

# National Coalition Against Two-Child Norm and Coercive Population Policies

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www.2cnpop.net

## Reflections

The National Coalition Against Two-Child Norm and Coercive Population Policies was established in December, 2011 to tackle the growing fears, myths and misconceptions around population growth. The media reporting around the seven billionth baby in India had revived the fear that 'population is a problem', which set into action some of the organisations in Delhi and other states to regroup in order to revisit and review the implications of population control policies like the two-child norm. Given the sheer scale of political and civil rights violations due to the two-child norm clause in some state panchayat acts/ development schemes or the deaths and failures due to poor quality sterilisations, the need for a coalition with the aim to monitor and respond to the policy environment, was realised.

### Goal of the coalition:

To raise awareness among different stakeholders about coercive nature of different population control policies and to advocate for their removal from policies and programmes at the state and central levels.

In the last ten months, the coalition has been responding to the queries and generating public concern on the issues of coercive sterilisation and two-child norm in India by promoting media coverage and by publishing articles and opinion pieces. The coalition has been advocating at the national and international forums about the negative implications of two-child norm as well as the need to adopt quality of care in contraceptive sterilisation services.

The coalition has been partnering with state level organisations in Bihar, Rajasthan, Odisha, Madhya Pradesh and Uttar Pradesh to address some of the practices that have contributed to creating a coercive environment, violations of basic human rights such as informed consent and wide flouting of minimum standards of health care. The coalition and its members believe that it is the need of the hour to provide reproductive and sexual health and life-skills education to the young and make arrangements for fulfilling the need for information on the basket of contraceptives and quality services for all those who need them. It is also necessary to change all policy provisions and entitlements that are linked with population or family size.

### Working Group Members

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**Mr. AR Nanda**, Former Executive Director, Population Foundation of India, former Secretary, Family Welfare, Government of India, New Delhi  
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**Mr. Swarup Pal**, Secretary, Manjari, Rajasthan  
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## In conversation with Mr. A. R. Nanda

The key critiques of the current India Family Planning Programme are:

Firstly, the over reliance of the leading policy and programme planners of centre and state governments on contraceptive-method specific targets from above that are cloaked as Expected Level of Achievement (ELA), instead of realistic local area plans based on community needs assessment; second, by and large there is an overemphasis on female sterilisation without providing 'informed choice' and utter indifference to 'Quality of Care' leading to adverse health outcomes for women from poor families; third, incentives and disincentives offered by government to clients and service providers, lastly, conditionalities like the 'two-child norm' complicate the programme further. Due to these factors, the family planning programme in India essentially turns into a coercive population control programme, which is disempowering to the marginalised women in society and risks their lives. Incentives (monetary or otherwise) to individuals to curb population have been counterproductive and ineffective all over the world. Apart from corruption inherent in administration of such incentive schemes, these tend to be unethical and potentially coercive. There are many factors which contribute to lowering the fertility rate or birth rate until the zero growth rates is reached, population stabilizes, and negative growth leads to population decline, as is now occurring in some countries in Europe and Japan.

Justifying a coercive one or two-child norm policy on a perceived benefit of a better quality of life or greater share of resources in a smaller family is too naive, simplistic, mechanistic and smacks of an authoritarian, elitist and neo-malthusian mind set. An informed and voluntary choice for a one or a two-child family is a reproductive choice and a right. Such a decision is right-based. Choice of a family size is dependent on many factors like infant and child mortality, son preference, income opportunities, educational level, access to health care, family planning products and services, etc. Better quality of life and sharing of resources intra or inter family is dependent more on the structure and pattern of consumption, income, ownership and access, as well as equity.

India's National Population Policy, 2000 advocates 'small family norm' without prescribing any number. The ideal 'small family norm' is supposed to be set voluntarily by each couple, considering all pros and cons in the context of the circumstances facing them. The State is responsible for creating favourable conditions towards such a choice, and not to prescribe or impose a norm of one, two or three. There is, of course, some apparent inconsistency or ambivalence in government policy referring to some promotional measures which prescribe two-child conditionality. Such distortions in laws and policies or programmes need to be set right.

