

# CHAPTER 1

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## Introduction

### 1.1 POPULATION ISSUES

In the 18<sup>th</sup> century, among moral philosophers of Europe, Montesquieu was one of the most influential writers on the population. His work *Letters Persanes* published in 1721, made a profound impact on population. In his view, the French nation was degenerated and the population, therefore declining. He attributed the decline to influence of the Catholic Church on the one hand; and the oppressive economic policies- in particular agricultural taxation of the aristocracy on the other. He called for thoroughgoing economic reforms to halt the decline of population and argued that a government must be concerned with increasing the population through the provision of employment (Tomaselli, 1998).

The ideas of Jean-Jacques Rousseau on the question of population were also distinctly pro-nationalist. In *Du Control Social*, published in 1772, he wrote:

What is the end of political association? The preservation and prosperity of its member.

And what is the surest mark of their preservation and prosperity? Their number and population...

The rest being equal, the government under which, without external aids, without naturalization or colonies, the citizens increase and multiply most is beyond question the best (Rousseau, 1772).

Steuart (1767) also gave importance of employment to population that full employment and industriousness were both essential. He emphasized on modern society where it was on the basis of the complex division of labour and the consequent exchange of goods and services that the wealth of a nation was built.

The most striking is that all the thinkers share population is regarded as the effects of changes in a complex web of inter-acting socio-economic factors and also the perception of desirability of large populations which are associated with plenty, equality and liberty. The perception of the population had shifted by the late 18<sup>th</sup> century due to enormously complex and is to be sought in the socio-economic milieu.

The study of population is incomplete without referring to ideology of Thomas Malthus, the British clergy man-turned-economist who wrote in the late 1700s and early 1800s. Malthus in his historic work *An Essay on the Principle of Population* set two basic propositions. "First, that food is necessary to the existence of man. Secondly, that the passion between sexes is necessary and will remain nearly in its present states". He also mentions that there is direct relationship between standard of living and child bearing; and law of diminishing returns operates in agriculture.

On these theories, he based the following factors:

1. Population will increase in geometric progression since passion between sexes is inevitable.
2. Food production will have a tendency to increase in arithmetic progression because of the application of the Law of Diminishing returns in agriculture.

3. Since population cannot increase beyond the means of subsistence when population growth outstrips food supply 'positive checks' will be applied from Nature.
4. If one wants to avoid the application of 'positive checks': 'preventive checks' like late marriage; moral restraint, celibacy, etc will be necessary.

Malthus stated that unless restrained by 'preventive checks' human populations would double every twenty-five years. The result would be geometric growth. According to Hartmann, she argued that Malthus was wrong because it is possible for population growth to slow and ultimately to stabilize, not because our members are held in check by 'natural' forces of famine and pestilence, but rather as a result of improvements in living standards and other social changes which alter the need for many children. She further argued that there are too many people and too few resources, but rather that too few people monopolize too many resources. The problem is not one of the absolute scarcity, but one of distribution. It's also addressing that Malthusianism diverts attention and resources away from addressing the real cause of poverty, hence of high birth rates.

In the late 19<sup>th</sup> century, there was a witness of a new scene namely, neo-Malthusianism which came equipped with contraceptive technology. Eugenists and birth controllers were the main motive behind the neo-Malthusianism.

Charles Darwin's *The Descent of Man* published in 1871 provided a significant measure of inspiration to the birth of the Eugenics Movement (Greer, 1984). Francis Galton, a cousin of Darwin named Eugenic Movement where racial purity and

improvement of the racial stock were the prime concerns. He pioneered the use of statistics on human populations. Eugenics had two sets of action on its agenda: the positive eugenics of Galton and the negative eugenics of Clapperton (Hume. 1885). The positive eugenic was firmly committed to the idea that the brightest and best should be encouraged to breed whereas negative eugenics received the attention of criminals, the mentally retarded, the insane, the tuberculous, lepers, alcoholics, epileptic, the feeble minded, the degenerate, immigrants and of course the poor who apparently bred all these characteristics (Rao, 1994). The eugenicist continues to exert a powerful attraction and started introduction of hormonal implant contraceptives in the US. Women on welfare, with either a criminal record or a record of 'child neglect' must have Norplant implanted in order to be eligible for welfare. Thus the vast majority are blacks or Hispanics (Srinivas et al., 1992).

Later the birth control movement came in with various streams of thought. One stream was the radical feminist, they believed strongly that it was women's right to control their own destinies, their own bodies. The second stream was the socialist. Their ideas on birth control were coloured by the feeling that the burden of repeated pregnancies was harmful to the health of working women; and, by the belief that it was in the interests of capitalists and not their own to have an unlimited supply of cheap labour (Gordan, 1976). The third stream was the neo-Malthusian. In terms of methodology, neo-Malthusianism and Malthusianism are not distinct. The main argument of neo-Malthusianism is that population growth eats into resources which are finite. In its statement shows that social problems of poverty and hunger are then attributed to that part of the population which is said to grow the fastest. It is argued that the rich nations of the globe constituting 18 percent of the population consume 66

percent of the gross world product, whereas the poorer nations of the globe with 50 percent of the world's population consume 14 percent of the gross world product (Bondestam, 1980). It is also seen that the early neo-Malthusians supported birth control as a means of improving the condition of the poor by limiting population growth: feminists and socialists believed it was a fundamental women's right; eugenicists embraced it as a way of influencing genetic quality. These combined work made to give the birth control movement a unique character.

