

## **Lecture 36: National Population Policy (NPP) 2000**

### **Slide 1**

In year 2000 Government of India passed the National Population Policy (NPP) 2000. It emphasized need for promotion of contraceptives once again but as a matter of choice, and in a target free environment. By this time planners had realized that target oriented approach leads to poor quality performance and cooking up of statistical data. It does not help. Those who want to limit family size are anyway doing this. Development aspirations have made people quite conscious about the need for limiting family size. The programme must particularly focus on meeting the unmet needs, i.e., providing services to those who do not want more children but have not found a suitable method. They must be provided required services. To quote:

**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.**

Box 10.2 presents the national socio-demographic goals for 2010.

## Slide 2

### **BOX 10.2 : NATIONAL SOCIO-DEMOGRAPHIC GOALS FOR 2010**

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.
- Reduce infant mortality rate to below 30 per 1000 live births.
- Reduce maternal mortality ratio to below 100 per 100,000 live births.
- Achieve universal immunization of children against all vaccine preventable diseases.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- Contain the spread of Acquired 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.
- Prevent and control communicable diseases.
- Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- Promote vigorously the small family norm to achieve replacement levels of TFR.
- Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred programme.

### Slide 3

In order to achieve the above goals Population Commission has identified 12 strategic themes. These are given below:

- i. Decentralised planning and programme implementation
- ii. Convergence of service delivery at village levels
- iii. Empowering women for improved health and nutrition
- iv. Child health and survival
- v. Meeting the unmet needs for family welfare services in urban and rural areas
- vi. Meeting the unmet needs for family welfare services specially among urban slums, tribal communities, hill area populations and displaced and migrant populations, and adolescents, and securing increased participation of men in planned parenthood
- vii. Diverse health care providers
- viii. Collaboration with and commitments from non-government organisations and the private sector
- ix. Mainstreaming Indian systems of medicine and homeopathy
- x. Contraceptive technology and research on reproductive and child health
- xi. Contraceptive technology and research on reproductive and child health
- xii. Information, education, and communication

It is clear that in 2000 there was a paradigm shift in population policy. The NPP 2000 has made family welfare a new responsibility of village panchayats. They are expected to develop area specific, needs based approaches to reproductive health services. It is believed that empowerment of women – political, economic and social – would strengthen this process further. The new policy suggests preparing 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.

#### **Slide 4**

**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.**

NPP 2000 recognizes the importance of improving maternal mortality. It says:

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.

NPP 2000 also recognizes the role of Ayurveda, Yoga, Unani, Siddh and Homeopathy systems of medicine and (AYUSH) and the role of private practitioners and traditional healers though it is felt that “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”. Ultimately the goal is to reach the people and promote low cost health care, specially the vulnerable sections of society such as urban slums, tribal communities, hill area populations and displaced and migrant populations, and adolescents.

## Slide 5

The new policy also provides space to the conventional strategic themes dealing with contraception, and information, education and communication (IEC) which are to play an important role in states where family planning acceptance is low and total fertility rate continues to be high.

### OPERATIONAL STRATEGIES

Under NPP 2000 the following operational strategies are adopted.

- i. Converge service delivery at village level
- ii. Empowering women for improved health and nutrition needs for family welfare services
- iii. Child health and survival
- iv. Meeting the unmet needs of the under-served population groups
- v. Use of diverse health care providers
- vi. Collaboration with and commitments from the non-government sector
- vii. Mainstreaming Indian systems of medicine and homeopathy
- viii. Contraceptive technology and research on reproductive and child health (RCH)
- ix. Providing for the older population
- x. Information education and communication

To strengthen health services in the country Ministry of Health and Family Welfare has launched National Rural Health Mission 2005-12. The mission aims at providing improved health services by strengthening health facilities at various levels, creating Accredited Social Health Activists (ASHA) at the grassroots (village) level, providing untied funds to village panchayats, implementation of village health plan, and focusing on 18 special focus states. ASHAs are responsible for:

## Slide 6

- Identify pregnant woman as a beneficiary of the scheme and report or facilitate registration for ANC
- Assist the pregnant woman to obtain necessary certifications wherever necessary,
- Provide and / or help the women in receiving at least three ANC checkups including TT injections, IFA tablets
- Identify a functional Government health centre or an accredited private health institution for referral and delivery
- Counsel for institutional delivery
- Escort the beneficiary women to the pre-determined health center and stay with her till the woman is discharged
- Arrange to immunize the newborn till the age of 14 weeks
- Inform about the birth or death of the child or mother to the ANM/MO
- Post natal visit within 7 days of delivery to track mother's health after delivery and facilitate in obtaining care, wherever necessary
- Counsel for initiation of breastfeeding to the newborn within one-hour of delivery and its continuance till 3-6 months and promote family planning.

