AN ABSTRACT OF THE THESIS OF

Ashley Rowe for the degree of Master of Arts in Women, Gender, and Sexuality Studies presented on June 5, 2017.

Title: The Politics of Population: A Transnational Feminist Analysis of India's National Population Policy of 2000.

Abstract approved:

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Janet Lee

The purpose of this study is to critically analyze whether India's National Population Policy of 2000 represents a paradigm shift in terms of how the nation-state conceptualizes and address population growth through formal population policy. Analyzed through transnational feminist theory, this study employed political discourse analysis as the research method. Composed of the three levels of analysis, PDA focuses on the political and historical contexts in which political discourse is constructed, how these contexts impact the formal linguistic and discursive features of policy, and the impact of political discourse on social practice. The findings from this study found that the NPP does represent a paradigm shift, specifically in terms of the policy framework upon which India's National Population Policy is premised. However, discourse and social analysis demonstrate that the focus of this policy continues to be economic development, meaning that while a paradigm shift has occurred, this shift has not necessary been for the betterment of India's women and marginalized populations.

The Politics of Population: A Transnational Feminist Analysis of India's National
Population Policy of 2000

by
Ashley Rowe

A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Master of Arts

Presented June 5, 2017
Commencement June 2017

Master of Arts thesis of Ashley Rowe presented on June 5, 2017

APPROVED:

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Ashley Rowe, Author

ACKNOWLEDGEMENTS

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LIST OF ABBREVIATIONS

NPP- National Population Policy

PDA- Political Discourse Analysis

GOI- Government of India

ICPD- International Conference on Population and Development

RCH- Reproductive and Child Healthcare Approach

INTRODUCTION

As the first nation-state to introduce and implement a national family planning program in 1952, India has an extensive history of population reduction efforts. Organized primarily through five-year development plans, India's efforts to influence and reduce fertility rates have been meet with varying success. What had begun as voluntary family planning with an emphasis on healthcare, evolved into coercive population paradigms during the mid-to-late twentieth century. To address the needs for family planning through a non-coercive paradigm, India's government announced their first national population policy in February, 2000. Known officially as the National Population Policy of 2000 (NPP), this policy attempts to reconcile the needs of India's citizens for family planning and reproductive healthcare with the desires of the nation-state for development. Praised by many in the international community as a paradigm shift away from coercive population policy, India's NPP has been heralded as a decisive and much needed change towards human rights for women and girls (Menon-Sen, 2013, p.160).

Paradigms are important to population policy in that they not only represent a consensus amongst certain epistemic communities as to how knowledge is produced and understood according to certain epistemological and theoretical frameworks, but they greatly frame and shape our understandings of the social world. The concept of paradigm shift refers to Thomas Kuhn's theory of knowledge production, in which the accumulation of new knowledge occurs through periods of transformation known as "paradigm shifts." According to Kuhn (1962), paradigm shifts occur when communities and scholars challenge existing long-held assumptions of particular paradigms, positing a new paradigm that replaces older forms of knowledge and understanding (p.114). Within the context of India, the shift from coercive population paradigms

to the NPP of 2000 represents, to many, a distinct paradigm shift not only in how population growth is understood in relation to the health and vitality of the nation-state, but also the extent to which the nation-state pursues population reduction efforts. However, as Mbisamakoro (2014) argues, two problems arise when claiming a paradigm shift in relation to population policy. First, paradigm shift "implies that population control is no longer an issue and that the debate on population control may now be over" (p.5). Second, paradigm shift also implies that what was wrong with previous population policies and plans is relegated to the past. In doing so, this creates a siloing effect in terms of understanding population policy within a broader policy context, as "the possibility of bringing the past into dialogue with the present is significantly reduced" (p.5).

Statement of Purpose

While discourse surrounding population during the 1990s began to change as international governmental organizations emphasized a reproductive rights and healthcare framework to population policies over that of coercion, the extent to which the NPP represents and reflects a paradigm shift has yet to be explored from a feminist framework of analysis. As such, the purpose of this scholarship is to analyze the NPP from a transnational feminist framework to understand whether the NPP represents a discursive paradigm shift towards the current international population paradigm of reproductive rights and healthcare or whether the NPP continues to replicate past policy paradigms of population control.

Research Question(s)

India and the NPP were chosen for study after completing a transnational feminism course during my first year of graduate school, in which I was asked to produce a scholarly article on a current transnational issue of our choice. Given my passion for reproductive justice

and women's healthcare prior to the course, I preliminarily began research on transnational reproductive justice within a Global South context, but soon found this topic to be quite broad for a scholarly article. Upon the suggestion of my professor, my research focus shifted to current events happening in 2016 that were related to transnational reproductive justice. It was around this time that many media outlets, particularly in the Global North, were focusing on the growing number of deaths that were occurring in India via mass sterilization camps, many of which were funded and supported by the government of India. What was shocking about this media coverage at the time was the amount of attention being paid to the purported "negligence" of the Indian government, believing that the nation itself was to blame for its "backwards" family planning practices.

However, what many of these news stories neglected to understand is the complexity of India's history in regards to family planning, and the role that international governmental institutions in the Global North have played in shaping family planning policies and practices. As a result, my scholarly research during this time focused on women's sterilization in relation to globalization and neoliberalism via the World Bank, in order to understand the ways in which women's bodies have been constructed as being tied to the development and health of the nation-state, and as such, are viewed as sites in which to enact neoliberal economic policies. While my research at the time began looking at and drawing connections between the ways in which institutions in the Global North continue to enact neocolonialist policies upon the Global South, my research failed to take into account the ways in which nation-states themselves play an active role via national population policies in shaping reproductive healthcare behavior and practices. Moreover, upon further reflection, it became apparent that my scholarship prior to this study positioned India as a passive agent in relation to international governmental organizations in the

Global North and the policies these organizations create and implement, which unintentionally reproduced colonialist power relations between the Global North and South.

Remaining interested in the topic of reproductive justice in India, particularly female sterilization, while also wanting to avoid replicating and reproducing problematic frameworks from earlier scholarship, my research evolved to focus on understanding how nation-states themselves create population policy, and how policy is connected to larger institutional structures, powers, and ideologies. India presents a particularly rich field of study in terms of population policy and reproductive justice, in that they have an extensive population policy history that reflects struggles for nation-state autonomy and agency, as well as involvement from international governmental organizations who have exerted political influence in shaping population policies in the Global South in very particular ways. As such, this complexity allows an understanding of the role of political actors in creating and shaping population policy, the ways in which involvement of particular political actors and institutions affect how population growth is discursively conceptualized and addressed within formal policy, and by extension, the ways in which nation-states address concerns over population growth through family planning programs.

It is important to recognize how my positionality as a scholar located in the Global North, writing about policy and policy analysis that focuses on the Global South, contributes to the creation of my research questions. I'm a white, college-educated woman who has lived her entire life in the Pacific Northwest. My formal education has occurred through the U.S.-centric public school system, which continues to center and privilege the Global North as drivers of "progress" and development, while portraying the Global South as "underdeveloped" and in need of assistance from the Global North. Having dual degrees in political science and women's studies

from a fairly large, liberal, predominately white public university, my undergraduate college

education focused primarily on U.S. institutions and structures as mechanisms of oppression and

marginalization, with minimal focus on international policy or issues affecting marginalized

communities within a global context. Given that much of my formal education and training prior

to graduate school has occurred through educational institutions with a U.S.- and Global North-

centric bias, it is important to recognize how this limits the epistemologies I draw from in

regards to political discourse analysis, the types of questions I ask, and the conclusions I produce

from this analysis.

      The central question that guides this scholarship is: Does India's NPP represent a

paradigm shift in terms of how the nation-state conceptualizes and addresses population growth

through its formal population policy? Given the complexity of population policy, political

discourse analysis methodology is employed that will analyze the NPP through three levels of

analysis: situational, textual, and social. While PDA as a methodology is explored in more detail

in chapter two, it is important to understand what PDA entails and how this methodology

structures my approach to my central research question. PDA as a method for analysis attempts

to understand the process of political discourse construction by political actors within political

institutions and the impact of political discourse on the social world (Jorgensen & Phillips, 2002,

p.18). Composed of the above-mentioned levels of analysis, PDA focuses on the political and

historical contexts in which political discourse is constructed, how these contexts impact the

formal linguistic and discursive features of policy, and the impact of political discourse on social

practice. These levels of PDA allow for a more nuanced understanding of my central research

question regarding paradigm shift by analyzing processes of knowledge production. The practice

of knowledge production is central to the emergence of new paradigms and necessitates being

analyzed and understood in relation to textual discourse and social practice. Through this

analysis, the following specific questions will be addressed:

1. What is the political and historical context in which the NPP was created?
2. In what ways have formal international governmental institutions influenced/informed the creation of the NPP?
3. How do political/historical contexts of knowledge production (i.e. policy) impact the types of voices, knowledges, and ideologies that are present within the text?
4. How does the presence or absence of particular voices and knowledges impact what is recognized and regarded as important?
5. How does the text of the NPP affect social practices and behaviors in regards to particular gendered, racialized, and classed bodies?
6. What impact does the language of the NPP have on the social practices of family planning and population growth reduction within India?

India's National Population Policy (NPP)

The NPP is a fairly short population policy with the "bulk" of the policy being around

nineteen pages in length (see Appendix B for the text of the NPP). Eight sections are included

within the NPP, which outline policy objectives and strategic themes that are to be addressed at

the national and state level. Strategic policy themes receive the most attention within the NPP,

with roughly ten pages devoted to outlining and discussing reproductive and child health care

needs as they relate to family planning and population reduction. These strategic themes

encompass a variety of topics, ranging from maternal health and childhood survival, the role of

NGOs in providing family planning care, and increased access to family planning through rural

clinics. Given that the purpose of the NPP is to address healthcare concerns as they relate to

population growth within the nation-state, it is not surprising that the majority of the policy itself

focuses on unmet reproductive and child healthcare needs that prevent stabilization in population

growth.

The text of the NPP itself includes several appendices which outline operational

strategies at the national and state level and government funding; suggest milestones in India's

population efforts; present a demographic profile including population growth rates; and give an overview of unmet family planning needs. Although at first glance the appendices that present the demographic profile and milestones in India's family planning efforts appear randomly to consider the purpose of the NPP to address population growth via reproductive and child healthcare, a deeper reading shows their inclusion is employed to create an argument for the necessity of a national population policy. The "milestones" included within the NPP appendices are rather sparse, detailing major historical and political events in terms of reducing population growth within India. Although these milestones do not provide much detail, when read alongside India's demographic profile, demonstrate that population reduction efforts have thus far been unable to address the growing population rate of the nation-state and as such, necessitate a national policy. For example, one of the milestones included is the introduction and implementation of the 1952 family planning program, which was launched by India's central government shortly following independence to address population growth concerns (GOI, 2000, p.36). The assumption when reading this milestone is that given India's extensive history of family planning and population efforts, population growth should be under control and no longer a concern. However, as India's demographic profile outlines, population growth rates as facilitated by high birth and death rates, have largely been untouched by family planning efforts, which can be attributed in part due to the varied success of their five-year plans.

The inclusion of the final appendix in the NPP, unmet family need, relates to the argument established in the appendix on family planning milestones and demographic profile, in that it is included to rationalize a national population policy. Unmet need refers to "the percentage of women of reproductive age, who have an unmet need for family planning. Women with unmet need are those who are want to stop or delay childbearing but are not using any

method of contraception" (U.N., 2014). Unmet need has and continues to be identified as a driver of population growth, as inadequate access to contraceptives and other family planning methods in linked to excessive reproduction and overpopulation. According to the NPP, "unmet need for contraceptive services is estimated at 28%", with states that have large percentages of rural, low-caste, and agricultural communities that lack access to contraceptives accounting for a projected fifty-five percent population increase" (GOI, 2001, p.43). Given that India's previous population efforts as outlined in the NPP appendix on family planning milestones have been largely ineffective at slowing population growth, the inclusion of a focus on unmet need is employed to argue the necessity of a national population policy, which is assumed to address family planning as a means to reduce population growth.

While the above mentioned appendices are important to the overall argument within the NPP regarding the need for the policy, the first NPP appendix, operational strategies, is rather striking in its lack of concreteness at both the national and state level, and in terms of funding, regarding how these strategies are to be accomplished and implemented, and through which governmental structures' funding is allocated. As mentioned previously, the purpose of the NPP is to address healthcare concerns as they relate to population growth within the nation-state in order stabilize population growth. This focus on healthcare for population stabilization is apparent within the operational strategies of the NPP, as maternal and child healthcare and increasing access to family planning are central to these strategies. Consisting of sixteen pages in length, these operational strategies varying greatly from addressing maternal health outcomes during pregnancy to the role of India's public health infrastructure in accomplishing improved health and population stabilization. While these strategies are important in their acknowledgement of health disparities that impact the health and well-being of women and

children, these strategies are, for the most part, lacking in concrete detail as to how they are to be achieved and implemented. For example, operational strategy seven of the NPP focuses on providing healthcare centers in rural areas, stating that a need exists to

> Strengthen the capacity of primary health centers to provide basic emergency and neo-natal health care (GOI, 2001, p. 23)
>
> Involve professional agencies in developing and disseminating training modules for standard procedures in the management of obstetric and neo-natal cases. The aim should be to routinize these procedures at all appropriate levels (GOI, 2001, p.23)
>
> Improve supervision by developing guidance and supervision checklists (GOI, 2001, p.23)

What these policy objectives demonstrate is an employment of language that lacks specificity in terms of how these objectives are to be accomplished or what their implementation looks like, as words such as strengthen, involve, and improve remain subjective and open to interpretation by political actors and healthcare providers.

Similarly, discussion of funding is largely absent from the NPP, where blanket statements such as "fund the nagar palikas, panchayats, and community organizations for interactive and participatory [family planning] activities" (GOI, 2001, p.34) are used in favor of concrete funding details. While there is some discussion of funding within the appendix on unmet need, these discussions are largely limited to the necessity of increasing funding to contraceptives, not to specific program themselves. Included within discussions of funding are acknowledgments of program cost in terms of healthcare infrastructure, particularly at the state level, and the inability of states to address these costs effectively. For example, the NPP states that:

> primary healthcare centers cost Rs. 24.50 lacs with a recurring liability of Rs 13 lacs. These expenditures are met by the state governments under the basic minimum services program. However, the financial position of the state government does not enable them to make these investments in health infrastructure (GOI, 2001, 43)

As this quote above demonstrates, the NPP recognizes the financial cost of providing primary healthcare, that of which states can not adequately provide to their citizens. By focusing on the cost of primary healthcare over that of contraceptives and family planning, the NPP discursively positions contraceptives and family planning as the "cheaper" option, that of which states have a vested interest in providing. In doing so, the generalized focus of funding on providing contraceptive services ignores the ways in which primary healthcare and other health related needs are ignored within the policy.

Finally, it is important to focus on the use of language in terms of the construction and interpretation of the NPP. Language within policy is important in that it is not only a mechanism in which to describe and convey ideas, but it is also reflective of particular nation-state histories. As a former British colonial territory, language employed within the NPP is reflective of the historical construction of language that occurred through colonial subjugation and territorial occupation. Written and distributed in English, India's NPP is a linguistically exclusionary policy in that it excludes large percentages of India's population from having access to the policy in a language they are able to fluently read and comprehend. As of the 2001 Indian Census, thirty major languages other than English were spoken by over one million native speakers and one thousand five-hundred fifty-nine total languages and dialects were recorded, making India one of the most linguistically diverse nation-states (GOI, 2001, p.1). Despite this diversity, policies and government documents continue to be written in English, which was adopted as the nation's official language by India's intellectual and political elite following independence, a trend that "has been replicated in many parts of the post-colonial world" (Baldridge, 1996, p.10). Although the percentage of English speakers within India has increased slightly to around twelve percent as of the last census, English as a first language accounts for less than one percent of India's total

languages spoken (GOI, 2001, p.2) and only around four percent of India's population is able to fluently speak and write English (Baldridge, 1996, p.10). This is particularly consequential for specific demographic populations whom the NPP is employed to regulate family planning and reproductive behavior, as a lack of access to the NPP in a language one is able to read and comprehend means that policy is applied and enforced upon specific populations who do not understand the policy itself. In many ways then, language employed within the NPP reflects the ways in which India's history with colonization continues to inform processes of policy creation, as language within policy is employed to re-colonize particular types of knowledges, voices, and experiences to fit within a linguistically constricted population policy

Theoretical Framework

This scholarship employs transnational feminist theory. According to Boeder-Harris (2010), transnational feminist theory is a multifaceted framework that explores "intersections of race, class, gender, sexual orientation, and geopolitical location in an attempt to identify the myriad oppressions of women that will allow for contextualizing, complicating, and ultimately strengthening the lens of critical analysis" (p.23). Committed to integrating diverse knowledges, experiences, and voices within the larger feminist movement, particularly from women in the Global South and subaltern communities, transnational feminist theory strives to decolonize knowledge production and praxis within and outside feminist spaces by challenging underlying Western assumptions that exist within knowledges of modernity. A central component of transnational feminist theory is the commitment to recognizing differences while engaging in "cross-national feminist solidarity building," in order to avoid erasing matters of difference that impact the lived experiences of women and marginalized communities from the Global South (Mohanty, 2003, p.509).

Transnational feminist theory emerged during the 1980s as a critique of liberal feminisms for its failure to recognize and incorporate diverse voices, knowledges, and experiences within feminist theory and praxis (Grewal and Kaplan, 1994, p.13). Arguing that liberal feminist theory, which is largely white, Westernized, and Global North-centric, privileges the experiences of women in the Global North and positions them as universal experiences for *all* women, (Mohanty, 1988, p.335) transnational feminist theory attempts to decenter hegemonic liberal analysis by recentering the histories, experiences, knowledge, and voices of marginalized peoples and communities from the Global South. Rejecting concepts of 'universal oppression' and 'global sisterhood,' transnational feminist theory argues the necessity of locating lived experiences within *multiple and specific* axes (i.e., social positionalities and contexts) of analysis to highlight diversity of experience for women and other marginalized communities in the Global South.

While transnational feminist scholars have produced a substantial amount of scholarship problematizing knowledge production within feminist spaces, important to this scholarship are critiques of knowledges of modernity. Modernity refers to "discourse which structures the perception of the world not only cognitively through the categories of rationality and science, but also by means of such values as progress and secularism, which are often inseparably entwined with the former" (Duara, 1991, p.67). Within the context of transnational feminist theory, attention is given to the ways in which knowledge production in the Global North participates in and legitimizes the concept of "progress" through which history is understood and structured. In particular, transnational feminist theory critiques assertions made within knowledges of modernity that construct colonization, or the act of territorial occupation and Indigenous subjugation (Buescher & Ono,1996, p.131), as a fact of the past that has no bearing on the

present. Recognizing that colonization has historically and contemporarily shaped the trajectory of nation-states in the Global South, transnational feminist scholars draw upon this history to examine the ways in which gendered colonization continues to impact the social, economic, and political experiences of women and communities (Grewal & Kaplan, 1994, p. 13). In other words, while the physical act of territorial occupation by colonial forces has ended, the enduring effects of colonization continue to inform the lived experiences of women and marginalized communities in the Global South. For this reason, gendered histories of colonization are central to transnational feminist epistemologies that examine and critique knowledge production in modernity.

Additionally, transnational feminist theory critically analyzes systems of oppression that are located within modernity to examine the ways in which histories of colonization and imperialism inform these systems. Of particular interest to transnational feminist scholars is globalization, which has come to structure power relations between the Global North and South (Herr, 2013, p.193), and by extension, impact the lives of women and marginalized communities. Drawing upon postcolonial paradigms, analysis of globalization focuses on the realities of Western colonialism and imperialism to understand how these histories have shaped the contemporary world and power relations between nation-states, and by extension, the lived experiences of women and marginalized communities. Specifically, transnational feminist theory argues that although colonialism and imperialism have formally ended, many aspects of globalization replicate neo-colonial practices that negatively impact the Global South. As Scholz (2010) states,

> Multinational corporations and global businesses, largely centered in Western
> nations, bring their own colonizing influence through business models,
> hegemonic culture, exploitation of workers, and displacement of traditional
> trades. Whereas traditional forms of colonialism entailed the colonizer assuming

the privilege of ruling the colony, this neocolonialism rules indirectly through the power it creates and enjoys by bringing manufacturing jobs to an area or providing consumer goods to a people – often Western inspired consumer goods as well. Old style colonialism often killed or displaced indigenous peoples; the new style of colonialism impoverishes a culture by swamping society with Western values, products or ideals. (p.139)

While neo-colonialism has been traditionally understood in relation to economic globalization, transnational feminist scholars have observed that many of the social and political conditions created by colonialism, such as racism, cultural marginalization, and asymmetrical power relations between the Global South by the Global North, have been sustained and intensified by neoliberal globalization processes (Weendon, 2002). As such, transnational feminist theory argues the necessity of examining processes of globalization and neocolonialism within multiple categories of inquiry to understand not only how the Global North asserts authority over the Global South, but how this assertion of power reinforces systemic inequality and marginalization.

Part and parcel of transnational feminist analysis of neoliberal globalization and neo-colonialism is the deconstruction of knowledge production that exists within these systems to understand the ways in which knowledge production and systems of oppression are mutually-constructing phenomena. Arguing that knowledge production within modernity is based upon concepts such as "progress", "modernization", and "development" that structure how history is understood in relation to the present, transnational feminist theory examines how knowledge production within systems of neoliberal globalization and neo-colonialism constructs these systems as "naturally"- occurring phenomena (Weendon, 2002). Of particular interest to transnational feminist analysis is examining the ways in which neoliberal globalization and neo-colonialism are constructed as natural extensions of "the upward slope of progress," and the consequences that arise from the normalization and justification of these systems. Transnational

feminist scholars have noted that knowledge production within systems of globalization and neo-colonialism serve larger purposes of upholding Western ideals and norms, particularly economic and political norms, to the detriment of women in the Global South, as these norms and ideals are positioned as a model for the Global South to replicate (Parekh & Wilcox, 2014, p.48). Subsequently, analyzing the cyclical relationship between knowledge production and systems/ processes of oppression and marginalization (i.e., neoliberal globalization and neo-colonialism) is a key facet of transnational feminist theory and scholarship.

To provide direction and structure, this thesis is organized into six chapters. Chapter one provides a review of relevant literature on India's population policy. The purpose of the literature review is to discuss as well as critique current scholarship via a transnational feminist framework Following the literature review is chapter two, methodology, which focuses on the origins of political discourse analysis, methods employed for data collection and analysis, justification for utilizing political discourse analysis for this particular type of research, as well as the methodological limitations of my research.

Chapters three through five focus on political discourse analysis of the NPP from the three levels of PDA. Chapter three focuses on situational analysis of the NPP, in which I explore the political and historical context in which the NPP emerged, and the political actors, both domestic and international, involved in the policy creation process. Analyzed through a transnational feminist framework, I engage in analysis from a lens of knowledge production to examine the presence and/or absence of subaltern voices and knowledges within processes of knowledge (policy) production. Situational analysis of the NPP explores the question of paradigm shift from the perspective of knowledge production and accumulation, which are necessary for the emergence of a new paradigm. In this chapter I ask the specific questions:

- What is the political and historical context in which the NPP was created?

- In what ways have formal international governmental institutions influenced/informed the creation of the NPP?

Building upon situational analysis, chapter four focuses on textual analysis of the NPP. Textual analysis attempts to understand how situational context of knowledge (policy) production may have bearing on linguistic and discursive features of the text itself. In this chapter, I explore the ways in which political and historical contexts of knowledge production (i.e.) policy, impacts the types of voices, knowledges, and ideologies that are present within the NPP and how the presence or absence of particular voices and knowledges impacts what is recognized and regarded as important. Textual analysis of the NPP is important to my central question of paradigm shift in that discourse within policy is reflective of the paradigm upon which it is based. This means that textual analysis can reveal how particular themes in policy are related to particular paradigms. In other words, textual analysis reveals the ways in which discourse and knowledge have or have not shifted in regards to population policy. In this chapter I ask the specific questions:

- How do political/historical contexts of knowledge production (i.e. policy) impact the types of voices, knowledges, and ideologies present within the text?

- How does the presence or absence of particular voices and knowledges impact what is recognized and regarded as important?

Chapter five, social analysis, examines the relationship between the text and social practice. "The aim of this [analysis] is to look at the consequences of the text on social practice [in terms of] whether the text reproduces or changes [dominant] discourses" (Mbisamakoro,

2014, p.13). In particular, this level of analysis focuses on the impact of the NPP on reproductive behavior, and whether this impact can be correlated to the ways in which population growth and reproductive health care are conceptualized within the NPP. This chapter explores the affects of the NPP on social practices and behaviors in regards to particular gendered, racialized, and classed bodies, and the impact on the social practices of family planning within India. Social analysis is important to my question of paradigm shift in that it reveals the impact of policy on social practices and behaviors, thus revealing whether a paradigm shift has or has not occurred within policy. In this chapter I ask the specific questions:

- How does the text of the NPP affect social practices and behaviors in regards to particular gendered, racialized, and classed bodies?

- What impact does the language of the NPP have on the social practices of family planning and population growth reduction in India?

Following chapter five is the conclusion, in which I provide a brief discussion of my research findings, what these findings mean in the context of the study, and their implications for future scholarly research.

Chapter One: Literature Review

Introduction

This chapter is concerned with providing an overview of population scholarship as it relates to India's population policies. India's population policies have been examined and critically analyzed substantially over the last four decades, as scholars within diverse fields of study have attempted to examine and understand these policies from different scholarly perspectives. Within existing literature on India's population policies, three distinct themes have emerged, which attempt to explain population growth as it relates to the health and vitality of the nation-state itself, as well as the role of the nation-state in controlling population growth. These three themes are: 1) the historical development of population policy; 2) reproductive health and family planning; and 3) the RCH and Target-Free Approach, a perspective that attempts to understand the impact of target-free population policy on family planning access.

Although some overlap exists between these themes, specifically in how population growth within India has, and continues to be, categorized as problematic in relation to the idea of "overpopulation", and subsequently in need of outside influence via population policy, distinctions between themes are apparent. In particular, themes one and two focus on the historical development of population policy as it relates to regulating population growth, whereas themes three takes a demographic and public health approach to understand the impact of population policy. Through this literature review, I attempt not only to position my thesis in relation to existing population scholarship, but also to demonstrate that while India's population policies have been examined and analyzed from a number of different paradigms and scholarly fields, there remain gaps within the literature in regards to analyzing policy as discourse from a transnational feminist framework.

1.1 The Historical Development of Population Discourse in India

As the first nation-state to implement a national family planning program in the mid-twentieth century, India has an extensive history of population reduction efforts via formal population plans and policies. This history has been the focus of numerous scholars who have attempted to understand the origins of India's population policies and the historical factors contributing to their emergence. Most often employing a "historical methodology approach" to analyze India's population policy, wherein the focus of analysis is on "the leaders of countries and organizations to determine what they did and what they believed as policy was developed," this strand of scholarship "focuses on telling a policy story based on credible sources" (Hoefer, 2012, p.21). This historical approach to analyzing India's population policies has typically been divided into two distinct time periods, that of pre- and post-1994 International Conference on Population and Development (ICPD). A considerable amount of scholarship has focused on policy development prior to the ICPD, with scholars such as Banerji (1989), Conly and Camp (1993), and Raina (1988) focusing on the creation and evolution of India's population policies following independence.