Privatisation of health care at the primary and secondary health care levels is likely to compromise equity in access and affordability for basic health and family planning products and services. The poor are bound to be affected adversely.

The ideal family size or a voluntary small family norm is linked with circumstances and factors particular to each case, to be exercised as a voluntary and informed reproductive right and choice.

## Key messages shared by

Mr. A. R. Nanda during his conversation with Leena Uppal.....

'Reproductive rights' are inalienable human rights to be respected by all, including the Government.

There is a need to understand the population issue in proper perspective of 'rights' and 'gender-sensitivity'.

Family planning has to be empowering, co-operative and not 'authoritarian' and should be implemented with a rights-based, gender-sensitive and holistic manner, integrated within 'reproductive health' and comprehensive primary health care.

Say 'No' to family planning targets from above and 'Yes' to decentralised local area community-based plans from each village/urban ward.

Advocate for informed choice with wider basket of contraceptives, and in case of female sterilisation (as the last resort) insist on 'Quality of Care' and close monitoring by community.

One or two-child norm as a policy prescription by government is not at all in the national interest. It distorts and subverts democracy, fundamental rights and is disempowering, particularly of women, the poor and the marginalised. It exasperates and accentuates skewed sex-ratio at birth, as China's one-child policy has shown during the last 30 years.

**A**. R. Nanda, Former Executive Director, Population Foundation of India, Former Secretary, Ministry of Health and Family Welfare, Government of India in conversation with Leena Uppal, Advocacy Officer, National Coalition Against Two-Child Norm and Coercive Population Policies.

## Case Study: My experience with sterilisation

I have four daughters; my husband and I decided that I should go for sterilisation. We contacted the General Nurse Midwife (GNM) of Ganeshpura sub-center; she connected me with a family planning camp organised in the nearby Dabi Public Health Centre (PHC). I sat for an hour and subsequently after my urine and blood was examined, I was asked to give my thumb impression on a piece of paper. Then, after half an hour I was given anaesthesia. I remained unconscious during sterilisation. I was discharged after half an hour after the operation from the hospital. I returned back home in an auto. They gave me two tablets. The fare was paid by the GNM. I was given Rs. 600/- after the operation. The GNM advised me to take rest and not to do heavy work till one month. The village ASHA or AWW did not come to see me after the operation. On the 2<sup>nd</sup>, 8<sup>th</sup> and 12<sup>th</sup> day GNM came for follow up. She gave me medicines for seven days and on the eight day she removed my stitches. After one year and two months I was told by the doctor at Dabi that I was three months pregnant. When I contacted the GNM, she was angry that I had not reported it to her and she refused to help me. My husband brought two tablets from Dabi, and after four days I got my period, the bleeding was heavy and continued for 10 days. I do not know that compensation is paid for sterilisation failure.

I do know that I should receive a certificate about my sterilisation status, but I haven't received any. I am also scared that I might get pregnant again as nobody in our village knows about temporary methods and these are also not available in my village.

Santosh Bhil, Age: 35  
Caste: Scheduled Tribe  
Village: Ganeshpura  
District: Bundi

## Sexual Reproductive Health and Rights include

- The right to information;
- The right to sexual pleasure without fear of infection, disease, unwanted pregnancy or harm;
- The right to sexual expression and to make sexual decisions that is consistent with one's personal, ethical and social values;
- The right to sexual and reproductive health care, information, education and services;
- The right to bodily integrity and the right to choose, if, when, how and with whom to be sexually active and engage in sexual relations with full consent;
- The right to enter relationships, including marriage, with full and free consent and without coercion;
- The right to privacy and confidentiality in seeking sexual and reproductive health care services;
- The right to express ones sexuality without discrimination and independent of reproduction;
- The right to freely decide the number and spacing of children, and to have the information and means to do so;
- The right to attain the highest standard of sexual and reproductive health;
- The right to make decisions concerning reproduction free of coercion, discrimination or violence.



