

Controlling the numbers

We need to change the mindset in high fertility states, says Amarjit Singh

A Tribune Special

TODAY is World Population Day. Considerable public interest was generated when the world population reached five billion on July 11, 1987. The United Nations Development Programme (UNDP) decided to celebrate it as an annual event as World Population Day (WPD) to raise awareness about global population issues.

Accordingly, each WPD is celebrated around a theme. This year, it is "everyone counts" literally because some countries like ours are engaged in decennial census operations, generating useful data for development. As the world's second most populous country, it is only appropriate for us to take stock on this day.

Our population has increased by over four times during the last century — from 23 crore in 1901 to 102 crore in 2001. In the nineties, we added 18 crore people, i.e. almost the population of Uttar Pradesh to our country!

Obviously, we are not content with this. We are currently growing at the rate of 1.4 per cent annually — almost two and a half times that of China's rate of 0.6 per cent. Soon we will have the pleasure of overtaking China as the world's most populous country.

Gloomy facts apart, there's some good news. Fourteen states, especially in the south, have reached the replacement level of fertility of less than 2.1 children per woman. The population of some larger or high fertility states in central India is, however, growing alarmingly. Over 45 per cent of the population growth by 2030 will be from Uttar Pradesh (22 per cent), Bihar (8 per cent), Rajasthan (8 per cent) and Madhya Pradesh (7 per cent). In comparison, the four states in the south will contribute only 13 per cent. So, while an average woman in Andhra Pradesh will give birth to 1.9 children in her reproductive years, her counterpart in UP will bear four children.

The high fertility states are also reeling under high maternal and infant mortality rates, which reflect poor quality of healthcare within. Recent studies show that unmet need for contraception in some states is as high as 46 per cent compared to the national figure of 22 per cent (which

