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A. INTRODUCTION

1. 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.
2. 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"¹. 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 rate² (TFR) should be achieved by the year 2000.
3. On 11 May, 2000 India is projected to have 1 billion³ (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 threefold 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.

Box 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).

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

Table 1: Population Projections for India (million)³

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

¹ Milestones in the Evolution of the Population Policy are listed at Appendix II, page 30

²TFR: Average number of children born to a woman during her lifetime.

³Source: Technical Group on Population Projections, Planning Commission.

5. 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.
6. The National Population Policy, 2000 (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 sector, working in partnership.

B. OBJECTIVES

7. 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.
8. In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated:

Box 2: National Socio-Demographic Goals for 2010

- (1) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- (2) 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.
- (3) Reduce infant mortality rate to below 30 per 1000 live births.
- (4) Reduce maternal mortality ratio to below 100 per 100,000 live births.
- (5) Achieve universal immunization of children against all vaccine preventable diseases.
- (6) Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

- (7) Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- (8) Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- (9) Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- (10) Contain the spread of Acquired Immunodeficiency 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.
- (11) Prevent and control communicable diseases.
- (12) Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- (13) Promote vigorously the small family norm to achieve replacement levels of TFR.
- (14) Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred programme.

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

Table 2: Anticipated Growth in Population (million)

| Year | If current trends continue | | If TFR 2.1 is achieved by 2010 | |
|------|----------------------------|------------------------|--------------------------------|------------------------|
| | Total Population | Increase in population | Total population | Increase in population |
| 1991 | 846.3 | - | 846.3 | - |
| 1996 | 934.2 | 17.6 | 934.2 | 17.6 |
| 1997 | 949.9 | 15.7 | 949.0 | 14.8 |
| 2000 | 996.9 | 15.7 | 991.0 | 14.0 |
| 2002 | 1027.6 | 15.4 | 1013.0 | 11.0 |
| 2010 | 1162.3 | 16.8 | 1107.0 | 11.75 |

Similarly, the anticipated reductions in the birth, infant mortality and total fertility rates are:

Table 3: Projections of Crude Birth Rate, Infant Mortality Rate, and TFR, if the NPP 2000 is fully implemented.

| Year | Crude Birth Rate | Infant Mortality Rate | Total Fertility Rate |
|------|------------------|-----------------------|----------------------|
| 1997 | 27.2 | 71 | 3.3 |
| 1998 | 26.4 | 72 | 3.3 |
| 2002 | 23.0 | 50 | 2.6 |
| 2010 | 21.0 | 30 | 2.1 |

Source for Tables 2 and 3: Ministry of Health and Family Welfare

9. Population growth in India continues to be high on account of :

- ☞ The large size of the population 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 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 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, accordingly, 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 of less than 24 months, which also results in high IMR.

The country's demographic profile is given in Appendix III (pages 32-35).

C. STRATEGIC THEMES

10. We identify 12 strategic themes which must be simultaneously pursued in "stand alone" or inter-sectoral programmes in order to achieve the national socio-demographic goals for 2010. These are presented below:

(i) Decentralised Planning and Programme Implementation

11. 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.

(ii) Convergence of Service Delivery at Village Levels

12. 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)⁴. 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 struggle 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. 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, in order to resolve unmet needs and extend coverage, the involvement of the voluntary sector and the non-government sector in partnership with the government is essential.
13. Since the management, funding, and implementation of health and education programmes has been decentralised to panchayats, in order to reach household levels, a one-stop, integrated and coordinated service delivery should be provided at village levels, for basic reproductive and child health services. 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. An equipped maternity hut in each village should be set up to serve as a delivery room, with functioning midwifery kits, basic medication for essential obstetric aid, and indigenous medicines and supplies for maternal and new born care. A key feature of the integrated service delivery will be the registration at village levels, of births, deaths, marriage, and pregnancies. Each village should maintain a list of community midwives and trained birth attendants, village health guides, panchayat sewa sahayaks, primary school teachers and anganwadi workers who may be entrusted with various responsibilities in the implementation of integrated service delivery.

⁴ Source: MOHFW Statistics, 1998.

14. The panchayats should seek the help of community opinion makers to communicate the benefits of smaller, healthier families, the significance of educating girls, and promoting female participation in paid employment. They should also involve civil society in monitoring the availability, accessibility and affordability of services and supplies.

Operational strategies are described in the Action Plan at Appendix I (pages 16-17).

