



Madhya Pradesh

**Population
Policy**

January 2000



Government of Madhya Pradesh

Population Policy of Madhya Pradesh

January, 2000

Department of Health and Family Welfare
Government of Madhya Pradesh

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Message



At the time of formulating the population policy of Madhya Pradesh, two things were brought to my notice. First, that even the poorest of poor in Madhya Pradesh wants to plan his family, and second, that our resources and services are falling short in fulfilling this desire. While the first information filled me with enthusiasm, the second left me perturbed and anguished. I was deeply agonised to know that 25 per cent of the total pregnancies taking place in Madhya Pradesh are unwanted and we are not able to reach out to those who would like to plan their families. Lack of access to family planning methods and other RCH services is resulting in higher fertility and mortality. I felt that even the pressure of present population of 7-8 crores is rendering the resources, services and the system futile, and a two fold increase in population will make our efforts meaningless.

This very concern motivated me to provide a Population Policy that is effective and could be implemented in totality—a policy which will make everyone's dream of small family come true, create a conducive environment, empower women, improve programme management, and establish an inter-departmental coordination.

While announcing this new policy we are faced with a challenging situation. It is a bitter reality that it took us one century to double when we were just one crore people, but today one crore people are adding to the population of the state every 7-8 years. This reflects an increase in life-expectancy of the people and the failure of family planning as well.

I am of the clear view that for stabilising the population, we will have to resort to certain other practical measures along with reduction in Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate. Key to the success of any policy lies in people's participation. This is also a pre-condition for the success of Population Policy. Village level democratic institutions have already emerged in our state, and these institutions are capable of ensuring overall people's participation in various programmes. Along with this we will have to bring about gender equality and equity in society, make population stabilisation programme a people's movement, create interest for longevity of life and small family norm, improve and expand our health services making them low-cost and accessible. Further the planned family has to be made a thing of pride and for this people have to be involved in the programmes, to provide new insight, new direction and modern thinking to the society.

We are introducing this new Population Policy in Madhya Pradesh with the hope that its success will contribute in paving the way for the building of a modern Madhya Pradesh.

Mukhya Mantri Nivas
Bhopal, Madhya Pradesh

Digvijay Singh

Abbreviations

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
BDO	Block Development Officer
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHC	Community Health Center
CPR	Contraceptive Prevalence Rate
DFWB	District Family Welfare Bureau
DPC	District Planning Committee
DPDCC	District Population and Development Coordination Committee
DUDA	District Urban Development Agency
FLE	Family Life Education
FP	Family Planning
HDI	Human Development Index
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IIHMR	Indian Institute of Health Management Research
IMR	Infant Mortality Rate
ISM	Indian System of Medicine
IUD	Intra-Uterine Device
MCH	Maternal and Child Health



MMR	Maternal Mortality Rate
MP	Madhya Pradesh
MSS	Mahila Swasthya Sangh
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NSS	National Service Scheme
NGO	Non Governmental Organization
ORS	Oral Rehydration Salts
PHC	Primary Health Centre
PHED	Public Health Engineering Department
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
SPDC	State Population Development Council
SPPIC	State Population Policy Implementation Committee
SPRC	State Population Resource Centre
TBA	Traditional Birth Attendant
TFA	Target Free Approach
TFR	Total Fertility Rate
TLC	Total Literacy Campaign



Glossary of Indian Terms

Anganwadi	A village-level centre under Integrated Child Development Services (ICDS) Programme
Dai	Traditional midwife
Gram Panchayat	Village-level local government
Mahila Swasthya Sangh	A group of women at village level created to discuss about various health and family planning issues every month
Nagar Palika/Parishad	Municipality/Corporation
Panchas	Members of Panchayat
Panchayat	Body of local government at village-level
Pradhan	Village-Head
Prajanan Swasthya Kendra	Reproductive Health Centre
Sarpanch	Panchayat Head
Zila Parishad	District-level local government



Definitions

Crude Birth Rate	Number of Births per 1000 population in a given year
Crude Death Rate	Number of Deaths per 1000 population in a given year
Couple Protection Rate	Percentage of couples effectively protected by modern method of contraception
Infant Mortality Rate	Number of infants dying under one year of age in a year per 1000 live births of the same year.
Maternal Mortality Rate	Number of deaths of women while pregnant or during delivery or within 42 days of delivery due to any cause related to pregnancy and child birth per 1,00,000 live births in a given year.
Neo-natal Morality Rate	Number of infants dying within the first month of life (under 28 days) in a year per 1000 live births of the same year.
Peri-natal Mortality Rate	Number of still births plus deaths within 1st week of delivery per 1000 births in a year.
Post Neo-natal Mortality Rate	Number of infant deaths at 28 days to one year of age per 1000 live births in a given year.
Population Stabilization	A population with an unchanging rate of growth and an unchanging age composition, because of age specific birth and death rates having remained constant over a sufficiently long period of time.
Replacement Level Fertility	The level of fertility at which a cohort of women on the average are having only enough daughters to replace themselves in the population. A TFR of 2.1 is considered to be replacement level.
Sex Ratio	Number of females per 1000 males in a population
Total Fertility Rate	Average number of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive span (15-49 years)



Introduction

1.1 A Profile

The present state of Madhya Pradesh came into existence on November 1, 1956 with the merging of Bhopal, Madhya Bharat, and Vindhya Pradesh provinces, the Mahakoshal region of the former Madhya Pradesh province, and Sironj sub-division of Rajasthan. With a land area of 443,446 square kilometers, it is the largest state in the country. According to the 1991 census, it had a population of 66 million, which is 8 per cent of the country's population. Its density is 149 persons per square kilometer, compared to 274 for the country as a whole. Ranking 6th in terms of population size and 22nd in terms of population density among the 32 states and union territories, it is a large state with a widely dispersed population and relatively low density.

From the point of view of per capita income, literacy, urbanization, infrastructure facilities and other development indicators, Madhya Pradesh belongs to the category of less developed states of the country. Administratively, Madhya Pradesh has 61 districts with considerable variation between districts on almost all demographic, social, and economic indicators. One district, Bastar (undivided), has an area of 39,114 square kilometers, which is larger than the area of the state of Kerala. The population density varies from a high of 488 in Bhopal district to a low of 54 in Bastar. Almost half

of all the villages in the state numbering 71,526 have fewer than 500 inhabitants, although this proportion varied from 29 per cent in the district of East Nimar to 66 per cent in Rajgarh.

Pucca (black top) roads connected only 23 per cent of villages. The percentage of households having basic facilities such as electricity, safe water, and toilets varied from 41 per cent in Indore district to 3 per cent in Raigarh district. Though the proportion below the poverty line has declined from 62 per cent in 1977-78 to 42 per cent in 1993-94, the actual number of poor in absolute terms remained constant at 30 million persons.

There are 11 languages spoken in the state. Hindi is the language spoken by the majority, 57 million, as per the 1991 census. There are at least seven different dialects of Hindi spoken in different parts of the state. The state has the highest number and percentage of tribal population in the country with 45 scheduled tribes that account for 23 per cent of the state population. Madhya Pradesh—marked by a complex social structure, a predominantly agrarian economy, a difficult and inaccessible terrain, and scattered settlements over vast area—poses several formidable problems to family planning and reproductive health service delivery systems.



1.2 Regional Diversity

Madhya Pradesh is a State with a considerable degree of regional diversity in terrain, culture, socio-economic conditions and status of women. The State is divided into seven regions based on geographical terrain and agro-climatic conditions that also help classify the regions in terms of cultural diversity, socio-economic conditions and status of women. Table 1 provides some of the basic demographic and socio-economic parameters of the State and its regions in comparison with India, that provide illustrative evidence of levels of regional variations existing in the State.

In terms of Human Development Index (HDI), the state lags behind the country as a whole, with an index value of 37 out of 100 compared to 45 for the country. Within the state, Chhattisgarh and Malwa Plateau are relatively more developed regions than Vindhya and South Western. The regions with a high proportion of tribal population, especially Chhattisgarh and South Central regions are having higher sex ratios than the Central region indicative of a relatively better status for women. The percentage of females married in the age group 15-19, which is also an index of the low status of women, is highest in the Vindhya (73 per cent signifying a very low status) and the lowest in South Central Madhya Pradesh (39 per cent indicating a relatively higher status).

On the sanitation front, the percentage of households having safe drinking water is highest in Malwa Plateau (68 per cent) and lowest in Vindhya region (27 per cent). Similarly in terms of economic development, judging from the percentage of households electrified in 1991, Vindhya and Chhattisgarh regions are the poorest

with only 31 per cent of the households electrified and the best are Malwa Plateau and South Western regions with 54 per cent of households having electricity. Similarly, levels of infant mortality as well as fertility vary from one region to another, as shown in the table. Infant mortality rate varied from 122 infant deaths per 1000 live births in the Northern region to 80 in the South Western region. The crude birth rate varied from 35 births per 1000 population in the Northern region to 28 in the South Central region. There is a need to take account of these regional differentials while planning and implementing the new population policies and programmes.