According to Raina (1988, p.110), India's population policies were developed according to five-year development plans, with population growth "remaining a major constraint " to India's development efforts. Different strategies to address population growth were employed in India's five-year plans, with a clinic-based approach featured in the First, Second, and Third Five-Year Plans, and an extension/target-based approach following the Fifth Five-Year Plan. For Raina, this shift from a clinic-based to extension/target approach represents a natural evolution to India's population efforts, as uncontrolled population growth threatened nation-state development, health, and wellbeing. Although efforts were initiated by India's central

government to move away from development-centered population plans during the late twentieth century, Raina notes that development discourse continues to be prevalent within government institutions, particularly at the state level. As a result, efforts to move away from development paradigms have been slow to materialize, with monetary and resource investments in health and human sectors remaining low. In order for India's population policies to evolve and meet the needs of its citizens, Raina (1988, p.200) argues the necessity of "higher investments in the special sectors, such as education and health," with a shift towards primary healthcare.

While scholars such as Raina posit that India's population plans and policies represent a natural evolution of policy, Banerji (1989) and Conly and Camp (1993) argue that these policies represent the creation of policy that concerns the interests of particular actors within India. In particular, Banerji (1989, p.48) argues that population policy arose in India "when population growth seemed to threaten the vital interests of the rich and powerful", resulting in the creation of population plans and a national family-planning program dominated by political actors. The result of this dominance by political actors, as Banerji observes, is that India's population efforts became coercive during the mid-twentieth century, as India's population plans "unleashed a coercive sterilization drive against helpless, poor people" (p.50) when population rates threatened the economic development and modernization of the nation-state. Echoing similar observations, Conly and Camp (1993) argue that population plans and policies within India following independence and prior to the ICPD reflect a dissonance between policy rhetoric and implementation, with a "substantial gap between the rhetoric of official policy and actual implementation" (p.17). Noting that this gap between rhetoric and implementation allowed coercive family planning practices to flourish, with "a single-minded focus on sterilization, poor quality of services, and an inflexible, overly centralized approach to resource allocation" (Conly

& Camp, 1993,p.17), Conly and Camp posit that in order for population policies and family planning to be more responsive to the needs of its citizens, India's government needs to demonstrate that policy rhetoric can be implemented into action.

Scholarship on India's population policy following the ICPD reflects an attempt to understand the impact of the ICPD on India's population efforts, specifically at the national level. To measure the impact of the ICPD on population policy, scholars Chaurasia and Singh (2014) focused on assessing family planning programs and policies to understand whether these programs and policies reflect a policy/program shift towards ICPD commitments. Through an "objective assessment" of four key areas areas: conceptual foundations of family planning efforts, administrative capacity, outputs of planned family planning efforts, and the impact of these efforts, Chaurasia and Singh observed that although family planning efforts within India have become more decentralized and have witnessed an increased presence of NGOs and the non-state sector, this has not necessarily shown to be beneficial to India's population efforts. In particular, they point to the ways in which the decentralization approach, as advocated in the ICPD and adopted by India's central government. has resulted in a dilution of family planning programs and efforts at the policy level . In other words, while India's population policy at the national level reflects an evolution and shift towards voluntary and non-coercive family planning as outlined in the ICPD, the decentralization and increased presence of non-state actors has not necessarily improved India's population efforts. As such, Chaurasia and Singh (2014) recommend an "integrated population and development approach" to sustain family planning and population policy at both the state and national level (p.10).

Although this historical approach to analyzing India's population policies provides a broader policy context in which to understand the historical trajectory of India's population

policies, it is not without critique. In particular, Kanenberg (2013) argues that the historical

methodology approach to policy analysis assumes objectivity and value neutrality in regards to

policy analysis, as the focus of analysis is on the policy document itself. However, to assume

objectivity and neutrality is to ignore the ways in which policies themselves are never value-

neutral, as they always reflect the interests and concerns of particular groups and actors.

Moreover, assuming neutrality and objectivity ignores how social positionality of the

researcher(s) impacts how policy is analyzed and interpreted. Additionally, McPhail (2003)

draws attention to the ways in which historical policy analysis approaches policy in a gender-

neutral manner, despite the ways in which population policy regulates particular gendered

bodies. As such, while historical methodology of policy analysis can reveal policy trends and the

actors involved in policy production, which is important when understanding the historical

contexts in which policy is created, it can only provide a partial picture in terms of understanding

policy impact.

1.2 Reproductive Health and Family Planning

A central facet to India's population plans and policies is the focus on reproductive health

and family planning. Understanding the impact of population policy on reproductive health and

family planning has been analyzed substantially within the context of India, as two fields of

scholarship, demography and public health, have focused a considerable amount of time on

understanding the relationship between population policy, population growth, and health. As

McCann (2017) notes, the field of demography has been an important component to India's

population policies, as understanding the impact of population policy on population growth has

been of interest to India's central government prior to and following independence (p.18). Given

the extensiveness of this field of study, my discussion of demography studies highlights key themes in regards to demographic studies of India's population policy.

Within India, the field of demography has focused on population policy to understand the impact of policy on population growth, and to predict future growth trends (Chaudhry, 1989) in relation to other variables such as economic growth rates. The purpose of these studies is to analyze the potential benefits and consequences of population policies, particularly in terms of population stabilization. An important theme of demographic scholarship is analyzing population policy in relation to demographic transition, wherein scholars such as Goli and Arokiasamy (2013), attempt to understand the effects of population policy in relation to fertility, birth, and death rates (p.1). Centered upon Notestein's theory of demographic transition, which understands population growth and nation-state development in relation to one another, this field of study has dominated political discourse and institutions within India, shaping population policy and implementation (McCann, 2017, p.20).

While demographic studies of India's population policy have provided insight into the effects of policy in terms of population growth and demographic transition rates, an equally-important field of study is that of public health, which attempts to understand policy in terms of health impact. In particular, public health scholarship related to India's population policy has focused on analyzing the impact of policy as it relates to reproductive health and family planning. Public health studies regarding population policy emerged within India during the 1980s, in large part due to increased funding and advocacy from the World Bank and World Health Organization (Mbisamakoro, 2014, p.32) to understand the role of population policy in impacting and facilitating reproductive health and family planning. Since that time, a considerable amount of public health scholarship has been produced, as researchers such as

Hardee et. al (1999), Visaria and Chari (1998), Farrell et. al (1998), and Visaria et. al (1999), have engaged in the field of public health to examine and assess population policy in relation self-efficacy, family planning education, and contraceptive access.

As with any field of study, demographic and public health scholarship on population policy is not without critique. According to McCann (2017), demographic studies of population policy within India have often been employed by political actors and institutions to create and implement policy that negatively impacts subaltern populations (p.15). McCann further notes that demography as a field of inquiry relies upon positivist science methodology that views population growth as something that can be understood through scientific means, rather than understanding population as a social phenomenon. Public health has also been critiqued for its biomedical approach to analyzing population policy, as well as its focus on healthcare services without deconstructing social structures in which policy is produced and implemented (Rao and Sexton, 2010, p.193).

1.3 RCH and Target-Free Approach

The reproductive and child health care approach (RCH) and target-free approach has been of interest to scholars and researchers following the implementation of this approach during the mid-1990s. Research on this approach and its relation to population policy has largely been divided into two "camps" of thought. The first of these two "camps" focuses on the history of target-setting within India's population policies and the social/political factors that led to their elimination. According to Reddy et al. (2000), target-setting in India's population policies and family planning program emerged as a "management tool, a means to assess the performance of the program and the personnel involved" (p.255), although later it became employed as a tool to target subaltern populations.

These findings are similarly echoed by Donaldson (2002), who notes that India's population policy evolved towards target-setting and coercion due to the involvement of India's upper-caste academics and research "experts" who argued that India's population growth was a threat to development that necessitated curtailing. Both scholarship by Reddy et. al (2000) and Donaldson (2002) posits that a shift towards a target-free approach occurred through the work of women's health advocates and political actors within India who, following the ICPD, approved a target-free approach (p.99). This method of population analysis borrows heavily from the historical methodology approach discussed earlier, as the focus is on understanding the historical and political contexts in which particular population policy approaches emerged.

The second "camp" of scholarship regarding the RCH and target-free population policy approach focuses on analyzing and understanding how this approach is "implemented at the field level, especially in relation to quality of services provided" (Koenig et. al, 2000, p.134). Utilizing empirical evidence on the accessibility and quality of services provided, scholars such as Koenig et. al (2000), Rao (12005), and Srinivasian (1995) have observed that despite efforts to move towards target-free family planning and population policy, restricted contraceptive choice, limited information provided to clients, and low levels of follow-up care have significantly reduced the effectiveness of this approach, particularly at the state level (Koenig et. al, 2000, p.136). Understanding the impact of the RCH approach on family planning is particularly important within the context of India's population policy, given that this approach/paradigm is the current policy framework of India's NPP.

Chapter Two: Methodology

2.1 Data

To achieve the objectives of this scholarship, primary and secondary scholarly sources are employed to analyze India's National Population Policy of 2000 (NPP) from a transnational feminist theoretical framework. India's NPP was selected for analysis partly due to its status as India's current population policy, meaning that it has the most bearing on how population growth is currently addressed via formal policy, as well as the ways in which nation-states address population growth through population reduction and family planning programs. Additionally, the NPP was selected due to the contentiousness of the policy itself, wherein institutions in the Global North have been quick to praise the NPP as a distinctive paradigm shift in how India and other nation-states in the Global South *should* address population growth, while political actors within India, particularly women's political organizations, have been critical towards the NPP, arguing that the NPP continues to target the reproductive autonomy of women. As Menon-Sen (2013, p.160) states, while the "NPP of 2000 document does indeed eschew the language of population control, replacing it with commitments to women's reproductive health and broader goals, such as expansion of the range of contraceptive choices," the extent to which the NPP represents a paradigm shift has yet to be fully understood.

My central research question is whether the NPP represents a paradigm shift in how the nation-state conceptualizes and addresses population growth via formal population policy. Focusing my analysis on India's NPP from the perspective of paradigm shift allows me to explore and examine the policy critically in terms of its intent and its impact on the reproductive behavior and choices of women, which would be lost if I were to approach this scholarship from a much broader perspective. In order to address this central research question, I employ political

discourse analysis as my research method, which allows for a multi-level analysis approach through which to analyze and understand the larger political and social contexts in which the NPP was created and implemented. While I explore PDA in more depth below, it is important to understand what PDA entails as a research method, and how this influenced the creation of research questions which guide this scholarship in its exploration of the central research question. PDA as a method for analysis attempts to understand the process of political discourse construction by political actors within political institutions and the impact of political discourse on the social world (Jorgensen & Phillips, 2002, p.18). Centered on three levels of analysis - situational, textual and social- PDA focuses on the political and historical contexts in which political discourse is constructed, how these contexts impact the formal linguistic and discursive features of policy, and the impact of political discourse on social practice. Through these three levels of analysis, the following specific questions will be explored:

1. What is the political and historical context in which the NPP was created?
2. In what ways have formal international governmental institutions influenced/informed the creation of the NPP?
3. How do political/historical contexts of knowledge production (i.e. policy) impact the types of voices, knowledges, and ideologies that are present within the text?
4. How does the presence or absence of particular voices and knowledges impact what is recognized and regarded as important?
5. How does the text of the NPP affect social practices and behaviors in regards to particular gendered, racialized, and classed bodies?
6. What impact does the language of the NPP have on the social practices of family planning and population growth reduction within India?

I address these questions through analysis of the text of the NPP, which is available to view online from India's official government webpage. To ensure that my data analysis adheres to ethics of qualitative research, I look at the entirety of the policy itself, rather than sections of the NPP that have been pre-selected and analyzed by other researchers. In doing so, this allows me to address sections of the policy that are relevant to my analysis, through which I draw my own

conclusions. Although I employ scholarship from other studies to support my analysis, the sections of policy that I analyze have been selected based on the needs and depth of the scholarship itself, and have not been selected based on the influence of similar studies.

2.2 Definitions

Before I discuss what political discourse analysis (PDA) methodology entails, and the theoretical underpinnings of this methodology, it is imperative to create a foundational understanding of the terms that I utilized in my scholarship. PDA as methodology is indebted to Foucault's theory of discourse, which understands that discourse shapes social structures and practices. As such, discourse, when referenced in my scholarship, is defined as "a group of statements which provide a language for talking about- i.e. a way of representing- a particular kind of knowledge" (Hall, 1992, p.291). Through discourse, particular types of knowledge are produced and legitimized, while delegitimizing other forms of knowledge, thus shaping how society is understood and structured. Consequently, "discourse refers to particular ways of representing and giving meaning," which "constrains what can be thought and known… constraining and dictating action" (Mbisamakoro, 2014, p.10). It is through this shaping, constraining, and dictating via discourse that the social consequences on social practice arise (Fairclough, 1989, p.20), thus demonstrating the interconnectedness of discourse on social life and practice. It is within this definition of discourse that political discourse takes shape. Although there are multiple definitions of political discourse, Teun van Dijk (1993) defines political discourse according to the specific actors and institutions that are involved in the construction and legitimization of political discourse. According to van Dijk, political discourse is "identified via its actors or authors, vis-à-vis politicians and political actors," who are formally "paid for their political activities, and who are being elected, appointed, or self-designated, as the

central players in the polity" (van Dijk, 1993, p.13). The discourse that political actors engage in differs from other types of discourse, in that political discourse is "attached to political actors-politicians, political institutions, and organizations" who are "engaged in political processes and events" (Fairclough, 2012, p.17). Thus, any discourse that individuals have outside of this political context is not recognized as political discourse, which helps us understand that political discourse is actor-driven and occurs in particular contexts. In other words, "discourse is political when it accomplishes a political act in a political institution [by a political actor]" (van Dijk, 2002, p.20). As such, for the purpose of this scholarship, I understand and employ the term political discourse in reference to van Dijk and Fairclough, as discourse that is centrally driven by formally-recognized political actors within the context of political processes and institutions. Defining political discourse as such is pragmatic, in that it prevents collapsing all of societal discourse into political discourse (Fairclough, 2012, p.17), and allows for us to understand how power and dominant ideologies are replicated and reproduced via political institutions.

Finally, I employ the word "text" throughout my scholarship in reference to written laws and policies that have been created and codified by the nation-state. Specifically, text refers to the language of the written policies themselves, and excludes any discourse that does not appear in the written text of the policies. Subsequently, "text" looks at "features of discourse which are relevant to the purpose or function of the political process or event whose discursive dimension is being analysed" (van Dijk, 1997, p.38), meaning that discourse from non-political actors and institutions is not considered when analyzing the linguistic features of policy. As such, text is utilized specifically when looking at the linguistic features of the policy itself to understand how written policies reflect social and political values and norms, and how, through language, these values and norms are normalized and legitimized through codified nation-state policy.

2.3 Political Discourse Analysis

This methodology is rooted in qualitative analysis. Political Discourse Analysis (PDA) is a branch of critical discourse analysis (CDA) that emerged in the 1990s as a field of linguistic and rhetorical analysis (Wodak & Meyer, 2009, p.3). It attempts to understand how political discourse is shaped and defined by political actors and structures, as well as the ways in which political discourse is transmitted and shapes other social structures outside of the political arena. While PDA has been traditionally employed to analyze verbal political discourse, i.e., political discourse that occurs during speeches, hearings, testimonies, etc., PDA as a method of analysis has expanded to include many genres, including law and policy analysis (van Dijk, 1997, p.18). As a branch of critical discourse analysis, the methodological and theoretical underpinnings of CDA are also present within political discourse analysis. In particular, CDA and PDA share an understanding of discourse analysis as a critical enterprise, in the sense that they both "aim to reveal the role of discursive practice in the maintenance of the social world, including those social relations that involve unequal relations of power" (Jorgensen & Phillips, 2002, p.64). PDA in particular focuses on political discourse from a critical perspective, which is "a perspective that focuses on the reproduction and contestation of political power through political discourse" (Fairclough, 2012, p.17). In other words, while CDA and PDA both analyze discourse from a critical perspective, PDA focuses specifically on political discourse as a critical practice in shaping social reality and institutions, as well as a tool through which power relations and ideology are transmitted and reinforced.

Political discourse analysis is indebted to poststructuralist discourse theory, which attempts to understand how "social relations, identity, knowledge and power are constructed through written and spoken texts" (Luke, 1995, p.4). Post-structuralism argues that the world and

society are shaped and molded by discourse, meaning that there is no value-neutral or rationalist view of the world. Rather, post-structuralism posits that through discourse, social structures and power are constituted and reinforced, meaning that discourse itself is used as a tool not only to construct and reinforce social structures, but to assign meaning and value within specific discursive contexts (Mann, 2012, p.218). In particular, Foucault's theory on discourse, which argues that "ways of constituting knowledge, together with the social practices, forms a subjectivity and power relations which inhere in such knowledges and relations between them" (Weedon, 1987, p.108), is essential to PDA's theoretical and methodological assumptions. According to Foucault, "discourses produce and reinforce power" (Mann, 2012, p.221), which is multidirectional and multifaceted, meaning that power is not simply exercised from a top-down approach, but rather, permeates from all directions. PDA borrows from Foucault's understanding of power and discourse by arguing that political discourse is utilized to not only shape social structures and practices, but through political discourse, certain types of knowledge and power are reinforced and legitimized, while other types of knowledge and understanding of the world are constructed as illegitimate.

This Foucauldian understanding of discourse, in which political discourse and the production of social structures and practices, which exist in a cyclical relationship with one another, is evident in PDA's central methodological characteristics, which identify three characteristics that define PDA as a method of critical analysis. The first characteristic of PDA is that cultural processes and social structures are linguistically-discursive, meaning that "discursive practices -- through which text are produced (created) and consumed (received and interpreted) -- are viewed as an important form of social practice which contributes to the constitution of the social world" (Jorgensen & Phillips, 2002, p.61). PDA as a methodology

argues that political discourse as a discursive practice produces texts that are created via political actors which are consumed and interpreted by society and enforced via social institutions, thus shaping not only social structures and institutions, but also creating and reinforcing power relations between social actors. In other words, the first characteristic of PDA is recognizing the ways in which political discourse shapes social institutions and structures, as well as the ways in which political discourse as a discursive practice is employed to legitimize and reinforce power relations between political and nonpolitical actors.

Second, for political discourse analysis, "discourse is a form of social practice which both constitutes the social world and is constituted by other social practices" (Jorgensen & Phillips, 2002, p.61). PDA does not view political discourse as solely constructive of social institutions and structures, but rather, political discourse exists in a cyclical relationship with these institutions and structures. By viewing political discourse in this manner, PDA argues that political discourse cannot be understood and analyzed solely on its ability to constitute and construct social structures and institutions, but rather, must be understood within the complexity of this constitutive relationship with social structures and institutions, whereby political discourse constructs and constitutes social structures, and social structures construct and constitute political discourse. In doing so, PDA positions political discourse in relation to social practices (i.e., the creation of social structures and institutions), meaning that political discourse cannot be understood in its entirety without understanding the ways in which social practices influence political discourse, and vice versa.

Building upon this relationship between political discourse and social practices, the third characteristic of PDA states that "language use should be empirically analysed within its social context" (Jorgensen & Phillips, 2002, p.62), meaning that discourse cannot be removed from the

social context in which it is created. The social context in which discourse originates provides us

with an understanding of multiple influencing factors in the production of discourse, which is not

simply limited to the types of political actors present in the shaping of political discourse, but

also includes factors such as history and political climate. The importance of social context in

PDA cannot be overstated, for political discourse has reverberating effects in terms of future

policies/laws and social practices, meaning that the social context in which political discourse is

constructed not only tells us about the actors, political influences, and political histories that

influenced the construction of particular types of policy, but it also provides us with insight into

how those policies will likely be interpreted. As such, PDA's incorporation of social context in

its analysis provides a much broader understanding of how policies are created and implemented

in particular ways given the social context of these policies, which allows scholars to analyze and

discuss the ways in which political discourse is situated within the complexity of social practices,

institutions, and structures.

Although PDA shares many commonalities with Foucault and other poststructuralist

theorists' understandings of discourse, PDA diverges from post-structuralism in its

conceptualization of discourse as ideology. According to Jorgensen and Phillips (2002, p.64),

political discourse analysis posits that "discursive practices contribute to the creation and

reproduction of unequal power relations… which are understood as ideological effects". The

concept of ideology is especially important to PDA, because ideology is understood to represent

discursive practices that intend to further the interests of one social group over another, whereby

ideology serves as a tool through which to not only oppress and subjugate particular social

groups, but as a means by which to justify oppression and marginalization. For Foucault and

similar poststructuralist theorists, however, ideology as a concept is not particularly useful in

understanding the complexity between discourse and social practices, because ideology "presupposes a 'truth' to which ideology stands in opposition, and implies that it is secondary to material infrastructure and proposes a universal subject" (O'Farrell, 2005, p.140).

While there are some political discourse analytical approaches that ascribe to Foucauldian views on power and ideology, which conceptualize power and ideology as "forces which create subjects and agents, that is as a productive force" (Jorgensen & Phillips, 2002, p.64), scholars who ascribe to PDA as methodology for the most part center ideology as important to understanding how texts are shaped and interpreted in very particular ways, as well as the ways in which political discourse in itself is inherently ideological. Subsequently, the importance of ideology to the methodology of political discourse analysis cannot be overstated, for analyzing and understanding "how texts and [social] practices arise out of and are ideology shaped by relations of power and struggles over power" (Fairclough, 1995, p.132) is inherent within the processes of PDA. In other words, the incorporation of ideology within PDA provides scholars with the means to understand how ideology impacts the production, interpretation, and implementation of texts, which is necessary when understanding the social and political conditions in which texts originate.

Despite the fact that PDA and poststructuralist methodologies diverge on the concept of ideology, the influence of post-structuralism on political discourse analysis is apparent. From the ways in which PDA conceptualizes the connection between discourse and social practice, to the importance of social context in understanding how political discourse is shaped, PDA as a methodology is heavily shaped and influenced by poststructuralist theory. It is for these reasons that I believe political discourse analysis has several advantages that contribute to this scholarship. First, due to PDA being a branch of critical discourse analysis, the relationship

between discourse and social structures is inherent within its methodology. According to Fairclough (1992), PDA problematizes discourse and its role in the shaping and reproducing of social structures, whereby "language does not reflect or represent 'reality' as some sort of transparent medium through which thought can be simply transmitted, rather, language helps construct and constitute reality" (Fairclough, 1992, p.3). Through the employment of a critical standpoint, PDA points to the ways in which discourse is not shaped free from interactions of power and dominant ideologies, but rather, argues that all political discourse is shaped by power and ideology, which must be considered during analysis. Second, PDA posits that the meaning of discourse cannot be fully understood through content analysis alone, but must be "critically read and interpreted in the light of their social, historical, and political contexts" (Fairclough, 1992, p.3). In doing so, political discourse analysis as a methodology reveals not only the political, social, and historical contexts in which discourse originates, but also reveals underlying power structures and ideologies that are present within these contexts that influence how particular discourses are created and disseminated, which are typically absent or downplayed as significant to the creation of discourse through other utilized methodologies.

2.4 PDA and Levels of Analysis

Given that PDA analyzes and problematizes the creation of discourse in relation to existing social structures, and the omnipresence of power and ideology within these given structures, PDA offers three levels of analysis that, when considered in relation to one another, provide a richer and more nuanced understanding of how political discourse is shaped and influenced by social structures and political actors. The first level of analysis is situational analysis, which focuses on the process and conditions of textual production. It identifies how particular conditions contribute to the production of the text, and how those conditions of

production influence how the text is interpreted by political actors (Jorgensen & Phillips, 2002, p.68). Through the employment of a transnational feminist framework, this stage of analysis focuses on the historical and political contexts in which knowledge (i.e. population policy) is produced and the political actors involved in knowledge production processes. Specifically, my analysis centers India's history as a former colonial territory as important to understanding processes of knowledge production and the types of actors/institutions present within these processes.

Building upon situational analysis, the second level of PDA, textual analysis, focuses on analyzing the ways in which situational context of knowledge production has bearing on the text itself. Textual analysis is important in that it can reveal "how formal features of texts may be associated with [particular ideologies and] social values, thus becoming involved in particular power relations" (Mbisamakoro, 2014, p.13). Engaging in textual analysis via a transnational feminist framework, my analysis is specific to examining how situational context of knowledge production impacts what voices, knowledges, and ideologies are present within the text.

The final stage of analysis, social analysis, explores the relationship between the text and social practice. "The aim of this stage is to look at the consequences of the text on social practice; whether the text reproduces or changes [dominant] discourses" (Mbisamakoro, 2014, p.13), and the impact of these consequences on the lives of women of color in the Global South. Particularly, this level of analysis focuses on contraceptive prevalence and sterilization rates to understand the impact of the NPP on reproductive (i.e., social) behavior, and whether this impact can be correlated to the ways in which population growth and reproductive health care are conceptalized within the NPP. These levels of analysis are summarized in figure 2.1.

Political Discourse Analysis

Political Discourse Analysis: Levels of analysis
1. Situational
2. Textual
3. Social

Level One: Situational Analysis
- Looks at the process and conditions of textual production
- What political actors and institutions are involved in the production of a particular text?
- What ideologies do these actors and institutions represent?
- Transnational Feminist Analysis:
    - What is the political and historical context in which the NPP was created?
    - In what ways have formal international governmental institutions influenced/informed the creation of the NPP?

Level Two: Textual Analysis

- Focuses on the linguistic/ formal features of the text
- Attempts to understand how involvement from particular political actors/institutions affects discursive features of the text
    - How is ideology embedded within the text and in what ways?
    - How is population growth understood in relation to the nation-state?
    - What paradigm do nation-states employ to frame population policy?
- Transnational Feminist Analysis:
    - How does political/historical contexts of knowledge production (i.e. policy) impact the types of voices, knowledges, and ideologies that are present within the text?
    - How does the presence or absence of particular voices and knowledges impact what is recognized and regarded as important?

Level Three: Social Analysis
- Explores the relationship between the text and social practice
- In what ways does the text impact social practices and behavior?
- Transnational Feminist analysis
    - How does the text of the NPP affect social practices and behaviors of reproduction in regards to particular gendered, racialized, and classed bodies?
    - What impact does the language of the NPP have on the social practices of family planning and population growth reduction within India?

Figure 2.1

2.5 Methodological Limitations

While PDA provides tools for the analysis of political texts via these three stages of analysis, it is important to recognize the methodological limitations of PDA, particularly regarding reflexivity. It is important to acknowledge that the role of the interpreter will affect the outcome of the research, for "what one 'sees' in a text, what one regards as worth describing and what one chooses to emphasize in a description, are all dependent on how one interprets the text"

(Fairclough, 1989, p.27). While the role of the interpreter determines the types of conclusions that are drawn, and different researchers may produce different conclusions, "this should not be perceived as grounds for consternation" (Fairclough, 1989, p.14). As such, I am aware that the role of the interpreter creates difficulty in producing results that are regarded as generalizable or applicable to similar scholarship. Given that PDA is a branch of critical discourse analysis and shares its methodological underpinnings, PDA "never aspires to produce the kind of generalizable knowledge that is universal, neutral, and based on a 'context-free' foundation" (Jorgensen & Phillips, 2002, p.156), but rather, attempts to provide scholars with tools to create multiple truths and sets of knowledge.

