UNIT 3 INDIAN LEGISLATION RELATED TO POPULATION AND DEVELOPMENT

Structure

4.0 OBJECTIVES

After reading this unit, you will be able to:

- explain the Indian legislation on population;
- analyze the impact of International debates on Indian Population Policies; and
- analyze the implications of certain acts and public policy on population growth.

3.1 INTRODUCTION

The International Conference on Population and Development (ICPD) at Cairo brought about a “paradigm shift” in the way population is conceptualized. This involved going beyond maternal health and family planning to include the broader framework of reproductive health and rights. How has India fared

with the paradigm shift? Is this about the population control by other means? Is it about social roots and its effect on population policy?

There is a need to have an informed debate on these issues of population and to bring it to the notice of policy makers at various levels viz., central and state legislatures, and local government: panchayats and municipal bodies. The changing international perspective was reflected in our national policies and programmes up to the middle of seventies, but during the Emergency the family planning received a setback in India due to the rigid implementation of target based approach. However post Cairo, it became clear that population was no longer about numbers, figures and statistics but about people and their quality of life. It was also agreed that no force, no coercion, no incentives or disincentives were required. Coercion infringes upon human rights and inhibits human development. The ICPD Programme of Action (PoA) placed individuals at the centre of development with a focus on building pillars of human rights, gender equity and equality. India's commitment to ICPD principles and recommendations of the PoA was affirmed when India – a signatory to the Cairo Declaration- released its National Population Policy (NPP) in 2000.

In this unit we will be studying about the legal framework pertaining to the issues of population and development in India.

3.2 NATIONAL POPULATION POLICY, 2000

The new National Population Policy of 2000 announced by the Govt, on 1st February, began with a statement that 'the overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society'.

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

By 2000 population of India had risen to 1 billion (100 crores). That was 16 percent of the world's population living on 2.4 percent of the globe's land area. If current trends continue, India would overtake China in 2045, to become the most populous country in the world. While global population has increased threefold during this century, from 2 billion to 6 billion, the population of India has increased nearly five times from 238 million (23 crores) to 1 billion in the same period. India's current annual increase in population of 15.5 million is large enough to neutralize efforts to conserve the resource endowment and environment.

NPP in tandem with ICPD did not stress on TFR and CPR (contraceptive prevalence rate) rather the focus became broader and holistic and different in nature. The NPP is gender sensitive and incorporates a holistic approach to health and education needs of women, adolescents and the girl child. It states that 'stabilizing population is not merely a question of making reproductive

health services accessible and affordable, but also increasing the coverage and outreach of primary and secondary education, extending basic amenities like sanitation, safe drinking water and housing, empowering women with enhanced access of education and employment'.

3.2.1 NPP 2000: The Commitments

The NPP reaffirms the commitment of government to work to:-

- Redress the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.
- Reduce infant mortality rate to below 30 per 1000 live births.
- Reduce maternal mortality ratio to below 100 per 100,000 live births.
- Achieve universal immunization of children against all vaccine preventable diseases.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 per cent institutional deliveries and 100 percent deliveries by trained persons.
- Achieve universal access to information/counselling, and services for fertility regularization and contraception with a wide basket of choices.
- Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- Contain the spread of Acquired Immuno deficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infection (RTI) and sexually transmitted infection (STI).
- Prevent and control communicable diseases.
- Integrate Indian System of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- Promote vigorously the small family norms to achieve replacement levels of TFR.
- Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred program.

The four core themes that drive the NPP are addressing unmet needs, decentralization and convergence in implementation with all other relevant social sectors, commitments from and collaboration with the NGO sector (PPP: public-private partnership) to augment the pool of diverse health care providers and mainstreaming the Indian system of medicines.

3.2.2 The Way Ahead

In spite of the ICPD agenda and the adoption of a NPP which have made radical departure from the old approach, the population debate in India remains constrained by fears of population explosion. Reproductive and Child Health (RCH) programme approach, 1997 and NPP, 2000 did open a new vista different from the 'target –free approach'. However, it failed to open up the minds of exponents and supporters of 'population control' and 'top-down targets'. This ambivalent attitude is often reflected in some state government policies. A number of state governments' population policies do not reflect the global shift in thinking regarding population. The debate is now underway in the states and also at the centre reflects these contradictions and conflicts.