Hartmann argued that Malthusianism has intimately and negatively affected the experience of millions of women with birth control. Married to population control, family planning has been divorced from concern of women's health and well being that inspired the first feminist crusaders for birth control. In the third world of health *and family planning programmes, contraceptive acceptance is their target because they themselves are caught in a system where sensitivity to meeting women's needs goes unrecorded but population control targets* (Hartmann, 1995). It is also seen that in many Third World countries the economic subordination of women is directly linked to high birth rates, since it both increases their need for children and impedes their ability to practice birth control. In India, the first family planning clinic was opened in 1925 by Karve who later went on to assist the formulation of official policy as a member of National Sub Committee on Population. The Indian chapter of the neo-Malthusian League was inaugurated in Madras in 1928 (Bosh et al., 1983). Later in the 40s and 50s population control became a respectable position which led for major shifts in the perspective in the discipline of demography.

Peter (1993) defined demography is the study of statistical methods of human population involving primarily the measurement of the size, growth, dimension of the numbers of the people, the proportion of living beings born dying with the same area or religion or the related fundamentals of fertility, mortality a marriage.

### **Theory of Demographic transition.**

This is based on the industrialized countries of the West. According to this theory the country passes through three stages.

- **First Stage-** The country generally happens to the backward and an underdeveloped country, primarily depending on an agrarian economy with little or no industries. This kind of economy is characterized by a high fertility rate and high mortality rate. Thus the population is more or less stable as both the fertility and mortality rates are high.
- **Second Stage-** As a result of economic growth, there is an appreciable decrease in the death rate. Due to the widespread availability of hospitals, medicines and universal vaccinations. Thus while the death rate declines; the birth rate continues to be high. Thus the population suddenly becomes very high as the death rate falls. This is the stage of Population Explosion.
- **Third Stage-** People have become more enlightened and begin to understand the implications of smaller families. The spread of female education further results in a change of attitude of women for unwanted maternity. Thus due to a fall in the fertility and mortality rate, population in these countries have to be sterilized.

Demographers observed that the extent of western fertility decline had not been related to advances in contraceptive technology. They had concluded therefore that fertility declined when the motivation to have children changed and was not strictly related to the ability to control fertility. Thus this demographic transition theory held that shifting in a large number of socio-economic variables, rising standards of living, the health revolution together brought the decline of death rates followed after a gap by a decline of birth rates. This leads to shift from **birth control to family planning**. After the World War II the social planning to the United States gave more directly in the provision of social services to the poor. The solution of the impoverishment of middle class people during the Depression made it difficult to blame poverty on genetic inferiority but bringing a social reform through welfare programs, which could improve the position of the individual.

The perceptions of demographic issues began to change during the postwar period in the United States. Emerging from World War II as the major power, the United States had a growing need for access to Third world raw materials in order to assure a steady supply for the country's industries. At the same time in the Third World, population growth rates were on the rise. The success of the Chinese Revolution, Indian and Indonesian nonalignment, independence movements in Africa, economic nationalism in Latin America-all these contributed to growing U.S fears of the Third World. Population growth, rather than centuries of colonial domination, was believed to fuel the nationalist fires, especially given the increasing proportion of Youth. Although government reports touched on these perils of overpopulation, private organizations and foundations were the main force behind the postwar population control boom (Hartmann, 1995:102).



In the 1940s the publications of the Planned Parenthood Federation began to emphasize the problem of overpopulation. Later in 1948, the International Planned Parenthood Federation (IPPF) was formed. In 1952, John D. Rockefeller III invited thirty prominent U.S. conservationists, Planned Parenthood leaders, demographers, and development experts to a population conference in Williamsburg, Virginia. At the conference the Population Council was born. By 1955, the Council was advising the government of India on setting up a family planning program, and in 1959 another technical assistance mission went to Pakistan, which at that time included East Bengal. But in India, in 1949 the Family Planning Committee was formed in Bombay with Lady Rama Rao as president. In 1951, it was renamed the Family Planning Association of India (FPAI).

The population establishment is by no means a monolith- it is made up of a wide range of organizations and individuals, pursuing different and sometimes conflicting activities and goals, some more attuned to women's rights than others. U.S. government is the largest single donor; it's contributing almost half of international population assistance. The major agencies like the U.S. Agency for International Development (AID), U.N. Fund for Population Activities (UNFPA), The World Bank, the International Planned Parenthood Federation, the Population Council, Private Agencies etc provide assistance of 3 billion to the Third World Countries for curbing the Population.

The World Fertility Survey (1980), conducted in twenty-seven developing countries, found that almost half the married women questioned wanted no more children, and that younger women especially tended to desire a smaller family size. In general, the *number of women who wanted no more children exceeded the number of those using*

contraception, and this was interpreted as indicating a large unmet need for birth control. The practice of population control is not limited to the Third World. In the U.S poor black, Native American and Hispanic women have been forcibly sterilized in federal Programme, in England, immigrants have been given Depo-Provera without their consent (Hartmann, 1995:50).