1.3 Democratic Decentralization

A process of democratic decentralization has been set in motion with the 73rd and 74th Constitutional Amendments passed by the Indian Parliament in 1992, which enabled decentralized governance through Panchayati Raj Institutions in rural areas and urban local bodies in urban areas. Madhya Pradesh was the first state to conduct elections to Panchayati Raj Institutions immediately after the Constitutional Amendment and devolved more authority and responsibility, in letter and spirit, to the elected bodies. The state government has transferred a number of activities of 18 departments that are critical for improvement of living conditions of rural people to different layers of the Panchayati Raj Institutions. These include education, health and family welfare, and women and child development, among others. At present, there are 31,500 Panchayati Raj Institutions at the village, block, and district levels in the state with about 484,000 elected representatives, of whom about 190,000 are

Table 1: Selected Demographic and Development Indicators for India, Madhya Pradesh and its regions

Region/State	INDIA	Madhya Pradesh	Chhattisgarh	Malwa Vindhya	South Central	South Plateau	Central	Western	Northern
Population 1999(000's)	981,324	78,346	20,664	10,786	7,947	13,453	9,951	6,921	8,623
HDI, 1995	45	37	39	32	38	39	37	33	37
Sex Ratio, 1991	927	931	985	910	887	934	952	939	839
Crude Birth Rate, 1997	27.2	31.9	28.3	33.9	32.8	31.6	27.5	30.4	35
Crude Death Rate, 1997	8.9	11	10.6	13	11.3	9.8	9.7	9	12.8
TFR, 1997	3.3	4	3.6	4.6	4.4	3.8	3.6	4.1	4.6
Infant Mortality Rate, 1997	71	94	84	108	105	100	96	80	122
CPR Due to Sterili. 1998	30.2	27.8	29.5	20.2	24.8	29.6	35.7	31	22.4
Adult Literacy Rate (15-34)									
Persons	56.86	48.02	46.62	41.12	54.58	47.24	54.5	47.02	47.75
Males	69.56	64.55	64.13	58.58	69.82	63.8	69.35	61.06	65.83
Females	43.48	30.41	29.14	22.27	37.18	29.76	38.96	32.07	26.17
Percent of SC Population, 1991	16.73	14.54	12.2	15.81	18.64	15.5	10.97	11.76	20.09
Percent of ST Population, 1991	7.95	23.27	32.46	20.24	8.3	20.73	29.68	33.58	6.01
Percent Urban 1991	25.7	23.2	17.4	16.3	33.55	29.95	23.2	77.6	27.14
Percent Females Married, 1991 (in 15-19 years)	35.3	58.8	41.89	72.53	53.88	55.18	39.25	40.09	66.31
Female Work Participation Rate (Main + Marginal) 1991	22.3	32.68	40.99	30.85	25.32	33.71	34.97	34.45	15.56
Percent of Agri. Labourers to Main Workers, 1991	26.1	23.51	23.06	25.81	25.33	20.7	27.66	29.61	12.45
Percent of households having Electricity, 1991	42.4	42.67	31.67	31.28	51.43	53.74	45.89	53.67	49.21
Percent of households having Safe Drinking Water, 1991	62.3	52.9	51.1	27.36	56.15	67.56	55.58	64.23	51.86
Percentage of Villages having Pucca Road	36.96	22.45	20.84	26.9	20.01	19.43	21.54	24.75	27.15

Note: HDI for the regions are calculated using the PFI estimate for the state as a whole and district level estimates from MPHDR, 1998.



women. In addition, many powers of the state government, hitherto exercised from the state capital, are decentralized and delegated to newly created District Planning Committees (DPC). The committees have a minister as chairperson, the District Collector as secretary, and a number of officials and non-officials as members. The District Planning Committee has powers and responsibilities to plan and implement many development programmes. The Panchayat Act also allows any elected Panchayat President to be disqualified if the majority of the electorate at the village level, called the 'Gram Sabha' decide to do so.

1.4 State of the Family Welfare Programme

Family Welfare Programme, which encompasses family planning and reproductive and child health activities, is vital from the standpoint of the need to control and stabilise the population. It has therefore, been adopted as a national programme by the Government of India; and it is funded by the central government. Following the national programme of family planning launched in the country in 1952 as a part of the first five-year development plan, the State of Madhya Pradesh also started a few family planning clinics in the cities since the late fifties. From plan to plan it followed the changes in the policies and programme strategies recommended by the central government. From 1962 the extension approach in the rural areas through the health centres was adopted and since the seventies the programme became heavily target-oriented, time-bound and sterilisation focussed activity. Various types of incentives were offered to couples to accept sterilisation. It was vasectomy that

was the most popular method among the couples until 1977 and after the emergency period during 1975-77, the programme suffered a serious set back, as in the rest of the country. The programme recovered slowly but steadily from the early eighties and now it is female sterilisation that is the most popular method as in the rest of the country. Taking a cue from the International Conference on Population and Development (ICPD) of Cairo in 1994 and realising the limitations of setting demographic targets, the Government of India took a significant and landmark policy decision regarding Family Welfare Programme when it adopted Target-free Approach (rechristened as Community Needs Assessment Approach - CNA) in April, 1996, with due emphasis on client orientation, informed choice and right for access to good quality services. In general, the results of this shift across the states in India are not very encouraging. In fact, the performance in several states has declined including Madhya Pradesh. Concern, therefore, has been repeatedly expressed that the country might revert to the old system of target setting and monitoring its progress in terms of target achievements. If this happens, it will not only be detrimental to the Reproductive and Child Health programme (RCH) of the country but could even become an obstacle to operationalising the programme of Action of ICPD to which India is a signatory. In other words, this calls for the creation of a conducive environment among the programme managers so that the re-oriented RCH programme could be implemented systematically as planned in the state.

In 1971 only ten per cent of currently married women in the reproductive ages (15-44) were using any family planning methods either to

delay child birth or preventing further child-bearing and over the decades the Couple Protection Rate (CPR) has steadily increased to reach the level of 42 per cent by 1999 as per the National Family Health Survey (NFHS-II). However, this increase in the contraceptive prevalence rate is not commensurate with the level of Total Fertility Rate (TFR). In 1996 the state of Kerala had reached a TFR of 1.8, less than half of Madhya Pradesh's fertility but with a contraceptive prevalence rate of 47 per cent only marginally above that of MP. In Madhya Pradesh most of the protection (70 per cent) by contraceptive use among couples is due to sterilisation after they have attained a fairly high parity, four or more children and by 32 to 33 years of age. On the other hand in Kerala, most couples have adopted sterilisation by 27 or 28 years of age after having two children. Thus in MP it is necessary to motivate couples to adopt limitation practices, if at all they want to, at younger age and low parity then only sterilisation will have significant impact on fertility. Further, significant declines in fertility in the state in the coming years can be achieved only by an

increased proportion of younger couples, with wives in the peak years of reproduction in the age groups 20-24 or 25-29, adopting effective family planning methods. According to the National Family Health Survey conducted in 1992-93, less than 5 per cent of eligible couples in the age group 15-19 and less than one-fifth in the 20-24 age group were using contraceptives. Couples in these age groups are likely to adopt more of spacing methods rather than sterilisation. Hence, there is a need to extend the contraceptive choice available to couples with a special drive to promote spacing methods among young couples.

It was observed that in the last five years (1994-99), the regional differentials in family planning performance have increased. The twenty districts that are below the state average, account for more than half of the total area of the state and 55 per cent of its population (Table 2). The trend in use of contraception since inception of the programme shows that it has increased considerably especially in last one decade. But at the same time, the use of family planning has not been able to bring about

Table 2: Classification of the districts according to the performance of Couple Protection Rate (CPR), Madhya Pradesh

Category	Districts	Area in Sq.Km ('000)	Population ('000)	CPR 1997-98
Madhya Pradesh	Total 45 districts as on 1991	443	66181.2	47.3
Performing at above state average	Betul, Chhindwara, Damoh, Datia, Dewas, East Nimar, Guna, Gwalior, Indore, Jabalpur, Mandasaur, Narsinghpur, Raigarh, Rajgarh, Rajnandgaon, Ratlam, Sehore, Seoni, Shajapur (19)	151 (34.1)	24061.9 (36.4)	48.0-75.1
Performing at below state average	Balaghat, Bastar, Bhind, Bhopal, Bilaspur, Chhatarpur, Durg, Jhabua, Morena, Panna, Raipur, Rewa, Sagar, Satna, Shahdol, Shivpuri, Sidhi, Surguja, West Nimar, Vidisha (20)	242 (54.6)	34992.9 (52.9)	34.0-47.1
Performing at varying levels	Dhar, Hoshangabad, Mandla, Raisen, Tikamgarh, Ujjain (6)	50 (11.20)	712.64 (10.7)	45.1-55.3



proportional decline in fertility. Many reasons have been cited for this situation. There are, however, two primary reasons: (1) the family welfare programme has not been effectively managed. It continues to be a diffused programme not providing area-specific, need-based and quality services as well as timely follow-up on a large scale; (2) the many-faceted population programme which is impacted by women's literacy, status, empowerment, age at marriage, etc. has not been properly implemented and monitored, and thus lacks inter-departmental cooperation. No systematic efforts have been made to tackle these issues although they have been widely discussed during the last forty years or so.