**M**anjari is working in Nainwa and Talera blocks of Bundi district of Rajasthan on health and child rights issues. Manjari collaborates with ASHA (Accredited Social Health Activist), AWW (Anganwadi Worker) and ANM (Auxiliary Nurse Midwife) in 10-12 villages of Nainwa block to improve the quality of health services. In 2009 a study was conducted in collaboration with CHSJ, New Delhi and SRM University, Chennai on 'Assessment of Quality of Care and Consequences of Female Sterilisation in Bundi District' published by UNFPA, India. Manjari is a member of the Coalition Against Two-Child Norm and Coercive Population Policies and Rajasthan Rajya Bal Adhikaar Samrakshan Sanjha Abhiyaan.

## FIGO's New Ethics Guidelines on Female Contraceptive Sterilisation

In March 2011, the Committee on the Ethical Aspects of Human Reproduction and Women's Health of the International Federation of Gynecology and Obstetrics (FIGO) updated its ethics guidelines on female contraceptive sterilisation. Currently chaired by Dr. Bernard Dickens, the committee studies contemporary ethical issues in obstetrics and gynecology, with a particular focus on international issues. The committee members for 2009-2012 include Dr. Duru Shah from India.

The updated guidelines emphasise the recent history of forced or coerced sterilisations of women by tubal ligation around the world. Information on the global extent of this phenomenon is available on the website of the Campaign to Stop Torture in Health Care (<http://stoptortureinhealthcare.org/>). The guidelines emphasise that it is a violation of human rights to perform procedures for the prevention of future pregnancy on women who have not freely requested the practitioners or given their free and informed consent to them. As the guidelines make clear, *"This is so even if such procedures are recommended as being in the women's own health interests."*

The ethical issue of what constitutes coercion is crucial with respect to countries that run large-scale programmes to incentivise female sterilisation as a birth control option. For sterilisation to be freely chosen by an informed person as her preferred method, she must have a meaningful opportunity to consider the range of birth control technologies available and to weigh her options. Programmes that incentivise the selection of any particular birth control method are inherently coercive. As the guidelines also state, it is unethical to perform sterilisation procedures *"within a government programme or strategy that does not include voluntary consent to sterilisation"*. The same obviously

applies to unsafe programmes that inherently endanger the lives of the women being sterilised.

Responding to recent cases from Europe, the updated guidelines also emphasise that 'medical emergency' is not an ethical justification for the performance of contraceptive sterilisation in absence of informed choice and consent, even if a future pregnancy might endanger a woman's life or health. Such sterilisations have been performed during the course of caesarian-section deliveries and violate human rights, as recognised by the European Court of Human Rights in recent judgments.

The guidelines affirm that sterilisations performed as a result of "coercion, pressure or undue inducement" by healthcare providers or institutions is unethical. Women should be provided with information about non-permanent contraceptive options as well as sterilisation. Consent to sterilisation should never be made a condition of the receipt of other medical care, assistance in any kind of delivery, medical termination of pregnancy, or any other benefit such as employment, release from an institution, public or private medical insurance or social assistance. Lastly, members of the medical profession have the duty to be 'a voice of reason and compassion, pointing out when legislative, regulatory or legal measures interfere with personal choice and appropriate medical care.'

A discussion of how these guidelines can be implemented in practice took place on 8<sup>th</sup> October, 2012, as part of FIGO's XX World Congress in Rome (see <http://www.figo2012.org/home/>). Dr Abhijit Das, Director CHSJ and convenor of the coalition discussed incentive systems in particular at that session. Other speakers addressed how practitioners can comply with the guidelines in the context of serving women living with disabilities and women living with HIV.

Link to new FIGO Guidelines: [www.figo.org](http://www.figo.org)

**G**wendolyn Albert is a human rights activist and ally of Romani survivors of forced sterilisation in the Czech Republic in their struggle for redress of these human rights violations. Gwendolyn is a consultant to the Council of Europe Commissioner for Human Rights, the European Roma Rights Centre, and the Open Society Institute as part of its Campaign to Stop Torture in Health Care. Her work includes direct outreach to the medical profession through the International Federation of Gynecology and Obstetrics (FIGO).