Family planning is a generic term, encompassing all types of birth control programme. It is designed to improve health and to expand women's control over reproduction but the notion is reduce birth rate as fast as possible. The population control programs impose birth control on women from above. It gives waste of resources because the Programme often limit choice of contraceptive method; fail to give adequate information and counseling; neglect screening, follow-up and the overall health of the woman; ignore the sexual politics of reproduction and are insensitive to local culture. Out of these interventions has grown a whole imported science of family planning in the Third World based on several key assumptions. Many programs are based on elitist assumptions, which are reflected in the inappropriate nature. In India, Indonesia, the main motto of the Family Planning Programme is that with two children, "we are happy & prosperous family" a common refrain in many other countries as well. But for a peasant without land or employment opportunities, limiting fertility hardly brings prosperity or happiness. Moreover women are always kept as subdued. Although women often want to limit or space birth, many want more than two children, especially in situations of high infant & child mortality. It usually does not include the needs of women outside of marital unions or of adolescents and fails to address a whole or more comprehensive reproductive health care.

Feminist criticism of fertility control policies had been maturing throughout the 1970s and at the 1975 International Women's Year Conference in Mexico women denounced coercive practices in contraceptive research and services (such as forced sterilization and incentives for contraceptive acceptors) as human right abuses. Women's activities were instrumental in ensuring that the 1975 Women's Conference grounded its assertion of the right to reproductive choice on a notion of bodily integrity and control.

In the UN Decade, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) was ratified in 1979. CEDAW was a more victory in the battle to secure women's equality with men, including the right to bodily integrity. However, CEDAW fails to specify a number of women's reproductive rights, except to affirm women's rights to family planning information, counseling and services and to have equal rights with men to decide on the number and spacing of their children.

In 1974, at the World Population Conference in Bucharest, U. N. Secretary Kurt Waldheim warned that "the problem posed by world population not only constitutes a danger, but the world's population is in danger". It was written in the draft World Population Plan of Action where the draft set out specific targets for world population "stabilization" and concentrated on population growth as the main obstacle to social and economic development. There were oppositions came from many Third World countries – India argued that "development is the best contraceptive" and criticized the high consumption of resources in the West. Feminists, demographers, and representatives of voluntary agencies also added their voices to the critique of population control (Hartmann, 1995: 109).

In July 1984, just before the Second World Population Conference took place in Mexico City, a large number of the world's women's health activities attended the first global conference convened by ICASC (International Campaign on Abortion, Sterilization and Contraception)<sup>1</sup> in Amsterdam. The conference cited the birth event of the International Reproductive Health and Rights Movement bringing together individuals representing initiatives throughout the world. On the occasion the Campaign changed its name to Women's Global Network for Reproductive Rights (WGNRR), under pressure from Southern activists who felt that the explicit reference to reproductive rights would more appropriately encompass Southern women's health agenda.

Even after almost ten years of debate, not all of Southern women's concerns have been integrated by the mainstream reproductive health analysis. The mainstream's initial adoption of reproductive health discourse has largely maintained a biomedical bias and restricted women's social roles to their biological reproductive function, especially by emphasizing maternal-child health and family planning programmes. While Southern women affirmed the critical importance of dimensions like adequate health services, gender system in the family, they called for an approach integrating the micro-dimensions with larger issues such the transformation of state social, demographic and economic development policies to incorporate women's social and economic rights (Corea et al., 1994).

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<sup>1</sup> ICASC ( International Campaign on Abortion, Sterilization and Contraception) founded in Europe in 1978 to counter pro-nationalist and anti-nationalist movements where they define reproductive rights- women's right to decide where, when and how to have children- regardless of nationality, class, race, age, religion, disability, sexuality or marital status.

## **1.2 RCH AT GLOBAL LEVEL**

UNFPA began to create in Mexico City pushed full steam ahead toward Cairo, scene of the 1994 U.N. International Conference on Population and Development (ICPD), and beyond. It is considered so pervasive and all-encompassing that only so-called extremist would opt to stay out. As the result of feminist pressure, the Consensus had broadened to incorporate many women's health and empowerment concerns.

In preparation for the ICPD, women have engaged their country representatives in dialogue at local, regional and international levels resulting in an ICPD document that by the time of the April 1994 session of the preparatory committee incorporated most of women's concerns.

Recognizing the basic reality that the issues go far beyond the simple question of contraception to involve power relationships at almost every social level, from the family on unto the national government, many feminist defined reproductive rights much more broadly. It includes:

- The right to economic security through the opportunity to earn equal pay for equal work, so that women can adequately care for themselves and their families.
- The right to a safe workplace and environment for all, so that women are not exposed to hazards that threaten their ability to bear healthy children, to forced to choose between sterilization and jobs.
- The right to equality of child care, so that women can enter the work force secure in the knowledge that their children will be looked after.

- The right to abortion free and informed contraceptive choice, and other forms of reproductive health care.
- The right to sex education, so that women and men of all ages are better able to understand and control their own bodies.
- The right to descent medical care, necessary not only to ensure contraceptive safety, but a basic human right.
- The right to choose how to give birth, and to have control over the development and use of new reproductive technologies.
- The right of lesbian women and women with disabilities to be mothers.
- The participation of man as equal partners in childbearing, housework, and birth control, so women no longer have to shoulder the “double burden”.
- The right to be free of all forms of violence.
- An end to discrimination so that all people – regardless of race, sex, or class- can lead productive lives, and exercise real control over their own reproduction (Hartmann, 1995:55).

