Population Policy in India: A Welfare-Political Perspective

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On May 11, 2000 India became the world's second demographic billionaire. If current trends continue, India may overtake China in 2045 to become most populous country in the world (GOI, 2000a). Given the rather poor state of the Indian economy and the very low level of living standards for most of its population, this fact puts a great strain on the government's efforts to promote social development. This study set out to explain the reasons for relative backward social development in India, not only by looking onto social and economic indicators, but also by highlighting the impact of the political system which is so much different from the China, where the government has been a great deal more successful in addressing the issue of rapidly increasing population growth and in supporting, or bringing forth, social and economic development.

Two thirds of India's population growth in the 20th century took place after 1971, that is the same time when the political leadership in China, that is Mao Ze-dong and his followers, came to realize the importance of population policy, and implemented the "one-child-per-couple" policy, which was, and still is today, enforced by virtually all means. Women that work in the state sector are forced to take a pregnancy test every year in the community they were born in. In case they are found to be pregnant a second time they lose their jobs and face defamation and a series of penalties. For this reason, the big cities where the party apparatus has been functioning well, the new population policy that has been introduced in the early 1970s has functioned well, reducing greatly China's birthrate, especially in the big cities. In the countryside, the population policy has been much less effective, and the new prosperity of the private sector industry has led to a new surge in birth-rates in cities in the much less-controlled, but economically fast developing suburban areas of developing cities on, for example, in China's south-eastern provinces of Guangdong and Fujian, where families with four and five children of the new rich, formerly rural population are very common and not the exception anymore (cf Chow, 1999; Aspalter, own observations).

Thus, the question that arises here is can we also detect the importance of the political sphere with regard to population growth in India? In India, leading politicians like Pandit Jawaharlal Nehru, set out to address the issue of population growth as early as in the 1940s. The National Planning Committee under the Chairmanship of Nehru set up a "sub-committee on population," which consequently recommended: (1) the gradual rising of the marriage age,

(2) the teaching of contraception in medical colleges, (3) a special training for doctors, nurses, and health visitors, (4) the establishment of birth control clinics, (5) provision of free contraceptive supply, (6) local manufacture of contraceptives, (7) a vigorous mass publicity campaign, (8) the education of the people on the population problem, and (9) the introduction of a eugenic program for sterilization of persons suffering from communicable diseases. Subsequently, the Health Survey and Development Committee appointed by the government in 1946 assessed the impact of control of transmittable diseases, famines and improvement in agricultural production and health standards on population growth rates. However, the members of the committee were not unanimous on the question whether the state should undertake a general birth control program. As a result, the committee recommended government support for contraception only for health reasons (cf Seshachalam, 1984).

In the face of the early recognition of the adverse effects of population growth on family welfare in India—on the contrary to China where Mao still supported the idea that having more Children would increase the strength of the Chinese nation in the 1950s and 1960s—the relative passiveness and/or failure of government policies in India is conspicuous. In the next sections, the author examines the development of governmental policies from the beginning of the 1950s until today, and the development of demographic and socio-economic indicators across India. Afterwards, he examines the impact of political institutions, and the political system as a whole, on social development and the politics of population policy in India. The author, then, concludes that the institutional school of theories in social policy is supported by the experience of Indian population policy in the past five decades, which stress that the absence of strong political institutions constitutes a key explanatory variable for the absence and failure of governmental policies in the field of social policy. Over the past half a century, India's leading politicians were willing to implement effective population control programs, but failed to do so on the account of fractured political power-bases, as well as the discrepancy between the theory of centrally planned social development and the reality of the federal structure of Indian democracy.

The Development of Population Policy in India

In the first decade of national population policy planning, from 1951 to 1961, the government—though having acknowledged the importance of achieving moderate rates of population growth for Indian social development—achieved little remedial action to the problem of population growth. The emphasis was more on "fertility control through self-control." Prime Minister Jawaharlal Nehru himself was personally in favor of scientific methods of birth control, but population policy was driven more by the general Gandhian ideology on government and the then Health Minister Raj Kumari Amrit Kaur who set on the effectiveness of socio-economic development measures to contain population growth (Seshachalam, 1984).

The five-year plan document (GOI, 1951), presented to the parliament in December 1952, referred to a program for "family limitation and population control." This program sought to reduce the birthrate "to the extent necessary to stabilize the population at a level consistent with the requirements of the national economy". The First Five-Year Plan (1961-1966) put forward the following principles: (1) The government should present a clear picture of the factors contributing to the rapid population increase in India. (2) Suitable techniques for family planning and device methods should be found by which the knowledge of these techniques could be widely disseminated. (3) The government's advice on family planning should serve as an integral part of the service network of government hospitals and public agencies. The Ministry of Health of the central government budgeted RS 6.5 million—however, only *Rupees* (RS) 1.5 million could be spent by end of the planning period—for the family planning program, which included a great number of activities: e.g. providing contraceptive advice; experimenting in the field with different family planning methods to determine their suitability, acceptability, and effectiveness in different sectors of the population; developing effective ways to educate the people on family planning methods; collecting information on reproductive patterns, attitudes, and motivations affecting family size; studying the interrelationships among economic, social, and population changes; and researching the physiological and medical aspects of human fertility control.