(iii) Empowering Women for Improved Health and Nutrition

15. 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. Undernutrition 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.
16. Impaired health and nutrition is compounded by early childbearing, 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.
17. Maternal mortality is not merely a health disadvantage, it is 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. The extent of maternal mortality is an indicator of disparity and inequity in access to appropriate health care and nutrition services throughout a lifetime, and particularly during pregnancy and child-birth, and is a crucial factor contributing to high maternal mortality.
18. Programmes for Safe Motherhood, Universal Immunisation, Child Survival and Oral Rehydration have been combined into an Integrated Reproductive and Child Health 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.
19. 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.

Operational strategies are described in the Action Plan at Appendix I (pages 17-20).

(iv) Child Health and Survival

20. 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, diarrhoea, vaccine preventable diseases, malnutrition and deficiencies of nutrients, including Vitamin A. Infant mortality rates have not significantly declined in recent years.
21. Our priority is to intensify neo-natal care. A National Technical Committee should be set up, consisting principally of consultants in obstetrics, pediatrics (neonatologists), family health, medical research and statistics from among academia, public health professionals, clinical practitioners and government. Its terms of reference should include prescribing perinatal audit norms, developing quality improvement activities with monitoring schedules and suggestions for facilitating provision of continuing medical and nursing education to all perinatal health care providers. 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 subcentre 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 subcentre levels.
22. Child survival interventions i.e. universal immunisation, control of childhood diarrhoeas 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 strategies are described in the Action Plan at Appendix I (pages 21-22).

(v) Meeting the Unmet Needs for Family Welfare Services

23. 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, subcentre 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.

Operational strategies are described in the Action Plan in Appendix I (page 22).

(vi) Under-Served Population Groups

(a) Urban Slums

24. 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.

Operational strategies are described in the Action Plan in Appendix I (pages 22-23).

(b) Tribal Communities, Hill Area Populations and Displaced and Migrant Populations

25. 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.

Operational strategies are described in the Action Plan at Appendix I (pages 23).

(c) Adolescents

26. 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.

Operational strategies are described in the Action Plan in Appendix I (page 24).

(d) Increased Participation of Men in Planned Parenthood

27. In the past, population programmes have tended to exclude menfolk. 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.

Operational strategies are described in the Action Plan in Appendix I (page 24).

(vii) Diverse Health Care Providers

28. 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.

Operational strategies are described in the Action Plan at Appendix I (pages 24-25).

(viii) Collaboration With and Commitments from Non-Government Organisations and the Private Sector

29. 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, 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.

Operational strategies are described in the Action Plan in Appendix I (pages 25-27).

(ix) Mainstreaming Indian Systems of Medicine and Homeopathy

30. 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.
31. Particular challenges 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 subcentres 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.

Operational strategies are described in the Action Plan in Appendix I (page 27).

(x) Contraceptive Technology and Research on Reproductive and Child Health

32. 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.
33. 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, to be published shortly. 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.

Operational strategies are described in the Action Plan in Appendix I (page 27).

(xi) Providing for the Older Population

34. 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 million⁵. 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.
35. 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.

Operational strategies are described in the Action Plan in Appendix I (page 28).

(xii) Information, Education, and Communication

36. 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.

Operational strategies are described in the Action Plan in Appendix I (pages 28-29).

D. LEGISLATION

37. 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.

⁵ Source: Technical group on Population Projections, Planning Commission.

E. PUBLIC SUPPORT

38. 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 opinion makers, will enhance its acceptance throughout society. The government will actively enlist their support in concrete ways.

F. NEW STRUCTURES

39. 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 multisectoral 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

40. A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all states and UTs, and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministries and Departments, for example 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, and 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.

(ii) State / UT Commissions on Population

41. 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

42. 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

43. 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.

G. FUNDING

44. 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 (in Appendix IV, page 36).
45. 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.

H. PROMOTIONAL AND MOTIVATIONAL MEASURES FOR ADOPTION OF THE SMALL FAMILY NORM

46. The following promotional and motivational measures will be undertaken:
- (i) Panchayats and Zila 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 has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation. This freeze needs to be extended until 2026.

I. CONCLUSION

47. In the new millenium, 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.
48. The vast numbers of the people of 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.

NATIONAL POPULATION POLICY, 2000 ACTION PLAN

Operational Strategies

(i) & (ii) Converge Service Delivery at Village Levels

1. Utilise village self help groups to organise 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. Organise neighbourhood 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.
2. 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: antipyretics for fevers, antibiotic ointments for infections, ORT /ORS¹ for childhood diarrhoeas, together with standardised 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.
3. Wherever these village self-help groups have not developed for any reason, community midwives, practitioners of ISMH, retired school teachers and ex-defence personnel may be organised into neighbourhood groups to perform similar functions.
4. At village levels, the aanganwadi centre 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 centres can also function as depots for ORS/basic medicines and contraceptives.

