

**SOCIAL EXCLUSION IN THE CONTEXT OF INDIA'S
NATIONAL FAMILY PLANNING PROGRAM**

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1. INTRODUCTION

The Government of India's Family Planning Program (FPP), the first in the world, has been the topic of on-going debate since its inception in 1951. The divergent ideologies surrounding the formation and maintenance of the FPP make it a controversial public health effort. On one hand there is the persistent belief that the FPP's primary objective should be to control population growth through the utilization of reproductive methods and technologies,^{1 2 3} while on the other hand a slowly increasing minority sees the program strictly as a vehicle to promote women's autonomy and choices in reproductive and sexual health-related decisions that pertain to their own bodies⁴. While population control sentiments, fueled by the idea of the impending explosion of the population bomb^{5 6 7} have continually dominated the national family planning agenda, the post-ICPD period, starting in the mid-1990s brought forth vocalization of the importance of rights in the family planning discourse. Coercive population policies have been a norm of the FP program since its inception^{8 9 10}, however, when faced with the culmination of forced population control measures immediately following the Emergency in 1977 and the ICPD conference in Cairo, the program renamed itself to the Family Welfare Program and re-oriented itself "away from a target-oriented approach and towards a service-oriented one"¹¹, as a measure to quell the anger and fear of people towards family planning methods and implementers^{12 13}.

Presently, the program policies outlined in the National Population Policy (NPP) and the current Reproductive and Child Health Program (RCH-II) claim to prioritize choice and diversity in both availability¹⁴ and usage of different FP methods and technologies. Whether the planners and implementers of the program accept this perspective, and whether it translates to action at the community level is something that needs to be systematically investigated.

This paper hopes to contribute to the process of investigation by exploring whether the talk of rights and choices in the matter of FP (as a part of the RCH program) is reflected in the ethos and implementation of the FPP. This paper will attempt to look at this from the perspective of traditionally marginalized communities, including Muslims, Dalits, and Tribals¹⁵, in the context of the experiences of these various sub-populations with regards to access and utilization of family planning services and related health indicators.

¹ National Population Policy 2000 – Objectives. National Commission on Population. Government of India
<http://populationcommission.nic.in/npp_obj.htm> Accessed: April 14, 2010.

² Visaria L, Jejeebhoy S, Merrick T (1999) *From Family Planning to Reproductive Health: Challenges Facing India* Guttmacher Institute

³ Maharatna A (2002) *India's Family Planning Programme: An Unpleasant Essay*, Economic and Political Weekly, 37(10), 9 March.

⁴ International Conference on Population and Development (ICPD) Programme of Action,
<<http://www.un.org/popin/icpd/conference/offeng/poa.html>> Accessed: April 14, 2010

⁵ Malthus T R (1809) *An Essay on the Principle of Population* Washington : Roger Chew Weightman.

⁶ Sanger M (1922) *Pivot of Civilization* New York: Brentano's

⁷ Fund H M (1954) *The Population Bomb* New York

⁸ Sen A (1995) *Population policy: Authoritarianism versus Cooperation*, International Lecture Series on Population Issues, Chicago: The John D. and Catherine T. MacArthur Foundation

⁹ Ashford L S (2001) *New Population Policies: Advancing Women's Health and Rights* Population Reference Bureau. Population. Vol. 56, No. 1. March 2001

¹⁰ Rao M (2004) *From Population Control to Reproductive Health: Malthusian Arithmetic*. New Delhi: Sage Publications 2004

¹¹ Zaman W *India Reorients its Family Planning Program* United Nations Population Information Network.
<<http://www.un.org/popin/unfpa/taskforce/icpdnews/icpdnews9510/highlite.html>> Accessed: April 14, 2010

¹² Gwatkin D (1979) *Political Will and Family Planning: The Implications of India's Emergency Experience*, Population Council.

¹³ Connelly M (2006) *Population Control in India: Prologue to the Emergency Period* Population and Development Review, Vol. 32, No. 4 (Dec., 2006), pp. 629-667

¹⁴ Reproductive and Child Health Program, National Rural Health Mission, Government of India
<http://www.mohfw.nic.in/NRHM/RCH/Background_new.htm> Accessed: April 14, 2010

¹⁵ Chatterjee C, Sheoran G (2007) *Vulnerable Groups in India*. Centre for Enquiry into Health and Allied Themes
<<http://www.cehat.org/humanrights/vulnerable.pdf>> April 14, 2010

The rationale for doing this is to explore the existing notion that the diverse family planning needs, practices, and preferences of different groups remain neglected¹⁶, despite the program's stated objective to offer comprehensive and diverse services. India has pledged itself to a rights-based approach to family planning through the signing of the ICPD, and whether it is following through on its commitment, and where it is lacking in action has to be understood. This paper aims to highlight some area for improvement within the FPP, through the exhibition of some available data.

2. BACKGROUND OF THE FAMILY PLANNING PROGRAM

Beginning in the early 20th century, as a response to cycles of famine, the issue of population began to be questioned as a cause of food and resource shortage¹⁷ in the country. It was also said that a large population was a threat to socio-economic progress in the country¹⁸. This philosophy was characteristic of the followers of the famous economist Thomas Malthus, and his theory on population¹⁹. Malthusian sentiments on population later evolved into a movement called Neo-Malthusianism, whose believers maintained that a large population was problematic to development, but prioritized the role of birth control methods as a major factor in the control of population²⁰.

The population control philosophy was incorporated into the policy-making process, starting with the 1st Five Year Plan from 1951-1956. This plan aimed for a "reduction in the rate of population growth" and tried to adopt a clinic-based approach, based on the Planned Parenthood model developed by Margaret Sanger, a famous proponent of the neo-Malthusian movement^{21 22}. Due to the newness of the 1st five-year plan program, the lack of funding, and technical and behavioral know-how the program failed to achieve its population-curbing objectives. Activities to inform the public about family planning and the availability of relevant services resulted in the wastage of funds and underutilization of whatever services existed²³. This was continued into the 2nd 5-year plan, 1956-1961, where from the government side only 411 clinics were established, and where the voluntary demand for sterilization services from people was minimal.²⁴ Subsequently, the 3rd 5-year plan in 1961, brought forth a more aggressive effort by the FPP, as evidenced by its "objective to stabilizing the rate of growth of population over a reasonable period must...be at the centre of planned development"²⁵. The Government of India (GoI) thus implemented an *extension-approach* where health workers took to the streets and made home visits to women of child-bearing age to urge them to limit their family size²⁶. It was also during this time that sterilization began to be financed by the government and was informally gaining recognition as the family planning method of choice, and demographic targets and goals, which were to be met by the national health program were set up²⁷. The 1960s were a pivotal period that marked the heavy use of sterilization through the HITTS model (health department operated, incentives-based, target-oriented, time-bound, and sterilization-focused program) to achieve established population targets^{28 29}. The 4th 5-year plan (1969-1974) marked the expansion of this model and its budget, and the highest percent of outlays to date at 1.8 percent³⁰. During this time, the incentive set-up for acceptors and motivators for sterilization were boosted, and mass sterilization camps were set-up in many places "so that these facilities are available for men in their own geographic proximity and the services of skilled surgeons could be optimally utilized"^{31 32}.