1.5 Trends in Population Growth

The key to the state's success in achieving sustained economic growth, reducing poverty, and safeguarding the environment is a simultaneous reduction in its population growth rate.

The pace at which the population has been growing can be gauged by the fact that the state's population doubled in the period of 30 years, between 1951 and 1981, from 26 million

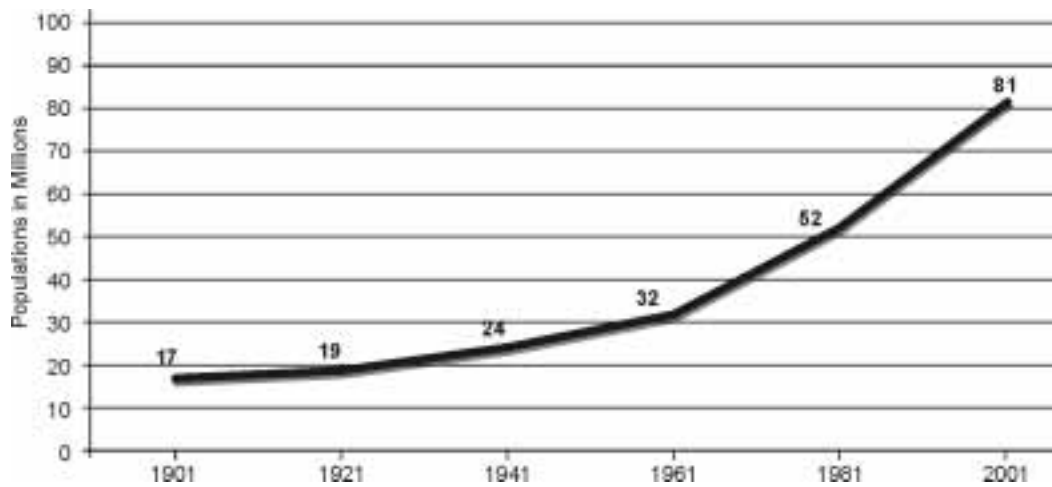
to 52 million. At the present pace, it will double again in the following 34 years, that is, from 52 million in 1981 to 104 million in 2015. With an estimated population of 78.4 million in 1999, the state has added 1.4 million people in the year 1998-99 compared to less than 0.7 million in the year 1955-56.

At the time of independence, Madhya Pradesh was the seventh most populous state in the country. Before the end of this century, it will become the fourth most populous state after Uttar Pradesh, Bihar, and Maharashtra. With 39 per cent of the population under 15 years of age and 48 per cent of the female population between the ages of 15 and 49, there is also a tremendous potential for growth built into the age structure of the population. In 1996, the Technical Group on Population Projections, constituted by the Planning Commission of the Government of India, concluded that Madhya Pradesh would reach replacement level fertility (e.g., a total fertility rate (TFR) of 2.1 and a prerequisite for initiating the process of population stabilization) after 2060. If this were to happen, the census of 2061 would show a population size in excess of 190 million. The impact of such a huge population base on

Table 3: Trends in Population Growth in Madhya Pradesh

Size	Achieved in the Year	Number of Years Needed	Average Annual Increase (in Lakhs)
First Crore	1821	—	—
Second Crore	1925	104 years	0.9
Third Crore	1957	32 years	3.1
Fourth Crore	1968	11 years	9.1
Fifth Crore	1978	10 years	10.0
Sixth Crore	1987	9 years	11.1
Seventh Crore	1994	7 years	14.3
Eighth Crore	2000	6 years	16.7
Ninth Crore	2006	6 years	16.7

Fig 1
Burgeoning Population of Madhya Pradesh



the quality of life of the people in the state of Madhya Pradesh can well be imagined.

1.6 Reproductive and Child Health Status

The current health status of mothers and children in the state needs considerable improvement. The infant mortality rate in 1997 has been estimated at 94 infant deaths per 1,000 live births, one of the highest rates in the country. Only the state of Orissa has a higher rate of 103. The per cent of children aged 12-23 months who have received any vaccine increased from 62 per cent in 1992-93 to 80 per cent in 1998-99 in rural areas and from 80 per cent to 94 per cent in urban areas. While immunization services have successfully reached more children than six years ago, the proportion of children receiving all required doses of all vaccines has not shown appreciable improvement.

The proportion of pregnant women that obtained antenatal care (ANC) services

increased from 52 per cent in 1992-93 to 62 per cent in 1998-99. Only 22 per cent of deliveries in Madhya Pradesh in 1998-99 were institutional deliveries; of these, two-thirds occurred in private health institutions. Trained personnel assisted less than one-third of total deliveries. Skilled personnel such as doctors, midwives and trained dais attended an additional 20 per cent of births at home. Over two-thirds of births in rural areas and about one-seventh of births in urban areas occur at home attended by traditional birth attendants, who are often untrained and work under unhygienic conditions. The maternal mortality rate in the state is the highest in the country with 498 mothers dying due to maternal causes per 100,000 live births.

Fertility levels are still quite high, although there is evidence of some decline in recent years. The crude birth rate has declined from 33.2 in 1995 to 31.9 in 1997. The contraceptive prevalence rate for modern methods has increased from 36 per cent in 1992-93 to 42 per cent in 1998-99, registering an annual



average increase of slightly more than one percentage point. In 1998-99, of all the modern method users, 89 per cent had been sterilized and 11 per cent depended on spacing methods. There are major differentials in contraceptive method use in urban and rural areas of Madhya Pradesh. In urban areas, 52 per cent couples used modern methods, of which 39 per cent accepted sterilization and 13 per cent used spacing methods. In rural areas, 39 per cent of couples used modern methods, of which 37 per cent relied on sterilization and only 2 per cent used spacing methods. Use of sterilization by couples with three or more children and insignificant use of spacing methods, particularly in rural areas, is a cause for concern. Irrefutable evidence based on several surveys suggests that longer birth intervals result in lower infant death rates. Use of spacing methods has a vital role to play in increasing the length of birth intervals and reducing the infant mortality rate. There is a sizeable unmet need for family planning with over one-fifth of currently married women of reproductive age not desiring any more children now or within the next two years but not using any contraceptive method. The focus of the family welfare programme has to be on meeting the prevailing unmet need for family planning as well as launching measures to

improve the maternal and child health services.

1.7 Need for Population Policy

The state's persistent effort to improve the quality of life of its people is rendered difficult by the continued high levels of fertility and mortality. Having realized the seriousness of the rapidly growing population and the high infant and child mortality rates, the Government of Madhya Pradesh has decided to set the goal of achieving replacement fertility level of 2.1 by 2011. This goal will only be achieved by adopting a more holistic approach to the problem of rapid population growth. A wide range of services that directly or indirectly contribute to the decline of fertility and mortality will be offered with the help of different departments of the state government, Panchayati Raj Institutions, urban local bodies, non-government organizations, and the private sector.

Hence the Government of Madhya Pradesh needs a comprehensive population policy to address the state specific issues and concerns. This policy document spells out the mission, objectives, policy initiatives, appropriate strategic thrust areas, political commitment and other programmatic efforts, which are time bound and realistic.

Table 4 : Expected Trends in the Population of Madhya Pradesh if a TFR of 2.1 is Achieved by 2011

Year	If the current trend continues		If a TFR of 2.1 is achieved by 2011	
	Total Population	Annual Increase (Million)	Total Population	Annual Increase (Million)
1991	66.2	—	66.2	—
1996	74.2	1.6	74.2	1.6
2001	81.2	1.4	81.6	1.4
2006	88.6	1.5	87.5	1.3
2011	96.6	1.6	93.1	1.1
2016	105.2	1.7	98.0	1.0
2021	114.6	1.9	102.9	1.0

The Policy Statement

2.1 The Mission

The mission of the population policy is to improve the quality of life of the people in the state by achieving a balance between population, resources, and environment. Rapid reductions in fertility and mortality are essential to achieve population stabilization and improvement in the quality of life.

2.2 The Premise

Although the family welfare programme has been successful in slowing the population growth rate, its primary focus on contraception and the reliance on female sterilization in particular can not be considered a holistic approach to the problem. Family planning efforts are more effective when coupled with implementation of other policies related to age at marriage, provision of comprehensive reproductive health services, universal education, empowerment of women, and social welfare. To facilitate a more holistic approach, all departments of the government especially development departments, non-governmental organizations, the community at large, and other stakeholders must play a major role.

2.3 The Objective

The main objective of the population policy is to reach a TFR of 2.1 by 2011. Contraceptive

prevalence must increase from the present rate of 42 per cent to around 65 per cent in 2011. To facilitate this process, steps would need to be taken to ensure that the infant mortality rate is reduced from the current level of 94 to around 62 by 2011. The maternal mortality rate would also need to decline from the current level of 498 per 100,000 live births to around 220 by 2011.