¹ Oral Rehydration Therapy /Oral Rehydration Salts

5. 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.
6. 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 subcentres to monitor and respond to maternal morbidity/emergencies at village levels.
7. 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 female participation in the work force.
8. Provide a wider basket of choices in contraception, through innovative social marketing schemes to reach household levels.

Comment : Meaningful decentralisation 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, in particular, the ICDS programme, is critical for extending outreach and increasing access to services. Intersectoral 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, this 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.

(iii) Empowering Women for Improved Health and Nutrition

1. Create an enabling environment for women and children to benefit from products and services disseminated under the reproductive and child health programme. Cluster services for women and children at the same place and time. This promotes positive interactions in health benefits and reduces service delivery costs.

2. As a measure to empower women, open more child care centres 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.
3. To empower women, pursue programmes of social afforestation to facilitate access to fuelwood 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.
4. 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, in particular women.
5. 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. There is need to:
 - ❖ Strengthen the referral network between the district health office, district hospital and the community health centres, the primary health centres and the subcentres in management of obstetric and neo-natal complications.
 - ❖ Strengthen community health centres to provide comprehensive emergency obstetric and neo-natal care. These may function as clinical training centres as well. Strengthen primary health centres to provide essential obstetric and neo-natal care. Strengthen subcentres 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 immunisation.
 - ❖ Establish rigorous problem identification mechanisms through maternal and peri-natal audit, from village level upwards.
6. Ensure adequate transportation at village level, subcentre levels, zila parishads, primary health centres and at community health centres. Identifying women at risk is meaningful only if women with complications can reach emergency care in time.
7. 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 immunisations at subcentre levels.
 - ❖ Strengthen the capacity of primary health centres to provide basic emergency obstetric and neo-natal health care.
 - ❖ 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.

8. 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 subcentre 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.
9. Improve technical skills of maternal and child health care providers by:
 - ❖ 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.
 - ❖ Training on integrated management of childhood illnesses for infants (1 week - 2 months).
10. Support community activities such as dissemination of IEC material, including leaflets and posters, and promotion of folk jattras, 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.
11. Programme development, comprising:
 - ❖ Partnership in family health and nutrition. The aanganwadi worker will identify women and children in the villages who suffer from malnutrition and/or micro-nutritional deficiencies, including iron, vitamin A, and iodine deficiency; provide nutritional supplements and monitor nutritional status.
 - ❖ 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.
12. Develop a health package for adolescents.
13. 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.

- ❖ Make safe and legal abortion services more attractive to women and household decision makers by (i) increasing geographic spread; (ii) enhancing affordability; (iii) ensuring confidentiality and (iv) providing compassionate abortion care, including post-abortion counseling.
 - ❖ Adopt updated and simple technologies that are safe and easy, e.g. manual vacuum extraction not necessarily dependant upon anaesthesia, or non-surgical techniques which are non-invasive.
 - ❖ Promote collaborative arrangements with private sector health professionals, NGOs and the public sector, to increase the availability and coverage of safe abortion services, including training of mid-level providers.
 - ❖ Eliminate the current cumbersome procedures for registration of abortion clinics. Simplify and facilitate the establishment of additional training centres for safe abortions in the public, private, and NGO sectors. Train these health care providers in provision of clinical services for safe abortions.
 - ❖ Formulate and notify standards for abortion services. Strengthen enforcement mechanisms at district and sub-district levels to ensure that these norms are followed.
 - ❖ Follow norms-based registration of service provision centres, and thereby switch the onus of meticulous observance of standards onto the provider.
 - ❖ 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 sterilisation, 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.
 - ❖ Ensure services for termination of pregnancy at primary health centres and at community health centres.
14. Develop maternity hospitals at sub-district levels and at community health centres to function as FRUs for complicated and life-threatening deliveries.
 15. Formulate and enforce standards for clinical services in the public, private, and NGO sectors.
 16. Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing as well as commercial sales.
 17. Create a national network consisting of public, private and NGO centres, 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 provider of the service. A group of management experts will devise checks and balances to prevent misuse.

(iv) Child Health and Survival

1. 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.
2. Set up a National Technical Committee on neo-natal care, to align programme and project interventions with newly emerging technologies in neo-natal and peri-natal care.
3. Pursue compulsory registration of births in coordination with the ICDS Programme.
4. 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.
5. Improve capacities at health centres in basic midwifery services, essential neo-natal care, including the management of sick neo-nates outside the hospital.
6. Sensitise and train health personnel in the integrated management of childhood illnesses. Standard case management of diarrhoea and acute respiratory infections must be provided at subcentres and primary health centres, 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.
7. 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 centres.
8. Pursue rigorously the pulse polio campaign to eradicate polio.
9. Ensure 100 percent routine immunisation for all vaccine preventable diseases, in particular tetanus and measles.
10. 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.
11. Children form a vulnerable group and certain sub-groups merit focused attention and intervention, such as street children and child labourers. Encourage voluntary groups as well as NGOs to formulate and implement special schemes for these groups of children.
12. Explore the feasibility of a national health insurance covering hospitalisation 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.