3.3 NATIONAL RURAL HEALTH MISSION (NRHM)

Rural Health Care forms an integral part of the National Health Care System. Provision of Primary Health Care is the foundation of all rural health care programmes. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, primary health care is accepted as one of the main instruments of action. Thus, recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India launched the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care.

The National Rural Health Mission (NRHM), a National effort at ensuring effective healthcare, especially to the poor and vulnerable sections of the society was launched on 12th April, 2005 for a period of seven years (2005-2012) throughout the Country with special focus on 18 states viz. Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.

The NRHM covers all the villages through village-based Accredited Social Health Activists(ASHA) who would act as a link between the health centers and the villagers. One ASHA will be raised from every village or cluster of villages. The ASHA would be trained to advise villagers about sanitation, hygiene, contraception, and immunization to provide Primary Medical Care for diarrhea, minor injuries, and fevers; and to escort patients to Medical Centers. They would also deliver Directly Observed Treatment Short Course (DOTS) for tuberculosis and oral rehydration; distribute folic acid tablets and chloroquine to patients and alert authorities to unusual outbreaks. Although these ASHAs would be honorary volunteers, there is a provision to provide them with performance-based compensation for undertaking specific health or other social sector programmes with measurable outputs, thus promoting employment for these volunteers.

If rural women want counselling on important issues such as birth preparedness, importance of safe delivery, breastfeeding and complementary feeding,

immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child, they may contact the concerned ASHA who will provide them with all relevant guidance and assistance. The general norm as decided under the programme is 'One ASHA per 1000 population'. In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, depending on workload.

Janani Suraksha Yojana **(**JSY) is another important component under NRHM. JSY is a centrally sponsored scheme to benefit pregnant women & certified poor families. The Government has introduced the Janani Suraksha Yojana to provide comprehensive medical care during pregnancy, child birth and postnatal care and thereby endeavour to improve the level of institutional deliveries in low performing states to reduce maternal mortality.

The NRHM provides broad operational framework for the Health Sector. Suggestive guidelines have been issued on key interventions like institutional deliveries, immunization, preparation of District Action Plan as well as schemes including ASHA, JSY etc. The States have the flexibility to project operational modalities in their State Action Plans.

It is envisaged that National Rural Health Mission shall be able to effectively improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, especially women and children. Few other initiatives taken under NRHM are:

- Increasing public expenditure on health
- Reducing regional imbalance in health infrastructure
- Pooling resources
- Integration of organizational structures
- Optimization of health manpower
- Decentralization and district management of health programmes
- Community participation and ownership of assets
- Induction of management and financial personnel into district health system
- Operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

Under the mission, health funding had increased from 27,700 crores in 2004-05 to 39,000 crores in 2005-06 (from 0.95% of GDP to 1.05%). As of 2009, economists noted that 'the mid-term appraisal of the NRHM has found that there has been a significant improvement in health indicators even in this short period'. However, in many situations, the state level apparatus have not been able to deploy the additional funds, often owing to inadequacies in the Panchayati Raj functioning. Fund utilization in many states is around 70%.

Despite its inadequate implementation NRHM is a great step towards Primary Health Care and towards overall objective of Health for All.

Check Your Progress 1

Note: a) Use the space below for your answer.
b) Compare your answers with those given at the end of the unit.

1) Elaborate the linkages between the themes of ICPD (1994) and Indian NPP (2000)

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2) How is NRHM a major step towards comprehensive primary health care system of India?

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3.4 ALMA-ATA DECLARATION

Concepts like Primary Health Care (PHC) and Health For All (HFA) were introduced in the international population debate in the Alma-Ata Declaration. This International Conference on Primary Health Care was convened in Alma-Ata, Kazakhstan, in 1978, and was attended by virtually all the member nations of the WHO and UNICEF. The Alma-Ata Declaration emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All.