Although the term “reproductive health” has been used since many years, its widespread acceptance came in 1994 with the adoption by 178 countries of the Programme of action of the ICPD held in Cairo, Egypt from 5-13 September. ICPD was a United Nations Conference, organized principally by the United Nations Population Fund (UNFPA) and the population Division of the UN department for Economic and Social Information and Policy Analysis. The Programme of Action (PoA) of the International conference on Population and Development clearly spelt out that human beings have to be the center of concern for population and development. It further clarified that advancing gender equality and equity and the

empowerment of women, elimination of all kinds of violence against women, and ensuring women's ability to control their fertility is the cornerstone of population and development-related programmes. The ICPD (PoA) urges governments to increase the ambit of population and development programmes to include concerns of the girl child, the adolescent, the elderly, to involve men, to focus on the special needs of indigenous people, migrants and displaced persons in addition to regular Sexual and Reproductive Health and Rights programmes.

### **1.3 RCH AT THIRD WORLD COUNTRY**

The ICPD was the turning point in policy-making on women's health and development particularly in the South Asia. At the ICPD, the issue of decriminalizing abortion and respecting women's reproductive rights received great media attention. In the south for many feminists development was the agenda for the issues of social, economic and political rights of women. The development demanded by these women of the south rejected the western paradigm of economic growth; instead, it was based on sustainable, equity-oriented model. These southern women's concept of development ensures meeting the basic needs of all the better living standards of the disadvantaged populations specially women.

Qadeer (2002) argued that unfortunately, there has been a worsening of disparities in many countries. The World Health Report (1995), Bridging the Gap, talks about worsening disparities both between and within countries. According to WHO (1995), women represent 70 percent of the 1.3 billion people who live in poverty worldwide, and therefore bear a greater burden of general health and reproductive illnesses. While the international conferences and instruments have drawn attention to equity

issues and more specifically, gender issues, international agencies like WHO and the World Bank have continued to develop their policies and programmes only on population control without ensuring that suit the needs of women in the developing countries.

By WHO definition of reproductive health, it is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It was argued in line with the above definition that reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It is thus seen that reproductive health issues were suddenly elevated to center stage by the media and by international agencies when the ICPD Programme of Action focused centrally on these issues. It can also be said that the demand for reproductive rights and health did not originate in Cairo, and that it is not an original idea formulated by population control agencies or international agencies that have supported them.

In the Cairo ICPD 1994, reproductive health approach means that:

- People have the ability to reproduce and regulate their fertility;
- Women are able to go through pregnancy and child birth safety;
- The outcome of pregnancy is successful in terms of maternal and infant survival and well being;



- Couples are able to have sexual relations free of fear of pregnancy and of contracting disease (Fathallah, 1988).

The women's movements' definition of reproductive rights has evolved over the years, and is now generally understood as the right of women to:

- regulate their own fertility safely and effectively, by conceiving when desired, terminating unwanted pregnancies, and carrying wanted pregnancies to term;
- bear and raise healthy children;
- remain free of disease, disability, fear, pain or death associated with reproduction (and the reproductive system) and sexuality (Ravindran et al., 1998).

Reproductive health is a part of women reproductive rights, thus reproductive health is similarly, a women's empowerment and 'gender equity' issue. Reproductive health concerns of women elsewhere (especially in India) are a product of the social milieu and need more than medical solutions.

The Fourth World Conference on Women, held in Beijing in 1995, reaffirmed this concept while advancing the idea of women's fundamental human right to reproductive and sexual health as being of central importance to people's well-being. The Beijing conference was most specific in stipulating that for women this means having the right to refuse unwanted sex, and to be protected from abuses such as rape, battery and genital mutilation.

Unfortunately in the Third world country like Indonesia, Malaysia, Thailand and the Philippines there was crisis in challenging to the implementation of the ICPD Programme of Action. The crisis has exacerbated the harsh realities of women's lives and made the attainment of gender equality and equity a more distant goal. Greater emphasis is being placed on the need to help the poor and less emphasis on the fact that some of the poorest and most disadvantaged members of society are women. The rising incidence of poverty, which has increased the pressures on women in all four countries to support families by whatever means necessary, leads more of them to commercial sex. Throughout the 1990s the senior health and family planning officials have been distracted from the task of implementing programmes to concentrate to the protection of budgets and the invention of strategies to ensure continuation of core activities. Reproductive health competes with a huge range of other Government Programmes for attention and funds. Many of the vital projects proposed by clinicians and project managers, including maternal health activities, seem less important than response to warnings of impending hunger, rising rates of poverty, widespread unemployment and various kinds of social disruption (UNFPA, 1998).

Likewise in India, there are targets in the Family Planning Programme for decades and that have been a major obsession. Consequently, policy makers and planners in India have consistently treated the country's population 'problem' as its favourite 'whipping boy'.

#### **1.4 RCH WITHIN INDIA**

According to census reports, the population of the country within its present geographical boundaries actually declined between 1911 and 1921, from 252.1 to