13. 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.
14. 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.

(v) Meeting the Unmet Needs for Family Welfare Services

1. Strengthen, energise and make publicly accountable the cutting edge of health infrastructure at the village, subcentre and primary health centre levels.
2. Address on priority the different unmet needs detailed in Appendix IV, in particular, an increase in rural infrastructure, deployment of sanctioned and appropriately trained health personnel, and provisioning of essential equipment and drugs.
3. Formulate and implement innovative social marketing schemes to provide subsidised 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.
4. Improve facilities for referral transportation at panchayat, zilla parishad and primary health centre levels. At subcentres, 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.
5. 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.
6. 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.

(vi) Under-Served Population Groups

(a) Urban Slums

1. Finalise a comprehensive urban health care strategy.
2. Facilitate service delivery centres in urban slums to provide comprehensive basic health, reproductive and child health services by NGOs and private sector organisations, including corporate houses.

3. 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.
4. Strengthen social marketing programmes for non-clinical family planning products and services in urban slums.
5. 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.
6. 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.
7. Streamline the referral systems and linkages between the primary, secondary and tertiary levels of health care in the urban areas.
8. 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

1. Many tribal communities are dwindling in numbers, and may not need fertility regulation. Instead, they may need information and counseling in respect of infertility.
2. 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.
3. Many tribal communities are dependent upon indigenous systems of medicine which necessitates a regular supply of local flora, fauna and minerals, or of standardised medication derived from these. Husbandry of such local resources and of preparation and distribution of standardised formulations should be encouraged.
4. Health care providers in the public, private and NGOs sectors should be sensitised to adopt a "burden of disease" approach to meet the special needs of tribal and hill area communities.

(c) Adolescents

1. Ensure for adolescents access to information, counseling and services, including reproductive health services, that are affordable and accessible. Strengthen primary health centres and subcentres, to provide counseling, both to adolescents and also to newly weds (who may also be adolescents). Emphasise proper spacing of children.
2. Provide for adolescents the package of nutritional services available under the ICDS programme.

Comment: 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 anaemia and low birth weight, prematurity, perinatal mortality, and maternal mortality has been extensively studied and established.

3. 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.

Comment: It will promote higher retention of girls at schools, and is also likely to encourage their participation in the paid work force.

4. Provide integrated intervention in pockets with unmet needs in the urban slums, remote rural areas, border districts and among tribal populations.

(d) Increased Participation of Men in Planned Parenthood

1. Focus attention on men in the information and education campaigns to promote the small family norm, and to raise awareness by emphasising the significant benefits of fewer children, better spacing, better health and nutrition, and better education.
2. Currently, over 97 percent of the sterilisations are tubectomies. Repopularise vasectomies, in particular the no-scalpel vasectomy, as a safe, simple, painless procedure, more convenient and acceptable to men.
3. 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.

(vii) Diverse Health Care Providers

1. At district and sub-district levels, maintain block-wise data base 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.

2. Revive the earlier system of the licensed medical practitioners who, after appropriate certification from the IMA, may participate in the provision of clinical services.
3. Involve the non-medical fraternity in counseling and advocacy so as to demystify the national family welfare effort, such as retired defence personnel, retired school teachers and other persons who are active and willing to get involved.
4. 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.
5. 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. gynaecologist/obstetrician, anaesthetist 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.

(viii) (a) Collaboration with and Commitments from the Non-Government Sector

1. 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 organisations and the private sector may identify these hurdles and prepare guidelines that will facilitate and promote collaborative arrangements.
2. Collaboration with and commitments from NGOs to augment advocacy, counseling and clinical services, while accessing village levels. This will require increased clinic outlets as well as mobile clinics.

3. Collaboration between the voluntary sector and the NGOs will facilitate dissemination of efficient service delivery to village levels. The guidelines could articulate the role and responsibility of each sector.
4. Encourage the voluntary sector to motivate village-level self-help groups to participate in community activities.
5. Specific collaboration with the non-government sector in the social marketing of contraceptives to reach village levels will be encouraged.