Despite these efforts on the part of the FPP, however, the resulting scenario included a growth of population indicated by the 1971 Census, combined with dissatisfaction associated with unmet sterilization targets³³. At this time, the 5th Five-Year

¹⁶ Braveja R. (2000) *Evaluating Contraceptive Choice through the method-mix approach: An ICMR Task Force Study Contraception*, Volume 61, Issue 2, Pages 113-119

¹⁷ Singer P (1972) *Famine, Affluence, and Morality Philosophy and Public Affairs*, vol. 1, no. 1 (Spring 1972), pp. 229-243

¹⁸ Taylor C E, Hall M F. (1967) *International health programs have an important role in promoting economic development and population control*. Health, Population, and Economic Development. Science. 1967 Aug 11;157(789):651-7.

¹⁹ Ibid: Malthus.

²⁰ Rao M. (1994) *An Imagined Reality Malthusianism, Neo-Malthusianism and Population Myth* Economic and Political Weekly: 5, 29 January

²¹ Hodgson D, Watkins S C. (1997) *Feminists and Neo-Malthusians: Past and Present Alliances* Population and Development Review, Vol. 23, No. 3 (Sep., 1997), pp. 469-523

²² Ibid, Maharatna (2002)

²³ Visaria, P and V Chari (1998) *India's Population Policy and Family Planning Programme: Yesterday, Today and Tomorrow*, A Jain (ed), Do Population Policies Matter? Fertility and Politics in Egypt, India, Kenya, and Mexico, Population Council, New York.

²⁴ Ibid, Maharatna (2002)

²⁵ Ibid, Visaria and Chari

²⁶ Ibid, Maharatna (2002)

²⁷ Ibid, Maharatna (2002)

²⁸ Ibid, Maharatna (2002)

²⁹ Srinivasan, K (1998) *Population Policies and Programmes since Independence*, Demography India, 27(1).

³⁰ Ibid, Maharatna (2002)

³¹ Ibid, Srinivasan

³² Ibid, Maharatna (2002)

³³ Ibid, Maharatna (2002)

Plan (1974-1979) was in place starting in 1974, which re-prioritized family planning as a critical issue and was given the “highest priority” by the central government. Expenditure on the FPP had doubled from the 4th 5-year plan, and the presence of mass camps for sterilization was rapidly increased³⁴. The “responsibility of achieving the targets set by the central government – on the basis of the desired decline of the birth rate- was in turn passed on to successive lower administrative units such as states, districts, primary health centers, and sub-centers and their functionaries.³⁵ To bolster the mission of the FPP, in 1976, the first National Population Policy (NPP) was formulated and encouraged states to make sterilization “compulsory for citizens” under certain conditions^{36 37}. What ensued was a time of horror when vasectomy camps were set-up in railway stations, and men were forcefully sterilized against their own will^{38 39}. The combination of pressure from the authorities to undergo operations, coupled with strong ideology at every level – from policy makers to health workers - was a lethal combination, which resulted in the unfair victimization of groups of people, particularly those of poor and marginalized communities. Between April 1976 and March 1977 as many as 8.26 million sterilizations were performed⁴⁰.

Following the lifting of the Emergency, the aftermath was characterized by large-scale public agitation towards the FPP. There was a great amount of pressure from the public, and politically, for the new government to re-strategize its mission and approach towards Family planning and to make it less ominous and more voluntary. It was renamed as the Family Welfare Program (FWP), and its sterilization targets were shed⁴¹. The government issued a Population Policy Statement in 1977 to vocalize the new stance of the FPP⁴². The 6th 5-year plan (1980-1985) revived the HIITS approach, however, this time with less emphasis on sterilization and more on spacing methods and child survival. At this point the number of men who came forward for sterilization had rapidly declined, while the number of women who underwent tubectomies began to slowly increase⁴³.

Despite its commitment to choice and free-will, the 7th 5-year plan (1985-1990) saw the continued presence of targets and population projections. This period continued the slow and increasing acceptance of sterilization by women. Numbers that were collected on the acceptance of reversible methods showed increasing acceptance, however this was not fully reflected in the marginal decline of the annual rate of population growth⁴⁴. It was suspected that “data were manipulated at the grass roots level to create an impression that the prescribed targets for these methods were achieved⁴⁵”. The 8th 5-year plan (1990-1995) realized that its population projections were unrealistic and revised them with a target period of 2011 to 2016⁴⁶. The 9th Five Year Plan (1997-2002) saw the intensification of women’s movements and realization of sterilization pressure as an infringement on women’s fundamental rights. This was an active period during which the International Conference on the Development of Women (ICPD) took place, there was a shift towards a more comprehensive health program through the introduction of the Reproductive and Child Health Program, and a New Population Policy was developed⁴⁷.

In 1994 India became one of the signatories to the ICPD Program of Action, which holds the view that population policies need to be comprehensive and guided by reproductive health, rights, and gender equity. Following the conference, the Family Planning program was once again renamed, this time as the Reproductive and Child Health Program (RCH), in an attempt to integrate family planning services with maternal and child health services to make them more holistic and target-free. Additionally, rights-centered principles were incorporated into the new and present NPP of 2000, which aims to “address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child care”, with a long term goal to “achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.⁴⁸”

³⁴ Ibid, Maharatna (2002)

³⁵ Ibid, Visaria & Chari

³⁶ Ibid, Maharatna (2002)

³⁷ Milestones in the Evolution of Population Policy of India. Statement of National Population Policy 1976. National Commission on Population < <http://populationcommission.nic.in/background.htm>> Accessed: April 14, 2010

³⁸ Ibid, Maharatna (2002)

³⁹ Landman L C (1977) *Birth Control in India: The Carrot and the Rod* Family Planning. Perspectives 9: 101-105,108-110.