Since the government came to realize that there was an "intrinsic demand for family planning services, and that supply would induce demand" the government set out to open the first family planning clinics in this period that functioned merely as service centers for the people who were expected to demand family planning services and to go to these new clinics on their own, after they have been created. However, as reality should show, demand was not induced by supply and, thus, people did not demand and receive family planning services in such a number as the government expected them to.

The belated comprehensive policy approach of the Indian government was certainly also influenced by the relative lack of advance in contraceptive technology during that period. The methods recommended were the use of the diaphragm and jelly, vaginal foam tablets, and condoms. In some states, sterilization services, especially vasectomies, were also provided.

In the second half of the 1950s, however, there were first signs of progress in the field of population policy. The government started to implement first initiatives in institution building for demographic research and training; organization of family planning clinics; pilot testing of contraceptives; and research on the status of people's knowledge, attitude, and practice regarding the use of contraceptives. However, no numerical targets were set for the crude birthrate, or for the population growth rate (cf GOI, 1951; Raina, 1988, 1994; Srinivasan, 1995a).

The Second Five-Year Plan (1956 to 1961) made it clear that the government understood that in countries like India, high rates of population growth unmistakably harms and, thus, reduces the rate of economic development and the living standards of the population:

> Given the overall shortage of land, capital and equipment relative to population size in India, the conclusion is inescapable that effective curb on population policy is an important condition for rapid improvement in incomes and levels of living (Government of India quoted in Seshachalam, 1984: 67).

In essence, the Second Five-Year Plan (1956-1961) continued the strategy of the previous five-year plan, expanding family planning service facilities through specialized clinics. Seen from this particular point of view, there has been made improvements, which however did not alter the trend on population growth throughout India. The rather passive strategy of offering services, seen from the present perspective, was a failure as the government clearly envisioned a sizeable reduction in birth rates that should have led to significant improvements in living standards, as well as overall economic and social development.

In this period the distribution of contraceptives was extended through primary health centers, government hospitals and dispensaries, and maternity homes run by state governments. In addition to that, the government issued contraceptives free-of-charge to those with a monthly income below RS 100, and at half price to those in the RS 100 to 200-income group. For the first time, the Central Family Planning Board—that was constituted in the previous planning period as an advisory body for the national government—recommended the inclusion of sterilization in the family planning program in hospitals and institutions where facilities existed. Later on, the Central Council of Health also suggested that the state governments should intensify the sterilization program and provide surgical facilities at their hospitals and medical institutions.

In the states of Madras and Bombay (today Tamil Nadu and Maharashtra), the sterilization program for men was introduced with much enthusiasm. An incentive scheme paying RS 10 to the sterilized person, as compensation for the loss of wages sustained in undergoing the operation was first introduced Tamil Nadu, followed by Maharashtra and other states. The number of clinics for provision of family planning services increased from 147 at the end of the First Five-Year Plan to 4,165 at the end of the Second Five-Year Plan. Research activities had been intensified, and extended to the fields of demography and communication action. Furthermore, training and education units have become a focus of the family planning policy. A broad-based training program was developed, which included the erection of centers for training instructors and educators in family planning, as well as rural training-demonstration and experimental centers, training clinics in the regional training centers, and ad hoc training courses for workers and supervisors. Family planning was, then, also incorporated into the normal training program of educational institutions for doctors and medical auxiliaries. The provision for family planning services under the Second Five-Year plan rose to RS 50 million—however only RS 21.6

million had been spent during the period of the Second Five-Year Plan (cf Raina, 1988; Srinivasan, 1995a; Chaubey, 2001).

The government extended its general support for family policy as it granted RS 248.6 million for Third Five-Year Period (1961-1966). Only after ten years of pushing towards a visible improvement in the attempted containment of population growth, the government, its officials and research came to the insight that the service-oriented approach alone is not capable of altering or reversing the trend in Indian population development. As a consequence thereof, the "clinic-/service-oriented approach" that has been adopted during the first two planning periods was replaced by an extension-education approach. Based on field experiments conducted at Gandhigram in Tamil Nadu, the government's new strategy focused on the inclusion of interested and influential village leaders in promoting the small family norm and carrying the message of family planning to the people. This new approach relied on the network of rural primary health centers and subcenters, urban hospitals, and family welfare training centers. Given the sheer size of the Indian subcontinent, such a network of governmental institutions proved to be vital for the success of the newly outlined family planning policy. The new "education and extension of services approach"—which still describes the core of India's family policy today—concentrated on: (1) the creation of a group norm of a small family size in every community by educating and involving opinion-leaders; (2) Providing information to every eligible couple on available contraceptive methods; and (3) Furnishing contraceptive services in a socially and psychologically acceptable manner.