## Peek into the History: Five-Year Plans and Emergence of Sterilisation in Family Planning Programme

India, has a much-publicised distinction of being the first developing country to have adopted a national family planning programme (as early as 1952). During the 1<sup>st</sup> Five-Year Plan period 1951-56, the family planning programme in India was focused on setting up of clinics for those who needed such services which was modeled on Planned Parenthood Organisation in the west. The rhythm method was the chief focus in this period.

In the 2<sup>nd</sup> Five-Year Plan period (1956-61), the distribution of contraceptives was extended through PHCs, government hospitals and dispensaries, and maternity homes run by the state governments. In both the rural and urban areas, contraceptives were issued free to those with a monthly income below Rs. 100/- and at half price to those whose monthly income fell within the bracket of Rs. 100-200/-. The Central Family Planning Board recommended the inclusion of sterilisation operations in the family planning programme in hospitals and institutions where facilities existed. An incentive scheme paying Rs.101/- to a sterilisation acceptor as compensation for the loss of wages was first introduced in Tamil Nadu followed by other states.

From 1966-69, the earlier programmes were continued with annual budgeting and target setting. The family planning programme was integrated with the maternal and child health services operated through the PHCs in rural areas and urban family welfare planning centers (UFWPCs) in town and cities. The camp approach was not introduced until the Fourth Five-Year Plan (1969-74). Kerala was the first Indian state to introduce a family planning programme and has been well known for its lowest birth rate in India. However, before it became the model for family planning, it witnessed mass sterilisation camps and these were known as S. Krishna Kumar camps in the 1970's. The camps spread far beyond the state of Kerala to some of India's poorest regions and other state governments aimed to undertake 'family planning festivals' through camps. During this time, another popular trend was that any person (not necessarily

working in the government) who needed government services (wherever government permission was required) was treated as a motivator to bring cases for sterilisation. Eventually, now it is one of the 'roles' of the health service providers as motivators to meet state announced targets of sterilisations. Education regarding temporary methods of contraception was neglected in favour of encouraging sterilisation. At its worst, India's policy included declaring a state of emergency in 1976 and implementing forced sterilisations in poor areas with a total of 8.26 million sterilisations, which was an all-time record.

By the 7<sup>th</sup> Five-Year Plan (1985-90), clear long term demographic goals were set up and in order to achieve the targets the government stipulated 31 million sterilisations. By the 9<sup>th</sup> (1997-2002) and 10<sup>th</sup> (2002-2007) Five-Year Plans, reduction in the population growth rate was recognised as one of the priority objectives. Though inter-sectoral co-ordination, community participation, special schemes for reduction of disease among children and oral contraceptive pills, the distribution was intensified, female sterilisation alone continued to account for more than 65% of all contraceptive methods used in India.

The government of India recognises that the Family Welfare programme has placed heavy emphasis on sterilisation as the major method of family planning. Many other Asian countries started their family planning programmes with spacing methods and then gradually introduced sterilisation. The 11<sup>th</sup> (2007-2012) and the 12<sup>th</sup> (2012-2017) Five Year Plans emphasise the importance of providing sterilisation services through well-trained medical personnel and well-equipped facilities. A permanent method may not be preferred when levels of infant and child mortality are high, or because of religious beliefs. Therefore, sterilisation should be the last resort than the first one in the contraceptive choices given to the public. There is a need to expand the range of choices of contraceptives as well as to improve the quality of services provided to couples, both in rural and urban areas.

[www.egyankosh.ac.in/bitstream/123456789/36907/1/unit-2-pdf](http://www.egyankosh.ac.in/bitstream/123456789/36907/1/unit-2-pdf)

How the Two-Child Norm in Himanchal was Withdrawn, Subhash Mendhapurkar, medico friend circle bulletin, June-July 2005

**L**eena Uppal (Advocacy Officer) in Centre for Health and Social Justice has been working in the field of health since the past 7 years and is currently advocating against the two-child norm through the National Coalition Against Two-Child Norm and Coercive Population Policies.