⁴⁰ Ibid, Maharatna (2002)

⁴¹ Ibid, Maharatna (2002)

⁴² Ibid, Maharatna (2002)

⁴³ Ibid, Maharatna (2002)

⁴⁴ Ibid, Maharatna (2002)

⁴⁵ Ibid, Visaria & Chari

⁴⁶ Ibid, Maharatna (2002)

⁴⁷ Ibid, Maharatna 2002

⁴⁸ National Population Policy 2000 Government of India < http://www.whoindia.org/LinkFiles/Policy_Population-Policy.pdf> Accessed: April 14, 2010.

Whether the shift in policies and the renaming and reorientation of the program is sufficient for alleviating the anxieties of people about the FP program has to be understood. In order to rectify previously done damage by the program, to restore trust of people in the FPP, and most importantly, to ensure that peoples' reproductive needs are being met in an effective and equitable way, we need to examine whether these rights-oriented policies are translated into action, especially in the context of marginalized populations – those groups who are excluded from different resources and opportunities based on their social identity.

3. EXPERIENCES OF SUBGROUPS

The following section will aim to highlight the perspectives and experiences of the various traditionally marginalized groups, including Muslims, Women, Adivasis, and Dalits, in the context of access and utilization of family planning services from the RCH program. The section will also aim to identify the diverse needs, practices, and preferences of these different groups based on their historical experience and current scenario.

3.1 INDIAN MUSLIMS

Muslims in India have experienced an inferior status in society since the beginning of India's independence. This has been fueled and demonstrated through both, spontaneous and on-going forms of discrimination and hostility, which have ranged from attacks such as the Babri Masjid demolition in 1992 and the 2002 Gujarat riots, to sustained and deeply embedded discrimination based on religious identity. The consequences of this discrimination have been far-reaching, especially for those communities that are marked with poverty and identify as Muslim. The hostility faced by Muslims in the realm of population and family planning is tremendous and occurs on a consistent and grand scale. The fertility rate of Muslims has been scrutinized and flouted as a consequence of religious belief and practice⁴⁹.

As a signatory to the ICPD, India is obligated to uphold certain values that promote the freedom of choice in reproductive matters. These choices include the right to decide when, how often, and how much to reproduce⁵⁰. Based on this fundamental fact, the focus of the population program should therefore not be on who has a higher fertility rate in an effort to curb a certain group's population growth, rather the focus should be shifted to evaluation of people's reproductive health needs and the barriers that different communities face in meeting them. Unfortunately, the case of the Muslim community in the context of FP reflects the disproportionate scrutiny on the changes in the proportions of the population by religious communities⁵¹.

Research and debates on the issue of inter-religious fertility are distinctively divided on opposite sides of the spectrum. On one hand, colored stereotypes about Muslims are also bolstered by some demographers, academicians, and researchers who help keep alive these stereotypes through biased research and publications⁵². Termed as *Saffron Demography*, these efforts have been implemental in perpetuating the vulnerable plight of Muslims in the realm of family planning and population, and the unjustified hostility they receive due to it. "*Saffron demography is concerned mostly with the relationships between religion on the one hand and fertility and population growth on the other; it is rarely concerned with mortality, and migration is mentioned only to highlight the possible effects of illegal immigration, not with reference to the full range of migration flows within and beyond India's boundaries*"⁵³. One example of this is through peer-reviewed research articles that use NFHS data where the size of fertility differentials is often exaggerated in various ways. For instance, either through inadequate weighting allocated to regional disparities, or through the failure to consider the implications of minority group status for Muslims in India⁵⁴. This movement has been pivotal in fueling the fires of communal rhetoric in the academic world, and for initiating catastrophic incidents such as the pre-mature release of 2001 Census data on religion, which misrepresented and inflated the fertility rate of Muslims. Not only did this add to the existing negativity faced by the Muslim community, but it also falsely justified the

⁴⁹ Ibid, Chatterjee and Sheoran.

⁵⁰ International Conference on Population and Development (ICPD) Programme of Action, <<http://www.un.org/popin/icpd/conference/offeng/poa.html>> Accessed: April 14, 2010

⁵¹ Jeffery R, Jeffery P (2000) *Religion and Fertility in India* Economic and Political Weekly, Vol. 35, No. 35/36 (Aug. 26 - Sep. 8, 2000), pp. 3253-3259

⁵² Mari Bhat P N, Francis Xavier A J. (2005) *Role of Religion in Fertility Decline* The Case of Indian Muslims Economic and Political Weekly, 40(5): 385-402

⁵³ Jeffery R, Jeffery P (2005) *Saffron Demography, Common Wisdom, Aspirations and Uneven Governmentalities* Economic and Political Weekly

⁵⁴ Ibid, Jeffery and Jeffery 2000

suspicions of those who view fertility of the Islamic community as problematic. Despite the census commission withdrawing the report, it has not prevented this information from being used as fodder for anti-Islamic purposes⁵⁵.

3.1.1 Dispelling Myths

The loyalty of Indian Muslims to India is often challenged by communal parties, which state that Muslims have harbored resentment over the partition of India⁵⁶. Based on this logic, Muslims are therefore said to reproduce with the intention to increase their minority population in a country of majority Hindus, and to give access to their friends in Pakistan to invade India⁵⁷. Therefore, audiences who are exposed to this rhetoric are led to interpret the intention of Muslims as wanting to outnumber Hindus through mass reproduction. When the Muslim perspective was sought on this issue through the Sachar Committee, concern was expressed about the double burden that they carry, the first being labeled as “anti-national” and the second as being “appeased”. While they have to prove on a daily basis that they are not anti-national or terrorists, their “appeasement” has not been effective in promoting investment in the socio-economic development of the Muslim community⁵⁸.

To understand the issue of family planning in the context of Islam necessitates examination and understanding of Quranic texts, as there are widely varying interpretations of the Quran’s messages both within and outside of the Muslim community. Polygamy is one such issue that has been falsely identified by those who subscribe to the communal politics in India, as a relevant factor that increases the fertility rate of Muslims⁵⁹. The belief exists that for every five Hindu children born, Muslims have fifty, and that Hindus would become a minority in India within twenty-five years⁶⁰. In reality however, data has shown that polygamy is not as common among Muslims as some groups would like to think, and that number of children born depends entirely on the number of women in a reproductive age group, and not on the number of wives a man has. A report on polygamy dispelled the myth of polygamy as it relates to Islam by pointing out that the incidence of polygamy was highest among Adivasis, followed by Buddhists, Jains, Hindus, and then Muslims⁶¹.