251.3 million because of the high mortality inflicted by the influenza pandemic of 1918-19. It is estimated that about 5 percent of the country's population - some 13 million persons - died in that epidemic. The population has increased steadily since 1921, largely because of epidemic and famine control measures undertaken simultaneously with sanitation programmes by the provincial governments. Hence 1921 is considered as the demographic divide in India. India's population increased slightly by more than 10 percent (or by 27.7 million) in a decade, with the 1931 census enumerating a population of 279.0 million (Hutton, 1932:1-32)). In this context there was concern of rapid rise in population from four groups: intellectuals-echoing the neo-Malthusian concerns frequently publicized in England and Europe, social reformers, especially those interested in improving the status of women, the Congress Party (the leading political party that spearheaded the movement for political independence) and the provincial governments in some provinces. Neo-Malthusian leagues were set up in Madras and Mumbai in the 'thirties and there were heated debates among intellectuals as how to deal with the continuing rise of population in the country. In 1943, the National Planning Committee of the Indian National Congress set up the Sokhe committee, a sub-committee on health. This committee realized the importance of a centralized authority to provide services for mothers and children, the need for a national level minimum infrastructure and the need for training paramedical workers and traditional *dias* to provide natal, antenatal and post-natal services. These in fact, became the basis for a Maternity and Child Health (MCH) focus within India's general health services (Qadeer, 2002). However the trigger for specific policy and action at the national level came after the Bengal Famine in which 1.5 million people succumbed during 1943-1944. The report of the Bengal Famine Inquiry Committee constituted by the Government of India which

submitted its report in 1945 contained a chapter on the potential dangers to the economy and life of people arising out of rapid population growth, especially a population living in abject poverty and deprived of the bare necessities of life. Similarly, the Health Survey and Development Committee popularly called, the Bhole Committee, which was set up in 1943 to make an assessment of the health conditions in India submitted its report in 1946 and recommended a suitable health infrastructure for the country. It also stressed the need for a national programme of family planning for improving the health status of population. The reports of these two committees, the Bengal Famine Enquiry Committee and the Bhole Committee, one for sheer survival and the other for an improvement on the health of the population, paved the way for the Government of India to adopt a National Programme of Family Planning after attaining its political independence in 1947 (Srinivasan, 2006).

#### **1.4 (i) Issues related to Population and Reproductive Health in India.**

Looking at the formulated Policies and Programmes (1947-2005), the population policies and the national programmes of family planning implemented after independence went through a number of changes: can conveniently be classified into seven phases as follows:

1. Clinical Approach (1951-61);
2. Extension Education Approach low intensity HITTS model (1962-69);
3. High intensity HITTS Approach (1969-75);
4. Coercive approach (1976-77);
5. Recoil and recovery Phase (1977-94);
6. Reproductive and Child Health Approach (since 1995) and
7. National Rural Health Mission 2005

A detailed description of these seven phases and its problems faced and achievements are given below (Srinivasan, 1995).

### **1. *Clinical Approach: 1951- 61***

India is the first country, which adopted family planning in the world. Government of India appointed a Population Policy Committee upon its recommendations under the Chairmanship of Minister of Health in April 1950. A Family Planning Cell was created in the office of the Director General of Health Services. The first Five Year Plan document presented to Parliament in December 1952, referred to a programme for Family Limitation and Population Control, terms that sought to reduce the birth rates to stabilize the population at a level consistent with the requirements of the national economy. The initial approach adopted by the Government was a *clinic approach* that included the activities such as motivation, education, research and clinical services. A number of family planning clinics were opened throughout the country assuming that there was already a strong desire to space and limit family size among the couples. Thus contraceptive services such as condoms, diaphragm and jelly, and vasectomy for men were offered in a clinic setting. The clinic approach was extended during the second plan period, 1956-61, increasing the number of clinics from 147 to 4165 (Srinivasan, 2006).

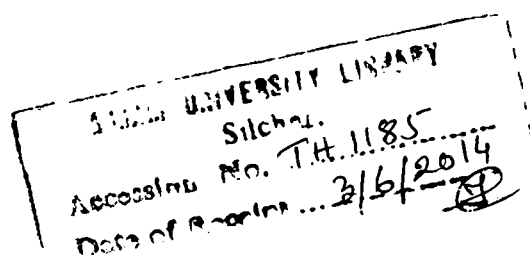
Looking at India of the plan outlay in Health and Family Welfare since the first plan. In the first and second plans period, the allocation were respectively only 3.33 percent and 3.01percent of the total outlays (shown in the Table: 1.1 below) much less than the irreducible minimum of 10 percent as recommended by Bhore committee. Though “maternal health was given initially prominence, it soon became secondary to family planning, which was perceived as an urgent national need.

Table: 1.1 Plan Outlay in Health and Family Welfare since the First Plan

Period		Percentage of Total Outlay	
		Health	Family Welfare
First plan	1951-56	3.33	0.01
Second plan	1956-1961	3.01	0.05
Third plan	1961-1966	2.63	0.29
Annual plans	1966-1969	2.12	1.06
Fourth plan	1969-1974	2.13	1.80
Fifth plan	1974-1979	1.73	1.26
Annual plan	1979-1980	2.30	1.00
Sixth plan	1980-1985	1.87	1.04
Seventh plan	1985-1990	1.88	1.81
Annual plan	1990-91&1991-92	1.64	1.32
Eight plan	1992-1997	1.75	1.50
Ninth plan	1997-2002	2.31	1.76

Source: 1. Planning Commission, Department of Family Welfare, Ninth Five year Plan, 1997-2002, Vol. II pp.246.

2. Government of India, 1999.



## *2. Extension Education Approach: Low Intensity HITTS Approach- 1962-69*

In 1961 census, it showed a continued rise in the population growth rate and an increase in the fertility levels. As a reaction, for the first time in the country, *a demographic goal was set* in 1962, to reach a crude birth of 25 by 1972. Since then reduction in fertility levels was the sole objective of the Indian population policy until the early eighties (Srinivasan, 2006). Thus in Third plan, the outlay in health allocation had decreased to 2.63 percent where Family Planning Programme received a great deal of emphasis by increasing 0.29 percent. The official acceptance of this policy came through the Mukherjee Committee Report (Government of India, 1966), which also recommended specific targets and incentives. Incentives were offered to vasectomy acceptors and to women who were accepting IUD insertions and the clinic approach was replaced by extension approach in which the family planning workers were asked to make house to house visits to motivate couples to accept family planning methods; targets on the number of contraceptive acceptors to be recruited were fixed to the workers.