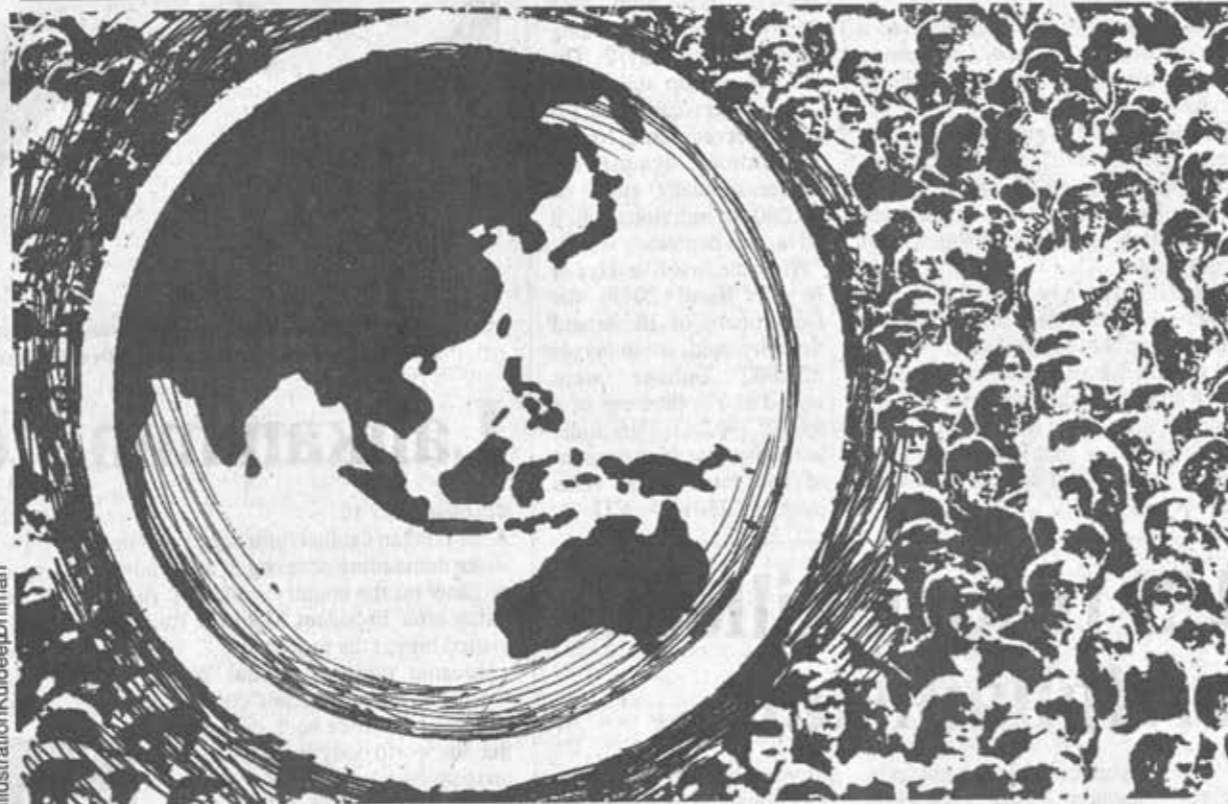


Illustration: Kuldip Himan

is just 11 per cent for Kerala). Ironically, even when services are available, they are delayed. Over 84 per cent sterilisations are carried out after three children have been borne and 97 per cent of the Intra-Uterine Devices inserted after two children in some of these states. Obviously, this is ineffective effort, with little impact on population stabilisation.

Apart from overall weak governance in some of these states, there are critical systemic issues accounting for the poor performance. In the better performing states of the south as well as west, there is a strong public health cadre trained to handle public health issues effectively. Whereas in the states under reference, most often one will find a clinical person with no idea of management or public health heading the district health team consisting of around a thousand auxiliary nurse-cum midwives, paramedics, and doctors.

There is also a poor understanding of epidemiology, surveillance, logistics, management information system, finance and man management. In other words, you have a chemical engineer where a structural engineer is required. Obviously, the district health teams are an undermined lot, working at sub-optimal levels. The result of the poor absorption capacity of these states is huge saving in these states of the fund allocations under the National Rural Health Mission (NRHM).

This is compounded by issues on the socio-economic front such as poor literacy, especially amongst girls. Such factors along with antiquated social norms contribute to early marriage. In the high fertility states, 60 to 70 per cent of girls in rural areas get married before the age of 18. Over 35 per cent of them begin child bearing before 18.

This largely contributes to high infant and maternal mortality, low

quality of life and increase in population. The only way out of the mess is girl child education up to the secondary level which not only empowers girls economically and socially but also enhances the acceptance of contraception and limits the family size as in Kerala, Tamil Nadu, West Bengal and now Himachal Pradesh.

Himachal remains by far the most admirable example of sustained and effective effort in this regard. More than 71 per cent of the Himachal girls have received Plus Two education in contrast to 15 per cent in Madhya Pradesh and 19 per cent in Bihar. The fruits of education have been sweet — only 9 per cent of the currently married girls in Himachal's rural areas were married before 18.

Along with education, delayed marriage is another way forward in our mission for population stabilisation. People must oppose vigorously

any move to reduce the age of marriage for girls as is being demanded by the Khap Panchayats prevalent in northern states.

We also need to explore innovative ways of service delivery. Despite our best efforts, in the last five years, under the NRHM, of 55 lakh deliveries in UP annually, only 21 lakh took place in institutions. The rest were supervised by quacks, dais or family members. Clearly, the government alone will not be able to fill the gaps.

There is a need to explore the possibilities of public private partnerships in reproductive and child health as well as family welfare programmes. Worthy of emulation is Gujarat's Chiranjeevi Scheme. It shows how small efforts can deliver big results. Under the scheme, an offer was made

scheme also saved many neonates who used to die because of poorly handled deliveries.

This reflects the promise of public-private partnership which must be explored by other states for enhancing access to high quality reproductive and child health services. As bigger partners, the states have to take proactive steps to involve NGOs. In Uttar Pradesh, over 4,000 obstetricians are willing to join hands with the government to strengthen reproductive and child health services and improve healthcare for the masses.

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through the Federation of Gynecological Societies of India (FOGSI) to the private obstetricians to collaborate with the Gujarat government to provide safe delivery facilities to the below poverty line (BPL) women.

Private obstetricians were offered an average of Rs 1,795 for a delivery and had to take up all BPL cases, regardless of the complexity. The state government offered an advance of Rs 25,000 to the private obstetricians opting for the scheme ensuring prompt payments and taking responsibility for mortality in case of severely anemic women.

So far 800 obstetricians have joined and have carried out more than 500,000 institutional deliveries for below poverty line mothers. At a maternal mortality rate of 300, the state could have lost 1,500 mothers. However, as the deliveries were carried out by skilled birth attendants, only 77 mothers lost their lives. The

years between each child.

We need to change the mindset towards son preference as well as active male involvement in family welfare and to redouble our investments to involve private sector to improve reproductive and child health and meet the unmet need for family welfare qualitatively and in a humane manner.

The focus in all this has to be on the high fertility states. Unfortunately after the Emergency days, even well-meaning people have relegated the issue to the backburner, with population stabilisation continuing to be a high stigma subject. This attitude must change to realise the full potential of the demographic dividend. ■

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