3.1.2. Contraception

The utilization of contraception is central to the debate on inter-religious fertility. The perception that Muslims oppose family planning methods is one that has been built up in the public’s mind. Despite currently available data that shows the utilization of contraceptives and unmet needs within the Muslim community, among others, the anti-Islamic rhetoric inflating Muslim aversion to family planning methods continues. The Sachar Committee report, one of the first comprehensive studies on Indian Muslims states that there is “substantial demand from the community for fertility regulation and for modern contraceptives”⁶². Very little consideration has been given to understanding practices, preferences, and to ensuring access to diverse family planning methods that meet diverse needs.

The picture depicted by communal parties falsely represents the preferences of Muslims and their usage of family planning methods. The allegation that Muslims want to reproduce with a vengeance, and do not adopt contraceptive methods for this reason is one extreme of the picture. While in reality, within the Muslim community there are varying stances on contraception based on various interpretations of religious leaders. Omran, one of the early Islamic scholars who addressed the issues of Islam and contraception, began his discourse by describing a husband and wife as forming the nucleus of a family, and their relationship as having two major qualities: love and within the overall objective of tranquility⁶³. According to the Quran, he saw marriage and children as a gift from God that should be cherished and enjoyed. In terms of contraception, he commented on the lack of clarity in Islamic texts over the acceptability of different forms of contraception, and noted that all forms of non-terminal family planning methods are acceptable⁶⁴. He dispelled the myth that Islam is inherently against family planning, as per him there is no text in Quran that prohibits the prevention of pregnancy.

⁵⁵ Jeffery R, Jeffery P (2006) *Confronting Saffron Demography: Religion, Fertility, and Women’s Status in India*. Three Essays Collective, 1st Edition

⁵⁶ Ibid, Jeffery and Jeffery 2000

⁵⁷ Ibid, Jeffery and Jeffery 2000

⁵⁸ Social, Economic, and Educational Status of the Muslim Community in India. Sachar Committee Report (2006) <http://minorityaffairs.gov.in/newsite/sachar/sachar_comm.pdf> Government of India Accessed: April 14, 2010

⁵⁹ Bandukwala J S (2008) *Indian Muslims: Past, Present and Future* Economic and Political Weekly

⁶⁰ Basu, T, Datta P, Sarkar S, Sarkar T, Sen S(1993): *Khaki Shorts, Saffron Flags*, Orient Longman, Delhi

⁶¹ 1961 Census

⁶² Social, Economic, and Educational Status of the Muslim Community in India. Sachar Committee Report (2006) <http://minorityaffairs.gov.in/newsite/sachar/sachar_comm.pdf> Government of India Accessed: April 14, 2010

⁶³ Omran, A R (1992): *Family Planning in the Legacy of Islam*, Routedledge, London and New York

⁶⁴ Ibid, Omran.

The question of whether permanent methods are acceptable still needs clarification. Most of the theologians are of the opinion that these methods are not allowed, except in cases where the health of the mother is in danger, because sterilization is viewed as an objectionable attempt to change what God has created⁶⁵. While sterilization appears to be the most contentious point in the family planning debate within the Muslim community, it does not cause an ideological hindrance in the decisions of Muslims to utilize non-permanent contraceptive methods.

3.1.3 Unmet Need for Contraception

Whatever the reasons, it cannot be denied that there is a large unmet need for contraception among Muslims. Unmet need for contraception is the *proportion of women who are at risk of unintended pregnancy, but not using contraceptives*⁶⁶. The intention of this measurement is to point to the women who have an unfulfilled desire to plan and space their child bearing. Data on unmet need can demonstrate the work that is left to be done in assisting women and couples to prevent unintended pregnancies. This concept came about in the 1960s when there was recognition in the developing world between women of the gap between women's fertility preferences and their use of contraceptives. It has been used to negotiate between the concerns of governments and experts who are focused on population growth, and those who are primarily interested in women's health and rights. This was helpful because the "need" for contraception is focused on the woman's perspective and with whether and when she wants a child⁶⁷.

India has the largest *number* of unmet needs by far, at 31million⁶⁸. According to the NFHS-3 survey, Muslims have the highest percent of overall unmet needs for contraception (18.8 percent) as compared to all other surveyed populations, including, SCs (13.4), STs (13.9), and Hindus (11.9), who have the lowest⁶⁹. Conversely, Muslims also have the lowest percent of overall met needs, with the highest percent of met needs in spacing methods, and lowest number of met needs in limiting methods. Muslims have the highest proportion of met needs at 6.8 percent, which can indicate that they are the mostly likely who have tried to seek out temporary methods of spacing. It also shows that their needs and preferences might indicate that they are not getting the services they need. Other groups might have a smaller proportion of met needs in spacing methods because they might be more likely to opt for limiting methods.

Table 1: Unmet & Met Need for Family Planning by Religion and Caste

	Unmet Need for family planning			Met need for family planning		
	Spacing	Limiting	Total	Spacing	Limiting	Total
Religion						
Hindu	5.8	6.1	11.9	4.5	53.3	57.8
Muslim	8.6	10.2	18.8	6.8	38.9	45.7
Caste						
SC	6.3	7.1	13.4	4.7	50.3	55.0
ST	6.8	7.1	13.9	3.0	44.9	47.9

Source: NFHS - India 2005-06 - Percentage of currently married women age 15-49 with unmet need for family planning, percentage with met need for family planning

This data has to be examined in its entirety to get a comprehensive picture. In reference to the current use of contraception, in any method, Muslims have the lowest use rate, even as compared to Adivasis. This number is even less in the use of modern methods. Sterilization for Muslim males and females is the lowest - which makes sense, as many Muslims prefer non-permanent methods. Their use is highest in non-permanent and spacing methods, such as the Pill, IUDs, Injectables, Condoms and all traditional methods of contraception. This shows their needs for diverse methods that exclude sterilization, and explains the high-level of non-usage of contraception when methods other than sterilization is are not available from the health system.