The personnel of local health centers, hospitals, and family welfare training centers were, however, not well paid, and not highly qualified either. They had the strenuous task of motivating couples to comply the small family norm and, thus, apply new contraceptive methods in backward and highly conservative rural villages. At least, this new approach helped so far to spread the message to the villages in every corner of the Indian subcontinent (cf Srinivasan, 1995a,b; Raina, 1988).

The Third Five-Year Plan, for the first time, set a demographic goal—that is, a crude birth rate of 25 by 1,000 population by the year 1972. However, this ambitious task could not be accomplished with the applied method of information and persuasion.

Due to the political crisis after the border conflict and war with China, the Indian government did not implement another national development plan between 1966 and 1969, this period was, then, termed a plan holiday. In 1966, the government again set the goal of achieving a crude birthrate of 25, this time to be realized by 1975/1976. Two years later in 1968, this goal was revised to a crude birthrate of 23 by 1978/1979. In terms of expenditures, the plan holiday period saw a hefty increase in governmental spending on family planning, as RS 704.6 million, nearly three times as much as the five years of the last planning period.

With the Fourth Five-Year Plan (1969-1974), family planning moved up the ladder of policy priorities of the Indian government, now occupying a place

among top priorities. Again the numerical target to be reached has been altered, to a crude birthrate of 39 by 1974, and to 25 by the year 1979. Consequently, a new target was also set for the number of newly conducted sterilizations. For reaching this more ambitious task, the government—again, for the first time—to the policy means of using the mass media to educate the Indian population on fertility control for the sake of improving their economic and social conditions. A concrete program was devised for motivating the populace to acquiesce with the new family planning policy. The sum that has been allocated to the family planning program was RS 3.15 billion, a more than fourfold increase compared to the preceding three-year period. This time the actual spending reached RS 2.84 billion, indicating either the success of preceding lingering extension of government services all across the Indian subcontinent, or a greater determination of administrators and government officials, or both.

The infrastructure of fertility control services and the network of clinics, health centers, and welfare centers was considerably extended during the early 1970s. The usage of contraceptive users doubled from 1.5 million in 1969/1970 to 3 million in 1974/1975; the number of sterilizations also rose significantly by 1972/1973, but, then, dropped again shortly thereafter. It has been estimated that about 12 million births were averted during this plan period (Srinivasan, 1995a). Moreover, the program to popularize oral contraceptives expanded considerably; however, due to a lack in necessary education and training, as well as motivational support, the pill was not widely accepted. In addition, a system for free condom distribution was initiated. In Kerala, the Ernakulam Camp, in which over 65,000 vasectomies were done in just two weeks, was organized during this plan and, subsequently, became a prime model for other federal states. Nevertheless, by the mid-1970s, the "mass-camp-vasectomy" approach was abandoned, for the reason of a large number of postoperative complaints from men that have been operated in these large camps. Furthermore, in 1971, the Indian federal government passed a new law (the Medical Termination of Pregnancies Act) that legalized induced abortions.

All in all, we need to conclude that the first decades of family planning in India showed devastating overall results, since the number of inhabitants on the subcontinent rose from 439.2 million in 1961 to 548.2 million in 1971—a 24.8 percent increase, as compared to 21.5 percent in 1951 to 1961 (cf Srinivasan, 1995a).

The Fifth Five-Year Plan (1974-1979) saw major changes in family planning policy of the government, which at a closer look seem to be the result of a highly alarmed government that saw nothing but long-term failure of its policies in the last decades. From 1974 to 1978, the government increased greatly the incentive payments to persons who accepted sterilization; and, furthermore, related those payments to the number of children of the persons in question. As well, the central government introduced an incentive program for state governments to adopt a more stringent policy stand in the field of family planning, by providing political and fiscal incentives. At that time, the central government also pursued a new policy of insisting on strict performance targets from the vast number of family planning personnel and improving the

coordinated efforts of all government departments in the program, which seemed to have proper results.

The imposition of national emergency between 1975 and 1977 (cf Malik and Vajpeyi, 1988; Srinivasan, 1995a) helped in shaking up the administrative system behind the family planning policy program, leading to a complete acceptance and support of the proposed family planning policies by the entire administrative machinery involved, especially vasectomy. The government even emphasized more the overall importance of a success in family policy for the goal of national socioeconomic development.