It is also important to acknowledge that political discourse analysis as a research method approaches population policy research from a very specific standpoint, and as such, limits the types of questions one can ask and the types of answers produced in the research process. In particular, PDA can only provide a partial view of policy impact upon individuals and communities, meaning that one cannot understand the "on the ground" impact of these policies in their entirety. PDA also limits the types of voices present in analysis, where the voices of political actors are privileged over that of marginalized individuals and communities. By focusing on political actors as the drivers of political discourse, this research method does not facilitate the space necessary for incorporating the voices of marginalized and oppressed peoples, meaning that the very power relations one is attempting to critique may be replicated during analysis. As such, I recognize that my thesis scholarship is but a contribution to the study of population policy research and should not be viewed as addressing all the pressing issues that population policy research attempts to understand and analyze, nor should it be viewed as the only way in which to understand population policy creation and its impact on women in the

Global South. However, while my scholarship may be incomplete in that it analyzes and addresses population policy within a specific methodological framework, and specific historical and geopolitical contexts, "unfinished is not the same as invalid" (Davis, 1997, p.1).

Moreover, it is important to recognize how my positionality as a scholar located in the Global North, writing about policy and policy analysis that focuses on the Global South, contributes to the limitations of my scholarly research. I am a white, college-educated female who has lived her entire life in the Pacific Northwest. My formal education has occurred through the U.S.-centric public school system, which continues to center and privilege the Global North as drivers of "progress" and development, while portraying the Global South as "underdeveloped" and in need of assistance from the Global North. Having dual degrees in political science and women's studies from a fairly large, liberal, predominately white public university, my undergraduate college education focused primarily on U.S. institutions and structures as mechanisms of oppression and marginalization, with minimal focus on international policy or issues affecting marginalized communities within a global context.

Given that much of my formal education and training prior to graduate school has occurred through educational institutions with a U.S.- and Global North-centric bias, it is important to recognize that this limits the epistemologies I draw from in regards to political discourse analysis, as well as the types of conclusions I produce from this analysis. To overcome these limitations, I rely on and center the voices of transnational feminist scholars within my scholarship to inform my analysis and discussion of the NPP. By centering the ideas and voices of these scholars within my own scholarship, I attempt to avoid *speaking over* scholars and activists who have contributed greatly to the study of feminist population policy research in the Global South, thus avoiding locating myself as *the authority* on feminist population policy

research. Centering these voices and scholarship is also important to avoid *speaking for*

marginalized or vulnerable populations who are impacted by the NPP, thus avoiding the

production of liberatory scholarship that intends to "save" marginalized communities.

Chapter Three: Situational Analysis

Introduction

This chapter is concerned with analyzing the situational context in which India's National Population Policy of 2000 (NPP) was created. Situational analysis, as outlined in my methodology chapter, looks at the processes and conditions of policy production to gain better insight into the political actors and institutions, as well as ideologies and discourses, involved in shaping particular policy. The two central questions guide this chapter include the following: 1) What is the political and historical context in which the NPP was created? and 2) In what ways have formal international governmental organizations influenced the creation of the NPP? To address these questions, I engage in situational analysis via a transnational feminist framework to understand how India's history as a former colonial territory informs processes of knowledge production in regards to policy crafting, and by extension, the political actors and institutions involved in policy creation.

Informed by Gayatri Spivak's concept of imperialist epistemic violence as outlined in their 1988 essay, "Can the Subaltern Speak?", which posits that through colonialism and imperialism, a colonial Other is constructed who is "foreclosed from any valid discourse of knowing and feeling" (p.76), my analysis of knowledge production attempts to understand why and how the subaltern is absent within processes of knowledge production. By engaging in PDA through a critical transnational feminist lens, I attempt to understand the ways in which knowledge production within India in the form of population policy is 1) informed by their history of colonization and 2) an exclusionary process that results in certain knowledges and voices being privileged, while others are excluded.

To provide structure to my analysis, this chapter is divided into three sections, each of which focuses on a specific aspect of situational analysis. In section one I analyze knowledge production within colonial India regarding conceptualizations of population growth in relation to governance. Through this analysis, I examine how knowledge production was shaped and guided by colonial occupation, and how this history informs the ways in which population growth was conceptualized and addressed following independence. Building upon the analysis, section two focuses on knowledge production within India following independence as represented by Five-Year Plans. My analysis is specific to examining India's Five-Year Plans in relation to the emergence of international political organizations and NGOs concerned with population growth in the Global South. By engaging in this analysis, I argue that India's population efforts following independence have been greatly shaped by international political organizations and NGOs, which subsequently impacts the types of knowledge produced in regards to population paradigm. Section three focuses specifically on a situational analysis of the actual text of the NPP. Through this analysis, I demonstrate that shifting population paradigms at the international level during the 1990s, as represented by the International Conference on Population and Development in 1994, greatly influenced the political climate in which the NPP was created, and by extension, the political actors and institutions involved in the policy processes. Following section three, I provide a brief conclusion that summarizes my findings.

3.1 Population Discourse in Colonial India

Prior to independence, population discourse within India was shaped by shifting understandings of population growth in relation to governance. Under British control until 1947, population growth within India during the early-mid 18th century was largely regarded as an important national resource that provided sociopolitical and economic benefits to the British

Empire. For British colonial forces, population growth was seen as a means through which to naturalize colonial occupation of India, in that it "demonstrated the superiority of British governance" (Sreenivas, 2009, p.1) in their ability to control large swaths of territory with an expanding population. Measuring the prosperity of their rule in relation to population growth (Chandraskkar, 1967, p.75), population growth provided justification for colonization of India and was generally regarded as an important colonial asset. However, conceptualizations of population growth changed during the late 18th and early 19th century, as India encountered a series of famines that prompted British colonial officials to question longstanding assumptions that "a large population was a good population." For over a century, India experienced a series of recurring famines that wrought disease, food shortages, and starvation upon the majority of its population. Faced with the crisis of famine and its reverberating effects upon "both the labour supply and revenue-collection" (Hodges, 2004, p.1158), British colonial officials responded with the creation of famine policy, which served to outline the extent to which famine relief assistance would be provided. Minimalist in nature and requiring people to "exhaust all other entitlements" (Hall-Matthews, 2005, p.108) before requesting relief from the government, as to avoid creating dependency on colonial assistance, colonial famine policy was largely ineffective at addressing the effects of famine upon Indian society.

Responding to this failure, British colonial officials turned to Malthusian population theory as a means through which to engage in colonial knowledge production to explain the apparent connection between population growth and India's famines and widespread poverty. Believing that famine and poverty was the direct result of failing to control population growth within the means of agricultural production, methods of measuring population growth, specifically birth and fertility rates, became a vital tool through which "the British could write

their own self-serving story of Indian inadequacy" (McCann, 2017, p.161). In particular, the creation of the census as a tool to measure population growth rates amongst various demographic groups became a powerful tool in the construction of colonial knowledge, as the quantification of population numbers allowed colonial officials to "count, classify and categorize bodies within a territory, producing a variety of new totalities: the social body, the nation, the people, the general public, mankind, and society itself" (McCann, 2017, p.32). While collection of census data had occurred prior to the Famine Years as a means to measure British prosperity, the collection and analysis of census data during and following the Famine Years represents a colonial fascination with quantifying and comparing fertility and birth rates amongst various demographic groups (Hodges, 2004, p.1158). By counting and classifying birth and fertility rates amongst multiple demographic categories, the census as a tool of colonial knowledge production allowed for "idealized and prescriptive norms" of reproduction to be created and written upon the bodies of colonial subjects (McCann, 2017, p.35).

Within the context of Indian population growth, these norms were ideologically based upon Orientalist conceptualizations of gendered and classed sexuality that perceived particular forms of sexuality and reproduction as problematic and consequential to the colonial state and governance (Said, 1978, p.216). Drawn along specific demographic lines, colonial constructs of sexuality positioned Indigenous reproduction within a binary of acceptable and unacceptable that was used to demarcate sexuality in relation to the colonial state and population growth. According to this binary, acceptable reproduction was that which occurred through educated and controlled means to ensure that unwanted pregnancies and births were avoided. Inherent within this construction are gender and class implications, with acceptable reproduction coming to signify educated, middle- and upper-caste Hindu families (McCann, 2017, p.106). It is important

to note that the construction and propagation of acceptable reproduction was not the sole creation of British colonial officials, as middle- and upper-caste Hindu men, particularly those who wielded power under British home rule, played an important role in distinguishing sexuality and reproduction along caste lines. Facilitated by perceptions of "religious superiority" due to caste status, middle- and upper-caste Hindu men perceived sexuality amongst the middle and upper castes as acceptable due to the adoption of European culture and norms regarding reproduction (Gupta, 2015, p.110). By engaging in colonial knowledge production processes, middle- and upper-caste Hindu men and women attempted to distinguish themselves from the "uncivilized" colonial Other who was ruled by nature and "primitive" cultural practices, rather than reason.

Where sexuality and reproduction for middle- and upper-caste Hindus was perceived to be acceptable, reproduction amongst subaltern groups was seen as unacceptable and consequential to the colonial state. Constructing low-caste agricultural workers, Hindus, and Muslims as "hyper-reproductive and lacking prudent restraint" (Nari, 2006, p.126) due to "backwards" and "uncivilized" cultural practices, colonial knowledge production positioned subaltern reproduction as something that needed to be tightly monitored and controlled for the public good. Of particular importance to the construction of subaltern reproduction was the creation of the "as-if woman of natural fertility who through 'backwards' reproductive practices produced the crisis of rapid population growth" (Herr, 2004, p.48). The "as-if woman" was created through the image of the "uncivilized", colonial Other, who, through "unchanging and ineradicable customs and habits," became an impediment to modernization and progress (Said, 1993, p.202). Facilitated by census data as well as Orientalist historical accounts by the East India Company, a distinct form of colonial knowledge was created that understood particular

types of reproduction as consequential to the health and well-being of the nation, as subaltern reproduction gave way to overpopulation.

Consequently, through the configuration and legitimization of census data to understand population growth amongst particular demographic groups, colonial officials, including those who ruled through British home rule, were able to engage in a particular type of colonial knowledge project that understood subaltern population growth as consequential to the state. The employment of census data to understand population growth trends became a vital tool in the legitimization of Malthusian overpopulation theory as a means to understand population growth in India, as census data and the "testimony of figures" pointed to "India's imperfect hold on modernity" due to population growth amongst subaltern groups (McCann, 2017, p.160). As such, through the legitimization of Malthusian overpopulation theory via census data, overpopulation became a common theme of colonial discourse which could be called upon to explain the social and economic ills within colonial India. While colonial officials were married to the idea of India as an overpopulated nation, the emergence of the Indian Nationalist Movement for independence spurred many to take up the question of population growth and the nation. During India's struggle from colonial rule, several key figures emerged that came to dominate political discourse, as a new form of knowledge production was taken up that attempted to understand not only population growth within the context of colonial occupation, but what population growth meant for a nation struggling to come into its own. These key figures, which I discuss below, are categorized as economists/sociologists, Indian Nationalists, and birth control advocates.

Dominated primarily by upper-caste, Western-educated men, the field of economics and sociology proved to be a fertile ground in which to engage in Indian knowledge production. Indian economists and sociologists such as P.K.Wattal (1916) and Gyan Chand (1939) were the

first to "draw broadly on census and public health statistics to configure an argument for a strong independent India" (Prakash, 1999, p.50). Employing Malthusian population theory to understand population growth within the context of colonial occupation, economists and sociologists argued that the problems facing India were not due to overpopulation, but colonial mismanagement and exploitation. Identifying British imperialism as "the root cause of the evils of ignorance, poverty and disease in India" (Chand, 1939, p.214), economists and sociologists viewed India's growing population as but *one* problem facing the nation, not the *sole* problem. However, economists and sociologists recognized the dangers of unbridled population growth for a nation trying to achieve independence and development, arguing for the necessity of adopting a small-family system (Mukerjee, 1938, p.217).

Similarly, Indian Nationalists, most of whom were upper-caste and Western-educated men, saw the "problem" of India's population growth as it related to British colonial rule. Indian Nationalists saw "British policies as responsible for the impoverishment of the populace because they caused great harm to the nation's economy and the well-being of its people" (McCann, 2017, p.162). Believing that self-governance would allow India to overcome the effects of British colonization, Indian Nationalists turned to science and religion to challenge colonial authority, which understood overpopulation to be the cause for India's lack of development, famine, and poverty. For Indian Nationalists, India represented a degenerated state that, through colonization, had been stripped of its past glory. Pointing to cultural changes that occurred during British colonization, Nationalists argued that the glory of India could be restored through "ancient Hindu science, which had anticipated the principles of modern science" (McCann, 2017, p.163). By drawing upon the power of science and heritage of Hinduism, Nationalists

attempted to create not only a vision for India's future, but a new form of discourse that was uniquely Indian and that challenged colonial knowledge.

Important to the construction of Nationalist discourse were gender and motherhood, which were employed to create a masculine nationalism centered on the concept of protecting India. Arguing that maternal and infant health had suffered under British rule, Indian Nationalists positioned themselves as the "caretakers of Mother India," who through "husbandly protectiveness could restore India's glory and ensure its future" (McCann, 2017, p.166). To ensure that Mother India would be protected, Nationalists saw "intellectual men" as the leaders of India's drive towards independence and modernity, who through "their knowledge of both sacred texts and modern science, the glory of India could be restored" (Prakash, 1999, p.127). Consequently, Nationalist discourse featured heavily the concept of a strong, masculine Indian nation that could achieve modernity through exclusionary leadership by particular caste and gendered bodies.

Although Indian Nationalists and intellectuals agreed that India's growing population presented concerns for a nation trying to unyoke itself from colonial rule, how to best address the population question and implement the small-family system was of much debate. Through debates on the merits of family planning to achieve population goals, birth control advocates emerged as strong supporters of the small-family norm, which they envisioned through the role of contraceptives and family planning. In the early years of the birth control debate, Indian women, particularly those middle and upper caste Hindus, were strong proponents of birth control, as they saw contraceptives as a means to address concerns related to women's health, infant mortality, and poverty mitigation (Chatterjee & Riley, 2001, p.821). While female birth control advocates were instrumental in advocating contraceptives to address maternal and infant

health, male birth control advocates dominated the public sphere of politics. The domination of the political sphere by male birth control advocates was achieved, in large part, through the representation of female advocates as "emotional propagandists who needed to be constrained by hard scientific facts" (McCann, 2017, p.75) regarding the necessity of population control.

Regulating maternal and infant health to the back burner of concerns for the nation, male advocates combined Malthusian and eugenics arguments to support their demands for access to birth control. For male advocates, India's degeneration of its past glory stemmed from uncontrolled population growth amongst subaltern populations, which, when combined with British colonization, had resulted in a population of "derelict people" (Chand, 1939, p.14). In order for India to be a strong, masculine, independent nation, limiting fertility to raise the "quality" of the population was seen as a central concern, as development and modernization rested on the backs of "the well-fed and well-educated modern Indian citizen" (McCann, 2017, p.167). Through this masculinized narrative of India's independence, birth control advocates linked contraceptives to the future of the nation-state, positioning them a tool of nation-building. While discourse from male birth control advocates was limited primarily amongst India's upper-caste political elite, as a more centralist approach was adopted by Indian Nationalists who sought to unify India against colonial oppression, discourse from male birth control advocates never fully disappeared from political thought within India, and as such, makes a reappearance and re-inserts itself during population efforts following independence.

Within colonial discourse and knowledge production, the absence of subaltern voices and knowledges is apparent. Knowledge and discourse production were exclusionary and silenced the subaltern, as colonial officials and those occupying privileged social positionalities engaged in production processes to construct narratives of population growth as it related to governance.

For colonial officials, population growth was a means of explaining social ills and lack of development, obfuscating the ways in which colonial governance had negatively impacted India. Rejecting this colonial narrative, Indian intellectuals and Nationalists during the Indian Independence Movement sought to construct their own population narrative that understood population growth within the context of nation-building. For intellectuals and Nationalists, population growth was seen as a symptom of a larger problem related to colonial neglect, and as such, rejected the colonial narrative of overpopulation. However, they recognized the danger of unbridled population growth for a nation struggling for independence, arguing the necessity of adopting the small-family system to ensure development and modernization following de-colonization. It is important to acknowledge that in Nationalist and intellectual narratives of population growth, the voices of the subaltern are absent, as India's future as an independent nation-state was written primarily by middle and upper-caste Hindu men. This absence of the subaltern, as I argue below, is prominent within population discourse and policy following colonial rule, reflecting the ways in India's narrative of independence was based on nationalist elitism.

3.2 Population Discourse and Policy After Independence

Concerned with raising standards of living for its citizens and addressing maternal and infant health disparities, population discourse within India directly following independence reflects an almost fanatical urgency in achieving development and modernization. In large part, this urgency stemmed from the after-effects of the 1944 Bengal Famine, which, when combined with effects of colonization on India's economy, left a substantial proportion of India's population facing dire living conditions. As Koenig (2013) notes, at the time of India's Independence, "the standard of living was dire, with nearly eighty-five percent of the population

residing in villages, seventy percent were employed in traditional, low productivity agriculture, less than a quarter of Indians at the time were literate, and mortality rates remained high" (p.26). Recognizing that British colonization and famine had severely crippled economic development and had left many of its citizens in poverty, economic development was perceived as necessary and urgent.

Reflective of this urgency was the creation of the First Five-Year Plan, which served to outline development goals that were to be achieved at national and state levels. In many ways, a commitment to Nationalist discourse regarding the regeneration of India through development, the First Five-Year Plan centered the necessity of eradicating poverty, modernizing agriculture, and mass industrialization. While population growth was of concern, the First Five-Year Plan was wary in explicitly linking socioeconomic and demographic change. Noting that "in the past there had been periods when population growth was accompanied by economic development," the first Five-Year Plan argued that "it was not always possible to determine the relationship between these phenomena" (Rao, 2004, p.28). In other words, the control and manipulation of fertility through family planning would not necessarily be desirable nor feasible, as the impact of population growth on development was not yet fully understood. However, the First Five-Year Plan still recognized the importance of family planning to the health and wellbeing of Indians, stating that "the main appeal for family planning is based on considerations of the health and welfare of the family" (Government of India, 1951, par.105). In many ways, then, the first Five-Year Plan can be read as a policy commitment to upper-caste Nationalist discourse regarding the development of India through masculinized development and husbandly protectiveness of the family, as facilitated by the central government.

While Nationalist discourse remained embedded within Indian politics for much of the early-to-mid 1950s, the introduction of non-governmental organizations (NGOs), particularly funding organizations, into India's political structures signaled the beginning of a reconstruction of population discourse and knowledge based on fear of the colonial 'other'. Having "identified India's rapid population growth as a major problem and concern," (Rao, 2004, p.27) organizations from the Global North, such as the Population Council, the Ford Foundation, and the Rockefeller Foundation, extended considerable amounts of funding to India to improve access to family planning. Funding NGOs from the Global North were guided, in part, by political concerns related to maintaining global hegemony following the aftermath of World War II. With "the collapse of European Colonialism and the rise of Communism" (McCann, 2017, p.10), nation-state in the Global North developed a crisis orientation to population growth in the Global South, identifying former colonial territories as fertile ground for the rise of communism. Important to this crisis orientation was Frank Notestein's theory of demographic transition, which argued the necessity of assisting demographic transition through fertility and population control, as this transition would ensure that nation-states achieve modernization and development through which communism could be avoided. For Notestein and demographers of his time, modernity could be achieved through the logics of science, as demographic discourse focused on constructing modernity through a scientific and technological lens.

Giving rise and legitimacy to the field of demography in a global context, Notestein's theory of demographic transition guided efforts by funding NGOs within India during much of the mid-1950s and 1960s. Having "selected India as a target for intensive research in demography," (Mass, 1974, p.655) NGOs were able to influence India's population discourse through funding for fellowship programs and institutions involved in India's family-planning

program. Training demography students "to view fertility as a variable capable of being

manipulated by contraceptive technology" these students were "trained to imbibe and share the

perception of the West about the population problem and its solutions" (Rao, 2004, p.107).

Providing funding for institutions involved in India's family-planning program, namely the

Central Family Planning Institute (CFPI), the National Institute for Health and Administration

(NIHAE), and the Family Planning Association of India (FPAI), proved to be another important

area in which the Global North could insert itself. These institutions were often headed by

Western-trained demographers who would make program recommendations and would often

serve in key cabinet positions in India's central government and health ministry.

Through this "finessed and standard choreography" (Rao, 2004, p.107) of providing

funding to students, researchers, and institutions to train them in the ways of Western

demography, NGOs became a means through which the Global North could extend its

imperialistic reach and shape population knowledge production and discourse in the Global

South. The impact of funding NGOs on India's population discourse is apparent within the

Second Five-Year Plan, as the focus of this plan is population control for the sake of economic

development. As noted in the Second Five-Year Plan,

> Over a period of time, the outcome of development efforts can be noticeably
> different if population trends are altered in the right direction. This is one of those
> fields in which traditional modes of thought and behavior are apt to offer
> considerable resistance to rational approaches…. Yet, these modes or attitudes are
> changeable. The logic of facts is unmistakable and there is no doubt that under
> conditions prevailing in countries like India, a high rate of population growth is
> bound to affect adversely the rate of economic advance. (Government of India,
> 1956, p.7)

What is interesting to note about the Second Five-Year Plan is the ways in which Nationalist

discourse of husbandly protectiveness of the family and motherhood is virtually absent from the

plan, as masculinized economic development is centered. There is also a distinct paradigm shift

in regards to population growth, as the plan leaves no room left to debate the nature of population growth on development. Moreover, the Second Five-Year Plan draws heavily from upper-caste constructions of subaltern sexuality and reproduction by painting India's population as irrational and ruled by traditional knowledge and modes of thought. In doing so, this plan "assumed that an irrational population simply did not know what was in its own interests," (Rao, 2004, p.28) and that it was the task of the government to lead "irrational people" through rational (i.e., scientific) approaches.

Successive five-year plans following the Second Five-Year Plan reflect the ways in which population paradigms within India became heavily imbibed with influence from NGOs, as well as international governmental organizations (IGOs). Development, which had been a component to India's five year plans in conjunction with addressing healthcare needs, quickly eclipsed India's population efforts and became a central driver to family planning programs. With the introduction of IGOs, the "Indian reproductive family became the target…. for a new global order," (Nielsen & Waldrop, 2014, p.124) as contraceptives, particularly long-term contraceptives, were emphasized as a means to achieve development. This emphasis on contraceptives arose in part due to the Mudaliar Committee Report, which, with an almost fanatical urgency, recommended that "appropriate legislative and administrative measures" had to be taken, as population rates continued to grow despite efforts to provide family planning services (Raina, 1988, p.65). The introduction of the World Bank as a leader in development funding to India, replacing NGOs as India's main donor, also accounted for contraceptive emphasis as "family planning was recognized as less costly than conventional development projects" (Mass,1974, p.665).

Long-term contraceptives, such as IUDs and male sterilization, were emphasized by IGOs as cost-effective measures to addressing family planning needs while also achieving development goals. Becoming central features to India's Third, Fourth and Fifth Five-Year Plans, IGO recommendations of IUD and sterilization targets were integrated into India's national family planning program, as achievement targets were set that state governments were expected to meet. Although achievement targets were set by India's central government to achieve "overall" population reduction, several state governments throughout India set sterilization targets and quotas of their own that healthcare professionals and clinics were expected to meet. Often set in the hundreds of thousands (Dowbiggin, 2008, p.190), healthcare and family planning professionals were often dispatched to rural cities, where they were tasked with "motivating" low-caste and poor populations to adopt long-term contraceptives. The introduction of long-term contraceptives and contraceptive targets is reflective of discourse that constructed India at war with population growth, a battle that India had to "win" in order to achieve "development". Within this discourse, "population is seen as representing faceless numbers" who, for the sake of the nation-state, "need to be combated and attacked" (Ahluwalia 2010, p.30). Not only is this discourse dismissive of people as human beings, but it serves to dehumanize people and communities, legitimizing state-sanctioned violence upon subaltern bodies.

As is apparent during the Emergency Period (1975-1977), the rise of "war-like" population discourse internationally, as well as within India, facilitated coercive population paradigms in which family planning targeted subaltern populations for their supposed "latitude" towards contraceptives. Declaring that "waiting for education and economic development to bring about a drop in fertility was impractical," India's central government initiated "a frontal

attack on the problem of population" (Mukkopadhyay, 2005, p.84). The result of this discourse was a massive sterilization campaign, wherein between 1975-1977, millions of Indian citizens, most of whom belonged to low castes and scheduled tribes, had their constitutional rights suspended and were forced to undergo sterilization for purposes of population control (Hartmann, 1995, p.250). During this time, the absence of subaltern voices is palpable, as political actors employed "war-like" discourse to support coercive policies, even going so far as to say that the nation supported drastic action. Consequently, this absence of subaltern voices from political discourse, particularly at the national level, facilitated coercive family planning within India for the better part of two decades.

3.3 National Population Policy of 2000

As demonstrated in my previous section of analysis, India's population paradigms have gone through numerous shifts following independence. While nationalist paradigms were featured heavily in the 1950s, development paradigms have, for the most part, dominated political discourse within India following the integration of NGOs and IGOs into India's political systems. Coalescing into coercive family planning practices and policies during the 1960s-1980s, India's population efforts following the emergency period reflect efforts to re-conceptualize population discourse within India, as "policy makers, governments and civil society alike began to argue for the need to understand social and human development that was centered on basic needs of people and to ensure lives free from deprivation" (Bhan & Panda, 2010, p.72). Facilitated by domestic actors as well as international governmental organizations, discourse on population shifted towards issues relating to family planning and reproductive health, rather than simply focusing on fertility control. This shift towards a more humanistic model of population regulation foregrounded efforts by India's government in the creation and implementation of a national population policy.

While the 1994 International Conference on Population and Development (ICPD), also known as the Cairo Conference, is often cited as the birthplace of India's NPP, events prior to the conference greatly contributed to its formation. The Swaminathan Committee, formed in 1993, played a substantial role in this regard, as the committee "recommended that a National Population Policy should be formulated by the government and endorsed by the Parliament." (Rao, 2004, p.203) Comprised of Indian "policy experts", most of whom were upper-caste men and had served in key parliamentary positions under previous administrations (McCann, 2017, p.208), the Swaminathan Committee set out to detail a new vision for India's national population policy, one that recognized the importance of voluntary and informed family planning.. Drafting what is known as *The Swaminathan Committee Report*, the Swaminathan Committee proposed a national population policy that would "take a long term holistic view of development, population growth and environmental protection, suggest policies and guidelines for formulation of programs and create a monitoring mechanism with short, medium and long term perspectives and goals" (Planning Commission, 1992).

