Honorable Prime Minister of Senegal, Honorable Ministers, Distinguished Panelists and Delegates:

It is indeed a privilege for me to share my reflections on India’s experience with family planning at this Conference on this distinguished panel.

Before I draw on India’s experience, I would like to underscore the importance of repositioning family planning in India – a country of 1.2 billion people – where a quarter of the population are adolescents and close to half the women are in the reproductive age group.

JRD Tata, the famous industrialist and visionary, who founded Population Foundation of India 4 decades ago, said I quote “achievement of demographic objectives is entirely dependent on a whole set of societal responses and policy initiatives which go well beyond contraception.”

I would like to illustrate this key value through my talk

For many of us working in the field of family planning

- is a matter of women’s rights and gender justice – of treating women with dignity
- It is a major contributor to 7 of the 8 Millennium Development Goals (MDGs)
- It advances sexual and reproductive health, saves lives, and empowers communities, especially women

We all know that effective family planning can prevent about a quarter to one-third of all maternal deaths - saving close to 150,000 lives a year

Moving on, allow me to make three sets of brief comments – reflecting on the Indian experience.

My first set of comments relate to India’s population story.

On the whole, there is good news as far as numbers are concerned. There is really no need to panic and worry about a population explosion or the ticking away of the population bomb though many people in India continue to believe in this misconception.
• The annual rate of population growth has slowed down by 1.9% over the decade 2001-2011
• TFR has been steadily falling across the country – from around 6 in the 1950s to 2.3 today
• Urban TFR has reached replacement level – and close to 30% of India’s population resides in urban areas

Much of the decline in fertility rates and birth rates has been partly the outcome of population policies that India has adopted and most importantly due to the decrease in wanted fertility (against the TFR of 2.7, the total wanted fertility rate was 1.9 for India in 2005-06) policies that have not remained static but have changed to incorporate new knowledge and new conditions though not enough and much more is needed.

• India is credited with establishing one of the world’s earliest national family planning programs in 1952.
• At that time, fertility control was seen as the sole aim of population programs
• And gradually, the entire program got reduced to an incentive based, target oriented sterilization campaign.
• The use of coercion to sterilize women in particular brought about huge protests from people and activists. This had a serious backlash – on both the political leadership as well as the family planning program itself during the 1970s – which lasted well into the 1980s
• The 1990s saw a marked shift thanks to both the ICPD Declaration towards a reproductive and sexual rights and human rights framework as well as growing evidence which called for change in India and across the world.
• In 1996 India adopted a target free approach to family planning based on a Community Needs Assessment.
• In 2000, Government of India announced a new National Population Policy which reflects changing perspectives on population, reproductive health, equity and rights.
• The Policy of 2000 is based on a framework on women’s empowerment, improving access to reproductive health services and involving communities.

However, there are also some shortcomings in India’s family planning program. Policies in India don’t always get translated into practice at the states and districts. And I want to point to some of them.
1. One, the contraception prevalence rate remains low. Though it has gone up from 37% in 1992-93 to 49% in 2005-06, less than half the women use any modern method of contraception which are as low as 18%.

2. Two, the choices available to families are limited. Female sterilization dominates as a method of contraception – accounting for almost 44% of all methods used. Injectables are not part of the public health program.

3. Three, women have limited access to reproductive health care. Even today, only 47% of women have access to a trained attendant at the time of giving birth to a child. The quality of services is a huge concern.

4. Four, women enjoy very limited freedoms. This is reflected in
   - Limited female agency and wide gender power imbalances- Almost 40% of women interviewed in NFHS -3 did not participate in decisions relating to their own health care and more than half (52%) were not permitted to attend a health facility unescorted (IIPS and Macro international, 2007). In fact, 62% of women who participated in most decisions, compared to 44% of those who did not participate in any, had practiced contraception. Almost half of all women aged 20-24 are married by the age of 18 years.
   - Child Bearing is initiated early and multiple pregnancies characterize the life of many young women. One in five young women aged 20-24 had their first baby before they were 18 years of age and one in eight young women had three children. As a result, both maternal and neonatal mortality are higher among the young compared to older women.
   - Son preference has led to alarming adverse sex ratios. 940 women for 1000 men. We have begun to learn the consequences of declining sex ratio. We need to pay attention to this in other parts of the world and not just Asia.

5. The poor quality of sexual and reproductive health services in the public sector is another area India needs to work on.

These shortcomings have serious implications for the drivers of population growth.