(viii) (b) Collaboration with and Commitments from Industry

1. The corporate sector and industry could, for instance, take on the challenge of strengthening the management information systems in the seven most deficient states, at primary health centre and subcentre levels. Introduce electronic data entry machines to lighten the tedious work load of ANMs and the multi-purpose workers at subcentres and the doctors at the primary health centres, while enabling wider coverage and outreach.
2. Collaborate with non-government sectors in running professionally sound advertisement and marketing campaigns for products and services, targeting all segments of the population, from village level upwards, in other words, strengthen advocacy and IEC, including social marketing of contraceptives.
3. Provide markets to sustain the income-generating activities from village levels upwards. In turn, this will ensure consistent motivation among the community for pursuing health and education-related community activities.
4. Help promote transportation to remote and inaccessible areas up to village levels. This will greatly assist the coverage and outreach of social marketing of products and services.
5. The social responsibility of the corporate sector in industry must, at the very minimum, extend to providing preventive reproductive and child health care for its own employees (if >100 workers are engaged).
6. Create a national network consisting of voluntary, public, private and non-government health centres, 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 system, duly counter-signed by the beneficiary and paid for by a system that will be fully articulated. The compensation will be identical to providers, across all sectors. The end user exercises choices in the source of service delivery. A committee of management experts will be set up to devise ways of ensuring that this system is not abused.
7. Form a consortium of the voluntary sector, the non-government sector and the private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education.

8. In the area of basic education, set up privately run/managed primary schools for children up to age 14-15. Alternately, if the schools are set up/managed by the panchayat, the private corporate sector could provide the mid-day meals, the text -books and/or the uniforms.

(ix) Mainstreaming Indian Systems of Medicine and Homeopathy

1. Provide appropriate training and orientation in respect of the RCH programme for the institutionally qualified ISMH medical practitioners (already educated in midwifery, obstetrics and gynaecology over 5-1/2 years), and utilise their services to fill in gaps in manpower at appropriate levels in the health infrastructure, and at subcentres and primary health centres, as necessary.
2. Utilise the ISMH institutions, dispensaries and hospitals for health and population related programmes.
3. Disseminate the tried and tested concepts and practices of the indigenous systems of medicine, together with ISMH medication at village maternity huts and at household levels for ante-natal and post-natal care, besides nurture of the newborn.
4. Utilise the services of ISMH 'barefoot doctors' after appropriate training and orientation towards providing advocacy and counseling for disseminating supplies and equipment, and as depot holders at village levels.

(x) Contraceptive Technology and Research on RCH

1. 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.
2. The International Institute of Population Sciences and the Population Research Centres will continue to review programme and monitoring indicators to ensure their continued relevance to strategic goals.
3. Government will restructure the Population Research Centres, if necessary.
4. Standards for clinical and non-clinical interventions will be issued and regularly reviewed.
5. 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.
6. A committee of international and Indian experts, voluntary and non-government organisations 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.

(xi) Providing for the Older Population

1. Sensitize, train and equip rural and urban health centres and hospitals towards providing geriatric health care.
2. Encourage NGOs and voluntary organizations to formulate and strengthen a series of formal and informal avenues that make the elderly economically self-reliant.
3. Tax benefits could be explored as an encouragement for children to look after their aged parents.

(xii) Information Education and Communication

1. 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 served to successfully mobilize local populations. The state of Tamil Nadu made exemplary use of the IEC strategy by spreading the message through every possible media, including public transport, on mile stones on national high ways as well as through advertisement and hoardings on roadsides, along city/rural roads, on billboards, and through processions, films, school dramas, public meetings, local theatre and folk songs.
2. 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.
3. Fund the nagar palikas, panchayats, NGOs and community organizations for interactive and participatory IEC activities.
4. Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behaviour 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 opinion makers, will enhance its acceptance throughout society.
5. Utilise 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.

6. Utilise dairy cooperatives, the public distribution systems, other established networks like the LIC at district and sub-district levels for IEC and for distribution of contraceptives and basic medicines to target infant/childhood diarrhoeas, anaemia and malnutrition among adolescent girls and pregnant mothers. This will widen outreach and coverage.
7. Sensitise 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 stabilisation programmes.
8. 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 later 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.

MILESTONES IN THE EVOLUTION OF THE POPULATION POLICY OF INDIA

- ❖ **1946**
Bhore Committee Report
- ❖ **1952**
Launching of Family Planning Programme
- ❖ **1976**
Statement of National Population Policy
- ❖ **1977**
Policy Statement on Family Welfare Programme

Both 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 appointed a Committee on Population with Shri Karunakaran as Chairman. The Karunakaran Report (Report of the National Development Council (NDC) Committee on Population) endorsed by NDC in 1993 proposed the formulation of a National Population Policy to take a "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**
Report on a National Population Policy by the Expert Group headed by Dr. Swaminathan. 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. During 11/97 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 the 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. On that basis, a fresh draft was submitted to Cabinet.