The 1977 elections brought an abrupt halt to the long-term one-party rule of the Indian National Congress and, as a result of that, also to the continuing improvements made in the domain of population policy. India, similar to what became mandatory in China, also considered the implementation of a compulsory law that would have required couples to stop reproduction after two or three children, as it was drafted and even placed before state legislatures for approval. One of the key issues of the 1997 election was the coercive enforcement of the family planning policy—that is, enforcing compulsory sterilization, and maybe later on also other punishments and incentives for abiding to a target number of children per couple. Would have this policy had advanced than certainly there would also have been room for major improvements with regard to population control in India.

But, the vague chances of success of, and the lengthy process implicated by, the federal government system of the Republic of India and, thus, the fragmented support from a great number of parties across the whole political spectrum—including that of communist, Hindu nationalist, and Muslim parties—that is needed for a comprehensive and fast implementation of such a birth-control policy in India would have probably endangered the overall success of such an attempt, even if there were no electoral defeat of the Congress Party in the 1977 parliamentary elections, where it not only lost control on national level, but also in most of the states that it had formerly ruled (cf Das, 1991; Narang, 1996; Raina, 1988; Srinivasan, 1995a; Kamal and Meyer, 1977).

From 1980 to 1985, the Sixth Five-Year Plan set out to achieve long-term policy goals rather than short-term ones. The government envisioned a two-child policy to become realized by the year 2001—in other words, a cero pollution growth—with a birthrate of 21 per 1,000 persons. Furthermore, the government included a twofold view of the problem of population growth, including for the first time the changing mortality rate of the Indian population as an additional factor behind population growth that needs to be taken into account when devising numeric population growth targets. Hence, the government began to focus on the net reproduction rate of the entire population in formulating its policy objectives. The new goal of the government in the Sixth Five-Year Plan was, hence, a net reproduction rate of 1.0, i.e. cero population growth. The Sixth Five-Year Plan aimed, among other things, at an increase in the effective protection rate to 36.6 percent by 1985.

When evaluating the success of the short-term goals of the Sixth Five-Year Plan, we me note that the government was increasingly able to fulfill its short-term objectives, since, in this five-year period, the government carried out 17 million sterilizations against 24 million targeted sterilizations; as well as 7 million IUD insertions against 7.9 targeted IUD insertions; and 9.3 million against 11 million targeted conventional contraceptive users in 1984-1985. However, national averages were lowered a great deal by the result of three particular federal states: Uttar Pradesh, Bihar, Rajasthan; accounting for nearly one third of the Indian population. The results in Madhya Pradesh and West Bengal were slightly lower than the national average as well, which are inhabited by about one sixth of India's population.

In addition to these long-term and short-term policy targets, the government also set up specific targets for general and maternal and child health services to ensure the reduction of general mortality, especially infant mortality, and to work towards the envisioned long-term goals (cf GOI, 1980; Srinivasan, 1995a).

In the Seventh Five-Year Plan the Indian government, once again, came to the conclusion that the net reproduction of 1.0 by the year of 2001 was unrealistic, and anticipated that the years 2006 to 2011 would be more likely to see this long-term population policy goal realized. Furthermore, it attempted to realize—once more—a crude birthrate of 29.1 by 1990, and an effective couple protection rate of 42 percent by the same year.

The government started to propose new educational programs through the mass media for enlightening the people on the positive effects of family planning and, besides, was setting up incentives for attracting younger couples to accept spacing methods, i.e. increasing the time span between e.g. the first and second birth.

Again it was difficult to ensure the support of political leaders and, most importantly, their personal commitment in implementing the family planning policy. The components of the program had been numbers and included, for example: the proclamation of demographic goals and family planning targets; a range of activities in the domains of information, education, and communication; the establishment and strengthening of educational and training facilities for skilled medical and paramedical personnel; the countrywide delivery of contraceptives and the necessary services related to it; as well as record-keeping and evaluation activities (cf Srinivasan, 1995a).

All these policy actions must, then, be in accord with the high quality requirements and virtually countrywide coverage of services offered in the sphere of family planning. As a matter of fact this was always and, still is, the key issue that needs to be addressed in Indian politics—that is, duality between central policy formation at national government level and the often absent or limited support of state policymakers and administrations, or, at least, the insecure support of theirs, at state government level throughout the country.

Only in some state parliaments, the family policy was granted full legislative support. The overall backward, and very limited, success of Indian population policies, thus, need to be explained—besides some major shortcomings in governance capacities of the Indian administration with regard to social policy

making (which was to be noticed especially until the mid-1960s)—by the overall deadlock of a divided political system in an even more divided society (which features hard-edged social, religious, cultural, ethnic, linguistic and economic cleavages). The Constitution of India left room for a big compromise between the calls for a federal republic that was demanded by the Muslims at the time of Indian Independence and the original intentions of Congress leaders to set up a strong, centralized nation state, which ever since led to a rather unclear power division between the central and state governments concerning the area of economic and social policy making; however, the prime responsibility for social and economic policy making has been assigned to the states by law (cf Kamal and Meyer, 1977: 83-6; ICON, 2002: Articles 12, and 38-47).