Created in response to criticism by women's political organizations, who argued that population policy so far "had been one of fertility control, pursued relentlessly, and at times coercively, through three decades," (Center for Women's Development Studies, 1997, p.8) the *Swaminathan Committee Report* included three overarching national population policy recommendations. First, the Committee recommended the abandonment of all family planning targets at the national and state level, particularly "the abandonment of targets for specific contraceptive methods, keeping in mind the urgent need for improving the quality of services." (Government of India, 1994, p.3) Additionally, the Committee recommended that contraceptive incentives and motivators should be discontinued, as they prevented women from making

voluntary and informed family planning decisions. While incentives and motivators were explicitly abandoned in the draft proposal of the NPP, disincentives were proposed as a tool for states and districts to achieve population reduction goals. Second, continuing earlier efforts to integrate family planning into the general public health sector, the Committee recommended a vertical program approach that would merge family planning services with services and programs curtailed to maternal and child-health (GOI, 1994, p.11). The purpose of this approach was to promote family planning without sacrificing overall health and wellbeing, particularly for women and children. Third, recognizing the socioeconomic and demographic diversity across states, the Committee called for a decentralized, bottom-up planning approach that would increase the roles of states and NGOs in addressing family planning needs and achieving population goals (Srinivasan, 1995, p.60). The *Swaminathan Committee Report* concluded that population stabilization could only be achieved if wide-range changes to the social and economic conditions of women and marginalized groups were to occur, thus advocating for systemic social change.

Submitted to members of parliament, as well as national and state agencies, for review in 1994 (Maharatna, 2002, p.977), the *Swaminathan Committee Report* garnered much criticism. In particular, women's organizations and health groups within India noted that while the proposal acknowledged voluntary family planning and reproductive choice as key to maternal and child health, the proposal was predicated upon Neo-Malthusian concerns of overpopulation and development (Rao, 2004, p.206). Of particular concern was the inclusion of disincentives at the state level, which advocated for widespread punishment for couples who did not accept the small-family norm, including barring of individuals with more than two children from voting in elections and preventing them from holding government jobs. These incentives, which "could

only be described as anti-democratic, anti-woman, and anti-poor," (Rao, 2004, p.207) were

contrary to goals of improving the health and opportunities for women and marginalized

communities through voluntary family planning, with the focus of these disincentives being to

influence family planning for the sake of population control. In other words, while the language

employed within the *Swaminathan Committee Report* reflected commitments towards voluntary

family planning and maternal and child health, concrete policy features, such as disincentives,

demonstrated that Malthusian overpopulation concerns continued to have a stronghold amongst

India's political institutions.

Decentralization of family planning, and the increased role of states and NGOs, as

outlined in the *Report*, drew much ire, as organizations within India voiced their concern

regarding the creation of private-public partnerships between NGOs and states in addressing

family planning needs. Arguing that this decentralized approach would leave family planning to

the whims of the market and non-governmental forces (Srinivasan, 1995, p.60), opponents of the

Report drew attention to the ways in which decentralization within the third and fourth five-year

plans had given rise to coercive family planning practices during the Emergency Period. In

particular, opponents were concerned that decentralization would grant states and NGOs

considerable power and authority to enforce family planning for the sake of population control,

allowing for discrimination against the poor, the Scheduled Castes, Scheduled Tribes, and

women (Rao, 2004, p.211). Especially vocal in their concern and criticism over the *Report* was

Dr. Devaki Jain, a key member of the Swaminathan Committee who later resigned and refused to

be signatory of the report once the final draft proposal was completed. In a strongly worded

statement, Dr. Jain called the final draft shocking,

> pointing out that the Swaminathan Committee had, at the beginning, unanimously
> agreed to abandon the entire current package of incentives and disincentives,

> including barring into legislatures, and organized sectors of employment, on the basis of size of the family. It was agreed that such policies were not only coercive but discriminatory. It had been agreed that basic needs, food security, livelihood, that is basic social and economic security for the poor, was a necessary condition for enabling them to make reproductive choices. (Rao, 2004, p.211)

Noting that the final draft had abandoned all earlier agreed-upon measures and remained committed to pursuing population control, Dr. Jain called the final document a betrayal and a war on India's women.

Facing opposition from women's organizations due to key provisions within the final draft that would allow states to use disincentives, as well as concern within India's Parliament "about the setting up of independent commission that would control most of the financial and other resources allocated to family planning" (Sen, 2000, p.16) the draft of the *Swaminathan Committee Report* was never finalized into a formal population policy. Entering the 1994 International Conference on Population and Development, also known as the Cairo Conference, without the successful passage of a national population policy, India's government was cautious in committing itself to implementing such a policy. Despite their reluctance, the ICPD proved to be an important turning point in India's population efforts for several reasons.

First, during conference proceedings, India's national family planning program, a central feature of India's population efforts, received an in-depth review by conference participants. Arguing that "ethics and quality of care should not be compromised for demographic goals" (Visaria et al., 1999, p.98) conference participants advocated a target-free approach, proposing that India's population policy should be guided by reproductive health, reproductive rights, and gender equity, not population control for the sake of development. These policy suggestions were by no means new, as many of the conference's policy suggestions were similar to those advocated for by women's organizations and healthcare professionals in India during the 1990s.

Rather, these policy suggestions merely echoed concerns from women's organizations within India regarding the necessity of a national population policy centered on maternal and child health, as well as family planning choice.

Second, the Cairo Program of Action, also known as the Cairo Consensus, greatly impacted policy efforts in regards to the creation of a national population policy. The Cairo Program of Action stressed the importance of 1) nation-states working together and adopting consensus-based population policy frameworks that struck a balance between nation-state goals of development and modernization with that of women's rights; and 2) centering women's health care and empowerment as overall objectives of nationally-implemented population policy. Through the employment of rights-based discourse, the Cairo Program of Action shifted existing population discourse by conceptualizing reproductive healthcare and family planning as fundamental human rights. Stating that people have the "right to have children by choice," (Program, 1994, p.42) and rights to universal access to healthcare, including reproductive healthcare and family planning, the Cairo Program of Action declared that the purpose of population policies should be to improve quality of life (Program, 1994, p.32), not to simply control population growth. By stressing quality of life over that of population control, family planning was understood "in terms of needs, that is meeting people's un-met needs, for safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility" (Program, 1994, p.43).

The Cairo Program of Action centered the importance of women's empowerment in relation to reproductive healthcare and family planning, wherein the ability of women to have control over their reproduction is seen as mutually beneficial for women and the nation-state in terms of development. Stating that while "the empowerment and autonomy of women and the

improvement of their political, social, economic, and health status is a highly important end in itself," the Program of action also recognized women's empowerment as "essential for the achievement of sustainable development" (Program, 1994, p.29). By tying women's empowerment via family planning to that of economic development, the Program of Action stressed the importance of nation-states in addressing issues of gender inequality and empowerment through formal population policy, for "the full participation of women in all aspects of life" (p.29) was perceived as necessary if nation-states were to achieve economic development. As such, the Cairo Conference fundamentally shifted population paradigms at the international level by moving away from development-based paradigms, which privileged goals of economic development, to a health-based paradigm which conceptualized development and improving quality of life through increased access to general and reproductive healthcare as mutually-existing goals.

While the Cairo Program of Action was not translated into population policy for some time, changes to India's family planning program began shortly after the ICPD signaled the beginning of efforts to address population from a health-based paradigm. In 1995, India's central government removed method-specific targets on an experimental basis in 17 districts across different states to measure whether a target-free approach to population policy would be feasible (Rao, 2004, p.212). Finding the results of this experiment mainly positive, India's Ministry of Health and Family Welfare announced the following year that all family planning targets were to be abandoned across the nation-state (Visaria, 2002b). That same year, India's family planning program was integrated into a larger program focused on reproductive and child health, creating a decentralized and vertical family planning program to address unmet reproductive and child healthcare needs. These two changes, which were outlined in the *Swaminathan Committee*

Report, would later become central facets of India's National Population Policy of 2000.

Although India's family planning program during the mid-1990s shifted towards a reproductive healthcare paradigm, scholars such as Rao (2004) remain skeptical as to whether this shift was the result of the ICPD. For Rao, this change can be traced to World Bank policies and practices, which shifted towards reproductive healthcare and women's rights following the ICPD. Rather than the ICPD directly influencing India itself, it was changes in population paradigms at the international level, particularly for international development funding agencies, following the conference that this change can be traced. As Rao (2004) states, "given the overwhelming influence of the World Bank on health and population policies of borrowing countries, it is not surprising that when the World Bank made a 'paradigm shift' to reproductive health, borrowing countries were quick to follow" (Rao, 2004, p.182).

Finding success through the elimination of family planning targets and integration of India's national family planning program, efforts were again made in 1996 to draft a national population policy. However, success was largely limited due to opposition by women's organizations within India, who noted that the Draft Statement on the National Population Policy revived state-level disincentives and granted state governments considerable power in implementing population policies outside those of the central government (Rao, 2004, p.211). Subsequently, debate on a national population policy continued, with efforts to create and implement a national population policy intensifying as political actors argued for the necessity of a national population policy for the new millennium. Given the political climate during the time and strong opposition towards policy that allowed states to use disincentives for family planning, India's central government attempted to control the final outcomes of a national population policy by limiting the actors present in the process. As Sen (2000) states,

> the National Population Policy of 2000 was drafted and discussed almost entirely within a closed circle of the central Government. The lack of openness was largely due to disagreements within the ruling Government about whether the policy should contain disincentives or not. Although there have been previous and more open discussions about the merits of incentives and disincentives, the draft this time was fairly tightly controlled. (p.17)

Although, as Sen notes, there were leaks of draft policy proposals to the Indian press, upon which women's organizations and NGOs responded, the actors involved in the policy-crafting process were limited to specific and privileged members of India's middle and upper castes. According to appendix two of the NPP, rounds of consultations with the Planning Commission and Group of Ministers, appointed by India's Prime Minister, were held in the year prior to the passage of the NPP to "deliberate over the nuances of the population policy" (GOI, 2001, p.37). Before finalizing the policy, "the Group of Ministers invited a cross-section of experts from among academia, public health professionals, demographers, social scientists, and women's representatives" (GOI, 2001, p.37), who were asked to discuss and evaluate the Draft National Population Policy, specifically the topic of incentives and disincentives. Despite inclusion of women's representatives during these consultations, the final policy reflects "ideas that flow from the one-track minds of bureaucrats" (Banerji, 2000 p.680), as the focus of the NPP continues to be on curbing population growth for the sake of nation-state development and modernization. In many ways, then, India's National Population Policy of 2000, represents an exclusionary form of knowledge production in which only certain actors (i.e., those occupying privileged positions of government power) were actively involved in shaping the policy.

3.4 Conclusion

The purpose of this chapter was to understand the political and historical contexts in which the NPP was created. Analyzed from a transnational feminist lens with a focus on knowledge production, I traced population discourse from colonial occupation through

independence to examine how population growth is conceptualized, and the actors involved in shaping paradigms. Informed by Gayatri Spivak's concept of imperialist epistemic violence, my analysis of knowledge production attempted to understand why and how the subaltern is absent within processes of knowledge production. Through this chapter, I have demonstrated that population discourse and knowledge production within India has been a primarily exclusionary process. Occurring within governmental structures and institutions, the voices of colonial officials- British and Indigenous and upper-caste economists, Indian Nationalists, birth control advocates, demographers, and political actors-were privileged in discourse production. Creating an "othering" and silencing of subaltern voices and knowledges, members of India's lower castes, Muslims, and rural poor have been predominantly excluded from formal political structures that facilitate discourse and knowledge production, particularly that of population policy.

This chapter also demonstrated that India's history as a colonial territory informs processes of discourse and knowledge production that are necessary for population paradigms. Through this analysis, I found that India's knowledge production following independence as represented by five-year development plans, was originally based upon elitist Nationalist discourse regarding India's development and modernization that had developed during colonization. However, through the introduction of NGOs and IGOs into India's political structures, knowledge and discourse evolved to reflect population growth concerns related to Global North hegemony, resulting in the emergence of development paradigms. In doing so, the focus of knowledge and discourse production became that of population control for the sake of demographic transition. Coalescing into coercive family planning practices during the late twentieth-century, efforts were made by India's political actors as well as IGOs to shift away

from development based population policy and towards policy focused on reproductive and child healthcare (RCH). Facilitated by the ICPD, this shift towards reproductive healthcare resulted in India's NPP, which is based upon the RCH policy framework advocated for during conference proceedings. In this regard, the RCH framework represents a paradigm shift, as old forms of knowledge regarding population growth and development were replaced with new knowledge focused on balancing social and economic development through reproductive and child healthcare. However, to understand whether the NPP represents a policy paradigm shift, it is necessary to analyze discourse within the policy, as discourse is reflective of the paradigm upon which policy is based.

Chapter Four: Textual Analysis

Introduction

In my previous chapter, I engaged in situational analysis to analyze the political and historical context in which India's National Population Policy of 2000 arose. Approached from a transnational feminist lens with a focus on knowledge production, I examined the genealogy of population discourse and knowledge production within India. Drawing upon Gayatri Spivak's concept of imperialist epistemic violence, my analysis of knowledge production attempts to understand why and how the subaltern is absent within processes of knowledge production. From this analysis, I demonstrated that discourse and knowledge production within India is largely exclusionary, with subaltern voices being silenced and "othered" and certain privileged voices having disproportionate influence.

Building upon analysis in my previous chapter, this chapter is concerned with engaging in transnational feminist textual analysis of India's NPP itself. Textual analysis, as outlined in my methodology, attempts to understand how situational context of knowledge (policy) production may have bearing on linguistic and discursive features of the text itself. This chapter is guided by the postcolonial feminist concept of palimpsest, which is a term that originates in archival research, "meaning a bit of papyrus or parchment from which the original script has been erased and a new script written instead" (Nikolajeva, 2005, p.14). Within the context of postcolonial feminist theory, palimpsest denotes the ways in which the past is present in the future despite the efforts to "erase and write a new script". Two central questions guide this chapter: 1) What voices and knowledges are present/absent within the text of the NPP?; and 2) How does the presence or absence of particular voices and knowledges within the text of the NPP impact what is recognized and regarded as important? Engaging in textual analysis via a

transnational feminist framework is important, because it can reveal how linguistic features of policy may be associated with particular social and political values/ideologies, as well as the ways in which these values/ideologies are connected to larger systems of oppression and marginalization. Through this analysis I argue that the subaltern is absent within India's NPP because we never hear the subaltern talk about itself, as subaltern voices have been pushed to the margins of political discourse and knowledge production. Instead, the subaltern "is a medium through which competing discourses represent their claims, a palimpsest written over the text of other desires, other meanings" (Gandhi, 1998, p.90).

This chapter is structured into three sections, each of which focuses on a specific theme of textual analysis. In section one, I provide a brief analysis of the policy framework upon which the NPP is based to understand the ways in which ideology is omnipresent within this framework, and how this impacts the ways in which discourse is constructed. In section two, I focus on the discursive construction of women's empowerment as it relates to the NPP's neoliberal framework. Section three focuses on the discursive theme of reproductive essentialization, wherein the category of woman is constructed in relation to women's ability to be wives and mothers. Following this analysis is a brief conclusion in which I discuss my findings. Analyzing the text of the NPP is important to my central research question regarding paradigm shift in that discourse within policy reflects the paradigm upon which it is based. This means that textual analysis can reveal how particular themes in policy are related to particular paradigms, revealing the ways in which discourse and knowledge have or have not shifted in regards to population policy.

4.1 Policy Framework- A Brief Overview and Analysis

As already discussed, the policy framework of the NPP was a product of changing population paradigms that occurred at the international level following the 1994 International Conference on Population and Development. The Cairo Program of Action, which was shaped substantially by transnational feminist advocates and activists who argued for the necessity of moving away from coercive population policy, is often seen as a "milestone" in population efforts. Introducing into international population discourse "concepts of informed choice, rights based, quality of care, and client oriented" (Simon-Kumar, 2016, p.3), the Cairo Program of Action is credited with shifting emphasis away from population control by advocating for a new population policy framework that was driven by goals of improving health and wellbeing for women and children. This new framework, also known as the reproductive and child health care (RCH) framework, emphasizes improving quality of life through increased access to reproductive and child healthcare services, as well as fostering reproductive autonomy for women. Centered upon ideas of "choice" and "human rights," the RCH positions women as autonomous beings who have rights to make "free" and "informed" choices about their reproductive health. Central to this framework is the importance placed on reproductive decision-making outside of coercion and force (Simon-Kumar, 2007, p.372), with the use of incentives and disincentives by national and state governments being discouraged, as they do not allow "true" reproductive autonomy and choice for women. In addressing issues related to equity of access, particularly in terms of contraceptives, emphasis is placed on contraceptive choice and informed family planning (Program of Action, 1994, item 7.2).

As Rao (2006) has noted, the impact of the Cairo Program of Action on India's NPP is apparent in regards to policy framework, which is based largely on the RCH framework outlined during conference proceedings (p.248). Acknowledging that population policy is more than

population control for the sake of development, the opening statement of the NPP declares that

"the overriding object of economic and social development is to improve the quality of lives that

people lead, to enhance their well-being, and to provide them with opportunities and choices to

become productive assets in society" (National Population Policy, 2000, p.1). Recognizing the

necessity of balancing economic and social development for the health and wellbeing of its

population, the NPP outlines fourteen policy objectives for improving health and healthcare

access for women and children. Ranging from improving nutrition to increased access to

education, the NPP's framework has been praised by some as a more "gender sensitive

framework" attuned to the needs of women and children (Vanita Mukherjee, 2002, p.69).

While the RCH framework that shapes India's NPP appears to be sensitive to the needs

of women and children through increased access to healthcare, the ideology underlying this

framework needs to examined, for ideology greatly influences and impacts how population

policy is discursively constructed and interpreted by political actors. As previously noted, the

RCH framework arose during the mid-1990s as a means by which to address concerns that

women from the Global South had in regards to development-driven population policies.

Although the 1990s is marked with increased transnational activism from women's

organizations, particularly in the sphere of politics through the rise of international conferences,

the 1990s is also marked with the ascendance of neoliberalism via globalization (Moghadam,

2005, p.28). Primarily understood as

> a form of economic organizing captured in the understanding of a free market and
> as an enabler of freedom, neoliberalism amalgamates political, social, and cultural
> narratives of organizing within the framework of the free market achieved
> through the participation of the individual in exchange processes. (Dutta, 2008,
> p.1)

As an ideology, neoliberalism is predicated upon concepts of individualism and choice in relation to the market, wherein the individual is seen not as a person, but as a consumer. By defining the individual as a consumer, citizenship within neoliberalism is re-conceptualized in relation to one's ability to participate in the market (Simon-Kumar, 2007, p.378). Above all, the market is central to the ideology of neoliberalism, as it "becomes the guiding principle for the relationship between the citizen and the state" (Simon-Kumar, 2007, p.366). While neoliberalism, as noted above, has been traditionally understood as an economic ideology that guides nation-states, neoliberalism also manifests itself in population policy. In particular, population frameworks, like the RCH that structures India's National Population Policy of 2000, reflect the dominant ideologies of their time. As such, the RCH framework, in many regards, is a neoliberal population framework that understands population growth and the role of the nation-state in relation to neoliberal ideals.

The ideology of neoliberalism underlies the RCH framework in several ways. First, "individual choice and individual-level decision making" (Basnyat & Dutta, 2014, p.339), in reference to family planning and reproductive healthcare, is centered. Importance is placed on the "informed" citizen who, through family-planning services, makes "rational" and educated reproductive choices. A central component to the NPP is its "commitment towards voluntary and informed choice and consent of citizens when availing reproductive healthcare services and a continuation of the target free approach in administering family planning services" (Government of India, 2000, p.6). By emphasizing informed family planning, the NPP constructs family planning as an individual-level choice that must occur through educated and informed means.

Second, the RCH framework constructs women as consumers of contraceptives and family planning services, wherein emphasis is placed on the supply-side of reproductive

healthcare via the market (Batliwala, 2007, p.174). As seen within the NPP, the construction of consumer is accomplished through the category of unmet contraceptive need, wherein these needs are assumed to be fulfilled by the market. For example, the NPP states that the "immediate objective of the NPP is to address the unmet need for contraception" (GOI, 2001, p.2), which is to be achieved through the market via private-public partnerships (GOI, 2001, p.32). The construction of consumer is further seen within the policy through the statement of "providing a wider basket of choices in contraception, through innovative social marketing schemes to reach household levels" (GOI, 2001, p.21). Here the construction of the consumer is most salient, as contraceptives are perceived to be simple, individual-level consumptive choices outside of existing structures that mitigate these 'choices.'

Third, the market is assumed to not only facilitate access to reproductive and family planning healthcare, but to address issues of social justice and equity. As Batliwala (2007) states, the RCH approach "addresses social injustices through market mechanisms, assuming, for instance, that economic restructuring and market liberalization will create 'trickle-down' effects that will, in turn, eradicate poverty and gender inequality" (p.174). Consequently, the RCH framework centers the role of the neoliberal economic market as not only a provider of reproductive healthcare and family planning, but as a facilitator of social justice and equity. In doing so, as I argue below, the underlying ideology within this framework greatly influences how India's NPP is discursively constructed in reference to two main themes: women's empowerment and reproductive essentialization.

4.2 Women's Empowerment

As mentioned previously, the NPP has been perceived by some as a more gender-sensitive policy, as it acknowledges women's empowerment as a central component to economic

and social development. Although women's empowerment is included as a policy theme within India's NPP, it is necessary to critically analyze how empowerment is discursively constructed within the confines of its neoliberal framework. Upon a close-reading of the NPP, women's empowerment is not explicitly defined, instead relying on chained equivalence to define empowerment. According to Ernesto Laclau (1990), chained equivalence refers to the "placement of words in relation to one another, wherein their meaning becomes contingent on the other words in the chain" (p.161). In the case of India's NPP, women's empowerment is defined in relation to two central concepts that include the neoliberal market and fertility control.

The neoliberal market features heavily in relation to India's conceptualization of women's empowerment, as the ability to access the market and engage in wage labor define the extent to which women are empowered. While economic productivity as general concept is discussed within the NPP as a key facet to economic development and population stabilization, as "the vast numbers of the people of India can be its greatest asset if they are provided with the means to lead healthy and *economically productive lives*" (GOI, 2001, p.19), economic productivity takes precedent in defining women's empowerment. Stating that efforts need to be made at state and community levels to increase "female participation in paid employment" (GOI, 2000, p.7), the NPP stresses the importance of women "leading economically productive lives" (p.19). This focus on women's empowerment through economic integration is further echoed in appendix one of the NPP which states, "as a measure to empower women, open more child care centers in rural and urban slums, where a woman worker may leave her children in responsible hands. This will encourage female participation in paid employment" (GOI, 2001, p.22). As these quotes demonstrate, women's empowerment is constructed exclusively in relation to the neoliberal market, wherein women are expected to become productive citizens outside the home.

For India's NPP, women's empowerment takes on a governmental function, as it "aims to produce aware and active subject-citizens who participate in the project of governance and mold their behavior toward certain ends" (Aradhana, 2008, p. 3). Through this governmental function, women's empowerment works to define and categorize groups of people, creating two distinct categories based on their relation to the economic market: empowered and disempowered women. Empowered women are seen as those who are self-aware, self-interested, competitive, profit-motivated, and fully integrated into the neoliberal market, thus making them productive citizens. They represent, as Ardhana (2008) states, the "rights-bearing, homo-economicus model of personhood" (p. 26). Inherent within this categorical construction of empowerment are caste implications, with empowered women coming to signify women from middle and upper castes, as their social positionalities do not limit access to the economic market. Within this categorization, disempowered women come to be defined in direct opposition to the self-aware, self-interested, empowered woman, as they are seen as "powerless and lacking the attitudes and means to become rational, economic agents," wherein the "solution is to supply them with those means and outlooks so that they can contribute to economic growth" (Ardhana, 2008, p.27). Conversely, disempowered women come to signify those who have "low social and economic statuses that limit their access to education" (GOI, 2001, p.8), which by extension limits their ability to be economically productive citizens. The assumption exists in this construction that women can become empowered simply by orienting themselves towards neoliberal norms and values and the market, as economic empowerment comes to represent women's empowerment.

This discursive construction of women's empowerment, in which primacy is given to economic dimensions of empowerment, has several implications for India's NPP. First, focusing on empowerment in relation to the market ignores the ways in which social and power

inequalities impact women's lives. While the NPP recognizes that social inequalities contribute

to health disparities for women, as "women's health is determined by multiple and complex

socio-cultural factors" (Government of India, 2000, p.7), there is no recognition of how these

inequalities translate into other aspects of women's lives. Through the discursive linking of

women's empowerment to the market, India's NPP erases the multi-dimensionality of women's

lived experiences and attempts to understand social inequality purely in relation to economic

access, ignoring other facets of women's inequality. It also conflates, as Cornwall (2015) notes,

> power and money and imbues the acquisition of money with almost magical
> powers: as if once women have their own money, they can wave a wand and wish
> away the social norms, affective relationships, and embedded institutions that
> constrain them. (p. 9)

In other words, focusing on women's empowerment in relation to the market is overly simplistic

and reductionist, as it fails to understand the complexity of women's positionalities and how

these positionalities intersect with institutions and norms that impact women's lives. Second, the

construction of empowerment through participation in the neoliberal market positions women as

empty "vessels" that can be infused with "power", as though "power" were a transmittable entity

(Cornwall, 2015, p.9). Focusing exclusively on power in relation to the market obfuscates other

forms of power and agency, constructing particular demographic groups as monolithically-

oppressed and powerless group due to their lack of access to the economic market. This, in turn,

replicates colonialist representations of the oppressed post-colonial woman who lacks agency

and power due to patriarchal control and tradition (Spivak, 1988, p.306).

Third, by constructing women as "vessels" in relation to power and the market, women's

agency becomes relational, wherein attention is given to what women are able to do for others.

As Cornwall (2015) notes, at the "destination of women's empowerment lie a host of good

things: better health, better governance, improved economic outcomes, the holy grail of

economic growth" (p.9). In the case of India's NPP, women's agency is constructed in relation to the family and motherhood, as better health and economic outcomes from women's empowerment are assumed to transfer to the family. This is most apparent in the objective entitled "Empowering Women for Improved Health and Nutrition," wherein the focus is on women's empowerment for the sake of infant and child health. Framed via discourse of maternal health and mortality, the NPP notes "a disparity and inequity in access to appropriate healthcare and nutrition services throughout the lifetime, particularly during pregnancy" (GOI, 2000, p.8). Linking women's health and nutrition to that of infants and children assumes better health outcomes for women via economic empowerment has generational impacts, meaning that women's "power" and "agency" is not simply her own. Women's relational agency is further seen in India's NPP in terms of poverty reduction and development, wherein the "transmission" of power and agency that comes with access to the neoliberal market is perceived to "reduce instances of poverty and facilitate development" (GOI, 2000, p.7) that will, in turn, positively impact families, communities, and the nation.

This construction of women's empowerment as a means to address poverty and development draws heavily from the "Women in Development" paradigm common within development scholarship, which views women as conduits through which economic development can be achieved (Cornwall et. al, 2000, p.3). This, in turn, thrusts the responsibility of development and poverty alleviation upon women, as it positions women as responsible for raising the post-colonial family and nation-state out of poverty and towards development. Consequently, India's NPP constructs women's empowerment as a conduit through which social ills can be solved, as though increasing women's agency and self-efficacy in itself are not policy goals that warrant attention.