2.4 Specific Objectives

2.4.1 Reduction in Fertility

To reduce the total fertility rate from the current rate of about 4 per woman to 3 by 2005 and further to 2.1 by 2011 with the following specific objectives:

- a. Increase the use of modern contraceptive methods from the current level of 42 per cent to 55 per cent by 2005 and to 65 per cent by 2011 through the provision of universal access to a full range of safe and reliable family planning methods.
- b. Reduce the proportion of couples having an unmet need for contraception to space and limit births by half by 2005, and 75 per cent by 2009, ultimately 90 per cent by 2011.
- c. Increase the proportion of male sterilization acceptors to total sterilization acceptors from the current 2 per cent to 7 per cent by 2005 and to 20 per cent by 2011.
- d. Increase the use of spacing methods to at least 50 per cent among young married



couples with wives aged 15 to 24 and ensure counselling and follow-up care for all spacing method users.

- e. Increase the average age at marriage for girls from the current 15 years to at least 18 years by 2011.
- f. Increase the age of the mother at the birth of her first child from the current 16 years to 20 years by 2005 and to 21 years by 2011.
- g. Increase the gap between the first and the second child to three or more years by 2005.
- h. Motivate all eligible couples with two or more children to adopt terminal contraceptive methods.
- i. Take account of regional variations in mortality and fertility levels among the seven regions of the state as shown in Table 1 and formulate appropriate service delivery strategies and systems suitable for each region.

2.4.2 Reduction in Maternal Mortality

To reduce maternal mortality from 498 per 100,000 live births in 1997 to 330 by 2005 and further to 220 by 2011 with the following specific objectives:

- a. Increase registration of pregnant women in the first trimester to 70 per cent by 2005 and to 90 per cent by 2009 and provide a full range of ANC services to all pregnant women.
- b. Raise the proportion of institutional deliveries from 15 per cent in 1995 to 25 per cent by 2005 and to 50 per cent by 2011.
- c. Ensure that trained birth attendants assist at least 75 per cent of all births by 2005 and 90 per cent by 2011.
- d. Create a pregnancy testing facility at each sub-centre by 2003.
- e. Create necessary facilities in 50 per cent of block-level health institutions for emergency obstetric care, medical

Table 5 : Desired Future Course in Fertility, Mortality, and Contraceptive Prevalence in Madhya Pradesh

Year	CBR	CDR	IMR	TFR	CPR
1997	31.5	11.1	97	4.0	42.0
1998	30.8	10.9	93	3.9	43.8
1999	30.1	10.7	90	3.7	45.3
2000	29.4	10.5	88	3.6	46.9
2001	28.7	10.2	85	3.5	48.6
2002	28.0	10.0	82	3.4	50.2
2003	27.3	9.8	80	3.2	51.9
2004	26.5	9.5	77	3.1	53.5
2005	25.8	9.3	75	3.0	55.2
2006	25.0	9.1	73	2.8	56.9
2007	24.3	8.8	70	2.7	58.5
2008	23.5	8.6	68	2.5	60.2
2009	22.7	8.3	66	2.4	61.9
2010	21.9	8.1	64	2.3	63.6
2011	21.1	7.8	62	2.1	65.3

Note: * Three-year moving average from SRS centered in 1997.
 ** From SRS, 1997
 *** Estimated from NFHS - I & II.

termination of pregnancy, and prevention and management of reproductive tract infections including sexually transmitted infections by 2005 and in all institutions by 2011.

2.4.3 Reduction in Infant and Child Mortality

To reduce infant mortality rate from 97 per 1,000 live births in 1997 to 75 by 2005 and to 62 by 2011 and to reduce child mortality from 120 in 1997 to 90 by 2005 and to 65 by 2011 with the following specific objectives:

- a. Achieve the total immunization of 70 per cent by 2005 and 90 per cent by 2009.
- b. Increase the use of oral rehydration salts (ORS) packets and recommended home available solutions among those children suffering from diarrhoea from the current level of 40 per cent to 80 per cent by 2005 and to 90 per cent by 2009.
- c. Reduce the incidence rate of acute respiratory infection (ARI) by 50 per cent by 2005 and 75 per cent by 2009.

- d. Introduce facilities for treatment of acute respiratory infections in all block-level health institutions by 2005.
- e. Create appropriate facilities for treatment of diarrhoea at all sub-centres by 2005.
- f. Ensure that at least 50 per cent of children receive all required doses of vitamin A by 2005 and that 90 per cent receive them by 2009.

2.4.4 Provision of Other Services

- a. Educate and counsel and provide services, including voluntary HIV testing, and improve access to male and female condoms to prevent transmission of sexually transmitted infections.
- b. Provide quality services to infertile couples at the district level by 2005.
- c. Achieve universal primary education by 2005 and ensure that at least 30 per cent of girls in the age group 14-15 complete elementary education by 2005 and 50 per cent complete elementary education by 2011.

Key Policy Initiatives

The success of any programme of population stabilization and reproductive health in the state will depend on a series of policy initiatives identified, spelled out, and implemented. Initiatives envisaged as part of this policy include creation of a conducive environment for family planning and reproductive health services; an increase in the demand for family welfare services; collaboration with other development sectors, non-governmental organizations, and Panchayati Raj Institutions; and improvement in service delivery systems mainly to enhance access to and quality of services. Specific policy initiatives that guide and direct the population stabilization efforts are:

3.1 Creating an environment conducive to planned family and creating demand for family planning and reproductive health services

3.1.1 The state is resolutely and strongly committed to the objective of population stabilization, as early as possible, and will take necessary steps to make this commitment widely known among different segments of the population through appropriate advocacy measures.

3.1.2 The empowerment of women and gender equality and equity are essential for achieving the objectives of any social development

programme, particularly in the areas of health and education. The state government will take all necessary steps to enhance the role of women in decision making and to improve the status of women in all spheres of life.

3.1.3 Enhanced community awareness, information, and problem-solving skills are key to the provision of services based on client needs. The state government will mobilize community support to the programmes through various locally relevant schemes and other forms of recognition.

3.1.4 The state government, with the help of other departments and non-governmental organizations, will take up the adolescent and family life education to reach target groups.

3.2 Increasing collaboration with the Panchayati Raj Institutions, the private sector and the non-government sector in community mobilization and programme implementation

3.2.1 The success of the population stabilization programme depends on the state's ability to harness all available resources within and outside the government. The process of democratic decentralization ushered in the state through the Panchayati Raj Institutions, urban local bodies, and District Planning Committees offers an

opportunity to establish inter-departmental linkages, to involve agencies in the non-government sector, and to take the programme nearer to the people. The government will further strengthen the role of local bodies in programme planning and implementation.

3.2.2 The convergence of services provided by various programmes, particularly at the village level, is important to realize the cumulative benefit of development efforts, avoid overlapping roles and responsibilities, and put scarce resources to optimum use. The government will initiate immediate action in this regard.

3.2.3 If they are to be sustained in the long run, population stabilization programmes have to be owned, planned and implemented by local communities. Resources will be mobilized from within the community for this purpose, and the total involvement of the community in the programme will be ensured from the beginning.

3.3 Improving the management of the family welfare programme to achieve excellence in meeting the needs of clients

3.3.1 Systematic application of modern management principles is necessary in the implementation of population stabilization programme, particularly in the areas of client segmentation, logistics planning and support, training and supervision, and monitoring and evaluation. All systems will be reviewed and appropriate corrective measures will be identified and implemented to improve programme efficiency and effectiveness.

3.3.2 Informed choice helps to motivate and recruit new clients and to improve continuity in

use of family planning and reproductive and child health (RCH) services. Service providers will be trained in counselling skills to promote informed choice and in technical skills to improve the quality of services provided. Furthermore, facilities at health institutions will be upgraded to provide the full range of services available at each type of health institution.

3.3.3 To harness fully and appropriately the powers of modern information technology, electronic media will be put to maximum use with the help of television and satellite communication channels to inform people, train personnel, motivate leaders, and develop interactive systems. Effective use of modern media will help overcome many of the difficulties posed by the deficiencies in infrastructure to communicate messages.

3.4 Developing appropriate implementing structures

3.4.1 Population stabilization efforts are necessarily inter-sectoral activities involving various departments of the government. Sharing common goals and pooling efforts and resources wherever possible is essential to achieve population stabilization. The government will create necessary mechanisms at all levels to ensure inter-sectoral coordination among departments such as education, public health and family welfare, women and child welfare, panchayats and social welfare, rural development, urban development, and tribal welfare.

3.4.2 Decentralized decision making is the hallmark of administration in Madhya Pradesh. The government will periodically review structures and functions of decentralized systems to further strengthen them.