The Eighth Five-Year Plan (1992-1997) saw major changes in the overall governance of India, which called for a new decentralization of governmental powers and responsibilities under the system of the Panchayati Raj that aimed at closing the gap between centralized decision-making and differing needs across the country. The new Panchayate Raj system, in essence, gives locally elected leaders at the level of the village government or the group-of-village government – most of which are members of the well-off upper-middle and upper classes – the authority to raise taxes, plan and implement local development programs while drawing on the assistance of governmental institutions at higher levels (cf GOI, 1992; Sharma, 1994; Shivaramu, 1997; Nagendra, 2000; Narayana and Kantner, 1992).

At heart, the Eighth Five-Year Plan led to a decentralization of the population control measures, the introduction of a new area-specific micro-planning; and this within the general framework of a national policy aimed at generating at people's movement with the total and committed involvement of community leaders, irrespective of their denominational affiliations and access to health services and mother and child care, while linking population control policies to those policies that aiming at enhance female literacy, women's employment, and general social security. Population control assumed an overriding importance in the Eighth Five-Year Plan; emphasizing the political commitment of all governmental institution at central, state, local level, as well as the necessity of generating a people's movement for ensuring the success of the family planning program, which up-to-date represents the vital elements of Indian population policies (cf GOI, 1992; GOI, 2000a).

EMPIRICAL DATA: A CROSS-STATE COMPARISON

When looking at the factual data of population growth, we can easily distinguish states with extremely high birthrates, or fertility rates, from states with moderate and low levels of birthrates/fertility rates. The highly varying performance of different states in the realm of family planning policy may be traced to, first, different important factors outside policy making (i.e. socio-economic and demographic factors) and, second, political factors that help to explain different degrees of efforts and success across the Indian Subcontinent.

With regard to socioeconomic factors, it needs to note that a high degree of poverty, low levels of female illiteracy, a high portion of Muslims in population, and – to some extent – also a lower degree of urbanization in general contribute to high population growth, i.e. high birthrates (cf Gandotra *et al.*, 1998). From Table 1, we can see that diverse fertility rates across different states of the Indian Republic are to be explained by all these main four indicators, and not just by one alone. Nevertheless, an in-depth study of each state and further-reaching knowledge about the socio-economic structures, ethnic composition, etc. is vital for any specific conclusions to be reached in each of these cases; but, for us here, the general picture of the macro factors will do.

When evaluating the results of Table 1 beneath, we see that the total fertility rates in four federal states are particularly high—that is, Uttar Pradesh, Bihar, Rajasthan, and Madhya Pradesh, with a total fertility rate of 4.8, 4.4, 4.2, and 4 in that order. All these four states are in the North of India, contributing to about 40 percent of India's population (cf GIO, 2000b). With exception of Rajasthan, these three states are among the poorest states in India. Orrisa and Assam, who are also marked with high poverty rates, display somewhat lower, but still very high fertility rates.

Concerning the four states with the highest fertility rates, the statistics for female literacy (cf Column 4 of Table 1) match that for the population below poverty line (cf Column 3 of Table 1). Again, Uttar Pradesh leads, before Bihar, Rajasthan, and Madhya Pradesh. The four federal states just pointed out feature extremely low levels of female literacy in a countrywide comparison. The clear association of low female literacy rates and high fertility rates become visible in Columns 4 and 2 of Table 1 without difficulty.

When taking religions into account, it seems that different believes – including their long-standing cultural and societal traditions – constitute an additional force are a part of the cause of high fertility rates. The study of Gandotra *et al.* (1998), for instance, shows a more explicit correlation between religions and high fertility rates, whereby Muslims, *in general*, have a significantly higher fertility rate than Hindus; and Hindus, again, a significantly higher fertility rate than members of other religions (such as Christians, or Sikhs).

Table 1 (Columns 5 and 6) also focuses on state-level difference in the composition of membership to religious communities and state-level fertility rates. For Uttar Pradesh and Bihar, the higher share of Muslims in the populations, i.e. 17 and 16 percent respectively, explain their relative higher total fertility in comparison to Rajasthan and Madhya Pradesh, which have only 6 percent of their population that follow the Muslim faith each. Other states with extremely high Muslim populations are Assam, Kerala, and West Bengal.[1] In Assam is not on top of the list with regard to female fertility rates (Table 1). Muslims count for 25 percent of the population in Assam, but fertility rates are rather moderate; however, while belonging to the group of the poorer states, Assam has a significantly higher female literacy rate, when compared to the four states with the highest fertility rates.