The UN advisory Mission (1966) recommended the de-linking of Mother and Child Programme (MCH) from family planning programme. In 1967, however, because of the close linkage between MCH and family planning, it was decided to integrate MCH with family planning. During this third Plan period the Mudaliar Committee recommended that expansion of services be stopped and the existing primary health centers be consolidated. There was also an attempt to integrate the services for family planning, control of communicable diseases and Mother and Child Programme (MCH) at the Primary Health Care centers level, which did not succeed fully and, in the process, MCH was ignored due to overemphasis on and target-oriented approach of family planning.

A separate department of family planning was set up in the center as Departments of Health and Family Planning that was fully funded from the central funds. The programme became entrenched in a *HITTS* model: i.e., Health department operated, Incentive based, Target-oriented, Time-bound and Sterilization-focused programme.

### *3. HITTS Approach: High Intensity: (1969-76)*

The HITTS approach was not as successful as it was expected to be. It was considered that retarding the economic development of the country was mainly because of high growth population. Hence the major thrust was on vasectomy through the 'camp Approach' which received financial support from a host of International aid agencies (Government of India, 1969). The involvement of officials from revenue and police departments added a touch of coercion and even compulsion in the programme. In this fourth plan period, the budget allocation for health further decreased with 2.13 percent while for Family Planning Programme (FPP) increased phenomenally by getting 1.80 percent. Thus MCH had been successfully overshadowed by FPP. During this period there was a scheme proposed to strengthen MCH services that was the Integrated Child Development Scheme (ICDS), where mothers were also targeted for nutrition and education.

### *4. Coercive Approach: The Emergency Period, (1975-77)*

In the fifth plan, it was made an effort to integrate FPP, MCH and Nutrition services through ICDS (Government of India, 1974). The primary objective is to provide minimum public facilities integrated with family planning and nutrition for vulnerable groups. The Minimum needs programme was also launched. But the entire situation was changed after the spread of Emergency, which called for a direct attack on the



population problem. India went through a phase of national internal emergency under the Prime Ministership of Mrs. Indira Gandhi during June 75 - March 77 where the powers of the judiciary curtailed with the government at the center assuming enormous authoritarian powers over the individuals and the state governments. For the first time, a National Population Policy was formulated and adopted by the Parliament (April 76) which called for a 'frontal attack on the problems of population' and which inspired the state governments to 'pass suitable legislation to make family planning compulsory for citizens' and to stop child bearing after three children, if the 'state so desires'. Various coercive tactics were used to control the fertility levels, mainly through increased number of vasectomies. The number of sterilizations done in India during April 1976 to March 1977 was 8.26 million, more than the total number done in the previous five years (Srinivasan, 2006). This led to political turmoil and changed the government in 1977.

#### ***5. Recoil and Recovery Phase: Post-Emergency period (1977-94)***

There was a tremendous backlash on the family planning programme, especially its insistence on targets for vasectomy. The new government changed the name of 'Family Planning' to 'Family Welfare', and made FPP a voluntary programme, an integral part of a comprehensive policy covering motivation, education, health, MCH and nutrition.. A revised Population Policy adopted in 1977 that was totally against compulsory sterilization and made the approach educational and wholly voluntary. The policy was made freedom of choice of contraceptive methods to be used by couples. The new government enacted into law of the policy of raising the minimum age at marriage of 18 for girls and 21 for boys which came into operation in October 1978. The period after 1977 can be considered to be a *Recoil and Recovery* phase for

the family planning programme where it helped to restore the family planning programme garbed as Family Welfare programme. During the revised sixth Five Year Plan, 1980-85, a Working Group of Population Policy was set up by the Planning Commission to formulate long-term policy goals and programme targets for Family Welfare programmes. The Sixth plan proposed to bring down the infant and maternal mortality through extension programmes such as the Extended Programme for Immunization, Anemia Prophylaxis, Supplementary Feeding and ICDS. With greater assistance from the international organizations, especially the UNICEF and the WHO, Universal Immunization Programmes (UIP) and Expanded Program of Immunizations (EIP) were launched in a systematic manner covering all the districts of the country in a phased manner. During this period the medical care was opened to the non-governmental sector including the private sector (Government of India, 1981).

In the Seventh plan, the investment in a more integrated welfare strategy was lost and resource investment in FP started increasing. During this period AIDS emerged as a new public health problem and the National AIDS Control Programme was launched in 1986 with loans from the United States and the World Bank (Government of India, 1985). No specific programmes were proposed for the general health of the women except raising their consciousness about health issues through education and communication programmes.