For women to access the neoliberal market and achieve empowerment, fertility control and adopting the "small-family norm" are viewed as essential. Within India's NPP, the small-family norm, which is not explicitly defined, but typically refers to having no more than two children, is linked to "promoting female participation in paid employment" (GOI, 2000, p.7) and "higher levels of participation in the paid workforce for women" (GOI, 2000, p.8). The argument for women's empowerment through fertility control within the NPP relies upon the demarcation of male and female reproduction, wherein fertility levels amongst certain sexed bodies are perceived as detrimental to economic opportunities. As stated in the NPP,

> in the past, population programs have tended to exclude menfolk. The active involvement of men is called for in planning families, supporting contraceptive use, and helping pregnant women stay healthy. In short, the active cooperation and participation of men is vital (GOI, 2001, p.11)

As this quote demonstrates, although male reproduction is mentioned within the NPP in terms of "motivating men to adopt contraceptives and the small family norm" (Mukherjee, 2007, p.10), fertility control for men is not linked to economic access or ability, discursively marking women's reproduction as a site that warrants control. The small-family norm and controlling fertility through family planning are central to neoliberal conceptualizations of women's empowerment, as uncontrolled or "natural" fertility is viewed as a hindrance in women's ability to participate in the market (i.e., be productive), and by extension, achieve agency and power.

However, by centering women's reproduction and fertility control as necessary for empowerment, India's NPP creates an overly simplistic understanding of women's empowerment that fails to take into account the complexity of the social world and the "multiple forms of power" (Mukherjee, 2007, p.3) that impact and intersect in women's lives. In particular, centering women's empowerment upon fertility control obfuscates the ways in which women's reproductive choices are mitigated by factors outside of simple "individual choice," wherein

power relations between men and women greatly impact the reproductive outcomes of women (Mukherjee, 2007, p.10), which, by extension, also impact their economic opportunities. While the NPP discursively recognizes that "gender inequalities in patriarchal societies ensure that men play a critical role in determining the education and employment of family members" (GOI, 2001, p.11), this recognition is only cursory as the focus of women's empowerment continues to be facilitated through fertility control, which is compounded by multiple and complex factors. In other words, by attempting to understand women's empowerment strictly through the lens of fertility control, wherein controlling fertility is necessary to engage in the market through which empowerment is achieved, India's NPP "demonstrates a simplistic and technical understanding and approach to women's empowerment" (Mukherjee, 2007, p.13) that is far removed from the lived experiences of India's women.

4.3 Reproductive Essentialization

In addition to women's empowerment, reproductive essentialization emerges as a central discursive theme of India's NPP. According to Inhorn (2006), reproductive essentialization refers to the process by which "women's most essential characteristic is seen as their ability to reproduce the generations" (p.347). In the case of India's NPP, reproductive essentialization is emphasized through its focus on maternal and child health, "breaking the links between general health and reproductive health for women" (Bhandal, 2014, p.11). This emphasis on motherhood and childhood is most saliently seen in objectives sixteen and seventeen of the NPP, which state that

> Impaired health and nutrition is compounded by early childbearing, and consequent risk of serious pregnancy related complications. Women's risk of premature death and disability is highest during their reproductive years. Malnutrition, frequent pregnancies, unsafe abortions, RTI and STI, all combine to keep the maternal mortality ratio in India among the highest globally. (GOI, 2000, p.8)

> Low social and economic status of girls and women limits their access to education, good nutrition, as well as money to pay for health care and family planning services. The extent of maternal mortality is an indicator of disparity and inequity in access to appropriate health care and nutrition services throughout a lifetime, and particularly during pregnancy and childbirth, and is a crucial factor contributing to high maternal mortality. (GOI, 2000, p.8)

As these policy objectives demonstrate, women are discursively positioned in relation to reproduction and motherhood, wherein reproduction and motherhood are viewed as central characteristics that define the category of "woman" (Bhandal, 2014, p.10). There is the discursive presumption that women will become wives and mothers, through which they will bear and raise children. Concerned primarily with maternal and child health, India's NPP does not extend its focus beyond periods of childbearing, thus restricting women's health to a narrow focus on fertility and motherhood (Ostlin et al., 2003, p.210). In turn, this narrow focus on childbearing fails to acknowledge the diversity of women's lived experiences and how this diversity impacts women's health and wellbeing, focusing instead on women's biological abilities. Lost in this narrow focus are health concerns outside of childbearing, including reproductive healthcare needs of adolescents, single mothers, and India's aging population. Although India's NPP acknowledges adolescents and other underserved populations within appendix one of the policy, stating that efforts must be made to "ensure access to information, counseling and services, including reproductive health services that are affordable and accessible" (GOI, 2001, 29), this acknowledgement is cursorily, as the central focus remains on addressing motherhood and childbearing. In doing so, India's NPP "redefined women's health as the health of the womb" (Bhandal, 2014, p.11), wherein the focus is on improving women's reproductive health so that they can later give birth to India's future generations.

India's NPP utilizes a biomedical understanding to maternal and child health that views health and wellbeing from a supply-side orientation. According to this approach, addressing maternal and child disparities can only be achieved if reproductive needs are met, with the focus being to prioritize women's and infants' health by addressing unmet healthcare needs by increasing access to health services and supplies. As discussed previously, this supply-side orientation is most salient within arguments of unmet contraceptive need, wherein the focus continues to be on lowering "high fertility rates due to the unmeet need for contraception" (GOI, 2001, p.9). Focusing strictly on women's and infants' health, however, "overshadows socio-economic, cultural, and environmental factors surrounding health" (Ostlin et. al, 2003, p.25), wherein the focus is on addressing healthcare in terms of unmet need and services. As seen within India's NPP, there is little recognition of how health and wellbeing for women and children is determined by complex and intersecting factors that impact if and how healthcare is availed. While the NPP does state that gender relations within patriarchal societies ensures that men play a central role in "access to and utilization of health, nutrition, and family welfare services for women and children" (GOI, 2001, p.11), the meaning of this statement is 'drowned out' by the policy focus on contraceptive supplies and services, In doing so, the assumption lies that the health and wellbeing of women and children can be addressed sufficiently by focusing on the supply-side of healthcare, as though healthcare were not embedded within social structures and institutions.

Within the realm of policy, motherhood and childhood are constructed as categories that need to be protected by institutions and the nation-state. Employing what Schurko (2012) refers to as "family-demographic discourse," in which women are positioned in relation to social policies aimed at protecting motherhood and childhood (p.262), India's NPP emphasizes

maternal and childhood health as a priority of the nation-state, as the future of India is linked to

the ability of women to reproduce strong and healthy future generations. Stating that "maternal

mortality is not merely a health disadvantage, it is a matter of social injustice" (GOI, 2000, p.8)

and that "infant mortality is a sensitive indicator of human development" (p.8), India's NPP

outlines strategies aimed at ensuring healthy reproduction and motherhood for women. These

policy strategies include "Programs for Safe Motherhood, Universal Immunization and Child

Survival" (GOI, 2000, p.8), as well as "intensifying neo-natal care" (p.9). By emphasizing

maternal and child health as a nation-state priority, India's NPP represents a

> tacit contract between women and the nation state, according to which women
> must carry out their reproductive function and certain responsibilities for raising
> children, while the state, which control this process, in turn assists and supports
> women, families, and children. This contract between women and the nation-state
> gives rise to the 'institutionalization' of motherhood, in which different state
> institutions are charged with providing care to the female reproductive body.
> (Schurko, 2012, p.262)

The institutionalization of motherhood is a central facet of India's NPP, in which neoliberalism

has widened the actors involved in providing care to the female body. Although nation-state

institutions, such as the Ministry of Health and Family Welfare, continue to play an important

role in assisting women in carrying out their reproductive functions, India's NPP acknowledges

the role of NGOs and private partnerships in carrying out maternal and infant healthcare.

According to the NPP, "a national effort to reach out to households [in providing

maternal healthcare] cannot be sustained by government alone. We need to put in place a

partnership of non-government voluntary organizations, the private corporate sector,

government, and the community" (GOI, 2001, p.12). This focus on the role of NGOs in

providing care to the female body is again echoed in appendix one of the NPP, stating that a

"collaboration between the voluntary sector and the NGOs will facilitate dissemination of

efficient service delivery" and that "specific collaboration with the non-governmental sector in the social marketing of contraceptives… will be encouraged" (GOI, 2001, p.32). The increased focus on the non-governmental sector and role of NGOs in providing maternal and child healthcare is reflective of the neoliberal ideology upon which the policy is structured, as the shrinking of the state is to be filled and supported by the NGOs and voluntary sector. Through the outsourcing of women's and children's healthcare to NGOs, greater emphasis is placed on the role of the non-profit and private sector in "filling the gaps" in terms of state provided healthcare, with maternal and child healthcare being of increased focus. While the increased role of NGOs and the private sector in providing maternal and child healthcare has been regarded as a natural extension of improving healthcare services in an increasingly-globalized world, the role of NGOs and the private sector has also served to institutionalize motherhood at the international level. Consequently, India's NPP serves to re-embed women within familial relations, wherein motherhood and the family have emerged as key sites in which the nation-state, as well as international institutions, exercise "neoliberal governmentality" (Cornwall et. al, 2008, p.5).

4.4 Conclusion

The purpose of this chapter was to engage in transnational feminist textual analysis of the NPP in order to understand how situational context of knowledge (policy) production affects the discursive features of the text. Guided by the postcolonial feminist concept of palimpsest, this chapter asks two central questions: what voices and knowledges are present/absent within the text and how does the presence or absence of particular voices and knowledges impact what is recognized and regarded as important? Through textual analysis of India's NPP, specifically discursive themes of women's empowerment and reproductive essentialization, I demonstrate that discourse within India's NPP reflects the continued absence and silencing of subaltern

voices from policy due to the neoliberal framework upon which the NPP is based. Within this framework, the voices of the subaltern are not recognized, as primacy is given to neoliberal actors and institutions. By keeping the subaltern silent, the NPP represents discursively constructed desires and meanings of the nation-state, wherein the goal of policy continues to be economic development and modernization through the re-construction of post-colonial subjects. Subsequently, the discursive commitment to economically driven population policy through neoliberalism demonstrates that while the NPP is based upon the RCH framework, India's political actors continue to draw upon particular population paradigms that replicate previous understandings of population growth in relation to the nation-state.

Chapter Five: Social Analysis

Introduction

In my previous chapter, I engaged in transnational feminist textual analysis to critically examine the ways in which discursive features of India's National Population Policy of 2000 reflect the situational context in which it was produced. Analyzed via the postcolonial feminist concept of palimpsest, I attempted to understand what voices and knowledges were present and/or absent within the NPP, and how this presence/absence of particular voices and knowledges impacted what was recognized and regarded as important within policy. Through this analysis, I demonstrated that marginalized voices have been excluded within the NPP, as they have been pushed to the edges of formal knowledge (policy) production. As a result, India's NPP discursively reflects the construction of the subaltern as a medium through which political actors and institutions can reconfigure and write their own desires and meanings. Specifically, discursive themes of women's empowerment and reproductive essentialization reflect the ways in which notions of the subaltern have been rewritten to fit within a narrow neoliberal policy paradigm that grants primacy to the market.

Building upon my analysis in chapter four, this chapter engages in social analysis of India's NPP via a transnational feminist lens to explore the relationship between the text (i.e.. policy) and social practice. The purpose of this chapter is to analyze how the text of the NPP impacts and informs social practices and behaviors, specifically that of reproduction. As such, this chapter is guided by two central questions: 1) How does the text of the NPP affect social practices and behaviors in regards to particular gendered, racialized, and classed bodies?; 2) What impact does the language of the NPP have on the actual social practices of family planning and population growth reduction within India? Through this analysis, I attempt to understand the

potential social consequences of India's NPP and how these consequences disproportionately affect particular populations within India.

This chapter is divided into three sections, each of which focuses on a specific aspect of social analysis. In section one, I focus on women's empowerment discourse to discuss the limitations of understanding empowerment in relation to economic access, as well as the potential social consequences that arise from defining empowerment within a narrow neoliberal framework. In section two, my analysis focuses on fertility and the discursive limitations of understanding women's empowerment in relation to fertility control. In particular, I analyze the ways in which women's empowerment through fertility control is predicated on particular caste and class norms of fertility and reproduction, wherein these norms have become universalized and rationalized to understand the social specificities of certain social classes. In section three, I focus on reproductive essentialization and bio-politics to understand how the discursive construction of motherhood and reproduction within the NPP reflects particular understandings of gendered, classed, and caste reproduction. Through this analysis, I attempt to make present the ways in which subaltern reproduction continues to be discursively constructed and understood within a narrow framework of overpopulation and control, resulting in reproductive and contraceptive disparities. Following that analysis, I provide a brief conclusion of this chapter and what my findings mean within the context of social analysis. Social analysis is important to my question of paradigm shift in that it reveals the impact of policy on social practices and behaviors, thus revealing whether a paradigm shift has or has not occurred within policy

5.1 Women's Empowerment: Is It Enough?

As discussed in my previous chapter, women's empowerment within the NPP is framed via neoliberal discourse, wherein the focus of empowerment has, and continues to be, integrating

women into economic structures to make them productive citizens for the nation-state. As a result, women's empowerment has "been both downsized and instrumentalized within this neoliberal paradigm," resulting in a monolithic conceptualization of empowerment (Menon-Sen, 2010, p.175). Through this conceptualization of women's empowerment through economic integration, several social consequences arise. First, monolithic notions of empowerment exclude marginalized voices and knowledges that are important to challenging systemic oppression and marginalization that impact women's lives. Given the unique spaces that marginalized peoples occupy in relation to structural oppression, the absence of these voices and knowledges means that nuance and complexity is lost in favor of standardization. In particular, monolithic notions of empowerment "miss culturally [and socially] relevant nuances around local understandings of the concepts and practices of empowerment" (Porter, 2013, p.5). The result of conceptualizing women's empowerment in relation to economic integration is that it fails to recognize complexity, and as a result, may exclude or inadequately address structural inequalities and oppression that are specific to women's social positionalities.

Additionally, focusing on women's empowerment in terms of economic access grants nation-states and NGOs considerable power over women, as empowerment is largely guided and shaped by political actors and institutions that are exclusionary. This is not to say that empowerment cannot or has not been redefined by grassroots organizations to reconceptualize empowerment within a larger framework that takes into account social positionalities and social structures. However, as Sharma (2008) argues, empowerment discourse at the nation-state and international level has "consolidated" women's empowerment in terms of economic access, with funding from NGOs and governmental organizations going towards economic women's initiatives and programs (p.36). While this funding has been viewed by NGOs and governmental

organizations as beneficial to women, as it has given rise to "empowerment" programs such as micro-loans and savings-and-credit groups, it's important to recognize that empowerment programs and initiatives can have negative consequences and reinforce social inequality when they are narrowly defined within a neoliberal framework.

Illustrative of these consequences were studies conducted by Rogaly (1996) and Mayoux (1997), that demonstrated the ways in which women's empowerment strategies do not always reach or benefit the marginalized when they focus strictly on economic dimensions of empowerment. Conducted in Andhra Pradesh, Rogaly and Mayoux attempted to understand the experiences of women who were members of a micro-enterprise group that had received loans from their local government following an aggressive government campaign focused on women's empowerment (Menon-Sen, 2010, p.176). Through this study, Rogaly and Mayoux found that women were often "persuaded" into taking multiple loans, as acceptor targets had been set, resulting in indebtedness and violence from their male partners when they became overburdened with financial debt. In a similar study, Karmin (2011) found that micro-finance initiatives and programs aimed at empowering women often disproportionately affect low-caste and poor Dalit women, reinforcing social inequalities and power relations between men and women (p.114).

Although these studies were conducted years apart and in different locations within India, they point to the ways in which women's empowerment in a practical sense, when defined in relation to economic access, fails to address the social structures and power relations that impact women's lives, and can therefore reinforce these structures. What these studies also demonstrate is the ways in which nation-states and NGOs, who define the extent of women's empowerment, can provide funding and grants towards women's empowerment initiatives that can be harmful, rather than helpful, to women and other marginalized communities. The ability of NGOs to

institute women's empowerment programs and initiatives that are harmful to marginalized communities is facilitated by the NPP itself, as no mechanisms or structures are discussed to regulate the roles of NGOs and the voluntary sector. While the NPP suggests the idea of "guidelines to articulate the role and responsibility of [the NGO sector]," and the formulation of "standards for clinical services in the public, private, and NGO sectors" (GOI, 2001, p.25), this suggestion is never built-upon with any real policy commitments, leaving the role of NGOs open to interpretation by NGOs themselves and India's central government. As such, the discursive construction of women's empowerment within India's NPP has multiple potential social consequences, including the reinforcement of structural inequality and power relations between women and men, as well as between women and the nation-state.

5.2 Fertility Control and the Limitations of Discourse

Within India's NPP, fertility control is a central theme, as empowerment is linked to the ability of women to control their fertility. For women, fertility control is constructed as a necessity, as uncontrolled fertility is perceived to limit economic opportunities and access to the market. Central to this construction is the concept of the "small-family norm," wherein limiting or preventing pregnancy after two children is seen as desirable to ensure healthy families (GOI, 2000, p.7). India's NPP devotes a substantial amount of space within the policy discussing the importance and necessity of the small-family norm, with seventeen promotional and motivational measures proposed for the adoption of the small family norm. These measures vary greatly in terms of promoting and motivating couples to adopt the small family norm, which include,

> Panchayats and Zila Parishads will be rewarded and honored for exemplary performance in universalizing the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling. (GOI, 2000, p.17)

> A Family Welfare-linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilization with not more than two living children, would become eligible for health insurance. (GOI, 2000, p.17)

> Couples below the poverty line, who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded. (GOI, 2000, p.18)

Of particular interest to the adoption of the small-family norm is the inclusion of motivational measure sixteen which states,

> The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha, on the basis of population, at 1971 census levels. The freeze is currently valid until 2001, and has served as an incentive for state governments to fearlessly pursue the agenda for population stabilization. This freeze needs to be extended until 2026. (GOI, 2000, p.18)

Through the use of aggressive language in terms of a 'fearless pursuit of population stabilization' at the state level, the NPP makes it clear that states and districts themselves have a vested interest in pursuing the small-family norm, as population growth is tied to the ability of states to represent themselves within India's Congress. Although family planning and reproductive autonomy for women are important, the construction of women's empowerment through fertility control represents a one-dimensional understanding of reproduction. Specifically, India's NPP fails to recognize the socio-cultural specificity of reproduction, as reproduction and family norms are constructed in relation to middle- and upper-caste reproduction. This has many implications for subaltern women, who often find themselves at the center of family planning efforts that affect particular caste and classed bodies.

As discussed in chapter three, middle- and upper-caste reproduction was constructed and propagated in relation to subaltern reproduction, wherein the ability to control and "unyoke" oneself from pregnancy was seen as desirable and indicative of one's civility. Inherent within this construction are caste and economic implications, as children amongst middle- and upper-

caste families were not perceived as an economic necessity, but rather, a "major source of costs for their parents, hence the incentive of having smaller families" (Hartmann, 1999, p.6). In this sense, limiting family size and having fewer children is understandable from an economic point of view, as middle- and upper-caste families did not have to rely upon their children for income and economic generation. However, for low-caste and poor families, having more children is seen as desirable, as they provide a vital source of income, labor, and security for parents (Mbisamakoro, 2014, p.49). As Mamdani (1972) observed in their study of reproduction in Manupur, India, having a large family is far from being irrational for low-caste and poor agricultural workers. Having a large family, in many regards, is a necessity for survival, as children constitute a crucial part of the family economy, particularly in terms of labor. For these families, controlling fertility would "mean voluntarily reducing the labor of the family, the basic economic unit, and courting economic disaster" (p.145). Thus, it can be argued that family size and fertility control depends on varying socioeconomic contexts in which people are located, as it may be rational for some to have smaller families while not being the case for others.

Yet, India's NPP does not recognize the socioeconomic contexts of family size or reproduction, instead "rationalizing and universalizing the idea that high fertility rates are a consequence of unmet needs, lack of education, and a lack of access to reproductive healthcare and family planning services" (Mbisamakoro, 2014, p.49). Moreover, by linking women's empowerment to fertility control, India's NPP attempts to flatten differences between social castes and classes in terms of economic access and resources, thus positioning high fertility rates and large families as the cause for social inequity. In doing so, the NPP constructs social complexity into a "simple problem-solution formula where suggested solutions can be applied universally" (Mbisamakoro, 2014, p.50). In the case of women's empowerment and fertility

control, the presumption exists that women lack empowerment due to high rates of fertility that prevent access to the market. The "solution," in this context, is to increase access to contraceptives and family planning services so that women can limit their family size and fertility, and by extension, become productive citizens within the neoliberal market.

However, by focusing on fertility control as a means for women's empowerment, India's NPP limits discourse on reproduction by understanding reproduction and fertility outside of the social contexts in which it is imbedded. In other words, the NPP "attempts to rationalize and universalize the specificities of certain social classes" (Mamadani, 1972, p.128) in regards to reproduction, wherein the reproductive behaviors/norms of middle- and upper-caste families are constructed as the ideal norms for all families regardless of their social positionalities. By understanding reproduction and population growth as a natural phenomenon, rather than a social one, several consequences arise. First, as I have argued above, "rationality is a product of particular social and historical contexts" (Mamdani, 1972, p.128), meaning that the small-family norm and limiting fertility does not, in certain contexts, make sense in terms of women's empowerment. Limiting fertility and adopting the small-family norm can, in some cases, disempower women, as economic security that comes with a larger family is removed. As Bhatnagar and Dube (2012) state,

> the postcolonial state's [population policy] strips the rural poor woman of her only resource and without changing any of the material economic conditions that causes her poverty, persuades her that the simple fact of less children and less labor power will result in more prosperity and better conditions for her. Thus, the state ignores the root cause (her poverty) and attacks the symptom (her many children). (p.10)

Second, understanding women's empowerment in terms of economic access and fertility control ignores the ways in which women's fertility and reproduction is contingent on multiple social factors, so that women's empowerment cannot simply be understood in relation to fertility

control and economic access as it does not account for social complexity. In particular, as Dixon-Mueller (1994) posits, understanding women's empowerment in relation to fertility control fails to account for the ways in which women's reproductive decisions are facilitated by multiple social actors, including their husbands and oftentimes mothers-in-law (p.145).

Third, the construction of women's empowerment via fertility control relies upon a eurocentric framework that understands reproduction and reproductive behavior within a framework of individual choice and individual-level decision making. By positioning reproduction in relation to individual choice, "women are seen as backward target audiences of interventions who can be persuaded through interventions" to adopt contraceptives and accept the small-family norm (Basnyat & Dutta, 2011, p. 345). This is particularly consequential for subaltern women, as I demonstrated in chapter three, as India's population policy history reflects periods of coercive family planning practices at the national level. While coercive family planning at the national level was removed during the mid-1990s as a target-free approach was implemented, Rao (2004) has observed that coercive practices still remain in place at the state level, as these practices have become entwined within neoliberal empowerment discourse as a means to justify coercive family planning (p.14). As such, the social consequences of constructing women's empowerment in relation to fertility control not only replicate reductionist understandings of reproduction and empowerment in relation to social positionalities, but these reductionist understandings have, and continue to, negatively impact the lives of subaltern women through specific social practices.

5.3 Reproductive Essentialization and Bio-Politics

According to Schurko (2012), women's bodies are discursively constructed "primarily as a 'political body,' a space where the state and institutions apply their knowledge and power,

manifested in both disciplining practices and bio-politics" (p.260). Reproduction and motherhood mark women's bodies as the site of both disciplining practices and bio-politics, as women's bodies are disciplined through practices and mechanisms applied directly to the body, such as contraceptives, while also being constructed as the "cornerstone of the reproduction of the population" (p.260). As seen within India's NPP, disciplinary procedures related to manipulating the female body (e.g., contraceptives, family planning) and regulatory mechanisms intended to encourage women to carry out their reproductive functions are central features of this policy. The result of this construction, wherein women's bodies are "political bodies," is that the nation-state, as well as NGOs, becomes increasingly involved with regulating and legislating the female body to not only ensure that they fulfil their reproductive function, but that this fulfillment is done "correctly".

Although women are expected to fulfil their reproductive function and become mothers, reproducing India's future generations, these reproductive functions are embedded within social structures and positionalities, wherein certain bodies are perceived as sites that warrant considerable regulation and legislation. Subaltern women have historically and contemporarily been the focus of policies intended to regulate as well as limit reproduction, as unbridled population growth amongst certain castes, classes, and religions has been perceived to be consequential to the nation-state. While, for the most part, discursive features of India's NPP reflect a commitment towards regulating motherhood to ensure that women fulfill their reproductive functions, it's necessary to recognize the ways in which the bodies and reproduction of subaltern women are seen as sites for reproductive regulation. Through statements such as "high fertility due to unmet need for contraception" (GOI, 2000, p.5) and "urgent steps are currently required to make contraception more widely available" (p.5), India's NPP implicitly

constructs subaltern reproduction as something that needs to be guided and controlled by the nation-state, as they are not able to engage in "informed" or "responsible" reproductive practices. This construction of subaltern reproduction is informed by colonial overpopulation discourse, which perceives the subaltern as being irrational for having too many children and failing to regulate fertility through family planning. By marking subaltern reproduction as a site of intervention for the nation-state, subaltern women are perceived to be "aggregated uteruses and prospective perpetrators of overpopulation" wherein they are "reduced to numbers, targets, wombs, tubes, and other reproductive parts" (Green, 2000, p.28).

The impact of the NPP on the actual social practices of family planning are most readily seen in relation to attempts of controlling subaltern reproduction. The consequences of marking subaltern reproduction as a site for regulation and control have been well documented within India, with coercive family planning practices continuing to be implemented disproportionately at the state level. Scholars such as Bhattacharya (2007) have observed that coercive state-level policies have typically been implemented within states that have high percentages of low-caste, Muslim, and poor populations, where fertility and population rates remain high (p.58). Often employing cash incentives and social disincentives to persuade couples to adopt family planning, state-level population policies demonstrate that although India's NPP does not explicitly address subaltern reproduction, implicit discursive constructions of subaltern reproduction influence the ways in which fertility and population growth is understood at the state and local policy levels. This, in part, has contributed to sterilization prevalence within India, as female sterilization remains remarkably high as a means to limit fertility and unwanted pregnancy. Within the context of population policy, sterilization prevalence "provides a 'snapshot' of overall levels of sterilization use, measuring the number of people in a population using this method at a given

point in time" (EngenderHealth, 2002, p.17), with India's sterilization prevalence as a whole

around thirty-four percent (Oliveira et al., 2014). While this percentage has remained fairly

consistent over the past decade, Padmadas et. al (2014) and Singh et. al (2012) have noted that in

within some states in North and South India, sterilization prevalence rates are around sixty-six

percent,- almost double the nation-state prevalence (Singh et al., 2012, p.178). Female

sterilization in particular remains the preferred method of limiting pregnancy, with many couples

undergoing sterilization without employing short-term contraceptives to space births or to plan

their families.

