility, but the programme did no help much to reverse the trend.

The national health policy was introduced in 1983. It emphasised the long-term objective of attaining the replacement level fertility by the year 2000 (now shifted to 2016), but such long-term goals were translated into short-term goals and the programme was monitored accordingly. In fact, the quantitative targets were obtained at the sub-centre level and distributed to each worker. The method of calculation of targets at the micro level was far from satisfactory. A huge information system was introduced which was largely suited for checking achievements against the targets. In effect, the programme suffered because of undue emphasis on achieving quantitative targets on proximate measures to assess the programme impact rather than to understand and monitor the process, which leads to acceptance. Targets became an end in itself rather than serving as a means to achieve the end (Bose, 1987). The quality of care and services suffered as a result of the emphasis on achieving the targets.

The second all India Survey conducted in 1980 by ORG revealed that 89 percent of the interviewed couples were not given any home visit by the health or family planning workers. The message given by the workers in cases where they did visit was to mainly persuade couples to adopt sterilization and inform them about the availability of incentives for accepting sterilization (Operations Research Group, 1983). A recent study on the quality of services and care in four states showed that the home visits by workers

can be crucial in influencing the utilization of family welfare services (Verma, et. al., 1995). The National Family Health Survey (NFHS) conducted in 1992-93 suggested that the follow-up home visits provided by the programme were far from satisfactory. Only 30 percent of the sterilization users reported to have received the follow-up care and it was much less (15 percent) in case for IUD and the pill users (IIPS, 1995). The NFHS revealed that sterilization is the mainstay of the programme accounting for more than three-fourths of the contraceptive use in the country. The emphasis on sterilization can also be understood from the fact that, though the knowledge of any method of family planning (i.e., sterilization) was almost universal, the knowledge of spacing methods was not wide spread. In Madhya Pradesh, Rajasthan and Bihar, 43, and 32 percent of currently married women respectively did not know about any of the modem spacing methods (IIPS, 1995). The study on quality of services and care also suggested that the decision about the method choice was largely made by the service providers. This was stated not only by the majority of the clients but also by the service providers themselves (Roy and Verma, 1995).

In India, the programme is fully funded by the central government but the responsibility of implementing it lies with the state governments. The priorities of the state governments are different. The wide spread variation in the performance of the programme is caused, in addition to the socio-cultural conditions, by the level of commitments shown by political leaders and the programme managers of the state towards the programme. A careful analysis or NFHS reveals that, better the maternal and child health care component of the programme in a state higher was its performance in family planning. For example, antenatal coverage was much less 31, 37 and 44 percent of births in Rajasthan, Bihar and Uttar Pradesh respectively where the contraceptive prevalence was below the national average. Another study based on NFHS data suggested that the contraceptive behaviour was more favourable among mothers who received antenatal care compared to those who did not receive it (Mishra, et al., 1996).

Lapham and Mauldin (1985) measured family planning programme efforts in different countries. According to them the strength of the programme in India was moderate when measured in a four-point scale as strong, moderate, weak and very weak. Their assessment was based on information collected from senior family planning programme personnel and observers from the concerned countries. However, this, appears to be an over-estimation. The family welfare programme in India has been quite weak, particularly so in the four larger states of Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan. The reasons for this have already been indicated. Very little effort has been made to create the demand. According to NFHS, only a very small proportion of the women, in these four states, favour a small family size norm of having two children. The excessive emphasis on achieving targets with the focus on the

terminal method of family planning led to an unfortunate neglect of paying adequate attention to providing better quality care and services. As a result, instead of it becoming a people's programme, people got alienated from it. Although a national consensus existed in terms of the need for arresting the growth of population, there is no consensus about the policy as it has developed over the years, so much so that the political commitment has also waned. The socio-economic development programme in the country too was not of much help.

In the recent period a change in the emphasis of the programme is noticeable. There is a definite concern to strengthen the child survival and safe motherhood programme. The International Conference on Population and Development (ICPD) in Cairo held in 1994 further strengthened the focus on social policies and reproductive health services with a stress on quality. As a first step, the earlier approach and emphasis on targets has been given up, and greater stress is now given to promoting spacing methods. There is an urgent need to work in these directions, the quality aspect should be given utmost importance and the educational component of the programme needs to be revamped. This is the way the programme can become a people's programme and hence can pave the way for generating a national consensus and acquire necessary political will to make it a success.

There is a genuine concern as to whether such a shift in the programme would slow down the fertility decline. Even if this happens, it is likely to be a temporary phenomenon. If the programme is pursued properly, the gains will far outweigh such a loss. It is true that without targets the programme may become aimless. But the targets, as it was pursued, did more harms than good. If the targets can be set at the local level, instead of the top down approach, as is being proposed, it might work. A suggestion is also made in the draft national population policy that each Panchayat and Nagarpalika will prepare a "socio-demographic charter" for their area and "will pay particular attention to achieving a balance between human population and land and water resources" (Expert Group, 1994). All these plans are laudable provided they can be implemented effectively. In the meantime, targets in terms of performance of maternal and child health care services or that reflecting quality of care can be introduced. For example, the targets can be set in terms of percent of mothers receiving antenatal care. The work of auxiliary nurse midwives can be supervised to the extent to which they give home visits and follow-up care.

During this period of transition, it would be better to focus attention on the adolescent fertility. The adolescent fertility in the country is substantially high. Curtailment of this fertility can ensure that the fertility continues to decline. More importantly, such a reduction will lead to substantial improvements in maternal and child health. The

educational component of the programme should effectively propagate the message that childbirth at early ages (below 20) can endanger the lives of both the child and the mother. This can be achieved either by delaying marriage or postponement of first birth. This is in line with the holistic approach emphasised in the ICPD's agenda, and it can be advantageous in many ways (Roy and Nangia, 1997). If the postponement of marriage of young daughters becomes difficult due to cultural reasons, the postponement of first birth by 3-4 years with the use of suitable methods should not pose problems. After all it involves the health of the mother and the child, and therefore the value attached to prove fertility soon after marriage can be changed. The communication revolution that we are witnessing can be used effectively to make it a success. It can lead to a reduction in maternal and child morbidity and mortality. Postponement of first birth will mean women will have greater opportunity to continue with their education and experience in skill formation. Postponement of birth at the initial stage of reproductive life will ensure a favorable attitude towards the small family norm. Last and not least it will have both direct and indirect effect in reducing the level of fertility. The indirect effect will accrue through reduction in infant and child mortality.

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