Strategic Thrust Areas

4.1 Creating a Conducive Environment

Advocacy has an important role to play in creating an environment conducive for family planning and reproductive health services. Political leaders, influential persons at the community level, and key individuals in various walks of life need to extend their unconditional support to the cause of population stabilization. In addition, empowerment of women, gender equity and equality, literacy, and widespread social support are essential prerequisites to achieve and sustain population stabilization. Success of any programme depends on the cumulative effect of several positive changes rather than on any single set of activities, however well conceived and executed. The Government of Madhya Pradesh has already initiated several measures for this purpose, such as access to primary education through the Education Guarantee Scheme with emphasis on girl's education, efforts towards gender equity, decentralisation of administration, etc. The Madhya Pradesh Government will strengthen the steps that have already been taken to accelerate the process of change and will initiate several new measures to create a positive new environment.

4.1.1 Enhancing Political and Social Support

People in every walk of life have an important role to play to support population stabilization

activities. Madhya Pradesh has a favourable political and administrative climate for successful implementation of the population stabilization programme. To ensure results, political and social support will be mobilized on a large scale through a variety of innovative activities. India's population will reach the one billion mark, as per the estimates of the Registrar General of India, on May 11, 2000. The Madhya Pradesh Government will declare May 11 as Population Stabilization Day.

- The Chief Minister of Madhya Pradesh will, on this day, address the people on radio and television on issues related to population stabilization efforts and improving the health of women and children.
- Meetings will be conducted on May 11 of every year to make people aware of consequences of unabated population growth. Political leaders irrespective of their ideological affiliations and social leaders from different spheres of life will be involved in public meetings conducted at various levels from the panchayat to the state capital.
- Debates, discussions, essay competitions, and exhibitions will be organized in all schools and colleges on the issue of population stabilization.
- Electronic and print media will be used to disseminate the key elements of the Madhya Pradesh population policy that contribute to population stabilization.

- In all public speeches, the Chief Minister and ministers and all other elected members will spend three to four minutes to make public aware of consequences of rapid population growth.
- Persons and organizations that have contributed substantially to the achievement of population stabilization and the improvement of reproductive and child health will be honoured and rewarded.

4.1.2 Empowering Women

One of the most important ingredients or principles that should guide the activities of all government departments is the empowerment of women. Empowerment of women is a desirable goal in itself but is also a powerful means for achieving rapid declines in mortality and fertility. A complex set of value systems, social structures, and norms and practices inhibit women's autonomy and act as barriers to their empowerment. Actions to enhance the status of women have to consider legal rights, education and employment of women, and their role in decision making within their families and the society at large. The Madhya Pradesh Government has already initiated a series of measures to enhance the status of women, empower them, promote gender equity, and make women equal partners in decision making. Several new steps will be initiated to accelerate the process of social engineering. No policy can succeed if it ignores the issues of women's marginalization, subordination, and discrimination.

- The government will launch a systematic campaign aimed at men to make them realize their responsibilities in empowering women.
- Measures will be taken to create and strengthen networks of women's groups at

the village level and to build the capabilities of these groups to carry out activities that help improve the status of women.

- Gender equity and equality is an essential prerequisite to make women equal partners in development programmes. The State Commission on Women will be entrusted the responsibility of identifying barriers to gender equity and equality and of suggesting effective measures to overcome the problems.
- In recent years, the government has introduced several schemes to improve female literacy and the retention rate of girls in schools through the Rajiv Gandhi Prathamik Shiksha Mission. In the next five years, more attention will be paid to encourage at least 30 per cent of girls in the age group 14-15 to complete elementary education and the goal of primary education is achieved by 2005.
- Literacy among women aged 15 years and above is very low. The total literacy campaign (TLC) through the Padhna and Badhna Samiti covering the entire state has been doing pioneering work to increase literacy among men and women and has achieved some significant results. The Padhna and Badhna Samiti will intensify their efforts to ensure that all women aged 15-35 become literate by the year 2005.
- Vocational training is necessary to encourage women to take advantage of self-employment schemes and to have gainful employment in non-traditional areas. One school in each block of the state will be identified to impart vocational training to girls who have completed elementary education.
- The Women and Child Welfare Department will constitute one self-help group for women in each panchayat by 2003. The self-help groups will be assisted to achieve economic



independence, which will, in turn, help to reduce their dependence on moneylenders and to create income-generation activities.

- Of the 23 per cent of working women in Madhya Pradesh, 95 per cent are in the primary sector. Their participation in secondary and tertiary sectors is extremely low. The government has already reserved 30 per cent of jobs in the government sector for women, and this proportion will be progressively increased. Private sector organizations will be encouraged to recruit more women employees.
- The mean age at marriage for women in the state is 15 years and the average age at the birth of her first child is 16 years. A large proportion of women marry and give birth to their first child even before attaining the legal age at marriage. To increase the age at marriage for women, the government will enact a Compulsory Marriage Registration Act and will conduct special campaigns with the help of government departments, non-governmental organizations, and Panchayati Raj Institutions to inform the public. In addition, the legal age at marriage will be made a criterion for those seeking jobs especially public jobs, getting admission in educational institutions, applying for loans, etc.
- Women spend considerable time—particularly in rural areas—on daily household chores such as fetching water, collecting fuel wood, tending cattle, cooking food, and looking after children. To reduce this enormous work load, the government will launch schemes to provide potable water and electricity to each village by 2011. Efforts will be made to provide cooking gas connections in rural areas. Working women hostels will be opened and

creche facilities will be provided in urban areas by 2005.

4.1.3 Introducing Adolescent Education and Family Life Education

Around 21 per cent of the population, or 15 million persons, are in the adolescent age group 10-19. About one-third of this group are in high school and under-graduate institutions. Adolescence is a particularly formative period in a person's life, when important decisions about their lives are made. It is, therefore, necessary to inform, motivate, and involve adolescents in various population and reproductive and child health issues. Given the high rate of child marriages in the state, the prevalence of childbearing among adolescents is also very high. As a result, the number of adolescents seeking abortions, often unsafe, is also high. The government is determined to reduce prevalence of adolescent pregnancies by increasing the age at marriage and by educating adolescents. Adolescent education will cover stereotypical ideas about the role of men and women, human anatomy, contraception, and pregnancy prevention. Family life education will be imparted to men and women in the age group 18-25, with emphasis on human sexuality, pregnancy and birth, abortions, use of contraceptive methods, and responsible parenthood.

- The Department of Health and Family Welfare and Department of Education will, in collaboration with partners in the public and private sectors, develop comprehensive curricula for adolescent and family life education keeping in mind the social and cultural ethos of the people of Madhya Pradesh.
- Parents will be sensitized about the need

for adolescent and family life education.

- Non-governmental organizations will be encouraged to include adolescent and family life education in their ongoing projects. Inclusion of adolescent and family life education will be compulsory in all future NGO projects funded by the government and donor agencies.
- The curriculum used in the total literacy campaigns and other educational programmes will be revised to include, wherever possible, key topics related to adolescent or family life education.
- Boys and girls in universities and colleges will be oriented through the National Service Scheme, and Scouts and Guides groups. They in turn will be encouraged to adopt villages and slums to impart adolescent education.

4.1.4 Mobilizing Community Support

Ownership of programmes is essential to their success. The top-down approaches followed so far have to be replaced by bottom-up approaches. Community participation in programme design and implementation will not only help to identify client-specific approaches for service delivery but also improve demand for and access to services. The government will introduce a series of schemes to mobilize community support.

- A committee will be constituted to work out a package of innovative community support programmes taking into consideration the recommendations of the Sub-committee on Population constituted by the National Development Council.
- From January 26, 2001, persons marrying before legal age at marriage will not be eligible to seek government employment in Madhya Pradesh.
- Persons having more than two children after

January 26, 2001 would not be eligible for contesting elections for panchayats, local bodies, mandis or cooperatives in the state. In case, they get elected and in the mean time they have the third child, they would be disqualified for that post.

- The girl-child scheme like Rajlakshmi to ensure retention of girls in schools and to prevent child marriages, will be launched in the state with the help of financial institutions.
- Awards will be given in the field of community support for population stabilization at all levels for the best performing health institutions, individuals, and Panchayati Raj Institutions every year.
- Rural development schemes, particularly those dealing with infrastructure, will be linked with family planning and reproductive health performance.
- Organize the newly wed groups and encourage members of the group to share information on use of spacing methods and other RCH issues

4.2 The Stakeholders

In recent times, there has been a major shift in population programme approaches. The focus is now on an integrated reproductive and child health approach instead of a segregated target-driven approach for reducing fertility. The other important aspect of the new approach is the encouragement of local initiatives and solutions based on micro planning and implementation. To make this paradigm shift a reality at the implementation level, involvement and active participation of other government departments and private partners is essential. The Population Policy, therefore, proposes the involvement of all



stakeholders, particularly Panchayati Raj Institutions, urban local bodies, NGOs, co-operatives, and the private sector in the delivery of reproductive and child health services, social marketing, and community mobilization. The government will define the roles of these institutions, specific areas of their involvement, and mechanisms for coordinating the efforts of partners at the grassroot level.