Kerala, with 24 percent Muslims, is among the very leaders with regard to low fertility rates. But, Kerala has achieved an extremely high female literacy rate, but also shows only a medium degree of poverty in national comparison. West Bengal, with 20 percent of Muslim population, has a rather moderate total fertility rate, but while poverty is quite widespread in West Bengal, again, the female literacy rate (as in the case of Assam) is quite high – i.e. about double as high as in Rajasthan, Bihar, or Uttar Pradesh.

Columns 7 and 8 of Table 1 reveal, first, that highly rural federal states do not necessarily suffer from high fertility rates and, second, that in those states with higher fertility rates there is in fact a great disparity between fertility rates of the rural population and that of the urban one. This, however, can be explained with the predominance of poverty and low female literacy rates in the countryside of these particular states. The disparity between rural and urban fertility is highest in Rajasthan, Madhya Pradesh, Bihar, West Bengal, Assam, and Uttar Pradesh, with 12.6, 10.5, 9.1, 8.9, 8.3, and 6.7 percent difference in fertility rates respectively.

Table 1: Total Fertility Rate (2000); Population Below Poverty Line (1993-94); Female Literacy Rate (mid-1990s), Share of Hindus and Muslims in Population (1992-93); Share of Rural Population and Crude Birth Rates in Rural Areas (2000), by states

Selected states	Fertility (TFR)	PBPL (%)	F-Literacy (per 1,000)	Hindus (%)	Muslims (%)	Rural Popul.	Rural Birth-R.
Uttar Pradesh	4.8	40.9	253	82	17	80.2	34.6
Bihar	4.4	55	229	82	16	86.8	32.7
Rajasthan	4.2	27.4	209	91	6	77.1	33.7
Madhya Pradesh	4	42.5	289	92	6	76.8	33.6
Assam	3.2	40.9	430	71	25	88.9	29
Gujarat	3	24.2	486	88	10	65.5	27
Orissa	3	48.6	347	97	1	86.6	27.2
Maharashtra	2.7	36.9	523	76	13	61.3	24.4
Punjab	2.7	11.8	504	38	1	70.5	24.9
West Bengal	2.6	35.7	466	77	20	72.5	24.8
Andhra Pradesh	2.5	22.2	327	87	9	73.1	23.1
Karnataka	2.5	33.2	443	85	11	69.1	23.9
Tamil Nadu	2	35	513	87	6	65.9	19.3
Kerala	1.8	25.4	862	56	24	73.6	17.9
Dehli	1.6	14.7	670	82	10	10.1	22.7
Goa	1	14.9	671	67	4	59	14.4

Note: PBPL = population below poverty line; F.Literacy = number of literates per thousand women.

Sources: Government of India (2000 b, c, d), and Gandotra *et al.*, (1998).

POLITICAL FACTORS BEHIND FAILURE AND SUCCESS OF POPULATION POLICY

Now, we would like to take a look at the political factors behind population policy in India. Obviously, when comparing the Indian case with that of China, it becomes clear that the successful Chinese model of population control rests on the power of the communist party within a one-party communist state. India, however, is completely different to China with regard to party politics, and its political system. This, as we are going to find out, also implicates a different success rate of its population policies that were, by and large, a great deal less ambitious, but in India the government took up its population policies a long time before China, who only introduced the new *one-child-per-couple* policy in the early 1970s (Mackerras *et al.*, 1994).

Besides the cultural and socio-economic aspects of population policy, one needs to take into account the different state structure and political system of India, which is responsible for long-term policy outcomes with regard to population policy in India. It needs to note that in India there is a vast discrepancy between central planning at central government level, and policy making and implementation at state government level.

Furthermore, one needs to consider the political commitment of local parties, factions, individual politicians in a particularly diverse and complex political system of India. In India there are hundreds of political parties at national and state level. There are Muslim parties, Hindu parties, and communist parties. Above and beyond, there is the long-ruling National Congress Party of India, which, at the time being, is the largest opposition party in the Indian national parliament (being composed of the *Lok Sabha* and the *Vidhan Sabha*, the two Houses of Parliament).

India, in addition, is plagued with a tremendous linguistic diversity. India lacks a national language, as well as a national script. Today, there are 24 national languages and scripts in India. On the other hand, China has only one national language and script ("Putonghua," i.e. Mandarin Chinese) that is easily understood by most Chinese. In India, the most widely understood language is Hindi, which is understood – in spoken and written form – by only about 40 percent of the population. This contributes to the limited capacity of Indian policymakers to ensure a highest degree of efficiency and success in policy planning, policymaking, and implementation.