Although numerous studies have been conducted to understand female sterilization

prevalence in different states within India, and many different factors have been attributed to this

prevalence, social demographics of population point to the ways in which subaltern populations,

in part, account for female sterilization prevalence. South Indian states in particular have

considerably high female sterilization rates due to the composition of its population, with high

percentages of low-caste, Muslim, and poor demographics (Heil et al., 2012, p.4). In these states,

family-planning options are often limited to what doctors and healthcare providers in clinics and

hospitals order and provide to their clients, despite the NPP declaring "fertility regulation and

contraception within a wide basket of choices" (GOI, 2000, p.3). Provider attitudes also account

for a high female sterilization prevalence in particular states within India, as attitudes about

intelligence and educational attainment affect the types of contraceptives offered to couples. In a

contraceptive study conducted by Bhawan (2007) in South India, it was found that attitudes of

healthcare providers towards particular demographic populations greatly affected the types of

contraceptives offered, as contraceptive choices and information "were likely to be withheld

from poor or poorly educated clients because providers believed that without some basic

education or awareness, women would not be able to absorb information, voice concerns, or seek clarification" (p.12). As this quote demonstrates, despite shifts in population policy paradigms, Malthusian population discourse within India continues to inform perceptions of subaltern populations, which, in turn, affects the health and family planning outcomes of particular populations.

As such, the discursive construction of reproductive essentialization within India's NPP positions the subaltern as hyper-visible within policy, as the reproductive body of subaltern women is viewed as a site of nation-state control and regulation. While, as discussed in chapter four, Indian women are perceived as wives and mothers who can and will bear children, this reproductive capability is highly regulated and dependent on the social positionality of women. For subaltern women, perceptions of overpopulation and the "as-if woman of natural fertility" impact how motherhood and reproduction are understood, as the nation-state, NGOs and international governmental organizations attempt to shape motherhood and reproduction in very particular ways. Through the institutionalization of motherhood, wherein multiple state and non-state actors are involved in providing care for the female body, motherhood and reproduction are shaped by understandings of middle and upper-caste motherhood and reproduction, as "responsible family planning" and the "educated and productive citizen" have come to represent idealized motherhood/reproduction within an Indian context. Consequently, this representation of motherhood and reproduction is specific to particular social positionalities and demographic categories, with government and non-government actors enforcing this idealized representation through coercive and non-coercive means. Although the most visible aspects of this enforcement are high rates of female sterilization and contraceptive prevalence, it's also important to recognize the ways in which political discourse on motherhood and reproduction shapes

perceptions of political actors in regards to formal policy crafting, which in turn affect the lives and well-being of subaltern women.

5.4 Conclusion

The purpose of this chapter is to analyze the impact of the text (i.e., policy) on social practices and behaviors, specifically that of reproduction. Guided by two central questions, this chapter attempts to understand: 1) How does the text affect social practices and behaviors in regards to particular gendered, racialized, and classed bodies? and 2) What impact does the language of the NPP have on the social practices of family planning and population growth reduction within India? Focusing on three themes: women's empowerment, fertility control, and reproductive essentialization, this analysis demonstrates that subaltern women are impacted by formal and discursive features of the text, particularly in terms of family planning and reproductive behavior. Through my discussion of women's empowerment, I demonstrate that empowerment as defined within the NPP favors that of economic access, with considerable attention granted towards empowerment programs and initiatives centered on women's economic empowerment. The result of defining women's empowerment in terms of economic access is that nation-states, NGOs and funding organizations may implement programs and initiatives, such as micro-financing, that, rather than empower women, result in further marginalization and inequity as structural inequality and power relations are reinforced.

Following this analysis, I then turned my attention to fertility control as a social practice, which was closely linked to women's empowerment within the NPP. Through this analysis, I argue that India's NPP does not recognize the socioeconomic contexts of family size or reproduction, wherein a one-size-fits-all understanding of fertility and population growth ignores the ways in which family size and fertility are dependent on women's social positionality and

other social factors. In my last section of analysis, I attempted to understand the social consequences of reproductive essentialization in relation to bio-politics. In particular, I demonstrated that reproduction and motherhood mark women's bodies as the site of both disciplining practices and bio-politics, as women's bodies are disciplined through practices and mechanisms applied directly to the body, such as contraceptives, while also being constructed as the producers of children. By analyzing the ways in which India's NPP implicitly constructs subaltern bodies as sites that warrant attention and control, this analysis attempts to position reproductive practices, such as sterilization prevalence, in relation to this discursive construction to examine the social consequences of population policy that perceives the subaltern in fixed discursive terms.

The findings from this analysis are important to my continued discussion regarding paradigm shift in that policy paradigms shape and guide social practices and behaviors. When paradigm shifts occur, social practices and behaviors change as well (Rosado, 1997, p.1). Within the realm of policy, paradigm shifts change social practices and behaviors through the re-allocation or creation of resources, programs, and institutions to support this new paradigm. As demonstrated in this chapter, the discursive construction of India's NPP according to a neoliberal policy paradigm means that social practices and behaviors, particularly those of the nation-state, are shaped accordingly. Given that the NPP is premised upon a neoliberal paradigm that grants primacy to the market and economic development, this results in nation-state practices that facilitate these objectives. As seen in this chapter, women's empowerment through micro-loans, fertility control through the small-family norm, and reproductive essentialization serve to restructure and re-conceptualize the post-colonial state to encourage economic development and modernization.

Conclusion

The purpose of this thesis is to analyze and examine India's National Population Policy of 2000 from a transnational feminist lens to understand whether India's NPP represent a paradigm shift in how the nation-state conceptualizes and addresses population growth via formal population policy. To answer this question, I employ transnational feminist theory within political discourse analysis methodology, which was facilitated through three levels of analysis: situational, textual, and social. PDA as a methodology was important to this scholarship in that it attempts to understand the process of political discourse construction by political actors within political institutions and the impact of political discourse on the social world.

Study Findings

In chapter three I attempted to understand the political and historical contexts in which the NPP was created. Analyzed from a transnational feminist lens of knowledge production, I traced population discourse from colonial occupation through independence to examine how population growth was conceptualized, and the actors involved in shaping discourse. Informed by Spivak's concept of imperialist epistemic violence, my analysis of knowledge production attempts to understand why and how the subaltern is absent within processes of knowledge production. Through this chapter, I demonstrate that population discourse and knowledge production within India has been a primarily exclusionary process. Occurring within governmental structures, the voices of colonial officials, including British and Indigenous and upper-caste economists, Indian Nationalists, birth control advocates, demographers, and political actors, were privileged in discourse production. Creating an "othering" and maintain the silence of subaltern voices and knowledges, members of India's lower castes, Muslims, and rural poor

have been predominantly excluded from formal political structures that facilitate discourse and knowledge production, particularly that of population policy.

This chapter also demonstrates that India's history as a colonial territory informs processes of discourse and knowledge production. Through this analysis, I found that India's knowledge production following independence as represented by five-year development plans, was based upon elitist Nationalist discourse that had developed during colonization. However, through the introduction of NGOs and IGOs into India's political structures, knowledge and discourse evolved to reflect population growth concerns related to Global North hegemony. The focus of knowledge and discourse production became that of population control for the sake of demographic transition. Evolving into coercive population paradigms, efforts were made by India's political actors as well as IGOs during the late twentieth-century to shift away from development based population paradigms and towards policy focused on reproductive and child healthcare (RCH). Facilitated by the ICPD, this shift towards reproductive healthcare resulted in India's NPP, which is based upon the RCH policy framework advocated for during conference proceedings. In this regard, the RCH framework represents a paradigm shift, as old forms of knowledge regarding population growth and development were replaced with new knowledge focused on balancing social and economic development through reproductive and child healthcare.

In chapter four, I engage transnational feminist textual analysis of the NPP in order to understand the ways in which situational context of knowledge (policy) production affects the discursive features of the text. Guided by the postcolonial feminist concept of palimpsest, this chapter asks what voices and knowledges are present/absent within the text and how the presence or absence of particular voices and knowledges impacts what is recognized and regarded as

important. Through textual analysis of India's NPP, specifically discursive themes of women's empowerment and reproductive essentialization, I demonstrate that discourse within India's NPP reflects the absence of subaltern voices due to the neoliberal framework upon which the NPP is based. Within this framework, the voices of the subaltern are not recognized, as primacy is given to neoliberal actors and institutions. By keeping the subaltern silent, the NPP represents discursively constructed desires and meanings of the nation-state, wherein the goal of policy continues to be economic development and modernization through the re-construction of post-colonial subjects. Subsequently, the discursive commitment to economically driven population paradigms through neoliberalism demonstrates that while the NPP is based upon the RCH framework, India's political actors continue to draw upon particular types of paradigms that replicate previous understandings of population growth in relation to the nation-state.

In chapter five, I engage in social analysis to examine the impact of the text of the NPP on social practices and behaviors, specifically that of reproduction. This chapter is guided by two questions, which attempt to understand the affects of the NPP on social practices for particular gendered, racialized, and classed bodies and the impact of language within the NPP the social practices of family planning and population growth reduction within India. Focusing on three themes -women's empowerment, fertility control, and reproductive essentialization- this analysis demonstrates that subaltern women are impacted by formal and discursive features of the NPP, particularly in terms of family planning and reproductive behavior. Through my analysis of women's empowerment, I demonstrated that empowerment as defined within the NPP favors that of economic access, with attention granted towards empowerment programs and initiatives centered on women's economic empowerment. The result of defining women's empowerment in terms of economic access is that nation-states, NGOs and funding organizations may implement

programs and initiatives, such as micro-financing, that rather than empower women, result in further marginalization and inequity as structural inequality and power relations are reinforced.

I then turned my attention to fertility control as a social practice, which was closely linked to women's empowerment within the NPP. I argued that India's NPP does not recognize the socioeconomic contexts of family size or reproduction, wherein a one-size-fits-all understanding of fertility and population growth ignores the ways in which family size and fertility are dependent on women's social positionality and other social factors. In my last section of analysis, I analyze the social consequences of reproductive essentialization in relation to bio-politics. In particular, my analysis demonstrates that reproduction and motherhood mark women's bodies as the site of both disciplining practices and bio-politics. Women's bodies are disciplined through practices and mechanisms applied directly to the body, such as contraceptives, while also being constructed as the producers of children. Through analysis of India's implicit construction of subaltern bodies as sites that warrant nation-state control, this analysis positioned reproduction practices, specifically sterilization prevalence, in relation to discursive constructions of subaltern reproduction to examine the social consequences of population policy that constructs the subaltern in static discursive terms.

Through PDA, the findings from this study suggest that India's NPP does represent a paradigm shift of sort, but not necessary for the betterment of India's women. While the policy framework of the NPP is premised upon the RCH approach, which was a paradigm shift at the policy level, textual and social analysis demonstrate that the focus of India's NPP continues to understand population growth as something that needs to be tightly monitored and controlled by the nation-state. The discursive commitment to economically driven population policy through neoliberalism shows that although the NPP includes issues related to women's empowerment

and health, India's focus continues to be economic development. These findings were further

supported through analysis of social practice, which found that women's empowerment

initiatives and programs continue to focus on economic aspects of empowerment while ignoring

social structures and power inequalities that impact other aspects of women's lives. As Menon-

Sen (2010) notes, "economic empowerment may marginally improve women's status within

households or communities, but it does not automatically spill over into other dimensions of

gender relations or eradicate deeply entrenched biases" (p.175). In other words, by focusing on

women's empowerment strictly in terms of economic access, existing social and power

inequalities are not acknowledged, meaning that women are simply integrated into the market

without any efforts to address social inequalities and power relations that impact women's lives.

The consequence of this narrow focus of women's empowerment is that through neoliberalism,

nation-states, NGOs, and international governmental organizations can claim women's

empowerment through programs and initiatives that further marginalize subaltern populations.

Moreover, my analysis found that social practices of reproduction within India continue

to be understood in relation to subaltern fertility control for the sake of nation-state economic

development. Consequently, family planning practices continue to target subaltern reproduction

through coercive and non-coercive means, resulting in contraceptive prevalence and disparity

amongst various demographic groups. As such, my findings suggest that although India's NPP

declares that "the overriding objective of economic and social development is to improve the

quality of lives that people lead, to enhance their well-being, and to provide them with

opportunities and choices to becomes productive assets in society" (GOI, 2000, p.1), the focus of

this policy continues to elevate economic development over that of social development and well-

being. For this reason, my scholarship concludes that India's NPP does represent a paradigm

shift as political actors and institutions drew upon new types of knowledge that understands

population growth within the context of neoliberalism. However, as my social analysis above

demonstrates, this has not necessarily been a positive paradigm shift for India's women and

marginalized communities.

Study Limitations

The main limitation to this study is a lack of access to debate transcripts or documents

detailing debate within India's central government in regards to population policy. While India's

population plans and policies were available to view on their government website, the actual

debates and discussions regarding particular plans/policies were not made available. This means

that this study can only offer a partial view in terms of policy creation, as potentially important

discussions and debates that lead to the creation of policy are absent. It is also important to

acknowledge that my research methodology, PDA, approaches population policy research from a

very specific standpoint. This means that the types of questions I ask and the types of answers

produced in this scholarship are limited. In particular, PDA can only provide a partial view of

policy impact upon individuals and communities, meaning that one cannot understand the "on

the ground" impact of these policies in their entirety.

Future Research

As discussed in chapter one, India's population policies have been critically analyzed

from three dominant themes: 1) the historical development of population policy; 2) reproductive

health and family planning; and 3) the RCH and Target-Free Approach. While these methods of

analyzing population policy are important to understanding policy crafting and program

implementation in the Global South, these methods tend to be very 'siloed' in terms of

understanding policy within larger social and political contexts. Population policy necessitates

analysis outside of singular fixed methods in order to fully understand not only how population policies are created, but how they are discursively constructed and implemented (Halfon, 2007, p.8). For this reason, PDA of India's population policy has the potential to enrich fields of study related to policy, family planning, and women's reproductive healthcare by offering a multi-layered framework in which to engage in policy analysis.

This study also has the potential to improve transnational feminist praxis in terms of women's reproductive healthcare. The issue of reproductive healthcare has been predominately occupied by white, western, women from the Global North wherein the focus has been on reproductive rights and ensuring legal protection for women's choices. Although legal protections for reproductive choice are important, it is also necessary to recognize that reproductive healthcare exists outside of the simple 'choice' paradigm. This rights based paradigm has largely failed women of color, subaltern women, and women from the Global South for the inability to understand complexity in relation to women's reproductive healthcare (SisterSong, 2017). For this reason, it is necessary for feminist scholars and activists to recognize the ways in which rights based paradigms further oppress and marginalize already marginalized people and communities. Moving away from rights based paradigms towards one of reproductive justice is necessary if we are to address and dismantle imperialist, white supremacist, capitalist, patriarchy.

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Appendix A: Five-Year Development Plans

India's Five Year Development Plans: 1951-1997								
Date	First Five-Year Plan 1951-1955	Second Five-Year Plan 1956-1961	Third Five-Year Plan 1961-1966	Fourth Five-Year Plan 1969-1974	Fifth Five-Year Plan 1974-1979	Sixth Five-Year Plan 1980-1985	Seventh Five-Year Plan 1985-1990	Eighth Five-Year Plan 1992-1997
Domestic Actors Involved in Plan Creation	India's Central Government: Prime Minister, Planning Commission	India's Central Government: Prime Minister, Planning Commission	-India's Central Gov.: Prime Minister, Planning Commission -Family Planning Association of India	-India's Central Gov.: Prime Minister, Planning Commission -Family planning organizations	India's Central Gov.: Prime Minister, Planning Commission	India's Central Gov.: Prime Minister, Planning Commission	India's Central Gov.: Prime Minister, Planning Commission, Department of Family Welfare	India's Central Gov.: Prime Minister, Planning Commission, Department of Family Welfare
IGOs and NGOs Involved in Plan Creation or Influence	International actors and NGOs were not actively involved with the creation of the plan.	Funding NGOs: Ford Foundation, Rockefeller Foundation, Population Council	-Funding NGOs -World Bank	-World Bank -U.N. Population Division	-World Bank -U.N. Population Division	-World Bank -U.N. Population Division	-World Bank -U.N. Population Division -NGOs	-World Bank -U.N. Population Division -NGOs
Main Objectives	-Balance population growth with economic development -Improve standard of living -Improve maternal and child health	-Continued emphasis on economic development -Creation of a program for family limitation and population control - Family planning in hospitals and clinics	-Stress the importance of family planning in stabilizing population growth -Expansion of family planning services -Introduction of long-term contraceptives	-Contraceptive targets: Sterilization and IUD insertions -Widen acceptance for oral and injectable contraceptives -Reduce birth rate to 32 per thousand from 39 per thousand -Increase conventional contraceptives -Creation of Department of family Planning	-Topmost priority to family planning -Increased male sterilization -Increased acceptance of IUDs for women -Enforcement of the small family norm	-Bring family planning efforts at the center stage of development -Goal of reducing net population growth to one by 1996 -Focus on health related issues tied to population growth	-Couple protection rate of 42% -Birth rate reduction to 29.1 per thousand -Stipulated 31 million sterilizations -21.25 million IUD insertions -14.5 million conventional contraceptive users -Universal immunization program	-Containing population growth -Reduce birth rate to 26 per thousand in 1997 -Stressed the need of a national population policy -Suggested an inter-sectoral approach -Target based approach eliminated -Child Survival and Safe Motherhood Program

Paradigm	Health and welfare of the family: family planning to secure better health for women and children	Economic development through population control	Planned Development	-Demographically driven planned economic development: demographic rational for family planning -Target approach to family planning	-Economic development following economic stagnation -Coercive family planning	-Economic development -Target based family planning	-Economic development through increased access to general and reproductive healthcare	-Community needs approach to family planning -Economic development through social development
Major Historical/ Political Event(s) That Influenced Plan	Indian Independence	Introduction of NGOS and International actors from the Global North	-Cold War concerns over Communism	-Economic and development stagnation -Loan requirements through the World Bank	-Emergency Period 1975-1977 -Economic Stagnation	Bucharest Population Conference	Increased activism from transnational feminist within and outside India	-Increased activism from transnational feminist within and outside India. International shift from strictly economic development to include a focus on healthcare
Outcome of Plan	Population growth continued to increase despite efforts to increase access to family planning clinics.	Population growth continued to increase despite efforts to control population growth through increased access to family planning	-Continued population growth -Increased usage of long-term contraceptives	-Population growth continued to increase -National emphasis on long-term contraceptives -Coercive family planning practices	-Suspension of constitutional rights of India's citizens -Mass sterilization camps -Defeat of Congress Party in 1977 general election	-Slight shift to include a focus on women's and children health within family planning efforts -Continued emphasis on target driven family planning -Continued population growth	-Despite efforts to decrease birth and death to control population growth, India's population growth rates remained steady. -Slight increase in family planning utilization	-Targets eliminated at the national level -Targets remained at the state-level through state lead population policies -Efforts to create a national population policy

Appendix B: India's National Population Policy of 2000
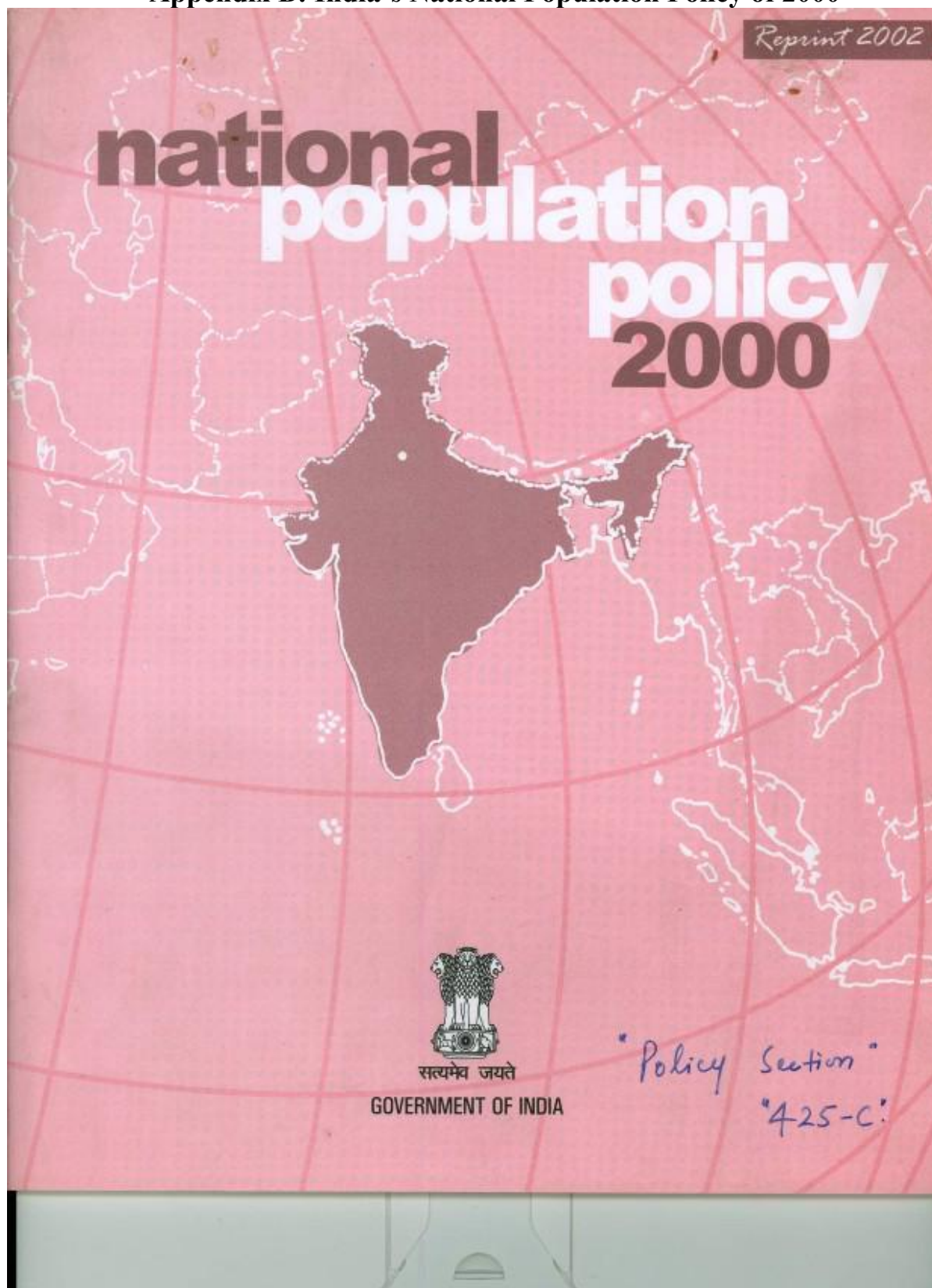
Department of Family Welfare
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सत्यमेव जयते
GOVERNMENT OF INDIA

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1. The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society.

2. In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy"[1] . After 1952, sharp declines in death rates were, however, not accompanied by a similar drop in birth rates. The National Health Policy, 1983 stated that replacement levels of total fertility rate[2] (TFR) should be achieved by the year 2000.

3. On 11 May, 2000 India is projected to have 1 billion [3] (100 crore) people, i.e. 16 percent of the world's population on 2.4 percent of the globe's land area. If current trends continue, India may overtake China in 2045, to become the most populous country in the world. While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India's current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resource endowment and environment.

Box 1 : India's Demographic Achievement

Half a century after formulating the national family welfare programme, India has:

- reduced crude birth rate (CBR) from 40.8 (1951) to 26.4 (1998, SRS);
- halved the infant mortality rate (IMR) from 146 per 1000 live births (1951) to 72 per 1000 live births (1998, SRS);
- quadrupled the couple protection rate (CPR) from 10.4 percent (1971) to 44 percent (1999);
- reduced crude death rate (CDR) from 25 (1951) to 9.0 (1998, SRS);
- added 25 years to life expectancy from 37 years to 62 years;
- achieved nearly universal awareness of the need for and methods of family planning, and
- reduced total fertility rate from 6.0 (1951) to 3.3 (1997, SRS).

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

Table 1: Population Projections for India (million)[3]

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

5. Stabilising population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications.

6. The National Population Policy, 2000 (NPP 2000) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services. The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health, and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child heath services by government, industry and the voluntary non-government sector, working in partnership.

objectives

7. The immediate objective of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

1 Milestones in the Evolution of the Population Policy are listed at Appendix II, page 36-37
2 TFR: Average number of children born to a woman during her lifetime.
3 Source: Technical Group on Population Projections, Planning Commission.

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

Box 2: National Socio-Demographic Goals for 2010

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.

- Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.

- Reduce infant mortality rate to below 30 per 1000 live births.

- Reduce maternal mortality ratio to below 100 per 100,000 live births.

- Achieve universal immunization of children against all vaccine preventable diseases.

- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

- Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.

- Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.

- Achieve 100 per cent registration of births, deaths, marriage and pregnancy.

- Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organisation.

- Prevent and control communicable diseases.

- Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.

- Promote vigorously the small family norm to achieve replacement levels of TFR.

- Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred programme.

3

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

Year	Table 2: Anticipated Growth in Population (million)			
	If current trends continue		If TFR 2.1 is acheved by 2010	
	Total Population	Increase in population	Total population	Increase in population
1991	846.3	-	846.3	-
1996	934.2	17.6	934.2	17.6
1997	949.9	15.7	949.0	14.8
2000	996.9	15.7	991.0	14.0
2002	1027.6	15.4	1013.0	11.0
2010	1162.3	16.8	1107.0	11.75

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

Year	Crude Birth Rate	Infant Mortality Rate	Total Fertility Rate
	Table 3: Projections of Crude Birth Rate, Infant Mortality Rate, and TFR, if the NPP 2000 is fully implemented.		
1997	27.2	71	3.3
1998	26.4	72	3.3
2002	23.0	50	2.6
2010	21.0	30	2.1

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

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

    ■ The large size of the population in the reproductive age-group (estimated contribution 58 percent). An addition of 417.2 million between 1991 and 2016 is anticipated despite substantial reductions in family size in several states, including those which have already achieved replacement levels of TFR. This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the population being currently in their reproductive years. It is imperative that the the reproductive age group adopts without further delay or exception the "small family norm", for the reason that about 45 percent of population increase is contributed by births above two children per family.

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- Higher fertility due to unmet need for contraception (estimated contribution 20 percent). India has 168 million eligible couples, of which just 44 percent are currently effectively protected. Urgent steps are currently required to make contraception more widely available, accessible, and affordable. Around 74 percent of the population lives in rural areas, in about 5.5 lakh villages, many with poor communications and transport. Reproductive health and basic health infrastructure and services often do not reach the villages, and, accordingly, vast numbers of people cannot avail of these services.

- High wanted fertility due to the high infant mortality rate (IMR) (estimated contribution about 20 percent). Repeated child births are seen as an insurance against multiple infant (and child) deaths and accordingly, high infant mortality stymies all efforts at reducing TFR.

- Over 50 percent of girls marry below the age of 18, the minimum legal age of marriage, resulting in a typical reproductive pattern of "too early, too frequent, too many". Around 33 percent births occur at intervals of less than 24 months, which also results in high IMR.

   The country's demographic profile is given in Appendix III (pages 38-42).

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

   These are presented below:

   ### (I) Decentralised Planning and Programme Implementation

11. The 73rd and 74th Constitutional Amendments Act, 1992, made health, family welfare, and education a responsibility of village panchayats. The panchayati raj institutions are an important means of furthering decentralised planning and programme implementation in the context of the NPP 2000. However, in order to realize their potential, they need strengthening by further delegation of administrative and financial powers, including powers of resource mobilization.