⁶⁵ Shaikh S (2003) *Family planning, Contraception and Abortion in Islam: Undertaking Khilafah: Moral Agency, Justice and Compassion* Published in *Sacred Choices: The Case for Contraception and Abortion in World Religions*, ed. by D. Maguire. Oxford: Oxford University Press.

⁶⁶ Sonfield A (2006) *Working to Eliminate the World's Unmet Need for Contraception*. Guttmacher Policy Review Winter 2006, Volume 9, Number 1

⁶⁷ Ibid, Sonfield

⁶⁸ Finger W R (1999) *Unmet Need Affects Millions*. Family Health International Network: Vol. 19, No. 4, Summer 1999

⁶⁹ National Family Health Survey 3 (2005-2006) Ministry of Health and Family Welfare, Government of India < <http://www.nfhsindia.org/nfhs3.html>> Accessed: April 14, 2010

Table 2: Current use of contraception (modern methods) by Religion & Caste

	Any Method	Any Modern Method	Female Sterilization	Male Sterilization	Pill	IUD	Injectables	Condom/ Nirodh
Religion								
Hindu	57.8	50.2	39.9	1.1	2.7	1.6	0.1	4.8
Muslim	45.7	36.4	21.3	0.6	5.7	1.8	0.3	6.8
Caste								
SC	55.0	47.1	38.3	1.1	2.8	0.8	0.1	4.0
ST	47.9	42.7	35.3	2.5	2.2	0.8	0.1	1.7

Source: NFHS-3:- Percent distribution of currently married women by modern contraceptive methods, India 2005-2006

Reliance on public sector health services is heavier in rural areas for sterilization purposes, as compared to private facilities. 58.4 percent of IUDs are received from public health facilities, as compared to 39.2 from private sources, and private sources and the spouse are the sources for condoms. This data shows and confirms the allegation against the public health system that sterilization is often the first and only method of contraception that is taken up – sources of contraception also can indicate that this is a prevalent method which can be based on availability of services. In the case of Muslims, although a specific breakdown is not available, it shows that they are not able to rely on public health services for spacing methods as much as they would like. The necessity to go to private health facilities for contraceptive services and the cost associated with getting these services could be a deterrent in the utilization of contraception. Muslim women, amongst everyone else, need more options that the government provider might not offer, and the prevalence of private health facilities that offer these services is higher in urban areas than rural, leaving them with an added disadvantage.

Table 3: Source of modern contraceptive methods asked to users

	Female Sterilization	Male Sterilization	Pill	IUD	Injectables	Condom/ Nirodh	All Modern Methods
RURAL							
Public	87.7	89.0	18.2	58.4	13.1	20.0	78.2
Private	11.4	6.8	58.0	39.2	78.4	37.5	16.6
Spouse	0.0	0.0	13.1	0.0	0.0	35.6	6.8
URBAN							
Public	74.2	77.4	10.4	36.2	6.8	8.4	56.8
Private	24.3	17.1	72.9	61.0	93.2	52.1	34.2
Spouse	0.0	0.0	18.0	0.1	0.3	35.7	3.5

Source: NFHS-3 2005-2006 – Private excludes NGOs, trust hospitals/clinics

3.1.4 Social Standing of Muslim Women, Power to Negotiate in FP, and Consequences

When addressing issues of anti-Islamic ideology in family planning and fertility in India, it is equally necessary to understand some of the barriers to family planning services from the perspective of the Muslim woman as an individual. There is a need to look at the cultural context in this case and how it affects FP practices, specifically in relation to her autonomy and decision-making power in FP issues.

Many authors who have looked into the Muslim woman in family planning highlight the contradictory images that are identified regarding the status of Muslim women. On one hand, demographers and sociologists state that the women in Muslim countries have a lower status^{70 71} while on the other, theologians counter that Islam as a religion gives women a high

⁷⁰ Obermeyer C M (1994) *Reproductive Choice in Islam: Gender and State in Iran and Tunisia* Studies in Family Planning, Vol. 25, No. 1 (Jan. - Feb., 1994), pp. 41-51

⁷¹ Weeks J R (1988) *The Demography of Islamic Nations* Population Bulletin 43(4). Washington, DC: Population Reference Bureau.

status⁷². Based on the interpretation of the Quran, the theologians argue that a woman is considered to be equal to a man in many social and economic aspects⁷³. For instance, she has the right to choose her husband; in marriage, she has the right to keep her maiden name; she can be completely independent financially and has the right to do with her money as she pleases, while the husband is responsible for providing for her and her children⁷⁴.

The first image, which is painted by the demographers, sociologists and anthropologists, implies that the lower status of the Muslim women is part of the explanation of high fertility in most of the Muslim countries, due to its relation with high fertility⁷⁵: Lower status is associated with restricted access to education and employment, leading to economic dependence and an insecure position, including limitation in her ability to negotiate in matters of family planning.

The plight of Muslim women often limits them to getting married at a young age, and having restrictive lifestyles where they are not as able to pursue an education. The reason that this is important is that both education and a delay in marriage age have been identified as major factors for fertility. This can sometimes play out in way where the woman does not have the power to decide how many children to have – and whether she can use a FP method, and which FP method. When autonomy is reproductive health decisions is not present then the woman has to get permission from her husband to get access to contraceptives. This can be uncomfortable for many women to bring this up with their husbands. As a last resort, women succumb to getting abortions, where they are faced with the thought that they have murdered and will go to hell⁷⁶. This also brings up the issue of unsafe abortion and about whether Muslim women are able to use regular facilities for these needs or they have to be secretive about it.

3.2 ADIVASIS

Judging by the Unmet Needs data given in the tables above, it is also evident that the Adivasis are having their minimal family planning needs met at only a disturbingly low level. As stated previously, the measure of unmet needs can be looked at as a minimum standards measurement, as it neglects the personal needs and preferences of women and communities, and overlooks the barriers to accessing various contraceptive methods and options. Despite not taking into account these different factors, and looking at Unmet Needs as a measurement that is dichotomous these figures remain alarmingly low.

Tribal populations have been on the periphery of society and their needs have often been neglected by the health systems. While they are a difficult to reach population, complacency on the part of program and policy formulators, combined with a consequential lack of understanding about the community's health needs, culture, and treatment-seeking behavior and their needs has resulted in unavailability of relevant health services, poor accessibility, and unfavorable health outcomes.