The following are excerpts from the Declaration:

- The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.
- The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.
- The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.
- Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to

maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.

- An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

In the ensuing years, several United Nations agencies and conferences have formulated strategies for human development stressing equity, the well-being of populations, and the alleviation of suffering and ill health. In 1998, an International Meeting on Primary Health Care, held in Almaty, Kazakhstan (new name for Alma-Ata) recognized the historical significance of the 1978 conference and the Declaration of Alma-Ata. It is useful to quote, here, some of the reflections of leaders in the health sector with respect to the twentieth-anniversary meeting in Almaty, on their reflections on Alma-Ata Declaration.

- *Dr. Gro Harlem Brundtland, Director General of WHO:* "Health for All" is a message to all stakeholders. Considering the forces shaping the world, with both progress in health and growing inequalities, there is a place for 'a new universalism' in health: with universal access to quality care as the bedrock principle. Commitment to primary health care, still a crucial part of the health sector twenty years after Alma-Ata. Reduce disparity between the outcomes of poor and those better off, anchored in equity and solidarity."

- *Dr. Halfdan Mahler, Director General Emeritus of WHO:* "Health is not a commodity that is given. It must be generated from within. Health action should not be imposed from the outside, foreign to the people; it must be a response of the communities to problems they perceive, supported by an adequate infrastructure. This is the essence of the filtering inwards process of primary health care."

- *Dr. Carl Taylor, Professor Emeritus, Johns Hopkins University:* "New understanding of growing social pressures and rapidly growing impatience of deprived millions around the world make this a critical time to promote community-based primary health care and social mobilisation which have recently been given special priority by UNICEF."

At the twentieth-anniversary meeting in Almaty, those present recognized that the principles and actions that characterize PHC at a global level include the strengthening of equity, health gain and quality of care, gender sensitivity, acceptability, participation, cost-effectiveness, and other HFA values.

3.5 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

Another related theme which has been under focus is the Sexual and Reproductive Health and Rights (SRHR)**.** Ms. Thoraya Ahmed Obaid, UNFPA Conference in 2004 said: "Nearly one-fifth of the worldwide burden of illness and early death among all people – men and women – is due to poor sexual and reproductive health. Worldwide, among women of reproductive age, it is one-third. That's one-third of all illness and early death, stemming largely from problems related to pregnancy and to sexually transmitted infections, including HIV/AIDS."

Ensuring universal access to sexual and reproductive health and rights (SRHR) is an important part of managing to achieve the Millennium Development Goals (MDGs). SRHR, maternal health and gender equality are core elements of human dignity and are central to human development.

Development agencies have long addressed issues of sexuality and reproduction. However, traditionally, they have dealt with them in largely negative ways. Whether through population programmes or the use of scare tactics in HIV prevention work, sex and sexuality have been regarded as a problem that needs to be controlled - rather than a positive force that can be part of the solution. The realisation of sexual rights is crucial for achieving equity and social justice.

Now, as a result of international agreements and activism from non-governmental organisations over the past two decades, new approaches are emerging which recognise sexual and reproductive health and rights as human rights - an end in themselves - as well as being central to health and well-being.

These positive approaches recognise that good reproductive health, and the realisation of sexual rights, including rights to pleasure and fulfilment, are crucial for achieving equity and social justice. Indeed, sexual well-being is integral to human development, underpinning all the major health and development goals. As rates of HIV infection continue to rise, and women's and men's sexual and reproductive ill-health threatens international development targets, there has never been a more pressing need to make positive connections between sexuality, health and human rights.

Holistic Framework

Overall Socio-Economic Development

(Health, education, nutrition/food security, employment, poverty alleviation)

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Comprehensive Primary Health Care

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Broader Context of Reproductive Health and Rights

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Positioning Family Planning

Check Your Progress 2

Note: a) Use the space below for your answer.
b) Compare your answers with those given at the end of the unit.