While High Wanted Fertility is estimated to contribute to only 10% of the population growth over the next two decades, Population Momentum is estimated to contribute to 70% of the population growth and High Unmet Need to 20% of population growth over the next two decades.
Let me move to my second set of comments on the lessons that we can learn from the Indian experience.

I have the privilege of working for Population Foundation of India, one of India’s oldest NGOs, which promotes planning of families. For we see that families that are planned are healthier and happier. We have found that it is very necessary to work on women’s rights and empowerment in our quest for a healthier India.

There are 5 lessons that I would like to highlight from the Indian experience.

1. One - It is obvious that economic growth alone is not sufficient to lower fertility rates. India has been experiencing close to 8% GDP growth rate over the past 15 years – and yet we find that women’s access to reproductive health is limited.

2. Two - For a population policy to succeed, it is important to count on people, and not simply count people. In other words, fertility reduction is not about numbers and CPR (Couple Protection Rate). It is about investing in people and women in particular in their education, in their empowerment, in their access to reproductive health, in their nutrition (take care of people, and population will take care of itself). Particular in their education, in their empowerment, in their access to reproductive health, in their nutrition. It is for this reason that some of us often say in India take care of people, and population will take care of itself.

3. Three - India’s nasty experience with forced sterilization and the success without use of coercion clearly points out that use of force, use of penalties, etc. in family planning programs is unwarranted. The proven path to reducing fertility is to improve child survival, improve women’s access to education, family planning methods, reduce poverty and so on.

4. Four - Fundamental to the success of any family planning program has to be the enhancement of women’s freedoms. I refer to the freedoms that young women need to exercise when it comes to deciding when to get married (age at marriage), when to have children, how many children to have, and so on. This requires society to address the distortions of patriarchal societies where the voices and rights of women are often suppressed.
5. Five – Repositioning family planning requires strong service delivery and technical support. Family Planning should not be implemented as a vertical program; there is need to prevent infections (STIs, RTIs, HIV/AIDS); there is need to improve women’s health and nutritional status; there is need to fill quality deficits in supply; and there is need to educate and empower women to make informed choice; fulfilling the huge unmet need for sexuality education for the young people. These are the concerns and discussions here in Dakar too.

This brings me to the last set of comments I want to make on moving on and looking ahead.

There is one trend that we need to take note of as we look ahead.

- Aid for Family Planning is Falling in All Recipient Countries.
  - The total aid to health globally has increased from 6557 million USD in 2000 to 19790 million USD in 2009
  - However, the aid to reproductive health care has been fluctuating between 6 % and 11% and has reduced substantially between, 2000 and 2009. What is really shocking is the stark reduction in aid to family planning, which was low to begin with and has come down from 8% in 2000 to 2.5% of the total aid to health in 2009.

And given the global economic recession, it is unlikely that we can expect large jumps in the quantum of assistance coming from the developed countries. Not to forget indeed the Gates Foundation and few other exceptions.

This makes it imperative for developing countries to marshall national resources and national capacities to advance the family planning agenda as China ---- much acknowledge has done.

Recognizing its importance, PFI has identified key areas of focus in the coming years to reposition family planning which sadly I will not have the time to share here. Though may I invite you to visit our website. We are fortunate in that India’s Health Minister has called for repositioning family planning. What does this mean?

The next 5 year plan in India has some of these key points -.

- It calls for delaying the age at marriage
- It calls for delaying the birth of the first child
• It calls for increasing the spacing between children
• It calls for improving the availability of contraceptive choices – a shift from primarily sterilization methods to a variety of other methods
  • It also requires the promotion of male sterilization
  • It requires recruitment of private providers to supplement public health systems and intensive training programs
  • Social marketing through frontline health workers

And it calls for making health care accessible to women.

It requires convergence of family planning with other departments and programs, like education, social justice, rural development, poverty alleviation, labour, employment and human resources and not only health.

It needs a commitment to ensure equity and social inclusion by focusing investments on poorest and the most vulnerable and marginalized – 233 districts with the worst indicators have been identified by the GOI for some and many of these investments.

It requires managing supply and access to services efficiently to meet huge the demand for family planning services.

The emphasis of repositioning family planning should be on planned families - Every woman a healthy woman, every child a wanted child.

This conference has given us enormous evidence and ideas for us to go back to our countries to use a systematic approach to develop and scale up proven solutions. I have learnt much here and thank all of you here for the motivation and education.