## Study Review: Increasing Post-Partum Contraception in Rural India: Evaluation of a Community-Based Behaviour Change Communication Intervention, 2012; Published in International Perspectives on Sexual and Reproductive Health

Review undertaken by Sophia Manuel, volunteer with Centre for Health and Social Justice

*International Perspectives on Sexual and Reproductive Health* is a peer-reviewed research journal serving researchers, policymakers, programme administrators and service providers in developing countries. The journal invites submissions based on qualitative or quantitative research on such topics as contraceptive practice and research; fertility levels, trends and determinants; adolescent pregnancy; sexual behavior; HIV and other sexually transmitted diseases; public policies and legal issues affecting family planning and childbearing; programme operation, development and evaluation; information, education and communication activities; reproductive, maternal and child health; and abortion.

This study<sup>1</sup> develops and tests a programme to enable women to increase the time between pregnancies. The study finds that community-based behavior change communication (BCC) can have an empowering and sustainable impact on increasing postpartum contraception in India.

In this report, Mary Philip Sebastian et al. explain that postpartum contraception is important because inadequate spacing between births increases the likelihood of health problems for the mother, fetus, and last child. Despite the health concerns and the desire of most women to extend the time between pregnancies, the average interpregnancy interval is only 31 months nationally and only 25 months for women aged 15-19 years. The report notes that the Family Welfare Program (formerly called the Family Planning Program) focuses on sterilisation, rather than on temporary contraceptive methods for increasing the interval between childbirths. The Programme, therefore does little to meet the needs and desire of most women for longer interpregnancy intervals.

The Population Council and Lala Lajpat Rai Memorial Medical College, Meerut, conducted this operations

research to assess the impact and feasibility of a BCC intervention that involves community health functionaries from existing government programmes in promoting postpartum contraception and the lactational amenorrhea method (LAM) among young pregnant women in rural Uttar Pradesh. Researchers trained Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Anganwadi Workers (AWWs) to carry out an education campaign for pregnant women and their mothers-in-law. The campaign used communication materials (posters, booklets, wall paintings, and leaflets) and counseling to educate women in the study area about "healthy timing and spacing of pregnancy..., postpartum care, the lactational amenorrhea method and postpartum contraception."

Researchers randomly selected two blocks in Meerut district for the intervention and two blocks for the comparison. Approximately 600 (under 25-years-old) respondents were selected from each set of blocks. They completed a baseline survey to test the participants' knowledge and behavior related to contraception and spacing before the intervention. The BCC campaign was then implemented in the intervention group between September 2006 and January 2007. Researchers interviewed women in the comparison and intervention groups at four months and nine months postpartum in order to measure the differences in the changes in their knowledge and behavior.

On the whole, the study finds that behavior change communication can be successful in expanding the use of postpartum contraception and LAM. Community health workers from different departments can be trained to work together to implement the intervention. The method is sustainable because the health workers can continue to train their successors and to educate future pregnant women.

<sup>1</sup> Sebastian, Mary P., Mohammed E. Khan, Kaushal Kumari, and Rukma Idnani. "Increasing Postpartum Contraception in Rural India: Evaluation of a Community-Based Behavior Change Communication Intervention." *International Perspectives on Sexual and Reproductive Health* 38.2 (June 2012): 68-77.

## Facts about Two-Child Norm Policy in India

### 1. What is the Two-Child norm policy?

- The two-child norm is one of India's target oriented family-size control policy prescriptions, which encourages parents to limit their families to two children and creates disadvantages for couples with more than two children.
- It was believed that through the two-child policy, the national target of Total Fertility Rate (TFR) of 2.1 will be achieved by 2010.
- The main logic behind introducing this policy law was that people's representatives (politicians/leaders) would set an example for others by having only two children themselves. This way the population of the whole village would be controlled.
- This policy has increasingly been viewed as anti-democratic because it seeks to prevent people from participating in local self-governance after they have been elected through people's mandate.
- Owing to the discriminatory nature and negative impacts of this policy, states like Madhya Pradesh (2000), Chhattisgarh (2000), Haryana (2005) and Himachal Pradesh (2005) revoked the policy. Some states that are continuing this policy in panchayats even today are Rajasthan, Odisha, Andhra Pradesh, Maharashtra, Gujarat and Bihar (Urban local bodies).