ASHAs are playing a vital role in improving institutional deliveries in rural areas. This should improve maternal health (particularly by reducing anaemia) and reduce maternal mortality ratio, infant mortality rate, child mortality rate and child morbidity.

## Slide 7

### CRITICAL EVALUATION OF NPP

As said above, NPP 2000 has produced a paradigm shift in thinking on population issues. It has a rights based approach and aims at empowering women and vulnerable communities. Nobody has an issue with that. However, especially in the context of NRHM 2005-12, and Janani Suraksha Yojana, 2006 some believe that it has to some extent halted the declining trend in fertility in low performing states. The members of poor and vulnerable communities who get money for deliveries in the health facility are no more motivated to limit family size. To produce a baby is to get 1400 rupees in low performance states and 700 rupees (for BPL only) in high performing states plus money for transport which is much above the incentive or compensation for sterilization. Doctors at PHC say that people are more interested in producing babies than in family planning. Only the next census will tell whether these fears came true.

Increase in institutional deliveries has also put a lot of pressure on health officials and health facilities. Staff position and health infrastructure have not changed but number of deliveries has increased fast. This has led to deterioration in quality of services at most places. The staff is overworked, their number must be increased. More medicines, space, theatre facilities and equipment and materials need to be made available.

Lastly, it has to be stressed that so far all efforts have been made to reduce fertility. And this has certainly produced results. Several states have below or just replacement level fertility and others are experiencing declining fertility. If India also witnesses the second demographic transition and its fertility goes below the replacement level on a long term basis it will also suffer from aging, a risk afflicting the industrially advanced economies of the world. That means one has to think about achieving optimum levels of fertility rather than low fertility.

## Questions and Exercises

### Slide 1

1. What is the history of family planning programme in India? Why did the planners start with Gandhian approach to family planning?
2. Distinguish between:
  - a. clinical approach and extension education approach
  - b. knowledge, attitude and practice of family planning
  - c. target oriented approach and target free approach
  - d. terminal and spacing methods
  - e. the concepts of family planning and family welfare
3. Study the two population policy statements, one issued by Dr. Karan Singh, another by Janata Government. Identify major similarities and dissimilarities between the two.
4. Discuss the salient findings of National Population Policy 2000.
5. Why do the people who do not want another child but are not using family planning methods are not using family planning methods?
6. Would you say that family planning programme in India has failed?
7. What are national socio-demographic goals for 2010? Are they achievable?
8. Should we plan for declining fertility only or start thinking about optimum fertility? What will happen if fertility continues to decline in all parts of India?
9. What was Dr. Karan Singh's position on making sterilization compulsory? What went wrong with that?
10. Define multi-media motivational strategy in family planning? How would that help?



## References

### Slide 1

Dyson, Tim, 2003, India's Population: Past, Present and Future, The Pravin Visaria Public Lecture, delivered at Gujarat Institute of Development Research, Conference Hall of the Ahmedabad Management Association on March 4.

Government of India, 2009, Janani Suraksha Yojana, [http://mohfw.nic.in/dofw%20website/JSY\\_features\\_FAQ\\_Nov\\_2006.htm](http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm) [accessed on 24 December 2009].

Government of India, 2009, National Rural Health Mission, <http://www.mohfw.nic.in/NRHM.htm>.

National Commission on Population, 2000, *National Population Policy 2000*, [http://populationcommission.nic.in/npp\\_intro.htm](http://populationcommission.nic.in/npp_intro.htm) [accessed on 19 November 2009].

Sharma, A. K., 1985, *Social Inequality and Demographic Processes*. Delhi: Mittal Publications.