4.2.1 Panchayati Raj Institutions and Urban Local Bodies

Madhya Pradesh was the first state to enact one of the most progressive legislations in India, called Panchayati Raj Adhinyam in 1993. There are nearly 32,000 Panchayati Raj Institutions with about 480,000 elected representatives, of whom above 190,000 are women. Similarly, there are elected bodies in urban areas. The Panchayati Raj Institutions and the urban local bodies are the implementing agencies for reproductive health programmes. Local implementation agencies will make programmes more efficient and responsive to local needs and hence lead to greater utilization of services. In order to enable the local leadership to discharge their responsibilities with respect to programme planning, implementation, supervision, and monitoring, the following measures will be undertaken

- The members of Panchayati Raj Institutions and the urban local bodies will be trained in area-specific efforts needed to achieve population stabilization and to improve the health status of women and children.
- The Department of Panchayat and the Department of Urban Development, in collaboration with the Department of Health and Family Welfare, will develop necessary guidelines for participation of Zilla

Panchayat, Janpad Panchayat, and Gram Panchayat members and the elected members of urban local bodies in the implementation and supervision of reproductive and child health programmes.

- To facilitate their effective functioning, the members of Panchayati Raj Institutions and urban local bodies will receive training on reproductive and child health issues and how to monitor the programme. The State Institute of Health Management and Communication will design appropriate training modules for the elected members.
- Women members of elected bodies have a vital role to play in the reproductive and child health programme. In order to ensure their greater participation in RCH programme planning and implementation, their involvement in the Mahila Swasthya Sanghs, Mahila Mandals, and self-help groups will be encouraged and strengthened.
- At the grassroots level, workers and volunteers of different departments interact with villagers to provide services. For instance, the Women and Child Welfare Department has 140,000 women voluntary workers, called Anganwadi workers and helpers, and 2,600 women supervisors. An equal number of workers, teachers, and volunteers are in the departments of Health and Family Welfare and Education. Integration of services is essential to derive cumulative benefit and to achieve synergy. The government, with the help of Panchayati Raj Institutions, will immediately initiate steps to converge services at the village level.
- To remind the village community of the impact of rapid population growth, the Village Panchayat will ensure that each village has a Population Information Display Board in a prominent place that contains



information on population size, the number of births and deaths, and other vital events. The proposed State Population Resource Centre will help in providing all the basic information for this purpose.

- The flow of resources to the Panchayati Raj Institutions and urban local bodies will be appropriately linked to the progress made by these institutions in reducing fertility and mortality and increasing female literacy.

4.2.2 The District Planning Committee (DPC)

The Madhya Pradesh District Planning Committee Act was enacted in 1995 to review the plans prepared by the panchayats and urban local bodies and to prepare a consolidated development plan for the entire district. Following this legislation, the government set-up a District Planning Committee, popularly known as Zila Sarkar, in all districts with a state-level minister as chairperson.

- DPC shall compulsorily address the concerns of FP and RCH issues as the first item of agenda in all meetings.
- DPC will be used to monitor the programme and coordinate all activities with other development departments and non-governmental organizations at the district level. A suitable coordinating mechanism has been proposed for this purpose.
- DPC will ensure implementation of and closely monitor the registration of births, deaths, marriages and first trimester pregnancies.

4.2.3 The Private Sector

Private sector health institutions and individuals have been playing a major role in providing health services in the state. A large proportion of the population in both urban and rural areas depends on the private sector, particularly the

indigenous medical practitioners, for health services. The potential of these institutions and individuals will be harnessed to provide quality reproductive health services. Private sector can also play a key role in social and commercial marketing of reproductive and child health concepts and products.

- The private sector will be encouraged to open Prajanan Swasthya Kendras, particularly in urban areas, to provide essential reproductive and child health services. With the help of the Madhya Pradesh State Financial Corporation, the government will provide soft loans to medical practitioners, with preference to lady medical practitioners, to open clinics in areas not effectively served by the government health institutions.
- Indigenous medical practitioners, particularly in rural areas, will be trained to provide reproductive and child health services and they will be networked to sell contraceptives and other reproductive health products. They will also be encouraged to refer high risk cases to other institutions.
- Innovative strategies will be worked out to make social marketing products widely available in rural and urban outlets.

4.2.4 The Corporate Sector

Various chambers of industry and commerce have a clearly defined charter to provide reproductive health and family planning services. Many large and medium industrial units have their own captive hospitals and provide high-quality health services to their personnel. A few units have also adopted villages near industrial units to undertake development activities, including health services.

- Industrial units not having health facilities



within their premises and units not having village development programmes will be requested, through the relevant chamber of commerce and industry, to launch such programmes.

- Industrial units having well-equipped health facilities will be persuaded to use the facilities to provide reproductive and child health services not only to its own employees but also to the general population.
- Innovative projects will be launched with the help of chambers of commerce and industry to cover small industrial units.
- Linkages will be built up between industrial units and government health institutions to provide better quality services and to improve access to services.

4.2.5 Non-Governmental Organizations (NGOs)

The government will increasingly encourage non-governmental organizations to make the reproductive and child health programme and population stabilization efforts more dynamic and innovative. NGOs have a major role to play in reaching the population in remote and less accessible areas. NGOs have a proven ability to mobilize community support, generate demand, provide wide-ranging services, and evolve and implement innovative integrated development strategies based on local needs and requirements. Madhya Pradesh has more than 650 non-governmental organizations, which indicates the vast and not yet fully tapped potential that exists.

- The government is committed to build NGO capacity in the state by organizing a series of training programmes to impart knowledge and skills in regard to project development, monitoring and evaluation, and cost-effective models of service delivery.
- NGO networks will be created with the help

of large NGOs (Mother NGOs) to make their activities sustainable and exchange successful experiences.

- NGOs not working in the reproductive health areas will be encouraged to include reproductive health elements in their projects and programmes.
- NGO representatives will be involved in government programmes particularly in activities related to planning, strategy development, and monitoring.

4.2.6 Co-operatives and Other Agencies

Co-operatives of all hues, such as milk co-operatives, Tendu Patta co-operatives, Beedi workers co-operatives, Oil Seeds co-operatives, with about seven million members spread all over the state with a good understanding of rural marketing and excellent logistics support systems will be involved in population and reproductive health services. Special innovative projects in activities related to family life education, contraceptive distribution, antenatal care, and immunization of children, will be designed to involve different types of co-operatives. Services of other agencies, such as the District Urban Development Agency and Nehru Yuvak Kendras in rural areas, will be used.

- Systematic efforts will be made to orient the office bearers of the co-operatives and other agencies and involve them in population stabilization efforts and in the provision of reproductive health services.
- Co-operative societies will be involved in registration of pregnant women in the first trimester, and the Government of India scheme that provides Rs 300 for eligible pregnant women will be routed through the co-operatives.
- Linkages will be established between co-



operatives and social marketing agencies in the state to create a vast network of contraceptive distribution points at a very low cost. This network of distribution points will help the subsidized products reach every corner of rural area.

- Some co-operatives, such as beedi workers co-operatives, have hospitals exclusively providing health services to cooperative members. These institutions will be used as referral units for reproductive health services.
- The District Urban Development Agencies (DUDAs) have been playing a major role in improving the quality of life of slum dwellers. Reproductive and child health services will become an integral part of the services offered by DUDAs to slum dwellers.
- Nehru Yuvak Kendras, with about 300 youth in each district, can play an active role in mobilizing the support of youth for population stabilization efforts and in imparting adolescent and family life education to rural youth.

4.3 Role of Development Departments

The Population Policy of Madhya Pradesh envisages active and effective involvement as well as specific contributions of government departments, especially development departments, in achieving population stabilization in the state. Since most of these departments have significant presence at the village level and come in contact with the people, they can help to achieve population objectives of the state. These departments, therefore, will work as a catalyst for the generation of demand for family planning (FP) and reproductive and child health (RCH)

services. Some of these departments may also provide services, though the Department of Health and Family Welfare will undertake major responsibility in the delivery of services, as noted earlier. For this purpose, it is recommended that each of the concerned departments will finalise the activity plan, implement it and monitor the progress on a regular basis. Such continuous monitoring/ review will not only help in the actual implementation of the activity plan but also allow timely corrections, if needed. It is, thus, recommended that all the departments concerned, especially the major ones, constitute a committee consisting of three members - one from department, another from the Department of Health and Family Welfare and the third an outside expert familiar with FP and RCH programmes. It is proposed that the departments concerned will finalise the activity plan as well as monitoring mechanism and the same will be submitted to the Chief Secretary, for review and necessary action. A government order will be issued under the signature of the Chief Secretary detailing the roles of the departments in promoting spacing and small family norms. In addition, it is recommended that various large institutions (like Secretariat, Directorate, Public Undertakings etc.) should have a post of counsellor to advise on family planning services.

The role of the departments concerned in achieving replacement level fertility will be worked out by themselves. However, an outline of the expected roles is given below.