In addition to these special conditions for policymaking in India, policymakers have also difficulty coordinating policy implementation across the great number of different department involved in policymaking. At Central Government level, the following ministries are concerned with population policy making in one or the other form: The Ministry of Education, which conducts the National Population Education Project and the National Adult Education Program; the Ministry of Labor and Employment, which e.g. included Population Education as part of the Social Studies in the curriculum of Industrial Training Institutes that train young craftsmen and apprenticeship trainees, as well as workshops for different directors, officers, and trade union leaders; the Ministry of Agriculture and Rural Development, which educates agricultural workers and rural development functionaries; and the Ministry of Social Welfare, conducts various programs in population education and family

planning (often known as "family welfare"), the largest of which is the Integrated Child Development Service Scheme, by which educates women at the age of marriage on a number of issues, such as family size and the traditional attitude towards children, husband's attitude towards family planning, status of women, population problems in relation to health, nutrition, housing, clothing, and so forth (Chowdhry, 1985: 88-91).

At federal state level (see Table 2), we can make out a great inconsistency in the organizational set-up of administrative units in charge of social welfare, and also those in charge of family welfare/family planning. When studying the organizational units, case by case, one can see the implication of between the distribution of powers and responsibilities of Central Government and State Governments in the field of social welfare. Every state government, in effect, has set up its own welfare state system, that is working in those areas not covered by Central Government schemes and those schemes financed or partly financed by the Central Government. Some states have installed a great diversity of welfare units, focusing on a great number of schemes, such as Assam (with 33 units), Uttar Pradesh (24 units); but also the small union territory of Meghalaya (23 units); hence, size does not matter. Important family planning programs, the most important of which is the Integrated Child Development Services program (that focuses on the education of young mothers and couples), are existent in large and smaller states and union territories alike, such as Uttar Pradesh, Meghalaya, Andhra Pradesh, Bihar, Jammu & Kashmir, Pondicherry, and Nagaland. The nonexistence of the Integrated Child Development Services program elsewhere, the highly independent set-up of welfare institutions, and the existence of highly diverse social welfare programs in the member states of the Indian Union disclose the relative absence of a centralized welfare state system in India. The reason of which is to be found in the Constitutional organization of India itself.

Accordingly, the welfare state in India is, and never could have been, a strong welfare state in the Western sense. The ensuing variations in policy outcomes and welfare standards across the Indian Subcontinent are not intended, but rather accidental, when seen from a historical and political perspective.

Table 2: Overview of Administrative Set-Up for Social Welfare With Special Reference to Population Policy in States/Union Territories

Selected State/ Union Territory	Authority in charge of population policy	DDSW	OU/WP[2]	ICDS
Assam	Social Welfare Dept.; Dir. of Social Welfare & Probation	2	33	No
Uttar Pradesh	Dept. of Social Welfare; Dir. of Harijans & Social Welfare	4	24	Yes
Meghalaya	Dept. of Social Welfare/ Dir. of Social Welfare	2	23	Yes
Andhra Pradesh	Dept. of Women & Child Welfare; Dir. of Women & Child Welfare	7	20	Yes

West Bengal	Dept. of Social Welfare; Dir. of Harijans & Social Welfare	5	20	No
Gujarat	Social Welfare & Tribal Welfare Dept.; Dir. of Social Defense	5	18	No
Bihar	Dept. of Welfare; Dir. of Welfare	10	14	Yes
Jammu & Kashmir	Dept. of Social Welfare; Dir. of Social Welfare	5	13	Yes
Orissa	Community Development Dept.; Dir. of Com. Dev. & Rural Reconstruction	5	13	No
Dehli	Dept. of Social Welfare; Dir. of Social Welfare	4	12	No
Pondicherry	Health, Electricity & Works Dept./ Dir. of Social Welfare	2	11	Yes
Nagaland	Dept. of Social Welfare/ Dir. of Social Welfare	2	11	Yes
Maharashtra	Dept. of Soc. Welfare, Cultural Affairs, Sports & Tourism; Dir. of Soc. Welfare	5	10	No
Rajasthan	Social Welfare Dept.; Dir. of Social Welfare	4	10	No
Kerala	Local Administration & Social Welfare Dept.; Dir. of Social Welfare	7	9	No
Madhya Pradesh	Dept. of Social Welfare; Dir. of Social Welfare	4	9	No
Tamil Nadu	Dept. of Social Welfare; Dir. of Social Welfare	8	8	No
Karnataka	Welfare Dept.; Welfare Dir.	4	8	No
Punjab	Dept. of Social Welfare; Dir. of Social Welfare	2	8	No

Note: Dept. = Department, Dir. = Directorate; DDSW = number of Departments and Directorates in Charge of Social Welfare; OU/WP = number of organizational units/welfare programs; ICDS = Integrated Child Development Services (the major program for population policy)
Source: Based on Table 4.1 in Goel and Jain (1988), pp. 149-92.