1) Explain the importance of the Alma-Ata Declaration.

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2) Explain how Sexual and Reproductive Health and Rights (SRHR) is imperative for overall socio economic development of any country.

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3.6 STATE POPULATION POLICIES AND THE TWO CHILD NORM

Several State Governments have already formulated their state specific population policies. It is a distinct difference in tone and attitude between the NPP and some of the state population policies. Some of the state policies reflect the neo–Malthusian "population control" mindset viewing population growth as a human crisis and are more upfront in methods in achieving demographic goals through a series of incentives and disincentives and short cut vertical programmes and strategies.

One such policy is the Two Child Norm. While the NPP advocates a small family norm based on the idea of informed choices, individual decision making, human dignity especially of women, nowhere does it mentions two child norm. Some state governments however have misinterpreted this as two child norm implying two children per family and have system of incentives and disincentive/ punishments for achieving it. Several state governments had enacted legislation to enforce two child norm as a general disqualification clause in election to Panchayati Raj Institutions and urban local bodies. This was done with the avowed intention of controlling family size and stabilizing population growth. This norm has become a cause of anxiety for human rights activists and women's organizations. It has potential to cause immense harm to women's health in the existing social situation where son preference is high and women's status is low. It tends to penalize women, who anyway have little control over reproductive decision making.

In the states where these laws have been imposed scores of cases have been documented, where women have been deserted or forced to undergo sex selective abortions. Children have also been abandoned or given up for adoption. In general, such a two child norm provides an impetus for an increase in sex-selective abortions worsening the already existing dismal child sex ratio in the country.

However due to very intensive advocacy efforts from the civil society organizations* and activists, the two child norm in the sates of Himachal Pradesh, Haryana and Madhya Pradesh has been withdrawn.

*An exploratory study on "Panchayati Raj and Two Child Norm : Implications and Consequences" was taken up by Mahila Chetna Manch, a Bhopal-based NGO, in the states of Andhra Pradesh, Haryana, Madhya Pradesh, Odisha and Rajasthan.(2003)

3.7 PNDT ACT

Prenatal child sex determination and female child infanticide has plagued India for long. According to the 2011 census figures, female infanticide, foeticide and every other form of female infant genocide seems to be alive and kicking. The national female-male sex ratio has dipped to an all-time low of 940/1000. In some states, the situation is dire. Haryana, for example, has 877 females to 1,000 males. Chandigarh has 818 and Daman and Diu 618, Punjab, 893. The sex ratio of children in the 0-6 age group is no better. While the all-India figure is 914/1000, Haryana has 830 female children and Punjab 846 against per 1000 male child.

The Pre-natal Diagnostic Techniques (PNDT) (Regulation and Prevention of Misuse) Act, 1994, was enacted and brought into operation from 1st January, 1996, in order to check female foeticide. Rules have also been framed under the Act. The Act prohibits determination and disclosure of the sex of foetus. It also prohibits any advertisements relating to pre-natal determination of sex and prescribes punishment for its contravention. The person who contravenes the provisions of this Act is punishable with imprisonment and fine.

Recently, PNDT Act and Rules have been amended keeping in view the emerging technologies for selection of sex before and after conception and problems faced in the working of implementation of the ACT and certain direction of Hon'ble Supreme Court after a PIL was filed in May, 2000 by CEHAT and Ors, an NGO, on slow implementation of the Act. These amendments have come into operation with effect from 14th February, 2003

- The PNDT (PRINCIPAL) ACT 1994
- The PNDT (PRINCIPAL) RULES 1996
- The PNDT Advisory Committee Rules, 1996
- The PNDT Amendment Act, 2002
- The PNDT Amendment Rule, 2003

As per this act

1) No Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic unless registered under this Act, shall conduct or associate with, or help in, conducting activities relating to pre-natal diagnostic techniques;

2) No Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic shall employ or cause to be employed any person who does not possess the prescribed qualifications;

3) No medical geneticist, gynaecologist, paediatrician, registered medical practitioner or any other person shall conduct or cause to be conducted or aid in conducting by himself or through any other person, any pre-natal diagnostic techniques at a place other than a place registered under this Act.