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Further, since 33 percent of elected panchayat seats are reserved for women, representative committees of the panchayats (headed by an elected woman panchayat member) should be formed to promote a gender sensitive, multi-sectoral agenda for population stabilisation, that will "think, plan and act locally, and support nationally". These committees may identify area-specific unmet needs for reproductive health services, and prepare need-based, demand-driven, socio-demographic plans at the village level, aimed at identifying and providing responsive, people-centred and integrated, basic reproductive and child health care. Panchayats demonstrating exemplary performance in the compulsory registration of births, deaths, marriages, and pregnancies, universalizing the small family norm, increasing safe deliveries, bringing about reductions in infant and maternal mortality, and promoting compulsory education up to age 14, will be nationally recognized and honored.

(ii) Convergence of Service Delivery at Village Levels

12. Efforts at population stabilisation will be effective only if we direct an integrated package of essential services at village and household levels. Below district levels, current health infrastructure includes 2,500 community health centres, 25,000 primary health centres (each covering a population of 30,000), and 1.36 lakh subcentres (each covering a population of 5,000 in the plains and 3,000 in hilly regions)[4]. Inadequacies in the existing health infrastructure have led to an unmet need of 28 percent for contraception services, and obvious gaps in coverage and outreach. Health care centres are over-burdened and struggle to provide services with limited personnel and equipment. Absence of supportive supervision, lack of training in inter-personal communication, and lack of motivation to work in rural areas, together impede citizens' access to reproductive and child health services, and contribute to poor quality of services and an apparent insensitivity to client's needs. The last 50 years have demonstrated the unsuitability of these yardsticks for provision of health care infrastructure, particularly for remote, inaccessible, or sparsely populated regions in the country like hilly and forested areas, desert regions and tribal areas. We need to promote a more flexible approach, by extending basic reproductive and child health care through mobile clinics and counseling services. Further, recognizing that government alone cannot make up for the inadequacies in health care infrastructure and services, in order to resolve unmet needs and extend coverage, the involvement of the voluntary sector and the non-government sector in partnership with the government is essential.

4 Source: MOHFW Statistics, 1998.

13. Since the management, funding, and implementation of health and education programmes has been decentralised to panchayats, in order to reach household levels, a one-stop, integrated and coordinated service delivery should be provided at village levels, for basic reproductive and child health services. A vast increase in the number of trained birth attendants, at least two per village, is necessary to universalise coverage and outreach of ante-natal, natal and post-natal health care. An equipped maternity hut in each village should be set up to serve as a delivery room, with functioning midwifery kits, basic medication for essential obstetric aid, and indigenous medicines and supplies for maternal and new born care. A key feature of the integrated service delivery will be the registration at village levels, of births, deaths, marriage, and pregnancies. Each village should maintain a list of community midwives and trained birth attendants, village health guides, panchayat sewa sahayaks, primary school teachers and aanganwadi workers who may be entrusted with various responsibilities in the implementation of integrated service delivery.

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

Operational strategies are described in the Action Plan at Appendix I (pages 21-22).

(iii) Empowering Women for Improved Health and Nutrition

15. The complex socio-cultural determinants of women's health and nutrition have cumulative effects over a lifetime. Discriminatory childcare leads to malnutrition and impaired physical development of the girl child. Undernutrition and micronutrient deficiency in early adolescence goes beyond mere food entitlements to those nutrition related capabilities that become crucial to a woman's well-being, and through her, to the well-being of children. The positive effects of good health and nutrition on the labour productivity of the poor is well documented. To the extent that women are over-represented among the poor, interventions for improving women's health and nutrition are critical for poverty reduction.

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16. Impaired health and nutrition is compounded by early childbearing, and consequent risk of serious pregnancy related complications. Women's risk of premature death and disability is highest during their reproductive years. Malnutrition, frequent pregnancies, unsafe abortions, RTI and STI, all combine to keep the maternal mortality ratio in India among the highest globally.

17. Maternal mortality is not merely a health disadvantage, it is a matter of social injustice. Low social and economic status of girls and women limits their access to education, good nutrition, as well as money to pay for health care and family planning services. The extent of maternal mortality is an indicator of disparity and inequity in access to appropriate health care and nutrition services throughout a lifetime, and particularly during pregnancy and child-birth, and is a crucial factor contributing to high maternal mortality.

18. Programmes for Safe Motherhood, Universal Immunisation, Child Survival and Oral Rehydration have been combined into an Integrated Reproductive and Child Health Programme, which also includes promoting management of STIs and RTIs. Women's health and nutrition problems can be largely prevented or mitigated through low cost interventions designed for low income settings.

19. The voluntary non-government sector and the private corporate sector should actively collaborate with the community and government through specific commitments in the areas of basic reproductive and child health care, basic education, and in securing higher levels of participation in the paid work force for women.

Operational strategies are described in the Action Plan at Appendix I (pages 22-26).

(iv) Child Health and Survival

20. Infant mortality is a sensitive indicator of human development. High mortality and morbidity among infants and children below 5 years occurs on account of inadequate care, asphyxia during birth, premature birth, low birth weight, acute respiratory infections, diarrhoea, vaccine preventable diseases, malnutrition and deficiencies of nutrients, including Vitamin A. Infant mortality rates have not significantly declined in recent years.

21. Our priority is to intensify neo-natal care. A National Technical Committee should be set up, consisting principally of consultants in obstetrics, pediatrics (neonatologists), family health, medical research and statistics from among academia, public health professionals, clinical practitioners and government. Its terms of reference should include prescribing perinatal audit norms, developing quality improvement activities with monitoring schedules and suggestions for facilitating provision of continuing medical and nursing education to all perinatal health care providers. Implementation at the grass-roots must benefit from current developments in the fields of perinatology and neonatology. The baby friendly hospital initiative (BFHI) should be extended to all hospitals and clinics, up to subcentre levels. Additionally, besides promoting breast-feeding and complementary feeds, the BFHI should include updating of skills of trained birth attendants to improve new born care practices to reduce the risks of hypothermia and infection. Essential equipment for the new born must be provided at subcentre levels.

22. Child survival interventions i.e. universal immunisation, control of childhood diarrhoeas with oral rehydration therapies, management of acute respiratory infections, and massive doses of Vitamin A and food supplements have all helped to reduce infant and child mortality and morbidity. With intensified efforts, the eradication of polio is within reach. However, the decline in standards, outreach and quality of routine immunisation is a matter of concern. Significant improvements need to be made in the quality and coverage of the routine immunisation programme.

Operational strategies are described in the Action Plan at Appendix I (pages 26-27).

(v) Meeting the Unmet Needs for Family Welfare Services

23. In both rural and urban areas there continue to be unmet needs for contraceptives, supplies and equipment for integrated service delivery, mobility of health providers and patients, and comprehensive information. It is important to strengthen, energise and make accountable the cutting edge of health infrastructure at the village, subcentre and primary health centre levels, to improve facilities for referral transportation, to encourage and strengthen local initiatives for ambulance services at village and block levels, to increase innovative social marketing schemes for affordable products and services and to improve advocacy in locally relevant and acceptable dialects.

Operational strategies are described in the Action Plan in Appendix I (pages 27-28).

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(vi) Under-Served Population Groups

(a) Urban Slums

24. Nearly 100 million people live in urban slums, with little or no access to potable water, sanitation facilities, and health care services. This contributes to high infant and child mortality, which in turn perpetuate high TFR and maternal mortality. Basic and primary health care, including reproductive and child health care, needs to be provided. Coordination with municipal bodies for water, sanitation and waste disposal must be pursued, and targeted information, education and communication campaigns must spread awareness about the secondary and tertiary facilities available.

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

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

25. In general, populations in remote and low density areas do not have adequate access to affordable health care services. Tribal populations often have high levels of morbidity arising from poor nutrition, particularly in situations where they are involuntarily displaced or resettled. Frequently, they have low levels of literacy, coupled with high infant, child, and maternal mortality. They remain under-served in the coverage of reproductive and child health services. These communities need special attention in terms of basic health, and reproductive and child health services. The special needs of tribal groups which need to be addressed include the provision of mobile clinics that will be responsive to seasonal variations in the availability of work and income. Information and counseling on infertility, and regular supply of standardised medication will be included.

Operational strategies are described in the Action Plan at Appendix I (page 29).

(c) Adolescents

26. Adolescents represent about a fifth of India's population. The needs of adolescents, including protection from unwanted pregnancies and sexually transmitted diseases (STD), have not been specifically addressed in the past. Programmes should encourage delayed marriage and child-bearing, and education of adolescents about the risks of unprotected sex. Reproductive health services for adolescent girls and boys is especially significant in rural India, where adolescent

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marriage and pregnancy are widely prevalent. Their special requirements comprise information, counseling, population education, and making contraceptive services accessible and affordable, providing food supplements and nutritional services through the ICDS, and enforcing the Child Marriage Restraint Act, 1976.

Operational strategies are described in the Action Plan in Appendix I (pages 29-30).

(d) Increased Participation of Men in Planned Parenthood

27. In the past, population programmes have tended to exclude menfolk. Gender inequalities in patriarchal societies ensure that men play a critical role in determining the education and employment of family members, age at marriage, besides access to and utilisation of health, nutrition, and family welfare services for women and children. The active involvement of men is called for in planning families, supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoiding delays in seeking care, helping after the baby is born and, finally, in being a responsible father. In short, the active cooperation and participation of men is vital for ensuring programme acceptance. Further, currently, over 97 percent of sterilisations are tubectomies and this manifestation of gender imbalance needs to be corrected. The special needs of men include re-popularising vasectomies, in particular no-scalpel vasectomy as a safe and simple procedure, and focusing on men in the information and education campaigns to promote the small family norm.

Operational strategies are described in the Action Plan in Appendix I (page 30).

(vii) Diverse Health Care Providers

28. Given the large unmet need for reproductive and child health services, and inadequacies in health care infrastructure it is imperative to increase the numbers and diversify the categories of health care providers. Ways of doing this include accrediting private medical practitioners and assigning them to defined beneficiary groups to provide these services; revival of the system of licensed medical practitioner who, after appropriate certification from the Indian Medical Association (IMA), could provide specified clinical services.

Operational strategies are described in the Action Plan at Appendix I (pages 30-31).

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

29. A national effort to reach out to households cannot be sustained by government alone. We need to put in place a partnership of non-government voluntary organizations, the private corporate sector, government and the community. Triggered by rising incomes and institutional finance, private health care has grown significantly, with an impressive pool of expertise and management skills, and currently accounts for nearly 75 percent of health care expenditures. However, despite their obvious potential, mobilising the private (profit and non-profit) sector to serve public health goals raises governance issues of contracting, accreditation, regulation, referral, besides the appropriate division of labour between the public and private health providers, all of which need to be addressed carefully. Where government interventions or capacities are insufficient, and the participation of the private sector unviable, focused service delivery by NGOs may effectively complement government efforts.

Operational strategies are described in the Action Plan in Appendix I (page 32).

(ix) Mainstreaming Indian Systems of Medicine and Homeopathy

30. India's community supported ancient but living traditions of indigenous systems of medicine has sustained the population for centuries, with effective cures and remedies for numerous conditions, including those relating to women and children, with minimal side effects. Utilisation of ISMH in basic reproductive and child health care will expand the pool of effective health care providers, optimise utilisation of locally based remedies and cures, and promote low-cost health care. Guidelines need to be evolved to regulate and ensure standardisation, efficacy and safety of ISMH drugs for wider entry into national markets.

31. Particular challenges include providing appropriate training, and raising awareness and skill development in reproductive and child health care to the institutionally qualified ISMH medical practitioners. The feasibility of utilising their services to fill in gaps in manpower at village levels, and at subcentres and primary health centres may be explored. ISMH institutions, hospitals and dispensaries may be utilised for reproductive and child health care programmes. At village levels, the services of the ISMH "barefoot doctors", after appropriate

training, may be utilised for advocacy and counseling, for distributing supplies and equipment, and as depot holders. ISMH practices may be applied at village maternity huts, and at household levels, for ante-natal, natal and post natal care, and for nurture of the new born.

Operational strategies are described in the Action Plan in Appendix I (page 33).

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

32. Government must constantly advance, encourage, and support medical, social science, demographic and behavioural science research on maternal, child and reproductive health care issues. This will improve medical techniques relevant to the country's needs, and strengthen programme and project design and implementation. Consultation and frequent dialogue by Government with the existing network of academic and research institutions in allopathy and ISMH, and with other relevant public and private research institutions engaged in social science, demography and behavioural research must continue. The International Institute of Population Sciences, and the population research centres which have been set up to pursue applied research in population related matters, need to be revitalised and strengthened.

33. Applied research relies upon constant monitoring of performance at the programme and project levels. The National Health and Family Welfare Survey provides data on key health and family welfare indicators every five years. Data from the first National Family Health Survey (NFHS-1), 1992-93, has been updated by NFHS-2, 1998-99, to be published shortly. Annual data is generated by the Sample Registration Survey, which, inter alia, maps at state levels the birth, death and infant mortality rates. Absence of regular feedback has been a weakness in the family welfare progamme. For this reason, the Department of Family Welfare is strengthening its management information systems (MIS) and has commenced during 1998, a system of ascertaining impacts and outcomes through district surveys and facility surveys. The district surveys cover 50% districts every year, so that every 2 years there is an update on every district in the country. The facility surveys ascertain the availability of infrastructure and services up to primary health centre level, covering one district per month. The feedback from both these surveys enable remedial action at district and sub-district levels.

Operational strategies are described in the Action Plan in Appendix I (pages 33-34).

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(xi) Providing for the Older Population

34. Improved life expectancy is leading to an increase in the absolute number and proportion of persons aged 60 years and above, and is anticipated to nearly double during 1996-2016, from 62.3 million to 112.9 million[5]. When viewed in the context of significant weakening of traditional support systems, the elderly are increasingly vulnerable, needing protection and care. Promoting old age health care and support will, over time, also serve to reduce the incentive to have large families.

35. The Ministry of Social Justice and Empowerment has adopted in January 1999 a National Policy on Older Persons. It has become important to build in geriatric health concerns in the population policy. Ways of doing this include sensitising, training and equipping rural and urban health centres and hospitals for providing geriatric health care; encouraging NGOs to design and implement formal and informal schemes that make the elderly economically self-reliant; providing for and routinising screening for cancer, osteoporosis, and cardiovascular conditions in primary health centres, community health centres, and urban health care centres at primary, secondary and tertiary levels; and exploring tax incentives to encourage grown-up children to look after their aged parents.

Operational strategies are described in the Action Plan in Appendix I (page 34).

(xii) Information, Education, and Communication

36. Information, education and communication (IEC) of family welfare messages must be clear, focused and disseminated everywhere, including the remote corners of the country, and in local dialects. This will ensure that the messages are effectively conveyed. These need to be strengthened and their outreach widened, with locally relevant, and locally comprehensible media and messages. On the model of the total literacy campaigns which have successfully mobilised local populations, there is need to undertake a massive national campaign on population related issues, via artists, popular film stars, doctors, vaidyas, hakims, nurses, local midwives, women's organizations, and youth organizations.

Operational strategies are described in the Action Plan in Appendix I (pages 34-35).

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

37. As a motivational measure, in order to enable state governments to fearlessly and effectively pursue the agenda for population stabilisation contained in the National Population Policy, 2000, one legislation is considered necessary. It is recommended that the 42nd Constitutional Amendment that freezes till 2001, the number of seats to the Lok Sabha and the Rajya Sabha based on the 1971 Census be extended up to 2026.

38. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout society. The government will actively enlist their support in concrete ways.

39. The NPP 2000 is to be largely implemented and managed at panchayat and nagar palika levels, in coordination with the concerned state/Union Territory administrations. Accordingly, the specific situation in each state/UT must be kept in mind. This will require comprehensive and multisectoral coordination of planning and implementation between health and family welfare on the one hand, along with schemes for education, nutrition, women and child development, safe drinking water, sanitation, rural roads, communications, transportation, housing, forestry development, environmental protection, and urban development. Accordingly, the following structures are recommended:

(i) National Commission on Population

40. A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all states and UTs, and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministries and Departments, for example Department of Woman and Child Development, Department of Education, Department of Social Justice and Empowerment in the Ministry of HRD, Ministry of Rural Development, Ministry of Environment and Forest, and others as necessary, and reputed demographers, public health professionals, and NGOs as members. This Commission will oversee and review implementation of policy. The Commission Secretariat will be provided by the Department of Family Welfare.

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(ii) State / UT Commissions on Population

41. Each state and UT may consider having a State / UT Commission on Population, presided over by the Chief Minister, on the analogy of the National Commission, to likewise oversee and review implementation of the NPP 2000 in the state / UT.

(iii) Coordination Cell in the Planning Commission

42. The Planning Commission will have a Coordination Cell for inter-sectoral coordination between Ministries for enhancing performance, particularly in States/UTs needing special attention on account of adverse demographic and human development indicators.

(iv) Technology Mission in the Department of Family Welfare

43. To enhance performance, particularly in states with currently below average socio-demographic indices that need focused attention, a Technology Mission in the Department of Family Welfare will be established to provide technology support in respect of design and monitoring of projects and programmes for reproductive and child health, as well as for IEC campaigns.

funding

44. The programmes, projects and schemes premised on the goals and objectives of the NPP 2000, and indeed all efforts at population stabilisation, will be adequately funded in view of their critical importance to national development. Preventive and promotive services such as ante-natal and post-natal care for women, immunisation for children, and contraception will continue to be subsidised for all those who need the services. Priority in allocation of funds will be given to improving health care infrastructure at the community and primary health centres, subcentre and village levels. Critical gaps in manpower will be remedied through redeployment, particularly in under-served and inaccessible areas, and referral linkages will be improved. In order to implement immediately the Action Plan, it would be necessary to double the annual budget of the Department of Family Welfare to enable government to address the shortfall in unmet needs for health care infrastructure, services and supplies (in Appendix IV, page 36).

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45. Even though the annual budget for population stabilisation activities assigned to the Department of Family Welfare has increased over the years, at least 50 percent of the budgetary outlay is deployed towards non-plan activities (recurring expenditures for maintenance of health care infrastructure in the states and UTs, and towards salaries). To illustrate, of the annual budget of Rs. 2920 crores for 1999-2000, nearly Rs 1500 crores is allocated towards non-plan activities. Only the remaining 50 percent becomes available for genuine plan activities, including procurement of supplies and equipment. For these reasons, since 1980 the Department of Family Welfare has been unable to revise norms of operational costs of health infrastructure, which in turn has impacted directly the quality of care and outreach of services provided.

46. The following promotional and motivational measures will be undertaken:

(i) Panchayats and Zila Parishads will be rewarded and honoured for exemplary performance in universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling.

(ii) The Balika Samridhi Yojana run by the Department of Women and Child Development, to promote survival and care of the girl child, will continue. A cash incentive of Rs. 500 is awarded at the birth of the girl child of birth order 1 or 2.

(iii) Maternity Benefit Scheme run by the Department of Rural Development will continue. A cash incentive of Rs. 500 is awarded to mothers who have their first child after 19 years of age, for birth of the first or second child only. Disbursement of the cash award will in future be linked to compliance with ante-natal check up, institutional delivery by trained birth attendant, registration of birth and BCG immunisation.

(iv) A Family Welfare-linked Health Insurance Plan will be established. Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible (along with children) for health insurance (for hospitalisation) not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilisation.

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(v) Couples below the poverty line, who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded.

(vi) A revolving fund will be set up for income-generating activities by village-level self help groups, who provide community-level health care services.

(vii) Crèches and child care centres will be opened in rural areas and urban slums. This will facilitate and promote participation of women in paid employment.

(viii) A wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent.

(ix) Facilities for safe abortion will be strengthened and expanded.

(x) Products and services will be made affordable through innovative social marketing schemes.

(xi) Local entrepreneurs at village levels will be provided soft loans and encouraged to run ambulance services to supplement the existing arrangements for referral transportation.

(xii) Increased vocational training schemes for girls, leading to self-employment will be encouraged.

(xiii) Strict enforcement of Child Marriage Restraint Act, 1976.

(xiv) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994.

(xv) Soft loans to ensure mobility of the ANMs will be increased.

(xvi) The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation. This freeze needs to be extended until 2026.

47. In the new millenium, nations are judged by the well-being of their peoples; by levels of health, nutrition and education; by the civil and political liberties enjoyed by their citizens; by the protection guaranteed to children and by provisions made for the vulnerable and the disadvantaged.

48. The vast numbers of the people of India can be its greatest asset if they are provided with the means to lead healthy and economically productive lives. Population stabilisation is a multi-sectoral endeavour requiring constant and effective dialogue among a diversity of stakeholders, and coordination at all levels of the government and society. Spread of literacy and education, increasing availability of affordable reproductive and child health services, convergence of service delivery at village levels, participation of women in the paid work force, together with a steady, equitable improvement in family incomes, will facilitate early achievement of the socio-demographic goals. Success will be achieved if the Action Plan contained in the NPP 2000 is pursued as a national movement.

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

1. Utilise village self help groups to organise and provide basic services for reproductive and child health care, combined with the ongoing Integrated Child Development Scheme (ICDS). Village self help groups are in existence through centrally sponsored schemes of: (a) Department of Women and Child Development, Ministry of HRD, (b) Ministry of Rural Development, and (c) Ministry of Environment and Forests. Organise neighbourhood acceptor groups, and provide them with a revolving fund that may be accessed for income generation activities. The groups may establish rules of eligibility, interest rates, and accountability for which capital may be advanced, usually to be repaid in installments within two years. The repayments may be used to fund another acceptor group in a nearby community, who would exert pressure to ensure timely repayments. Two trained birth attendants and the aanganwadi worker (AWW) should be members of this group.

2. Implement at village levels a one-stop integrated and coordinated service delivery package for basic health care, family planning and maternal and child health related services, provided by the community and for the community. Train and motivate the village self-help acceptor groups to become the primary contact at household levels. Once every fortnight, these acceptor groups will meet, and provide at one place 6 different services for (i) registration of births, deaths, marriage and pregnancy; (ii) weighing of children under 5 years, and recording the weight on a standard growth chart; (iii) counseling and advocacy for contraception, plus free supply of contraceptives; (iv) preventive care, with availability of basic medicines for common ailments: antipyretics for fevers, antibiotic ointments for infections, ORT/ORS[1] for childhood diarrhoeas, together with standardised indigenous medication and homeopathic cures; (v) nutrition supplements; and (vi) advocacy and encouragement for the continued enrolment of children in school up to age 14. One health staff, appointed by the panchayat, will be suitably trained to provide guidance. Clustering services for women and children at one place and time at village levels will promote positive interactions in health benefits and reduce service delivery costs.

3. Wherever these village self-help groups have not developed for any reason, community midwives, practitioners of ISMH, retired school teachers and ex-defence personnel may be organised into neighbourhood groups to perform similar functions.

1 Oral Rehydration Therapy /Oral Rehydration Salts

4. At village levels, the aanganwadi centre may become the pivot of basic health care activities, contraceptive counseling and supply, nutrition education and supplementation, as well as pre-school activities. The aanganwadi centres can also function as depots for ORS/basic medicines and contraceptives.

5. A maternity hut should be established in each village to be used as the village delivery room, with storage space for supplies and medicines. It should be adequately equipped with kits for midwifery, ante-natal care, and delivery; basic medication for obstetric emergency aid; contraceptives, drugs and medicines for common ailments; and indigenous medicines/supplies for maternal and new-born care. The panchayat may appoint a competent and mature mid-wife, to look after this village maternity hut. She may be assisted by volunteers.

6. Trained birth attendants as well as the vast pool of traditional dais should be made familiar with emergency and referral procedures. This will greatly assist the Auxiliary Nurse Midwife (ANM) at the subcentres to monitor and respond to maternal morbidity/emergencies at village levels.

7. Each village may maintain a list of community mid-wives, village health guides, panchayat sewa sahayaks, trained birth attendants, practitioners of indigenous systems of medicine, primary school teachers and other relevant persons, as well as the nearest institutional health care facilities that may be accessed for integrated service delivery. These persons may also be helpful in involving civil society in monitoring availability, quality and accessibility of reproductive and child health services; in disseminating education and communication on the benefits of smaller and healthier families, with emphasis on education of the girl child; and female participation in the work force.

8. Provide a wider basket of choices in contraception, through innovative social marketing schemes to reach household levels.

Comment : Meaningful decentralisation will result only if the convergence of the national family welfare programme with the ICDS programme is strengthened. The focus of the ICDS programme on nutrition improvement at village levels and on pre-school activities must be widened to include maternal and child health care services. Convergence of several related activities at service delivery levels with, in particular, the ICDS programme, is critical for extending outreach and increasing access to services. Intersectoral coordination with appropriate training and sensitisation among field functionaries will facilitate dissemination of integrated reproductive and child health services to village and household levels. People will

willingly cooperate in the registration of births, deaths, marriages and pregnancies if they perceive some benefit. At the village level, this community meeting every fortnight, may become their most convenient access to basic health care, both for maternal and child health, as well as for common ailments. Households may participate to receive integrated service delivery, along with information about ongoing micro-credit and thrift schemes. Government and non-government functionaries will be expected to function in harmony to ensure integrated service delivery. The panchayat will promote this coordination and exercise effective supervision.

(iii) Empowering Women for Improved Health and Nutrition

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

2. As a measure to empower women, open more child care centres in rural areas and in urban slums, where a woman worker may leave her children in responsible hands. This will encourage female participation in paid employment, reduce school drop-out rates, particularly for the girl child, and promote school enrolment as well. The aanganwadis provide a partial solution.

3. To empower women, pursue programmes of social afforestation to facilitate access to fuelwood and fodder. Similarly, pursue drinking water schemes for increasing access to potable water. This will reduce long absences from home, and the need for large numbers of children to perform such tasks.

4. In any reward scheme intended for household levels, priority may be given to energy saving devices such as solar cookers, or provision of sanitation facilities, or extension of telephone lines. This will empower households, in particular women.

5. Improve district, sub-district and panchayat-level health management with coordination and collaboration between district health officer, sub-district health officer and the panchayat for planning and implementation activities. There is need to:

   - Strengthen the referral network between the district health office, district hospital and the community health centres, the primary health centres and the subcentres in management of obstetric and neo-natal complications.

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- Strengthen community health centres to provide comprehensive emergency obstetric and neo-natal care. These may function as clinical training centres as well. Strengthen primary health centres to provide essential obstetric and neo-natal care. Strengthen subcentres to provide a comprehensive range of services, with delivery rooms, counseling for contraception, supplies of free contraceptives, ORS and basic medicines, together with facilities for immunisation.

- Establish rigorous problem identification mechanisms through maternal and peri-natal audit, from village level upwards.

6. Ensure adequate transportation at village level, subcentre levels, zila parishads, primary health centres and at community health centres. Identifying women at risk is meaningful only if women with complications can reach emergency care in time.

7. Improve the accessibility and quality of maternal and child health services through:

- Deployment of community mid-wives and additional health providers at village levels; cluster services for women and children at the same place and time, from village level upwards, e.g. ante-natal and post-partum care, monitoring infant growth, availability of contraceptives and medicine kits; and routinised immunisations at subcentre levels.

- Strengthen the capacity of primary health centres to provide basic emergency obstetric and neo-natal health care.