Despite using the unifying term Adivasis for the many tribes of India, there is a vast diversity of their practices and cultures. What might be true for one tribe might not be the case for another. Relatively little attention has been paid to the tribal patterns of demographic behavior, with the exception of a few studies.

Historically, Kingsley Davis, a famous sociologist and demographer, tried to systematically compare tribal fertility with other religious groups for the period of 1911-31⁷⁷. Though only limited data was available at this time, he concluded that tribal fertility at the national level was superior to other groups, including Hindus, and except Muslims. Kingsley attributed this to the primitive nature of the tribes and associating their reproductive habits to other aboriginal groups. For instance he stated that they have a greater toleration of widow remarriage and a relatively high female age at marriage as compared to other religious groups.

Others who have also studied this area see Tribal fertility behavior as different from the role of complete submission demanded by Hindu ideals. Importance is not attached to the virginity of the girl, as it is in mainstream society. Elopement is recognized as a form of marriage, and infant marriage is not a custom known to many tribals, many of the marriage take place between the age of 16 to 21⁷⁸. For instance, the timing of a tribal marriage was said to depend on the ability of the

⁷² Ibid, Omran.

⁷³ Ibid, Omran.

⁷⁴ Ibid, Omran.

⁷⁵ Ibid, Omran.

⁷⁶ Ibid, Bandukwala

⁷⁷ Gandotra MM, Patel G. (2001) *The Demography of Tribal Population in Western India Session: S48 The Demography of Vulnerable Population* Paper presented in the XXIV General Population Conference of IUSSP held at Salvador, Brazil, 18-24 August, 2001

⁷⁸ Sharma R, Rani M. *Contraceptive Use among Tribal Women of Central India: Experiences among DLHS-RCH -II Survey* Research and Practice in Social Sciences Vol. 5, No.1 (August 2009) 44-66

couple to institute an independent economic unit. There is pre-marriage sexual mixing, and the attitude of indifference to the sexual behavior of unmarried youths and girls is shared also by the parents of adolescent and grown up. Extramarital relationships are also quite common among the tribal population⁷⁹. Contrary to Davis' theory, some studies have show that tribal fertility can actually be lower due to later entry into marriage, "Girls are married as adults mostly to men of their own choice...while high-caste Hindus marry their daughter between the ages of 8 and 12. The spousal age gap at marriage is generally much smaller among tribal populations than that for Hindus". Female status/autonomy in society is also a factor where it is said to be higher among tribal populations⁸⁰.

Given that Adivasis communities vary geographically and in their cultures and practices what is found in one study cannot be fully generalized to a scattered and diverse population. Therefore its not possible to make a blanket statement and say, the way Kingsley Davis did, that tribal fertility is higher everywhere. We have to be more realistic and say that fertility varies not only across Indian states, but is higher in some regions and lower in others compared to the fertility of the mainstream populations. Given the dearth of reliable and comprehensive data we must rely mostly on the NFHS quantitative data for our information.

Table 4: Unmet & Met Need for Family Planning by Caste

	Unmet Need for family planning			Met need for family planning		
	Spacing	Limiting	Total	Spacing	Limiting	Total
Caste						
SC	6.3	7.1	13.4	4.7	50.3	55.0
ST	6.8	7.1	13.9	3.0	44.9	47.9
OBC	6.7	6.7	13.4	3.8	50.4	54.2
Other	5.2	6.1	11.3	6.6	55.2	61.8

Based on a break down of castes, Scheduled Tribes (STs) have the highest proportion of unmet needs overall (13.9 percent). They have the highest unmet needs in spacing methods, and are equal to scheduled castes in the limiting methods (7.1 percent). They have the lowest met needs in family planning, both overall (47.9 percent), in spacing methods (3.0 percent) and limiting methods (44.9 percent).

Table 5: Current use of contraception (modern methods) by Caste

	Any Method	Any Modern Method	Female Sterilization	Male Sterilization	Pill	IUD	Injectables	Condom/ Nirodh
Caste								
SC	55.0	47.1	38.3	1.1	2.8	0.8	0.1	4.0
ST	47.9	42.7	35.3	2.5	2.2	0.8	0.1	1.7
OBC	54.2	48.0	39.7	0.7	1.8	1.5	0.1	4.2
Other	61.8	51.4	34.1	1.0	5.1	2.8	0.2	8.2

STs also have the lowest use of contraception, with only 47.9 percent of the surveyed ST population utilizing a birth control method, and even fewer (42.7 percent) using a modern method. STs have the lowest percent of usage out of all surveyed caste groups in IUDs - on par with SCs (0.8 percent), and significantly lower use of condoms (1.7 percent), as compared to SCs (4.0 percent). However, in reference to sterilization their use (35.3 percent) is higher than general caste (34.1 percent). In reference to male sterilization they outnumber all other groups with 2.5 percent, followed by SCs at 1.1 percent.

Table 6: Knowledge of contraceptive methods of Women across Caste

	Know any method		Know any modern temporary method	
	Women	Men	Women	Men
SC	96.1	97.6	87.6	94.9
ST	92.6	94.5	77.2	89.6

⁷⁹Ibid, Gandotra at Patel

⁸⁰ Maharatna A (2000) *Tribal Fertility in India Socio-Cultural Influences on Demographic Behavior* Economic and Political Weekly, Vol. 35, No. 34 (Aug. 19-25, 2000), pp. 3037-3047

OBC	96.6	97.7	87.3	94.6
Other	96.4	97.3	90.8	95.9

In terms of knowledge, NFHS data shows that STs have the lowest level of awareness about any contraceptive methods across the board. This awareness is even lower for the female counterparts. The differences in knowledge between STs and all other comparison groups are significant. This might be due to several different factors, which can include the absence of a community health worker or absence of IEC materials which could otherwise inform people about various family planning options [source]. Various studies have confirmed this notion by stating that sterilization is the most commonly known method because of its high level of promotion as compared to other methods. One study states that because motivation for sterilization is a one-time event it is the method preferred by community health workers. From the demand side, sterilization might appeal as an option, especially to those facing economic hardships, due to the compensation. The question of why male sterilization is higher within the Tribal community might have something to do with the higher level of autonomy among women combined with financial need.

One study shows that while the Tribal population has its own indigenous methods of health care it has heavily relies on government facilities for family planning services, and therefore despite the NPP saying that it wants to make services available for these populations, it does not seem to have done much.