DEMOGRAPHIC PROFILE

India is following the demographic transition pattern of all developing countries from initial levels of “high birth rate - high death rate” to the current intermediate transition stage of “high birth rate - low death rate” which leads to high rates of population growth, before graduating to levels of “low birth rate - low death rate”.

1. Age Composition

1. (i) The age distribution of the population of India is projected to change by 2016, and these changes should determine allocation of resources in policy intervention. The population below 15 years of age (currently 35 percent) is projected to decline to 28 percent by 2016. The population in the age group 15 - 59 years (currently 58 percent) is projected to increase to nearly 64 percent by 2016. The age group of 60 plus years is projected to increase from the current levels of 7 percent to nearly 9 percent by 2016.

Table 4 : Age Composition as Percentage of the Total Population²

| Year | Below 5 years | Between 0-15 | Between >15 -59 years | + 60 years |
|------|---------------|--------------|-----------------------|------------|
| 1991 | 12.80 | 37.76 | 55.58 | 6.67 |
| 2001 | 10.70 | 34.33 | 58.70 | 6.97 |
| 2011 | 10.10 | 28.48 | 63.38 | 8.14 |
| 2016 | 9.7 | 27.73 | 63.33 | 8.94 |

2. Inter-State Differences

2. (i) India is a country of striking demographic diversity. Substantial differences are visible between states in the achievement of basic demographic indices. This has led to significant disparity in current population size and the potential to influence population increases during 1996-2016. There are wide inter-state, male-female and rural-urban disparities in outcomes and impacts. These differences stem largely from poverty, illiteracy, and inadequate access to health and family welfare services, which coexist and reinforce each other. In many parts, the widespread health infrastructure is not responsive.
2. (ii) At least 9 states and union territories in India have already achieved replacement levels of fertility. These are ranked in accordance with their total fertility rates. Additionally, in each of the three tables below, the current population of each state/union territory, the ratio of this population to the country population, the infant mortality rate and the contraceptive prevalence rate of the state / union territory is also indicated:

² Technical Group on Population Projections, Planning Commission.

Table 5 : Population Profile of 9 States and Union Territories of India with TFR less than or equal to 2.1

| State | Population Size (in millions) as on 1 March 1999* | Percent of Total Population | Total Fertility Rate 1997 | Infant Mortality Rate 1998 | Contraceptive Prevalence Rate 1999 |
|--|---|-----------------------------|---------------------------|----------------------------|------------------------------------|
| INDIA | 981 .3 | | 3.3 | 72 | 44 % |
| Group A (TFR less than or equal to 2.1) | | | | | |
| Goa | 1.5 | 0.2 | 1.0@ | 23 | 27.1 |
| Nagaland | 1.6 | 0.2 | 1.5@ | NA | 7.8 |
| Delhi | 13.4 | 1.4 | 1.6@ | 36 | 28.8 |
| Kerala | 32.0 | 3.3 | 1.8 | 16 | 40.5 |
| Pondichery | 1.1 | 0.1 | 1.8@ | 21 | 56.9 |
| A&N Islands | 0.4 | 0.04 | 1.9@ | 30 | 39.9 |
| Tamil Nadu | 61.3 | 6.2 | 2.0 | 53 | 50.4 |
| Chandigarh | 0.9 | 0.09 | 2.1@ | 32 | 35.0 |
| Mizoram | 0.9 | 0.09 | NA | 23 | 34.6 |

@ Three year moving average TFR1995-97

*Population Projections by Technical Group on Population Projections, 1996

Source: Registrar General of India

2.(iii) There are 11 states and union territories that have a total fertility rate of more than 2.1 but less than 3.0, ranked accordingly :

Table 6 : Population Profile of 11 States and Union Territories of India with TFR > 2.1 but < 3

| State | Population Size (in millions) as on 1 March 1999* | Percent of Total Population | Total Fertility Rate 1997 | Infant Mortality Rate 1998 | Contraceptive Prevalence Rate 1999 |
|---|---|-----------------------------|---------------------------|----------------------------|------------------------------------|
| Group B (TFR > 2.1 and < than 3.0) | | | | | |
| Manipur | 2.21 | 0.2 | 2.4@ | 25 | 20.1 |
| Daman & Diu | 0.1 | 0.01 | 2.5@ | 51 | 30.2 |
| Karnataka | 51.4 | 5.2 | 2.5 | 58 | 55.4 |
| Andhra Pradesh | 74.6 | 7.6 | 2.5 | 66 | 50.3 |
| Himachal Pradesh | 6.5 | 0.7 | 2.5 | 64 | 48.2 |
| Sikkim | 0.5 | 0.06 | 2.5 | 52 | 21.9 |
| West Bengal | 78.0 | 7.9 | 2.6 | 53 | 32.9 |
| Maharashtra | 90.1 | 9.2 | 2.7 | 49 | 50.1 |
| Punjab | 23.3 | 2.4 | 2.7 | 54 | 66.0 |
| Arunachal Pradesh | 1.2 | 0.1 | 2.8@ | 47 | 14.0 |
| Lakshadweep | 0.07 | 0.01 | 2.8@ | 37 | 9.1 |