#### *6. Reproductive and Child Health Approach (Since 1995)*

According to Dr.M.S. Swaminathan Committee Report (which was, submitted in May 1994) contains that gender equity is essential for development and is an integral

component of development itself. Some of the broad goals were set for achieving reductions in selected demographic parameters by the year 2010, such as in the TFR values from the existing level to 2.1, IMR to less than 30, maternal mortality rate to less than 100 per 100,000 live births, negligible incidence of marriage below age 18 for girls, and rapid improvements on a number of other social indicators such as female education, abolition of child labour, and accessible quality primary health care. The Committee recommended some new structures such as setting up a Population and Social Development Commission at the centre with the Prime Minister as Chairman and also similar commissions at the state level; integration of the Department of Family Welfare at the central level with the Department of Health Services and a Population and Social development Fund to direct the flow of funds for population and related programmes. At the same time Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in September 1994, were discussed in the committee and debated. ICPD, 1994 marked the start of a global rhetoric on reproductive well-being. In India, in 1995, the Ministry of Health and Family Welfare introduced the Reproductive and Child Health Programme (RCH) as part of a paradigmatic shift in its on going Family Welfare Programmes (Rachel, 2001). When we look at the definition of 'reproductive health' that addresses the reproductive processes, functions, and systems at all stages of life, and is a condition in which the reproductive goals of individuals can be accomplished in a state of physical, mental and social well-being (Sethi et al., 1996).

CONCEPT	MEANING
Reproductive processes, functions, and system	Addressing the needs that arise regarding, for example, sexual function and dysfunction, menstruation, menopause, reproductive infections and diseases, conception, pregnancy, breastfeeding.
At all stages of life	Addressing the service and information needs of young girls and boys, adolescents, married and unmarried man and women, and older adults.
Reproductive goals of individuals	Addressing the desires of people who may want, for example, to be sexually active, to have children, to postpone births, or to stop having children- all the while ensuring that the choice is the individual's and the couple's.
Accomplished	Addressing reproductive health concerns with the highest quality of care possible, including informed choice in health decisions and a range of available services.
Physical, mental and social well-being	Addressing the full context in which people carry out these functions, including the gender environment, education, employment, and social equity.

The Reproductive and Child Health Programme draws the same principle of the ICPD and defines the reproductive health approach as people having the ability to reproduce and regulate their fertility, women able to go through pregnancy and childbirth safely, and the outcome of pregnancies (being) successful in terms of maternal and child

survival and well-being, and couples able to have sexual relations free of pregnancy and contracting diseases.

There are two separate packages of reproductive health services likely comprehensive (expanded package) and essential package. The main motive for bringing the package approach was to implement the sweeping changes in the health system. Looking at the two packages of reproductive health services which are as follows:

1. Comprehensive package which at present would have limited application and
2. An essential package, which is recommended for nationwide national implementation.

The framework was made to implement in each service component at various levels of the health system. Some can be implemented at Sub center, primary health center, and others may be implemented at higher levels like district/sub district hospital levels. Comprehensive Reproductive health services package, the following are included in a comprehensive reproductive health services package.

- Prevention and management of unwanted pregnancy
- Services to promote safe motherhood
- Services to promote child survival
- Nutritional services for vulnerable groups
- Prevention and treatment of reproductive tract infections and sexually transmitted infections
- Prevention and treatment of gynecological problems
- Screening and treatment of breast cancer
- Reproductive health services for adolescent

- Health, sexuality and gender information, education and counseling.
- Establishment of effective referral systems.

The following are the package of essential reproductive health services:

- Prevention and management of unwanted pregnancy
- Services to promote safe motherhood
- Services to promote child survival
- Nutritional services for vulnerable groups
- Prevention and treatment of reproductive tract infections and sexually transmitted infections.
- Reproductive health services for adolescents
- Health, sexuality and gender information, education and counseling
- Establishment of effective referral systems (Pachauri, 1996).

The Government of India, which was a signatory to ICPD Programme of Action, promptly experimented with the 'target-free' approach but the effectiveness of the approach was not reached up to the expectation. While all the services included in the packages are theoretically included in the national programmes but there have been serious problems with their implementation at various levels of the health delivery system.

It is also seen in the Eight plan that India accepted formally Structural Adjustment Policies prescribed by the International Monetary Fund (IMF) and the World Bank (Government of India, 1992) where there were sharp cuts in investments for welfare, especially in the health sector: privatization of medical care; opening up of the public

sector in health to private investments; and massive cuts on public distribution system. Ultimately the health policy focused on provision of contraceptives, sterilization, safe motherhood and child health services (Government of India, 1992). According to Qadeer (1995), the Eight-plan period saw three other policy documents. The country Statements from India at the ICPD made all the correct political statements and then reverted to calling family Planning a basic need. The draft Population Policy made even more radical proposals such as non-target approach, better inheritance laws for women, integration of health and family planning and MCH services, and gender-sensitive, sustainable and equitable development.

Three policies seem to be in operation in the country that has direct impact on population issues and availability of family planning services. These are the National Population Policy 2000 (NPP, 2000), the National Health Policy (NHP, 2001) and National Rural Health Mission (NRHM, 2005).

In the Ninth plan, there was a paradigm shift by declaring “Empowerment of Women” to be one of its nine primary objectives. “Women’s components Plan was adopted as special strategy to ensure that not less than 30 percent of funds flow to women from other developmental sectors. The National Population Policy 2000 (NPP) focuses on the quality of people’s lives but it is still very much within the demographic framework of bringing down the Total Fertility rate. It also promoted delaying of marriage for girls rather promoting vocational training and occupational opportunities for empowerment. The NPP 2000 relates to the prevention and control of communicable diseases; priority to containment of HIV/AIDS infection; universal immunization of children against all major preventable diseases; and addressing the

unmet needs for reproductive and basic health services. The National Health Policy (NHIP) 2001 also recognizes the role of empowered women in improving the overall health standards of the community and the emphasis is once again the population stabilization to promote health standards.