To ensure that registered clinics/labs follow this act, the act further requires every Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic to maintain a register showing, in serial order, the names and addresses of the women given genetic counselling, subjected to pre-natal diagnostic procedures or pre-natal diagnostic tests, the names of their husbands or fathers and the date on which they first reported for such counselling, procedure or test. Further every Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic is also required to prominently display on its premises a notice in English and in the local language or languages for the information of the public, to effect that disclosure of the sex of the foetus is prohibited under law. Further the act requires every ultrasound centre to submit a monthly report to the local municipal corporation. The person who contravenes the provisions of this Act is punishable with imprisonment and fine**.**

3.8 CHILD MARRIAGE RESTRAINT ACT

Child marriage is a gross violation of human rights that puts young girls at risk. A marriage where either of the contracting party is a child is considered as child marriage. Child or minor under this law is defined as 18 years in case of girls and 21 years in case of boys. All children have right to care and protection; to develop and grow to become a complete and full individual, regardless of their social and economic situation. Child marriage is a blatant violation of all these rights. Child marriages deny children their basic rights to good health, nutrition, education and freedom from violence, abuse and exploitation.

When the people in the marriage are children their body and mind are put to grave and heinous danger. Most often the child is not even aware of what really awaits her/him as a consequence. Marriage by its very institution imposes certain social responsibilities on the persons involved in it. It also provides the legal sanction for engaging in sexual activity and procreation. This amounts to sanction for child sexual abuse and rape. Child Marriage resulting in early motherhood means, placing both the young mother and her baby at risk. This leads to increase in infant mortality and maternal mortality.

It is submitted that, there is no doubt that the Child Marriage Restraint Act 1929, also called the Sharda Act, was a law to restrict the practice of child marriage was in existence even before and after Independence. This act stands repealed after the New Act called the Prohibition of Child Marriage Act 2006 was enacted by the Union of India.

3.8.1 The Prohibition of Child Marriage Act, 2006

Coming into effect on 1 November 2007, the Prohibition of Child Marriage Act (PCMA) was put into place to address and fix the shortcomings of the Child Marriage Restraint Act. The New Act is significant as it indicates Zero tolerance of the Government towards any incidence of Child Marriage and shows the total commitment of the Government to prohibit and prevent this rampant social evil.

The change in name was meant to reflect the prevention and prohibition of child marriage, rather than restraining it. This Act kept the ages of adult males and females the same but made some significant changes to further protect the

children. Boys and girls forced into child marriages as minors have the option of nullifying their marriage up to two years after reaching adulthood. In certain circumstances, marriages of minors can be rendered null and void before they reach adulthood. All valuables, money, and gifts must be returned if the marriage is nullified, and the girl must be provided with a place of residency until she marries after attaining adulthood or when she becomes an adult. Children born from child marriages are considered legitimate, and the courts are expected to give parental custody with the children's best interests in mind. Any male over 18 years of age who enters into a marriage with a minor or anyone who directs or conducts a child marriage ceremony can be punished with up to two years of imprisonment or a fine. Latest Judgment under Prohibition of Child Marriage Act, 2006, has been held by the Delhi High Court that Prohibition of Child Marriage Act, 2006, overrides all personal laws and governs each and every citizen of India. The object behind enacting the Prohibition of Child Marriage Act, 2006 was to curb the menace of Child Marriage, which is still prevalent in this country and is most common in rural areas. Child Marriage is a social evil which has the potentialities of being dangerous for the life and health of a female child, who cannot withstand the stress and strains of married life. It often leads to early deaths of such minor mothers. Even after the passing of the new Act, i.e., Prohibition of Child Marriage Act, 2006, certain loopholes still remain, the legislations are weak as they do not actually prohibit child marriage. It can be said that though the practice of child marriage has been discouraged by the legislations but it has not been completely banned.