The complex and rather problematic distribution of powers between the governmental institutions of the Central Government and State Governments – that has been laid down in the Constitution – is the result of a historical compromise in the late 1940s, which Pandit Jawaharlal Nehru had to accept – following pressure from the Muslim League, the largest Muslim party and power, which heavily insisted on the creation of a highly decentralized country (while Nehru and the Congress Party had a highly centralized India in mind) (cf Kamal and Meyer, 1977: 83).

That's why the central government was least effective in getting the states to carry out centrally conceived policies, such as the family planning program. Only when financial offers or restraints were at the Prime Minister's disposal could the central government be reasonably sure of cooperation from the side of

state governments (cf Kamal and Meyer, 1977: 86). While family welfare was completely devised and financed by the central government, the implementation, recording, and control of such policies were largely dependent on the will and the capacities of state legislatures and administrations.

On top, there had been lengthy delays in financing family planning programs, due to unfortunate distribution of powers, functions and responsibilities between the numerous departments and directorates involved (cf Jagannadham, 1967). Even more adverse effects had been noticed in the field of health care, where the central government also formulates the national health policy, it only finances the construction of health facilities, such as hospitals and health care centers, the concurrent costs are to be born by state budgets; implementation, recording, control are again a matter of the individual states. Above and beyond, there are problems in the governance of financial and policy matters between state governments and local governments (cf Berman, 1996: 342, 254; Sharma, 1998: 227).

POLICY AND POLITICS MATTERS: THE CONCLUSION

It has been observed from the analysis above that, as a rule, poorer states and states with a low average rate of female literacy are among those most likely to generate higher levels of fertility, which again delays economic development and reinforces poverty. Muslims, seen from a macro scale, have more children than their Hindu, or Christian counterparts, but – as it has been shown in the case of Kerala – Islam does not generate high fertility rates by itself alone (cf also Panandiker and Umashankar, 1996: 218-19). Instead, the role of female literacy must not be underestimated, which e.g. contributed to record-low birthrates in the state of Kerala. Economic development and urbanization is a plus, but not the only key factor with regard to fertility rates of single states. Without a shred of doubt, the nuts and bolts of decade-long policy planning of the central government – that focused on economic development as the solution to the problem of high population growth – were not astutely conceived.

In most cases, policy measures in the field of population planning (family planning, or "family welfare") were more *ad-hoc* measures than a carefully planned and vigorously implemented set of policies. All things considered, it can be concluded that the politics of social policy lacked a strong lobby in the National Parliament and State Parliaments (the "State Assemblies"), as well as in the Local Self Governments. Into the bargain, the political power structure of the country (cf Prasad, 1973) did not lead to a better administrative and political environment that would have generate more effective and far-reaching policies, from Kerala in the South, to the heartland of the Indian nation – i.e., between Dehli and Calcutta – in the North.

When looking closer, we see that the political system of India constitutes a major factor that has contributed to the failure of its long-standing population policy: First, policy targets have been set very low. Second, central planning in a highly decentralized federal state radically changed the outcome of the family

planning program. Third, political parties that form the central government are usually opposed by different political parties and faction that dominate the various state governments.

Fourth, a common aim in population policy is unlikely in India, due to different social and political realities, and the fragmented, and highly independent, administrative set-up of government authorities (esp. in social welfare) in different federal states. Fifth, by the very nature of their existence, regional parties are dependent on the population strength of their specific constituency and, thus, are more than reluctant to implement population policies of the central government. [3] Lastly, the financial and man/womanpower capabilities of governmental institutions are inadequate to complete the – sheer impossible – task of changing the reproduction habit of a highly illiterate population (up to 40 percent of the overall population, of more than a billion souls) that is living for the most part in the countryside, who, in addition, do not speak an unanimous national language, or read a universal national script either, and who often fight religious and national battles with the enduring system of a high birthrate (cf Ishtiaq, 1996; Chandra, 1999; Basu, 2000; Aspalter, 2002).

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[1] The state of *Jammu & Kashmir* is not the leader in terms of large Muslim populations, due to the great number of Hindus living in Jammu, and a sizeable number of Buddhists in Kashmir itself.

[2] That is, the number of organizational units/welfare programs of all departments or directories in charge of social welfare, which demonstrates the organizational differentiation of the administration of social welfare in State Governments.

[3] That is to say, the number of seats that can be won by a regional party is highly dependent on the population size of the federal state, or federal states, in which the regional party is based. The number of seats in the National Parliament for each federal state/union territory, and hence the possible influence of each state/union territory on national politics, depends on the size of the population in each state/union territory.