The Approach paper to the Tenth Five-year Plan (2002-2007) identified some of the deficiencies in social sector achievements. The document defines the major focus of the Family Welfare programme as improved access of families to health care facilities to enable them to achieve reproductive goals. According to Qadeer (1995), it was mentioned that the draft document of tenth five-year plan policy on health does more for the free market rather than for the health of the underprivileged. It is seen that most government programmes have generally ignored the fact that reproduction takes place through sexual relations, which are a part of broader gender relations.

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of the citizens, the Government of India launched the National Rural Health Mission.

#### *7. National Rural Health Mission*

The National Rural Health Mission 2005-2012 (NRHM) is a departure from the earlier policy and plan documents in two aspects. First, it takes the programme in a “Mission Mode” Secondly, it focuses on inputs, strategies and programmes to be done, and leaves the ultimate impact as an outcome of what is done. This is a more realistic approach for the improvement of the health of the people. The Mission adopts an approach by relating health to determinants of good health viz. segments



of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimisation of health manpower, decentralization and district level management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health.

The main aim of NRHM is to provide accessible, affordable, accountable, affective and reliable primary health care, especially to the poor and vulnerable sections of the population. The Goal of the Mission is to “improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children” (NRHM, 2005). Experience has probably taught the planners that it is difficult to set targets on outcome parameters such as fertility rate, infant mortality rate, maternal mortality rate, prevalence rate of different diseases etc. With regard to inputs into the programme the emphasis of the NHRM is different from the NPP and NHP. Unlike the latter two documents that talk about percentage of GDP or percent of total government budget to be spent on public health, the NIHRM talks about actual money to be spent, Rs 6.500 crores during 2005-06 and, if needed to be raised by 30 percent every year (Srinivasan, 2006). Similarly, under inputs it talks of committees to be formed at each level, village, district, state and national levels, and the activities including training and monitoring programmes to be initiated. It also aims at bridging the gap in Rural Health Care through a community liaison person in every village at the rate of 1 for 1000 population called ASHA an acronym for

“Accredited Social Health Activist” similar to the *Anganwadi* Worker but functioning under the control and guidance of the health department.

ASHA will be selected from the young ever married women of a village with at least middle school education and an interest in the community. She will be given needed training in primary health care services focusing on maternal and childcare, will be paid a monthly honorarium and monetary incentives to take care of the pregnant women, for arranging for and caring during institutional delivery. It is refreshing to note that the NRHM is more pragmatic in its approach and emphasizing more on inputs and strategies. Also, the Policy ensures the provisioning of financial resources, in addition to technical support, monitoring and evaluation at the national level by the Centre. NRHM has major five parts viz: Part A- RCH II; in the RCH Programme there are two separate packages of reproductive health services; comprehensive (expanded package) and essential package. Part B- New Initiatives under NRHM, Part C- Routine Immunization Strengthening, Part D-Disease Control Programme and Integrated Surveillance and Part E-Programme Convergence. But all vertical Health and Family Welfare Programmes at district and state level merge into one common “District Health Mission” at the District level and the “State Health Mission” at the state level. However, to optimize the utilization of the public health infrastructure at the primary level, a gradual convergence of all health programmes under a single field administration is envisaged. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, as also the RCH and Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached.

#### **1.4 (ii) Issues of Adolescents' Health in RCH**

World Health Organization uses to define “adolescence” as 10-19 years old. “youth” as 15-24 years old, and “young people” as 10-24 years old (United Nations, 1999). Adolescence, the second decade of life is a period when young people acquire not only new capacities for progress, but also a time during which rapid physical growth, physiological and psychosocial changes, the development of secondary sexual characteristics and reproductive maturation occur. Nevertheless, adolescence should be considered as a phase rather than a fixed age group, with physical, psychological, social and cultural dimensions.

Unfortunately, young people worldwide face social, economic, and health challenges that were unimaginable since decades. It is also a time of heightened vulnerabilities. Programs that can provide information, ensure access to services, and develop life skills are crucial to the future of this population. With an estimated 1 billion adolescents alive today, the world is experiencing the largest adolescent population in history. As a result, adolescent reproductive health is an increasingly important component of global health. In 1994, the International Conference on Population and Development (ICPD) Programme of Action called for organizations to initiate or strengthen programs to better meet the reproductive health needs of adolescents (ICPD 1994; Alcalá, 1995). However, much still needs to be done to ensure adequate information and services to the world's young people. Unfortunately adolescent reproductive health has been neglected and over shadowed by population policy since years especially in Third World countries. Today about 5 billion is spent each year on family planning in the Third World countries. Around 3 billion is spent by Third World governments with China, India and Indonesia the biggest spenders; over 1

billion is donated by governments of developed countries, multilateral institutions, and private agencies that constitute the Western population establishment; and the rest is spent by individual contraceptive users (Hartmann, 1995).

From the above discussion, it is understood that adolescents' health is totally neglected not only in global but also in Third World countries including India. In this context, the researcher tries to look into the gap between the needs of adolescent girls' health and RCH Programme in Manipur by focusing only on the component of adolescents' health within the packages of RCH Programme. Hence, in-depth study is important to understand the status of adolescents' health in Manipur. In this regard, the next chapter will highlight the relevant literature related to the research area.

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