The NPP has a special section which identifies various groups as being underserved and has defined various strategies for how to increase the likelihood of their needs to be met in family planning. In the section titled, "Tribal Communities, Hill Area Populations, and Displaced and Migrant Populations" one of the strategies that has been outlined is that, "*Many tribal communities are dwindling in numbers, and may not need fertility regulation. Instead, they may need information and counseling in respect of infertility.*"⁸¹ While it is commendable that the GoI is taking a population-based stance in the family planning matters of Adivasis, individual and family-level perspectives and experiences should not be over-shadowed by ignorance and assumptions that Adivasis do not want to limit or space their reproduction. Factors, including socio-economic influences can contribute to the decision of Adivasi women and families to limit their family size. This interest in family planning methods is clearly demonstrated through the NFHS data on Unmet Needs. If the Government of India wants to address infertility is a problem, it should not limit its effort just to tribal populations, but should also include those non-Tribal individuals who face infertility as a problem.

3.3 DALITS

Dalits have long been recognized as a socially marginalized group in India due to their caste identity. While much attention has been given to understanding their status in society and experiences of marginalization, the study of these experiences in the area of health and health service, specifically family planning is fairly recent and limited.

In the realm of development, Dalit women have been the special targets of population control programs, in a bid to limit their family size and to provide them an 'opportunity for development.' Horror stories have been related by Dalit women of how they and their sisters have been butchered in 'family planning camps,' often without their knowledge of what is being done to them. Injectable contraceptives and other hormone drugs are tested on these powerless, voiceless women by unscrupulous multi-national businesses⁸².

While NFHS-3 data listed above shows that Dalits are faring much better than Tribals, it does not necessarily mean that their experiences are good. At the community level there is a need to understand the quality of the interaction of Dalits with public health system providers. Apart from the general systemic availability of health services we need to understand whether Dalits face further exclusion due to their caste identity.

4. GENDER INEQUITY IN FAMILY PLANNING

While society does not always give women the autonomy to make reproductive-health related decisions in their life, they are simultaneously expected to shoulder the responsibility of these decisions. It is important to ensure that women's rights and

⁸¹ NPP 2000

⁸² Aranha C, Fernando P, and Mahale P. (1999) *Dalit Women in India. Beyond The Fire Line: Perceptions of Eight Tribal Women*. New Delhi: Indian Social Institute

choice as they pertain to reproductive health are upheld not just by the health system structure, which meets their needs through informed and appropriate services, but also through an environment where social norms uphold, enable, and encourage these freedoms. Part of this environment is the participation and involvement of men in family planning matters. This involvement is two-fold. One is through the participation of men in using family planning methods, and the second is through men's involvement in helping to provide space in discussion and use of family planning methods in the relationship. There is an iniquitous expectation that men do not have to shoulder responsibility in the issue of family planning. Unless it is addressed, the situation will remain a catch-22 situation where women are seemingly given rights and choices through declarations like the ICPD, when in reality they cannot avail these choices due to an inferior status at the household and individual level.

4.1 Men's Adoption of Contraception

In the evolution of family planning services in India, up to the Emergency in late 1970s there was a considerable focus on targeting men for vasectomies for the purpose of population control. The emergency then caused a backlash and subsequently, the focus shifted to targeting women mostly through tubectomies with the purpose of trying to control populations. In the 70s vasectomy was seen as the best method and then in the 6th and 7th 5 year plans the sterilization of women began to be favored. Since then, however, the focus has stayed mostly on women, with very little effort from the FP program to diversify FP options to people and to especially encourage men to pursue FP options⁸³.

The status of male sterilization is in shambles as evidenced through the extremely low number of men who undergo vasectomies. According to the NFHS-3, only 0.9 percent of the men surveyed (between the ages of 15 – 49) have undergone sterilization, as compared to the utilization of condoms who are 8.4 percent. Across different caste groups, it is the STs who have the highest current use of male sterilization (2.5 percent), with SCs following with 1.1 percent. Across religions, Buddhists/Neo-Buddhists have the highest percent of current use with 4.5 percent as compared to Hindus at 1.1 percent and Muslims at 0.6 percent. Across states, Himachal Pradesh leads the way with the highest number of male sterilizations at 6.3 percent, followed by Sikkim at 4.5 percent. The lower states are UP with 0.2 percent, Arunachal Pradesh with 0.1, and Goa with the same⁸⁴.

Demand for male sterilization is very low for various reasons. One is the consequences of the Emergency, where men were forcefully sterilized, and second are the stereotypes associated with sterilization – where men believe that they are less virile and their manhood will be taken away. Coercive policies and camps that forced men to undergo sterilization have driven men away from this family planning option. Aversion towards male sterilization also stems from the perceptions of NSV that it causes a loss of sexual activity, impotence, loss of strength, fear of failure, and lack of understanding of the technique – another reason for not getting this done was because of the amount of time it would take for recovery and having to miss days of work⁸⁵. The NSV is improved and easier procedure which is said to take less time for recovery. Aside from that they have also tried to introduce more friendly technology such as the NSV to encourage men to get sterilization⁸⁶. The new technology, which is supposed to take less time and requires a shorter recovery period is also reversible⁸⁷

The government is cognizant of these attitudes, and is making efforts to increase men's acceptance of sterilization. To help increase these numbers there have been some incentives that encourage men to undergo sterilization – from the state governments and from the national level. While some states use money as an incentive, others, like Uttar Pradesh promise gun licenses to those get sterilization. The ethics and validity of these methods need to be examined because they have back-firing consequences. One example of the landlord drugged his laborers to get them sterilization, without their consent illustrates the consequence of policies that are not well-thought through⁸⁸.

On a larger scale, the adoption of male contraception, particularly sterilization is a problem not just in India, but in many different parts of the world, where little time and research goes into finding male reproductive technology⁸⁹. Not only does there need to be shift in attitude and perspective about the responsibility of men in family planning, but there also needs to

⁸³ For *Sterilization, Target is Women*. New York Times. November 7, 2003. <<http://www.nytimes.com/2003/11/07/world/for-sterilization-target-is-women.html?pagewanted=1>> Accessed: April 14, 2010

⁸⁴ NFHS-3

⁸⁵ Robey B and Drennan M. (1998) *Male Participation in Reproductive Health - Network: Spring 1998*, Vol. 18, No. 3

⁸⁶ Khan M E, Patel B C. (1997) *Male Involvement in Family Planning: A KABP Study of Agra District Uttar Pradesh* Population Council, New Delhi June 1997

⁸⁷ Das D (2009) Vasectomy Still Troubles Men <<http://timesofindia.indiatimes.com/city/bangalore/Vasectomy-still-troubles-men-/articleshow/4637264.cms>> Accessed: April 14, 2010

⁸⁸ India Vasectomies. August 29, 2004 <<http://www.smh.com.au/articles/2004/08/28/1093518169764.html>> April 14, 2010

⁸⁹ Ibid, Robey and Brennan

be a push from the supply side where more effort goes into raising awareness about different contraceptive options by the public health system. This need has been recognized in the NPP which states that “attention on men in the information and education campaigns to promote the small family norm, and to raise awareness by emphasizing the significant benefits of fewer children, better spacing, better health and nutrition, and better education”⁹⁰.