4.3.1 Department of Women and Child Development

- Link FP and RCH programmes to programmes like general empowerment of



- and income generating activities for women.
- Promote the small family norm and adolescent health through various agencies involved in women's development.
- Promote the convergence of the activities of health and ICDS workers at the grassroot level.
- Use Anganwadi Workers as depot holders and also use them as change agents.
- Discuss issues on maternal and child care as well as family planning regularly in the mahila mandal meetings.
- Generate support for women's empowerment programmes like *Mahila Samakhya* and organise and strengthen self help groups and use these to provide FP and RCH services.
- Promote joint training programmes at various levels for health and women and child development functionaries.

4.3.2 Departments of School and Higher Education

- Introduce adolescent and Family Life Education (FLE) at the post primary level in a phased manner.
- Strengthen and use population cells at colleges, and arrange debates, essay and other competitions on population related topics.
- Introduce population and development issues in curricula of schools and colleges.
- Involve NSS, scouts and guides, etc. in the propagation of messages on spacing and small family norms and implementation of FLE.
- Pay due attention to the issue of women's education that is crucial for the success of social development programmes including population stabilization efforts.
- Include messages on population in Total Literacy Campaign and Post Literacy

Campaign, and achieve total adult literacy by 2005.

- Achieve universalization of primary and elementary education by 2005.
- Ensure at least 30 per cent of girls in the 14-15 age group complete elementary education by 2005 (from the current level of 18 per cent).
- Open creches at the school sites to ensure greater participation of girls who come with younger siblings.
- Establish linkages with the Department of Family Welfare especially with the IEC Bureau to enable the education material on population issues reach the larger community.

4.3.3 Departments of Panchayats and Social Welfare

- Review of family welfare programmes should be a permanent agenda in the meetings of *Zilla, Janpad* and *Gram Panchayats*
- Make PRIs responsible for the implementation of family welfare programme
- Arrange meetings at *Gram Panchayat* level on population issues every year.
- Encourage village panchayats to monitor the programme regularly and to report to the Zilla Panchayat.
- Create and strengthen self help groups and promote spacing and small family norms.
- Make special efforts to provide special care and protection to mentally and physically challenged children.

4.3.4 Department of Rural Development

- Make poverty alleviation programmes a significant entry point for adoption of spacing and small family norms.
- Determine flow of resources to Panchayats



on the basis of their performance in family planning and RCH programmes.

4.3.5 Department of Indian System of Medicines

- Propagate spacing and small family norms and contribute to FP and RCH services.
- Work as depot holders for spacing methods.
- Prepare an appropriate communication strategy for spacing and small family norms.
- Identify pregnant women at risk and refer them to a nearby first referral high unit.
- Strengthen referral system for risk cases.

4.3.6 Department of Industries

- Encourage industrial units to provide counselling and FP and RCH services to their workers.
- Persuade industrial units having well equipped health facilities to provide all services not only to their own employees but also to the general population living in surrounding areas.
- Develop closer linkages between industrial units and government health facilities to provide FP and RCH services.
- Co-ordinate with chambers of commerce and industries to provide FP and RCH services among their members.

4.3.7 Departments of Agriculture

- Use farmer groups as a platform for popularizing population issues.
- Display small family norm messages on fertilizers/seeds/pesticide packages, etc.
- Generate demand for family planning services among villagers through farmer self groups.

4.3.8 Department of Public Health Engineering

- Provide safe drinking water to each village by 2005.

- Display messages on small family norm on water tanks, etc. and create demand for FP and RCH services.

4.3.9 Department of General Administration

- Ensure adoption of small family norm while sanctioning loans and subsidies to employees.
- Make legal age at marriage a criterion to those seeking government jobs.
- Introduce population stabilization concerns in all training programmes conducted by various government departments.

4.3.10 Department of Home

- Amend existing Child Marriage Restrain Act suitably and make the child marriages cognizable offence.
- Implement with vigor the Child Marriage Restraint Act with better coordination between the police, women groups, PRIs and the NGOs.
- Reduce crimes and atrocities against women and establish women's police thanas.

4.3.11 Department of Planning and Economics and Statistics

- Compulsory registration of marriages and other vital events (births and deaths).

4.3.12 Department of Youth and Sports

- Use Nehru Yuvak Kendras and other youth groups to create environment for spacing and small family norms.

4.3.13 Department of Food and Civil Supplies

- Display slogans on spacing and small family norms on ration cards.
- Involve fair price shops to distribute contraceptives.
- Use fair price shops for advertising messages on spacing and small family norms.



4.3.14 Department of Transport

- Make it compulsory for all commercial vehicles to display messages regarding small family norm.
- Display of small family norm messages at bus stands, taxi stands and other transport facilities.
- Print messages on small family norm on permits, receipts, tickets, driving license, etc.

4.3.15 Department of Public Relations and Information

- Use modern communication technology to disseminate messages on population issues.
- Display messages on spacing and small family norms in cinemas and during the screening of the films.
- Orient and involve journalists in population issues.
- Provide technical assistance for producing material on population issues.
- Make it compulsory for all sponsored advertisements to display messages on small family norm.

4.3.16 Department of Labour

- Educate all members of transport unions in regard to prevention of AIDS.
- Get support from labour unions to spread messages on spacing and small family norms among their members.
- Involve labour union leaders in motivating their members regarding spacing and small family norms.
- Strengthen FP and RCH counseling services in all ESI hospitals.
- Reactivate the tripartite agencies of government, employers and employees for promoting spacing and small family norms.

4.3.17 Department of Forest

- Educate all staff on the impact of population growth on deforestation and environmental degradation.
- Involve the Joint Forest Management Committees (JFMC) in popularising the messages on spacing and small family norms.

4.3.18 Department of Urban**Administration and Development**

- Display posters, slogans, and other materials regarding population issues at all important points in urban areas.
- Arrange meetings with the help of elected officials to orient communities about spacing and small family norms.
- Involve District Urban Development Agency (DUDA) hierarchy to propagate spacing and small family norms in the community.
- Develop a service delivery system in collaboration with the Department of Public Health and Family Welfare for urban areas especially slum areas.

4.3.19 Department of Cooperatives

- Motivate members of co-operatives to use modern contraceptive methods.
- Print messages on small family norm on all vehicles and product packaging.
- Use general meetings of co-operatives to discuss population issues.
- Reward those cooperative societies who have done well in population stabilization efforts.
- Use primary co-operatives to work as depot holders for distribution of contraceptives.

4.3.20 Department of Revenue

- Involve Patwaris as agents of change for popularising spacing and small family norms.
- Encourage Patwari, Tehsildars and Kotwars to use all opportunities to sensitize the



community regarding population stabilization issues.

- Print messages on small family norm on all registration documents.

4.3.21 Department of Tribal Welfare

- Identify unique problems of tribal areas particularly in regard to access to and quality of services.
- Prepare area specific plans, in collaboration with other departments, to address unique problems faced by the tribal population.

4.4 Improving Management of the Family Welfare Programme

The current level of total fertility in the state is around 4 children per woman, which is just double the replacement level fertility of 2.1 children. And, that level is required to initiate the process of population stabilization in the state. To attain the objective of replacement level fertility by 2011, the contraceptive prevalence rate should increase from the current level of 42 per cent to 65 per cent.

When translated into absolute numbers, the increase in prevalence means that the Department of Health and Family Welfare—with the help of other partners—should serve 2.7 million eligible couples in the year 2000. This number includes continuing users of spacing methods. The number to be served will progressively increase to 4.5 million in 2011. It is a daunting but achievable task given that around two and half million currently married women of reproductive age group had an unmet need for contraception in 1992-93 and that unmet need has further increased in recent times. The proportion of eligible couples who do not want any more children has increased from 19 per cent in the year 1992-93 to 25 per cent in 1998-99. Further, there is also a significant gap between desired family size and actual family size. To convert couples with an unmet need for family planning to users of contraception, the programme has to systematically address issues related to access to and quality of services, devise IEC strategies to generate demand for family planning services, and promote informed choice.

Table 6: Madhya Pradesh: Contraceptive Use to be Achieved by 2011

Year (As on March 31)	Eligible couples (In Million)	Percentage of current users	Total couples to be protected each year
1999	14.2	42.0	—
2000	14.4	43.3	2.74
2001	14.7	45.2	2.84
2002	15.0	47.7	3.07
2003	15.2	50.4	3.24
2004	15.4	52.9	3.39
2005	15.8	55.2	3.59
2006	16.1	57.3	3.68
2007	16.4	59.2	3.84
2008	16.7	61.1	4.00
2009	17.0	63.2	4.18
2010	17.3	64.3	4.34
2011	17.6	65.0	4.51



4.4.1 Revamping Programme Management

The Department of Health and Family Welfare has a central role to play in the delivery of quality reproductive and child health services. The department now implements several different health and family welfare programmes. Over time, the complexity of tasks involved in programme implementation and the number of institutions providing different types of services at various levels have increased and programme orientation, in general, after the introduction of Community Needs Assessment Approach has undergone major changes. The transfer of reproductive health programmes to Panchayati Raj Institutions led to major changes in the service delivery strategies, structures, and systems. As a result, it is necessary to review and revamp the programme to make it more effective.