- Involve professional agencies in developing and disseminating training modules for standard procedures in the management of obstetric and neo-natal cases. The aim should be to routinise these procedures at all appropriate levels.

- Improve supervision by developing guidance and supervision checklists.

8. Monitor performance of maternal and child health services at each level by using the maternal and child health local area monitoring system, which includes monitoring the incidence and coverage of ante-natal visits, deliveries assisted by trained health care personnel and post-natal visits, among other indicators. The ANM at the subcentre should be responsible and accountable for registering every pregnancy and child birth in her jurisdiction, and for providing universal ante-natal and post-natal services.

9. Improve technical skills of maternal and child health care providers by:

- Strengthening skills of health personnel and health providers through classroom and on-the-job training in the management of obstetric and neo-natal emergencies. This should include training of birth attendants and community midwives at district-level hospitals in life-saving skills, such as management of asphyxia and hypothermia.

- Training on integrated management of childhood illnesses for infants (1week - 2 months).

10. Support community activities such as dissemination of IEC material, including leaflets and posters, and promotion of folk jatras, songs and dances to promote healthy mother and healthy baby messages, along with good management practices to ensure safe motherhood, including early recognition of danger signs.

11. Programme development, comprising:

- Partnership in family health and nutrition. The aanganwadi worker will identify women and children in the villages who suffer from malnutrition and/or micro-nutritional deficiencies, including iron, vitamin A, and iodine deficiency; provide nutritional supplements and monitor nutritional status.

- Convergence, strengthening, and universalisation of the nutritional programmes of the Department of Family Welfare and the ICDS run by the Department of Women and Child Development, ensuring training and timely supply of food supplements and medicines.

- Include STD/RTI and HIV/AIDS prevention, screening and management, in maternal and child health services.

- Provide quality care in family planning, including information, increased contraceptive choices for both spacing and terminal methods, increase access to good quality and affordable contraceptive supplies and services at diverse delivery points, counseling about the safety, efficacy and possible side effects of each method, and appropriate follow-up.

12. Develop a health package for adolescents.

13. Expand the availability of safe abortion care. Abortion is legal, but there are barriers limiting women's access to safe abortion services. Some operational strategies are:

- Community-level education campaigns should target women, household decision makers and adolescents about the availability of safe abortion services and the dangers of unsafe abortion.

- Make safe and legal abortion services more attractive to women and household decision makers by (i) increasing geographic spread; (ii) enhancing affordability; (iii) ensuring confidentiality and (iv) providing compassionate abortion care, including post-abortion counseling.

- Adopt updated and simple technologies that are safe and easy, e.g. manual vacuum extraction not necessarily dependant upon anaesthesia, or non-surgical techniques which are non-invasive.

- Promote collaborative arrangements with private sector health professionals, NGOs and the public sector, to increase the availability and coverage of safe abortion services, including training of mid-level providers.

- Eliminate the current cumbersome procedures for registration of abortion clinics. Simplify and facilitate the establishment of additional training centres for safe abortions in the public, private, and NGO sectors. Train these health care providers in provision of clinical services for safe abortions.

- Formulate and notify standards for abortion services. Strengthen enforcement mechanisms at district and sub-district levels to ensure that these norms are followed.

- Follow norms-based registration of service provision centres, and thereby switch the onus of meticulous observance of standards onto the provider.

- Provide competent post-abortion care, including management of complications and identification of other health needs of post-abortion patients, and linking with appropriate services. As part of post-abortion care, physicians may be trained to provide family planning counseling and services such as sterilisation, and reversible modern methods such as IUDs, as well as oral contraceptives and condoms.

- Modify syllabus and curricula for medical graduates, as well as for continuing education and in-house learning, to provide for practical training in the newer procedures.

- Ensure services for termination of pregnancy at primary health centres and at community health centres.

14. Develop maternity hospitals at sub-district levels and at community health centres to function as FRUs for complicated and life-threatening deliveries.

15. Formulate and enforce standards for clinical services in the public, private, and NGO sectors.

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16. Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing as well as commercial sales.

17. Create a national network consisting of public, private and NGO centres, identified by a common logo, for delivering reproductive and child health services free to any client. The provider will be compensated for the service provided, on the basis of a coupon, duly counter-signed by the beneficiary, and paid for by a system to be devised. The compensation will be identical to providers across all sectors. The end-user will choose the provider of the service. A group of management experts will devise checks and balances to prevent misuse.

(iv) Child Health and Survival

1. Support community activities, from village level upwards to monitor early and adequate ante-natal, natal and post-natal care. Focus attention on neo-natal health care and nutrition.

2. Set up a National Technical Committee on neo-natal care, to align programme and project interventions with newly emerging technologies in neo-natal and peri-natal care.

3. Pursue compulsory registration of births in coordination with the ICDS Programme.

4. After the birth of a child, provide counseling and advocacy about contraception, to encourage adoption of a reversible or a terminal method. This will also contribute to the health and well-being of both mother and child.

5. Improve capacities at health centres in basic midwifery services, essential neo-natal care, including the management of sick neo-nates outside the hospital.

6. Sensitise and train health personnel in the integrated management of childhood illnesses. Standard case management of diarrhoea and acute respiratory infections must be provided at subcentres and primary health centres, with appropriate training, and adequate equipment. Besides, training in this sector may be imparted to health care providers at village levels, especially in indigenous systems.

7. Strengthen critical interventions aimed at bringing about reductions in maternal malnutrition, morbidity and mortality, by ensuring availability of supplies and equipment at village levels, and at sub centres.

8. Pursue rigorously the pulse polio campaign to eradicate polio.

9. Ensure 100 percent routine immunisation for all vaccine preventable diseases, in particular tetanus and measles.

10. As a child survival initiative, explore promotional and motivational measures for couples below the poverty line who marry after the legal age of marriage, to have the first child after the mother reaches the age of 21, and adopt a terminal method of contraception after the birth of the second child.

11. Children form a vulnerable group and certain sub-groups merit focused attention and intervention, such as street children and child labourers. Encourage voluntary groups as well as NGOs to formulate and implement special schemes for these groups of children.

12. Explore the feasibility of a national health insurance covering hospitalisation costs for children below 5 years, whose parents have adopted the small family norm, and opted for a terminal method of contraception after the birth of the second child.

13. Expand the ICDS to include children between 6-9 years of age, specifically to promote and ensure 100 percent school enrolment, particularly for girls. Promote primary education with the help of aanganwadi workers, and encourage retention in school till age 14. Education promotes awareness, late marriages, small family size and higher child survival rates.

14. Provide vocational training for girls. This will enhance perception of the immediate utility of educating girls, and gradually raise the average age of marriage. It will also increase enrolment and retention of girls at primary school, and likely also at secondary school levels. Involve NGOs, the voluntary sector and the private sector, as necessary, to target employment opportunities.

(v) Meeting the Unmet Needs for Family Welfare Services

1. Strengthen, energise and make publicly accountable the cutting edge of health infrastructure at the village, subcentre and primary health centre levels.

2. Address on priority the different unmet needs detailed in Appendix IV, in particular, an increase in rural infrastructure, deployment of sanctioned and appropriately trained health personnel, and provisioning of essential equipment and drugs.

3. Formulate and implement innovative social marketing schemes to provide subsidised products and services in areas where the existing coverage of the public, private and NGO sectors is insufficient in order to increase outreach and coverage.

4. Improve facilities for referral transportation at panchayat, zilla parishad and primary health centre levels. At subcentres, provide ANMs with soft loans for purchase of mopeds, to enhance their mobility. This will increase coverage of ante-natal and post natal check-ups, which, in turn, and will bring about reductions in maternal and infant mortality.

5. Encourage local entrepreneurs at village and block levels to start ambulance services through special loan schemes, with appropriate vehicles to facilitate transportation of persons requiring emergency as well as essential medical attention.

6. Provide special loan schemes and make site allotments at village levels to facilitate the starting of chemist shops for basic medicines and provision for medical first aid.

(vi) Under-Served Population Groups

(a) Urban Slums

1. Finalise a comprehensive urban health care strategy.

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

3. Promote networks of retired government doctors and para-medical and non-medical personnel who may function as health care providers for clinical and non-clinical services on remunerative terms.

4. Strengthen social marketing programmes for non-clinical family planning products and services in urban slums.

5. Initiate specially targeted information, education and communication campaigns for urban slums on family planning, immunization, ante-natal, natal and post-natal check-ups and other reproductive health care services. Integrate aggressive health education programmes with health and medical care programmes , with emphasis on environmental health, personal hygiene and healthy habits, nutrition education and population education.

6. Promote inter-sectoral coordination between departments/municipal bodies dealing with water and sanitation, industry and pollution, housing, transport, education and nutrition, and women and child development, to deal with unplanned and uncoordinated settlements.

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7. Streamline the referral systems and linkages between the primary, secondary and tertiary levels of health care in the urban areas.

8. Link the provision of continued facilities to urban slum dwellers with their observance of the small family norm.

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

1. Many tribal communities are dwindling in numbers, and may not need fertility regulation. Instead, they may need information and counseling in respect of infertility.

2. The NGO sector may be encouraged to formulate and implement a system of preventive and curative health care that responds to seasonal variations in the availability of work, income and food for tribal and hill area communities and migrant and displaced populations. To begin with, mobile clinics may provide some degree of regular coverage and outreach.

3. Many tribal communities are dependent upon indigenous systems of medicine which necessitates a regular supply of local flora, fauna and minerals, or of standardised medication derived from these. Husbandry of such local resources and of preparation and distribution of standardised formulations should be encouraged.

4. Health care providers in the public, private and NGOs sectors should be sensitised to adopt a "burden of disease" approach to meet the special needs of tribal and hill area communities.

(c) Adolescents

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

2. Provide for adolescents the package of nutritional services available under the ICDS programme.

   Comment: Improvements in health status of adolescent girls has an inter-generational impact. It reduces the risk of low birth weight and minimizes neo-natal mortality. Malnutrition is a problem that seriously impairs the health of adolescent and adult women and has its roots in early childhood. The causal linkages between anaemia and low birth weight, prematurity, peri-natal mortality, and maternal mortality has been extensively studied and established.

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3. Enforce the Child Marriage Restraint Act, 1976, to reduce the incidence of teenage pregnancies. Preventing the marriage of girls below the legally permissible age of 18 should become a national concern.

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

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

(d) Increased Participation of Men in Planned Parenthood

1. Focus attention on men in the information and education campaigns to promote the small family norm, and to raise awareness by emphasising the significant benefits of fewer children, better spacing, better health and nutrition, and better education.

2. Currently, over 97 percent of the sterilisations are tubectomies. Repopularise vasectomies, in particular the no-scalpel vasectomy, as a safe, simple, painless procedure, more convenient and acceptable to men.

3. In the continuing education and training at all levels, there is need to ensure that the no-scalpel vasectomy, and all such emerging techniques and skills are included in the syllabi, together with abundant practical training. Medical graduates, and all those participating in "in-service" continuing education and training, will be equipped to handle this intervention.

(vii) Diverse Health Care Providers

1. At district and sub-district levels, maintain block-wise a data base of private medical practitioners whose credentials may be certified by the Indian Medical Association (IMA). Explore the possibility of accrediting these private practitioners for a year at a time, and assign to each a satellite population, not exceeding 5,000 (depending upon distances and spread), for whom they may provide reproductive and child health services. The private practitioners would be compensated for the services rendered through designated agencies. Renewal of contracts after one year may be guided by client satisfaction. This will serve as an incentive to expand the coverage and outreach of high quality health care. Appropriate checks and balances will safeguard misuse.

2. Revive the earlier system of the licensed medical practitioners who, after appropriate certification from the IMA, may participate in the provision of clinical services.

3. Involve the non-medical fraternity in counseling and advocacy so as to demystify the national family welfare effort, such as retired defence personnel, retired school teachers and other persons who are active and willing to get involved.

4. Modify the under/post-graduate medical, nursing, and paramedical professional course syllabi and curricula, in consultation with the Medical Council of India, the Councils of ISMH, and the Indian Nursing Council, in order to reflect the concepts and implementation strategies of the reproductive and child health programme and the national population policy. This will also be applied to all in-service training and educational curricula.

5. Ensure the efficient functioning of the First Referral Units i.e. 30 bed hospitals at block levels which provide emergency obstetric and child health care, to bring about reductions in Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR). In many states, these FRUs are not operational on account of an acute shortage of specialists i.e. gynaecologist/obstetrician, anaesthetist and pediatrician. Augment the availability of specialists in these three disciplines, by increasing seats in medical institutions, and simultaneously enable and facilitate the acquisition of in-service post-graduate qualifications through the National Board of Medical Examination and open universities like IGNOU in larger numbers. As an incentive, seats will be reserved for those in-service medical graduates who are willing to abide by a bond to serve for 5 years at First Referral Units after completion of the course. States would need to sanction posts of Specialists at the FRUs. Further, these specialists should be provided with clear promotion channels.

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

1. There remain innumerable hurdles that inhibit genuine long-term collaboration between the government and non-government sectors. A forum of representatives from government, the non-government organisations and the private sector may identify these hurdles and prepare guidelines that will facilitate and promote collaborative arrangements.

2. Collaboration with and commitments from NGOs to augment advocacy, counseling and clinical services, while accessing village levels. This will require increased clinic outlets as well as mobile clinics.

3. Collaboration between the voluntary sector and the NGOs will facilitate dissemination of efficient service delivery to village levels. The guidelines could articulate the role and responsibility of each sector.

4. Encourage the voluntary sector to motivate village-level self-help groups to participate in community activitie.

5. Specific collaboration with the non-government sector in the social marketing of contraceptives to reach village levels will be encouraged.

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

1. The corporate sector and industry could, for instance, take on the challenge of strengthening the management information systems in the seven most deficient states, at primary health centre and subcentre levels. Introduce electronic data entry machines to lighten the tedious work load of ANMs and the multi-purpose workers at subcentres and the doctors at the primary health centres, while enabling wider coverage and outreach.

2. Collaborate with non-government sectors in running professionally sound advertisement and marketing campaigns for products and services, targeting all segments of the population, from village level upwards, in other words, strengthen advocacy and IEC, including social marketing of contraceptives.

3. Provide markets to sustain the income-generating activities from village levels upwards. In turn, this will ensure consistent motivation among the community for pursuing health and education-related community activities.

4. Help promote transportation to remote and inaccessible areas up to village levels. This will greatly assist the coverage and outreach of social marketing of products and services.

5. The social responsibility of the corporate sector in industry must, at the very minimum, extend to providing preventive reproductive and child health care for its own employees (if >100 workers are engaged).

6. Create a national network consisting of voluntary, public, private and non-government health centres, identified by a common logo, for delivering reproductive and child health services, free to any client. The provider will be compensated for the service provided, on the basis of a coupon system, duly counter-signed by the beneficiary and paid for by a system that will be fully articulated. The compensation will be identical to providers, across all sectors. The end user exercises choices in the source of service delivery. A committee of management experts will be set up to devise ways of ensuring that this system is not abused.

7. Form a consortium of the voluntary sector, the non-government sector and the private corporate sector to aid government in the provision and outreach of basic reproductive and child health care and basic education.

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

(ix) Mainstreaming Indian Systems of Medicine and Homeopathy

1. Provide appropriate training and orientation in respect of the RCH programme for the institutionally qualified ISMH medical practitioners (already educated in midwifery, obstetrics and gynaecology over 5-1/2 years), and utilise their services to fill in gaps in manpower at appropriate levels in the health infrastructure, and at subcentres and primary health centres, as necessary.

2. Utilise the ISMH institutions, dispensaries and hospitals for health and population related programmes.

3. Disseminate the tried and tested concepts and practices of the indigenous systems of medicine, together with ISMH medication at village maternity huts and at household levels for ante-natal and post-natal care, besides nurture of the newborn.

4. Utilise the services of ISMH 'barefoot doctors' after appropriate training and orientation towards providing advocacy and counseling for disseminating supplies and equipment, and as depot holders at village levels.

(x) Contraceptive Technology and Research on RCH

1. Government will encourage, support and advance the pursuit of medical and social science research on reproductive and child health, in consultation with ICMR and the network of academic and research institutions.

2. The International Institute of Population Sciences and the Population Research Centres will continue to review programme and monitoring indicators to ensure their continued relevance to strategic goals.

3. Government will restructure the Population Research Centres, if necessary.

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4. Standards for clinical and non-clinical interventions will be issued and regularly reviewed.

5. A constant review and evaluation of the community needs assessment approach will be pursued to align programme delivery with good management practices and with newly emerging technologies.

6. A committee of international and Indian experts, voluntary and non-government organisations and government may be set up to regularly review and recommend specific incorporation of the advances in contraceptive technology and, in particular, the newly emerging techniques, into programme development.

(xi) Providing for the Older Population

1. Sensitize, train and equip rural and urban health centres and hospitals towards providing geriatric health care.

2. Encourage NGOs and voluntary organizations to formulate and strengthen a series of formal and informal avenues that make the elderly economically self-reliant.

3. Tax benefits could be explored as an encouragement for children to look after their aged parents.

(xii) Information Education and Communication

1. Converge IEC efforts across the social sectors. The two sectors of Family Welfare and Education have coordinated a mutually supportive IEC strategy. The Zila Saksharta Samitis design and deliver joint IEC campaigns in the local idiom, promoting the cause of literacy as well as family welfare. Optimal use of folk media has served to successfully mobilize local populations. The state of Tamil Nadu made exemplary use of the IEC strategy by spreading the message through every possible media, including public transport, on mile stones on national high ways as well as through advertisement and hoardings on roadsides, along city/rural roads, on billboards, and through processions, films, school dramas, public meetings, local theatre and folk songs.

2. Involve departments of rural development, social welfare, transport, cooperatives, education with special reference to schools, to improve clarity and focus of the IEC effort, and to extend coverage and outreach. Health and population education must be inculcated from the school levels.

3. Fund the nagar palikas, panchayats, NGOs and community organizations for interactive and participatory IEC activities.

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4. Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behaviour and response patterns of individuals and communities. This serves to enthuse communities to be attentive towards the quality and coverage of maternal and child health services, including referral care. Public leaders and film stars could spread widely the messages of the small family norm, female literacy, delayed marriages for women, fewer babies, healthier babies, child immunization and so on. The involvement and enthusiastic participation of elected leaders will ensure dedicated involvement of administrators at district and sub-district levels. Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional, and religious leaders, media and film stars, sports personalities and opinion makers, will enhance its acceptance throughout society.

5. Utilise radio and television as the most powerful media for disseminating relevant socio-demographic messages. Government could explore the feasibility of appropriate regulations, and even legislation, if necessary, to mandate the broadcast of social messages during prime time.

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

7. Sensitise the field level functionaries across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, cooperatives) to the strategies, goals and objectives of the population stabilisation programmes.

8. Involve civil society for disseminating information, counseling and spreading education about the small family norm, the need for fewer but healthier babies, higher female literacy and later marriages for women. Civil society could also be of assistance in monitoring the availability of contraceptives, vaccines and drugs in rural areas and in urban slums.

- 1946
  Bhore Committee Report

- 1952
  Launching of Family Planning Programme

- 1976
  Statement of National Population Policy

- 1977
  Policy Statement on Family Welfare Programme

  Both statements were laid on the Table of the House in Parliament, but never discussed or adopted.

- 1983
  The National Health Policy of 1983 emphasized the need for "securing the small family norm, through voluntary efforts and moving towards the goal of population stabilisation". While adopting the Health Policy, Parliament emphasized the need for a separate National Population Policy.

- 1991
  The National Development Council appointed a Committee on Population with Shri Karunakaran as Chairman. The Karunakaran Report (Report of the National Development Council (NDC) Committee on Population) endorsed by NDC in 1993 proposed the formulation of a National Population Policy to take a " a long term holistic view of development, population growth and environmental protection" and to "suggest policies and guidelines (for) formulation of programs" and "a monitoring mechanism with short, medium and long term perspectives and goals" (Planning Commission, 1992). It was argued that the earlier policy statements of 1976 and 1977 were placed on the table, however, Parliament never really discussed or adopted them. Specifically, it was recommended that "a National Policy of Population should be formulated by the Government and adopted by Parliament".

- 1993
  An Expert Group headed by Dr. M.S. Swaminathan was asked to prepare a draft of a national population policy that would be discussed by the Cabinet and then by Parliament.

- 1994
  Report on a National Population Policy by the Expert Group headed by Dr. Swaminathan. This report was circulated among Members of Parliament, and comments requested from central and state agencies. It was anticipated that a national population policy approved by the National Development Council and the Parliament would help produce a broad political consensus.

- 1997

  On the 50th anniversary of India's Independence, Prime Minister Gujral promised to announce a National Population Policy in the near future. During 11/97 Cabinet approved the draft National Population Policy with the direction that this be placed before Parliament. However, this document could not be placed in either House of Parliament as the respective Houses stood adjourned followed by dissolution of the Lok Sabha.

- 1999

  Another round of consultations was held during 1998, and another draft National Population Policy was finalised and placed before the Cabinet in March, 1999. Cabinet appointed a Group of Ministers (headed by Dy Chairman, Planning Commission) to examine the draft Policy. The GOM met several times and deliberated over the nuances of the Population Policy. In order to finalise a view about the inclusion/exclusion of incentives and disincentives, the Group of Ministers invited a cross-section of experts from among academia, public health professionals, demographers, social scientists, and women's representatives. The GOM finalised a draft population policy, and placed the same before Cabinet. This was discussed in Cabinet on 19 November, 1999. Several suggestions were made during the deliberations. On that basis, a fresh draft was submitted to Cabinet.

demographic profile

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

1. Age Composition

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

Table 4 : Age Composition as Percentage of the Total Population'

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

2. Inter-State Differences

2. (i) India is a country of striking demographic diversity. Substantial differences are visible between states in the achievement of basic demographic indices. This has led to significant disparity in current population size and the potential to influence population increases during 1996-2016. There are wide inter-state, male-female and rural-urban disparities in outcomes and impacts. These differences stem largely from poverty, illiteracy, and inadequate access to health and family welfare services, which coexist and reinforce each other. In many parts, the widespread health infrastructure is not responsive.

2. (ii) At least 9 states and union territories in India have already achieved replacement levels of fertility. These are ranked in accordance with their total fertility rates. Additionally, in each of the three tables below, the current population of each state/union territory, the ratio of this population to the country population, the infant mortality rate and the contraceptive prevalence rate of the state / union territory is also indicated:

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2 Technical Group on Population Projections, Planning Commission.

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

State	Population Size (in millions) as on 1 March 1999*	Percent of Total Population	Total Fertility Rate 1997	Infant Mortality Rate 1998	Contraceptive Prevalence Rate 1999
INDIA	981.3		3.3	72	44 %
Group A (TFR less than or equal to 2.1)					
Goa	1.5	0.2	1.0@	23	27.1
Nagaland	1.6	0.2	1.5@	NA	7.8
Delhi	13.4	1.4	1.6@	36	28.8
Kerala	32.0	3.3	1.8	16	40.5
Pondichery	1.1	0.1	1.8@	21	56.9
A&N Islands	0.4	0.04	1.9@	30	39.9
Tamil Nadu	61.3	6.2	2.0	53	50.4
Chandigarh	0.9	0.09	2.1@	32	35.0
Mizoram	0.9	0.09	NA	23	34.6

@   Three year moving average TFR1995-97
*   Population Projections by Technical Group on Population Projections, 1996
Source: Registrar General of India

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

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

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

@   Three year moving average TFR1995-97
*   Population Projections by Technical Group on Population Projections, 1996
Source: Registrar General of India

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

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

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

@   Three year moving average TFR1995-97
*   Population Projections by Technical Group on Population Projections, 1996
Source : Registrar General of India

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

3. Maternal Mortality

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

Table 8 : Maternal Mortality Ratios in Asia[3]

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

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

Table 9 : Inter-State Differences within India in Maternal Mortality Ratios[4]

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

4. Infant Mortality

4. It is estimated that about 7 percent of new-born infants perish within a year. Poor maternal health results in low birth weight and premature babies. Infant and childhood diarrhoeal diseases, acute respiratory infections and malnutrition contribute to high infant mortality rates. Additionally, in India, across the board (rural or urban areas), there are more female deaths in the age group of 0-14 than elsewhere[5]. Although the Infant Mortality Rate (IMR) has decreased from 146 per 1000 births in 1951 to 72 per 1000 births (1997), and the sex differentials are narrowing, again there are wide inter-state differences recorded in 1998, as is clear from Table 4-6. In comparison, we note the infant mortality rates in South Asia and elsewhere:

Table 10 : Infant Mortality Rates in Asia[6]

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

3 UNFPA, The State of World Population, 1999, 6 Billion : A Time for Choices, 1995 estimates.
4 Registrar General of India.
5 UNICEF, The Progress of Indian States, 1995, India Country Office, New Delhi.
6 UNFPA, The State of the World Population, 1999, 6 Billion : A Time for Choices.

5. Sex Ratio

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

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

- 7,683 subcentres (1991), now estimated at 23,190 subcentres for the projected population in Year 2002. Capital cost of one subcentre is Rs. 3 lacs, with a recurring cost of Rs. 0.5 lacs. The Finance Minister in his Budget Speech, 1999-2000, announced a scheme for strengthening rural health infrastructure, to be implemented with responsibility for funding shared between the panchayat, state and central governments. Accordingly, the Department of Family Welfare is formulating a scheme for opening new subcentres where required, providing buildings and equipment to existing subcentres, wherever necessary.

- A shortage of 1,513 primary health centres (1991), now estimated at 4,212 PHCs for the population projected in 2002. Capital cost of one PHC is Rs. 24.50 lacs, with a recurring liability of Rs 13 lacs. These expenditures are met by the State Governments under the basic minimum services (BMS) programme. However, the financial position of the State Governments does not enable them to make these investments in health infrastructure.

- A shortage of 2,899 community health centres (1991), now estimated at 3,776 CHCs for the projected population for the year 2000. CHCs serve, mostly, as the First Referral Units and are critical for reducing the MMR and IMR, besides serving as operating theatres for family planning services. Capital cost of one CHC is Rs. 80.5 lacs, with a recurring liability of 27 lacs, currently met by State Governments under the BMS programme.

- The Department of Family Welfare funds 5,435 Rural FW Centres, some of which are being used as First Referral Units. Others are functioning as block-level PHCs.

The estimated additionality towards infrastructure is:

(Rs. in crores)

	A/C	1991	2002
Subcentres	Cap	230	695
	Rec	38	116
PHCs	Cap	370	1032
	Rec	196	547
CHCs	Cap	2320	3021
	Rec	783	1020
TOTAL	Capital	2920	4748
	Recurring	1017	1683

inadequacies in trained manpower

- Shortage in manpower is estimated as 27,501 ANMs, 64,860 male muti-purpose workers, and 4,224 LHVs, 5,126 Health Assistants (male), 2,475 medical officers in PHCs, 1,429 surgeons, 1,446 gynaecologists, 1,525 physicians, 1,774 pediatricians, and an overall shortage of 6,635 specialists.

- Other health manpower reflects a shortfall of 1,171 radiographers, 6,045 pharmacists, 12,793 Lab Technicians, and 18,851 nuse mid-wives, in the rural primary health care delivery system. The financial requirement to address these unmet needs for trained manpower is approximately Rs. 2,300 crores.

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

training

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