4.2 Men’s Involvement in Family Planning

While it is important that women have autonomy over their bodies, and reproductive rights to make decisions-based on contraception, we know based on many studies that this is not always the case in reality. Women have to rely on their husband to initiate a discussion or adoption of contraception, as the power to negotiate and make these decision is not always in the hands of the woman. It is important to recognize this as a barrier to contraceptive usage and as a cause for unmet need in contraception. The gap that is caused by the lack of partnership in family planning is evidenced by NFHS figures that show the differences in level of knowledge about contraception methods across the sexes.

Table 4: Knowledge of contraceptive methods among adolescents

	Know any method	Know any modern method	Know any modern temporary method
Women	96.0	95.9	87.6
Men	97.3	97.2	94.6

Source: NFHS-3 2005-2006

Table 5: Percent of men who agree that Contraception is a woman’s business

	Hindu	Muslim	SC	ST
Contraception is a woman’s business	21.9	21.5	21.9	25.6

Women are less knowledgeable about family planning options as compared to men. Furthermore, their knowledge of modern methods is considerably lower than that of men’s. Several factors could contribute to this, including the overshadowing of sterilization over other methods, the lack of availability of other methods, and absence of a community health worker to educate and increase access to contraception⁹¹.

Additionally, the autonomy of women is challenged as they are often under pressure to reproduce according to the desires and expectations of not only their husbands, but also their in-laws and other family members. In the context of reproductive rights, this poses a big problem because a woman is placed between a rock and a hard place, where not only does she have to reproduce but is also under pressure to give birth to a male child.

The consequences of these expose women to the pressure where they opt to participate in illegal pre-natal sex selection and repeated abortion – possibly in an unsafe way. In some places where this occurs on a larger scale it has led to uneven sex ratios. This is exacerbated by policies adopted by different states that adopt 2-child norms where the pressure to have male children increases.

5. OTHER GROUPS

While Muslims, Adivasis, Tribals, and women have been the groups identified in this paper as not having their family planning needs met for a number of reasons, it does not mean to trivialize the experiences of other communities that have not been addressed in this paper. The family planning needs of people living with HIV/AIDS, people living with mental illness, individuals of different sexual orientations also warrant attention and documentation.

6. DISCUSSION

⁹⁰ NPP 2000

⁹¹ Nair P S (1999) *Factors affecting source of family planning services in India* International Institute for Population Sciences; East-West Center Population and Demographics

The purpose of this paper was to give an overview of the perspectives and experiences of the various sub-groups of the poor population, including Muslims, Adivasis, and Dalits, in regards to access and utilization of family planning services. The core component that dictates these experiences is based on population-centered ideologies, which greatly influence the availability and manner of family planning service delivery. While the space for rights and choice is still fairly new and limited in the family planning discourse, the program is still mostly dominated by population explosion sentiments. The influence of this ideology is far-reaching, especially in aspects where family planning policies, services availability, and provision are concerned.

In the discourse of family planning the case for population control was justified by the reason of development. What 'development' means is different for different people. Proponents of population control see development as being challenged or hindered if growth and fertility rate is not curbed and kept in check. They see population as a threat to food and resources, and the greater number of people there are, the less there is to go around. The population-based view of development manifests in ways that are not friendly to the individual. It looks at population from the lens of larger perspective and sees the focus as having to control the growth of communities, rather than fostering the reproductive choices of people and providing services according to needs. While there is a push from rights advocates to make development more about human development, it remains connected to larger economic definitions. Those who advocate for the rights-based movement for reproductive health services tend to view development as an improvement or focus on socio-economic indicators and education and health are given priority. It sees development as also being of individuals and families where quality of life, health, and their determinants are prioritized. This includes priority on physical well-being, educational attainment, individual autonomy and economic advancement.

The divergent views have played out in the FPP where it limboes between control and choice, with a strong lean towards control. This type of confusion has given way to a number of consequences that include targeting and marginalization of certain groups, particularly the poor sections of society, for population control. Co-incidentally this happens to affect sub-groups of the poor populations, such as Muslims, Dalits, and Adivasis even more as a consequence of their own vulnerability of society. Women within these groups are at a marginal disadvantage due to their lack of choice, autonomy and decision-making power. The factors associated with poverty, which include a lack of education and early marriage have been proven to directly affect fertility, and these are issues that are highly neglected by the Family Planning Program. It also goes against the grain of logic that knowledge about fertility and contraception in these groups is consistently higher among men, than it is against women. This clearly negates the purpose and objective of women's empowerment and ownership of their bodies and highlights a crucial gap between policy rhetoric and ground-level realities. In reference to these communities, very little has been done to understand the needs and practices of family planning, and to ensure availability of services based on this diversity. In the case of Muslims, the obsessive focus on inter-religious fertility takes attention away from urgent problems like sex-selective abortions, female infanticide, and sex ratios.

Where we stand now with the Family Planning efforts in India is at a crossroad where there is a realization that RCH has to be viewed in the framework of reproductive health and human rights. The point is to not just to deliver services for the sake of curbing population growth but to make services accessible and available for all sections of society so that they can use it when and how they choose to. Aside from basic systemic deficiencies which are visible in all public health programs of the Government of India, there is the basic problem of mismatched ideology, programmatic intention and implementation at level, which has led to poor measurements in unmet needs, lack of comprehensive services, and poor access to other methods of FP. While rights was introduced as a central element to the reinvigorated family planning program, the NPP continues to maintain and prioritize population control. There is also an ideological disparity not just at the global level but at the national and sub-national level, where at the global level population was and is aimed at eliminating poverty through limiting the reproduction potential of poor people.