- Strengths and weaknesses of the organizational structure will be reviewed, and roles and responsibilities and authority and accountability will be redefined in tune with the Population Policy's objectives and key strategies.
- Keeping in view the general constraints of resources (financial, administrative and managerial) for pursuing the family welfare programme, the thrust would be to consolidate the existing infrastructure.
- The District Planning Committee will accelerate the process of decentralization of authority and responsibility for programme planning and resource utilization.
- An autonomous IEC bureau, by reorganizing the existing bureau, will be created and its activities will be strengthened. This body will be managed by professionals and will, in addition to IEC activities, carry out adolescent and family life education.
- A new unit called the State Population

Resource Centre (SPRC) will be established to strengthen monitoring and evaluation, a much needed component of effective programme management. The unit will provide constant support to planners and programme administrators in identifying strengths and weaknesses of the programme, in monitoring performance, in evaluating various programme components and in developing new strategies for service delivery. The SPRC will also prepare a technical report annually on the state of population stabilization efforts in the state and the same will be presented to the proposed State Population and Development Council. It will also work as a technical resource centre for the Council. The SPRC will be managed by the professionals with background in population programme management.

- The Family Welfare Programme is entirely funded by the Government of India. To provide enough flexibility in the use of resources and as a token expression of the commitment of the state to the population stabilization effort, the state government will allocate Rs 5 crores of its own resources to the programme every year to support the innovative measures like the proposed State Population Resource Centre, etc.

4.4.2 Strengthening Service Delivery Systems

Service delivery systems have to focus more on client needs and provide services in a socially acceptable manner. The department will endeavour to constantly improve access to services and the quality of services. Keeping this in view, the systems will be reviewed and revitalized.

- Health workers have been listing all eligible couples at the beginning of every financial



year. Such information will be used for micro-level planning with particular emphasis on segmentation of clients based on expressed needs of clients both for reproductive and child health and family planning services.

- Merely identifying the clients needing services will not help unless they are actually contacted by the workers and provided the services as desired by them. As such, a system of supportive supervision and a mechanism of concurrent internal monitoring and evaluation will be developed and introduced.
- The management information system will be streamlined with an emphasis on reliable and adequate collection of data and use of information for decision making. The data will be computerized at the district level to facilitate easy access to decision makers.
- The registration of pregnant women in the first trimester will be given priority and traditional birth attendants will be trained to register pregnant women and provide safe delivery.
- The Department has already initiated steps to rate the first referral units on the basis of minimum quality standards. Quality circles and social auditing of performance are other measures being considered. These measures will be further strengthened and extended to all health institutions.
- Spacing method use in rural areas of Madhya Pradesh is very low. More focused attention will be given to promotion of spacing methods. Given the new technological advances in spacing methods, particularly for non-hormonal oral contraceptives and new IUD devices, it is possible to make rapid strides in this direction.
- While sterilization would continue to play an important role in the population control

efforts, it would be ensured that the profile of the acceptors would be of the right quality in terms of age and parity. The no-scalpel vasectomy method will be promoted to increase male participation in family planning method use.

4.4.3 Improving Service Delivery System in Urban Area

To provide family planning and RCH-services, there exists a vast network of primary health care infrastructure in rural areas. But, there is no comparable infrastructure in urban areas.

- A suitable service delivery system will be developed for urban areas, especially covering slums and disadvantaged areas.
- In order to supplement the efforts of the government, the private sector will be involved in providing the essential package of services.

4.4.4 Developing Appropriate Communication Strategy

In creating a conducive environment by dispelling the myths as well as psychological barriers especially among the couples inclined towards the use of family planning services, communication will play a vital role.

- A communication strategy will be developed to cater to different segments of clients. Clients will be reached with an appropriate mix of interpersonal communication and mass media campaigns. Electronic media will be put to optimum use in a systematic way to convey messages on family planning and reproductive and child health services.
- The communication strategy will aim at creating a sense of pride among couples about the small family norm, promoting/encouraging male participation in a major



way, adherence to legal age at marriage, increasing age at first child and increasing awareness of existing government programmes from which couples can derive benefits, etc.

- Social mobilization by community leaders is essential to the success of the programme that emphasizes behavioural changes. The family welfare programme in Madhya Pradesh does not have the continuous support of community leaders to create a conducive environment for the programme. The support of religious leaders and village heads (*pradhans*) is crucial. The District Family Welfare Bureau will arrange a series of meetings, training programmes for these leaders to garner their support and involve them in family planning programme implementation.

4.4.5 Building Competencies of Human Resources

- Human resource development will be given

the highest priority and the training programmes intended to improve skills of health personnel and others will be reviewed and redesigned with the help of the State Institute of Health Management and Communication.

- The clinical training will be adequately addressed and strengthened.
- The present training programme of the Traditional Birth Attendants (TBA) needs further gearing up so that more and more TBAs are trained annually to cover all the villages of the state by 2003.
- The introduction of reproductive and child health and family planning education in the curricula of medical colleges is of urgent necessity. Specific courses in these areas for students of medical colleges will be introduced for upgrading their knowledge and providing exposure so the medical graduates having knowledge of reproductive and child health and family planning could serve with proficiency.



Implementation Mechanisms

Effective implementation of the Population Policy requires appropriate structural mechanisms. To strengthen political support, ensure inter-sectoral coordination, and institutionalize integration at the district level and below, the following new mechanisms will be put in place.

5.1 The State Population and Development Council (SPDC)

In order to streamline the efforts to achieve population stabilization within a stipulated time period, the apex body called the State Population and Development Council (SPDC) chaired by the Chief Minister will be formed. This body will review and adopt policies consistent with the state's socio-economic goals and reproductive health programme objectives. The SPDC will meet at least twice a year. The proposed State Population Resource Centre will act as a Technical Secretariat for the SPDC, and an Additional Chief Secretary will act as its Member Secretary. The Council will have the following members:

- i. Chief Minister, Chairperson
- ii. Ministers of Departments of Education, Medical, Health and Family Welfare, Women and Child Development, Home, Finance, Youth and Sports, Rural Development, Urban Development, Labour and Employment, Planning, Cooperatives, Environment, Agriculture, Industries and Tribal Welfare
- iii. Leaders of all political parties in the Legislative Assembly

- iv. Chief Secretary of the Government of Madhya Pradesh
- v. Eight members representing experts, NGOs, the organized sector, women's organizations, trade unions, and cooperatives
- vi. Additional Chief Secretary, Government of Madhya Pradesh, as the member secretary

Special Invitees

All Principal Secretaries of all relevant departments and Director, Public Health and Family Welfare.

5.2 State Population Policy Implementation Committee (SPPIC)

To coordinate and monitor implementation of various components of the Population Policy, a committee under the chairmanship of the Chief Secretary will be constituted. This committee will coordinate the activities of different partners, monitor performance, and take corrective measures necessary to achieve the policy's objectives. The committee will meet once every three months and consist of the following members:

- i. Chief Secretary, Chairperson
- ii. Member Secretary of SPDC
- iii. Principal Secretaries of all relevant departments as members
- iv. Representatives of non-government sector
- v. Principal Secretary (Health), Member Secretary of the Committee



5.3 District Population and Development Coordination Committee (DPDCC)

To achieve convergence at district and below levels, it is proposed to set up DPDCC. The committee will function under the leadership of the Chairperson of the District Planning Committee. Heads of all development departments at the district level, representatives

of the non-government sector, and other prominent personalities in the district will be members of the committee. The District Collector will coordinate the activities of the committee and act as its Member Secretary. The committee will meet once every two months to monitor programme performance, strengthen supervision and monitoring of field functionaries, and mobilize community support.



Concluding Remarks

The Madhya Pradesh Government is fully committed to improve the quality of life of its people. Social engineering programmes aimed at changing the values, attitudes, and practices of people have a central role to play in this effort. The Madhya Pradesh Government has taken a series of steps to improve the literacy rate, especially among females, and to empower women. All of these crucial measures will not yield results if the population grows at its current rate. To address the issue of rapid population growth, the Madhya Pradesh Government has decided to formulate a comprehensive population policy with special emphasis on decentralized integrated approaches based on client needs.

The Population Policy of Madhya Pradesh aims to create an environment that helps clients to make informed decisions. The Population Policy

follows a holistic approach and looks beyond family planning measures. Empowerment of women, the active participation of elected representatives of local elected bodies, integration of services, meaningful partnership between public and private sector agencies, and—above all—mobilization of community support are the major strategic thrusts of the policy. In addition, the policy will aim at increasing access to and improving the quality of reproductive health services at all levels.

After a thorough analysis and dialogue and deliberation with stakeholders, this Population Policy proposes various measures to achieve replacement level fertility by 2011. The proposed measures and their successful implementation will help Madhya Pradesh achieve sustainable development with hope and confidence.