@ Three year moving average TFR1995-97

*Population Projections by Technical Group on Population Projections, 1996

Source: Registrar General of India

2. (iv) However, there are at least 12 states and union territories that have a total fertility rate of over 3.0. These have been listed below:

Table 7 : Population Profile of 12 States and Union Territories of India with TFR greater than or equal to 3

| State | Population Size (in millions) as on 1 March 1999* | Percent of Total Population | Total Fertility Rate 1997 | Infant Mortality Rate 1998 | Contraceptive Prevalence Rate 1999 |
|--------------------------|--|-----------------------------------|------------------------------------|-------------------------------------|---|
| Group C (>3.0) | | | | | |
| Orissa | 35.5 | 3.6 | 3.0 | 98 | 39 |
| Gujarat | 47.6 | 4.8 | 3.0 | 64 | 54.5 |
| Assam | 25.6 | 2.6 | 3.2 | 78 | 16.7 |
| Haryana | 19.5 | 2.0 | 3.4 | 69 | 49.7 |
| Dadra & Nagar Haveli | 0.2 | 0.02 | 3.5@ | 61 | 29.1 |
| Tripura | 3.6 | 0.3 | 3.9@ | 49 | 25.2 |
| Meghalaya | 2.4 | 0.2 | 4.8@ | 52 | 4.6 |
| Madhya Pradesh | 78.3 | 8.0 | 4.0 | 98 | 46.5 |
| Rajasthan | 52.6 | 5.4 | 4.2 | 83 | 36.4 |
| Bihar | 98.1 | 10.0 | 4.4 | 67 | 19.7 |
| Uttar Pradesh | 166.4 | 17.0 | 4.8 | 85 | 38.2 |
| Jammu & Kashmir | 9.7 | 1.0 | NA | 45 | 15.0 |

@ Three year moving average TFR1995-97

*Population Projections by Technical Group on Population Projections, 1996

Source : Registrar General of India

- 2.(v) The five states of Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh that currently constitute nearly 44 percent of the total population of India, are projected to comprise 48 percent of the total population in 2016. In other words, these states alone will contribute an anticipated 55 percent increase during the period 1996-2016. Demographic outcomes in these states will determine the timing and size of population at which India achieves population stabilisation.

3. Maternal Mortality

- 3.(i) With 16% of the world's population, India accounts for over 20% of the world's maternal deaths. The maternal mortality ratio, defined as the number of maternal deaths per 100,000 live births, is incredibly high at 408 per 100,000 live births for the country (1997), which is unacceptable when compared to current indices elsewhere in Asia.

Table 8 : Maternal Mortality Ratios in Asia³

| Sri Lanka | China | Thailand | Pakistan | Indonesia | India | Bangladesh | Nepal |
|-----------|-------|----------|----------|-----------|-------|------------|-------|
| 30 | 115 | 200 | 340 | 390 | 437 | 850 | 1500 |

³ UNFPA, The State of World Population, 1999, *6 Billion : A Time for Choices*, 1995 estimates.

3. (ii) Within India, the inter-state differentials are a matter of concern.

Table 9 : Inter-State Differences within India in Maternal Mortality Ratios⁴

| Kerala | Bihar | Madhya Pradesh | Rajasthan | Uttar Pradesh | Orissa |
|--------|-------|----------------|-----------|---------------|--------|
| 87 | 451 | 498 | 607 | 707 | 739 |

4. Infant Mortality

4. It is estimated that about 7 percent of new-born infants perish within a year. Poor maternal health results in low birth weight and premature babies. Infant and childhood diarrhoeal diseases, acute respiratory infections and malnutrition contribute to high infant mortality rates. Additionally, in India, across the board (rural or urban areas), there are more female deaths in the age group of 0-14 than elsewhere⁵. Although the Infant Mortality Rate (IMR) has decreased from 146 per 1000 births in 1951 to 72 per 1000 births (1997), and the sex differentials are narrowing, again there are wide inter-state differences recorded in 1998, as is clear from Table 4-6. In comparison, we note the infant mortality rates in South Asia and elsewhere:

Table 10 : Infant Mortality Rates in Asia⁶

| Sri Lanka | Thailand | China | Indoneisa | India | Pakistan | Bangladesh | Nepal |
|-----------|----------|-------|-----------|-------|----------|------------|-------|
| 18 | 29 | 41 | 48 | 72 | 74 | 79 | 83 |

5. Sex Ratio

5. (i) India shares a distinctive feature of South Asian and Chinese populations as regards the sex ratio, with a century's old deficit of females. The (female to male) sex ratio has been steadily declining. From 1901 to 1991, the sex ratio has declined from 972 to 927. This is largely attributed to the son preference, discrimination against the girl child leading to lower female literacy, female foeticide, higher fertility and higher mortality levels for females, in all age groups up to 45.

⁴ Registrar General of India.

⁵ UNICEF, *The Progress of Indian States, 1995*. India Country Office, New Delhi.

⁶ UNFPA, *The State of the World Population, 1999, 6 Billion : A Time for Choices*.

UNMET NEEDS & DEFICIENCIES IN CONTRACEPTIVES SERVICES, HEALTH INFRASTRUCTURE, SPECIALISTS AND TRAINED MANPOWER WITH IMPLICATIONS FOR FUNDING

The unmet need for contraceptive services is estimated at 28%, necessitating an additionality of approx. Rs. 150 crores (for contraceptives, laproscopes, tubal rings, vaccines and RCH drugs).

Health infrastructure is inadequate, with estimated shortages as:

- ❖ 7,683 subcentres (1991), now estimated at 23,190 subcentres for the projected population in Year 2002. Capital cost of one subcentre is Rs. 3 lacs, with a recurring cost of Rs. 0.5 lacs. The Finance Minister in his Budget Speech, 1999-2000, announced a scheme for strengthening rural health infrastructure, to be implemented with responsibility for funding shared between the panchayat, state and central governments. Accordingly, the Department of Family Welfare is formulating a scheme for opening new subcentres where required, providing buildings and equipment to existing subcentres, wherever necessary.
- ❖ A shortage of 1,513 primary health centres (1991), now estimated at 4,212 PHCs for the population projected in 2002. Capital cost of one PHC is Rs. 24.50 lacs, with a recurring liability of Rs 13 lacs. These expenditures are met by the State Governments under the basic minimum services (BMS) programme. However, the financial position of the State Governments does not enable them to make these investments in health infrastructure.
- ❖ A shortage of 2,899 community health centres (1991), now estimated at 3,776 CHCs for the projected population for the year 2000. CHCs serve, mostly, as the First Referral Units and are critical for reducing the MMR and IMR, besides serving as operating theatres for family planning services. Capital cost of one CHC is Rs. 80.5 lacs, with a recurring liability of 27 lacs, currently met by State Governments under the BMS programme.
- ❖ The Department of Family Welfare funds 5,435 Rural FW Centres, some of which are being used as First Referral Units. Others are functioning as block-level PHCs.

The estimated additionality towards infrastructure is:

| | | (Rs. In crores) | |
|------------|-----------|-----------------|------|
| | A/C | 1991 | 2002 |
| Subcentres | Cap | 230 | 695 |
| | Rec | 38 | 116 |
| PHCs | Cap | 370 | 1032 |
| | Rec | 196 | 547 |
| CHCs | Cap | 2320 | 3021 |
| | Rec | 783 | 1020 |
| TOTAL | Capital | 2920 | 4748 |
| | Recurring | 1017 | 1683 |

Inadequacies in Trained Manpower

- ❖ Shortage in manpower is estimated as 27,501 ANMs, 64,860 male multi-purpose workers, and 4,224 LHVs, 5,126 Health Assistants (male), 2,475 medical officers in PHCs, 1,429 surgeons, 1,446 gynaecologists, 1,525 physicians, 1,774 pediatricians, and an overall shortage of 6,635 specialists.
- ❖ Other health manpower reflects a shortfall of 1,171 radiographers, 6,045 pharmacists, 12,793 Lab Technicians, and 18,851 nurse mid-wives, in the rural primary health care delivery system.

The financial requirement to address these unmet needs for trained manpower is approximately Rs. 2,300 crores.

- ❖ For safe abortion services, no MTP kits have been made available since 1997. However, during the CSSM programme, 1,748 MTP kits were distributed to the FRUs. Most of these are lying unused, on account of shortage of trained manpower. This year an additional 180 MTP sets are being procured.

Training

- ❖ For training, since the population policy emphasises convergence of training requirements as well as decentralisation to sub-district and village levels, the estimated additionality for the present is Rs. 10 crores.