Check Your Progress 3

Note: a) Use the space below for your answer.
b) Compare your answers with those given at the end of the unit.

1) What is Child sex ratio? How does two child norm add to a negative trend of this ratio?

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2) What are the factors responsible for female foeticide and what are its implications on population?

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3) What are various provisions of Prohibition of Child Marriage Act, 2006 and how it is improvement from Sharda Act of 1929?

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3.9 LET US SUM UP

ICPD 1994 was a milestone in the history of population and development as well as history of women's rights. It heralded a paradigm shift in approach to population and development, placed women's equity and equality centre stage and introduced importance of rights based programming. NPP is an affirmation and articulation of India's commitment to ICPD agenda. It forms the blue–print for Population and Developments Programmes in the country. It, in fact, sums up "Population Stabilisation" as a "Multi Sectoral" endeavour. In principle it is against incentive /disincentives. The issue of population stabilisation is not a technical issue. The need is to provide a linkage between social development and health status, especially through women's empowerment through greater gender equality.

3.10 KEY WORDS

Total Fertility Rate (TFR) : It is also known as the fertility rate, of a population is the average number of children that would be born to a woman over her lifetime.

Contraceptive Prevalence Rate (CPR) : It is the percentage of women who are practicing, or whose sexual partners are practicing, any form of contraception. It is usually measured for married women ages 15-49 only.

UN Millennium Development Goals(MDGs) : MDGs are eight international development goals viz., eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality rates, improving maternal health - were officially established following the Millennium Summit of the United Nations in 2000.

3.11 REFERENCES AND SUGGESTED READINGS

1) National Population Policy (2000) – Ministry of Health and Family Welfare (MoHFW), Government of India.

2) Nanda, A. R. & Ali A. (2006) - Health Sector: Issues and Challenges, Indian Social Development Report, Council for Social Development.

3) "United Nations Millennium Development Goals" Un.org. 2008-05-20

4) Government of India: Ministry of Women and Child Development, "The Child Marriage Restraint Act" http://wcd.nic.in/cmr1929.htm

5) Government of India: Ministry of Women and Child Development, "The Prohibition of Child Marriage Act, 2006," UNICEF http://www.unicef.org/india/Child_Marriage_handbook.pdf

6) International Center for Research on Women, "Child Marriage Facts and Figures" http://www.icrw.org/child-marriage-facts-and-figures

7) *india.unfpa.org/drive/NationalPopulation-Policy2000.*

3.12 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Your answer must include the following points:

- NPP in tandem with ICPD did not stressed on TFR and CPR(contraceptive prevalence rate)
- The NPP is gender sensitive and incorporates a holistic approach to health and education needs of women, adolescents and the girl child.

2) Your answers must include the following points:

NRHM provides platform for:

- Fostering inter-sectoral coordination
- Decentralized planning and implementation
- Strengthening of Primary Health Care
- Involves communities in monitoring services and convergence at the village level

Check Your Progress 2

1) Your answer must include the following points:

- Primary health care as the key to the attainment of the goal of Health for All(HFA)

2) Your answer must include the following points:

- Recognises sexual and reproductive health and rights as human rights - an end in themselves - as well as being central to health and well-being.
- Crucial for achieving equity and social justice.
- Sexual well-being is integral to human development, underpinning all the major health and development goals.

Check Your Progress 3

1) Your answer must include the following points:

- In India, the Child Sex Ratio is defined as the number of females per thousand males in the age group 0–6 years in a human population
- Existing social situation and cultural settings in India has a preference for son and women's status is low.
- It tends to penalize women, who anyway have little control over reproductive decision making.

2) Your answer must include the following points:

- Gender disparity is the phenomenon of sex selection and pre birth elimination of females.
- Concept of ‘Missing Girl’.
- Declining child sex ratio
- Gender and equity concern

3) Your answer must include the following points:

- 2006 act reflects the prevention and prohibition of child marriage, rather than restraining it.
- Boys and girls forced into child marriages as minors have the option of voiding their marriage up to two years after reaching adulthood.