### 2. Where and when did this policy originate in India?

- The two-child norm policy was modelled on China's one-child policy (1979) by which couples (including government officials and urban residents) were forbidden from having more than one child.
- In general, India's population was being perceived as a liability and a 'ticking bomb' responsible for slowing the rate of economic growth. Thus, coercive population policy legislations were started. The first Census Commissioner, Shri R. A. Gopalaswami, referred to "improvident maternity" as the primary cause of population problems in India.
- The National Development Council in India (apex body for decision making and deliberations on

development matters in India presided over by the Prime Minister) set up a Committee on Population. The committee under the chairmanship of the then chief minister of Kerala (K. Karunakaran) in 1992, recommended a legislation in the Parliament prohibiting persons with more than two children from holding any position in the panchayats or the Parliament in future.

### 3. How can a person be removed from their position in a panchayat/debarred from contesting for panchayat elections on the basis of this policy?

- Any person can file their nominations at the time of panchayat elections. However, after being elected to a panchayat, a panchayat representative may be removed from his/her position in case any person files a complaint to the state designated competent authority (for example collectors, commissioners) about him/her having more than two children.
- After a complaint is received, action is taken to remove the panchayat representative because he/she is seen as a violator of the policy.
- Alternatively, in certain states like Rajasthan and Maharashtra, a person can only contest for a panchayat elections after producing an affidavit to show that he/she do not have more than two children.

### 4. Is the two-child norm policy discriminatory?

- This law discriminates against young citizens in their reproductive prime, because it creates distinction based on number of children. For example, in Rajasthan the two-child norm was made applicable w.e.f. 27.11.1995. This means that a whole generation of young citizens who have or wish to have more than two children following the year 1995 are automatically debarred from election process. Older citizens who have had three or more children before the stipulated cut-off date are not affected.
- It negates the spirit of the 73rd Constitutional Amendment by preventing women, younger people

and those belonging to the weaker sections of society from participating in democratic elections.

- Given the strong son preference in our society, any enforcement of the two-child norm on Panchayat representatives will increase discrimination against the girl child and worsen the already declining child sex-ratio.

##### 5. Other than disqualification from panchayat, does two-child norm have direct relation to other developmental schemes?

- Some government schemes related to reproductive and child health are brought under the preview of two-child norm.
- Indira Gandhi Matritva Sahyog Yojana (IGMSY) which is a maternity benefit of Rs. 4,000/- is given to every pregnant and lactating woman of 19 years of age and above for the first two live births only.
- Tamil Nadu Agricultural Workers Act denies insurance benefits to people who are having more than two children.
- According to Maharashtra State Population Policy personal benefit schemes for government and semi-government employees are linked to acceptance of the two-child norm (<http://maharogya.gov.in/policies/default.htm>).
- Balri Rakshak Yojna in Punjab is a scheme which gives monthly incentive to the female child after whose birth either of the parents have adopted terminal method of the family welfare ([www.tribuneindia.com](http://www.tribuneindia.com)).

It is worth considering whether such conditions truly and directly contribute to changing perceptions about the girl child.

##### 6. Do we really need the two-child norm policy to control population?

According to NFHS 3 (2005-6), most Indian states including some high fertility north India states

have reached replacement level of desired/wanted fertility rate. Thus, most people in India do not wish to have more than two children, but the population is growing due to momentum effect and unwanted fertility. It is believed that fertility is influenced by variety of factors like education, media, economic changes, urbanisation, infant and maternal mortality rate, etc (Visaria and Visaria 2003). By now, there is a much wider consensus on the need to avoid authoritarian intervention in intimate and personal matters like reproductive behavior (Sen 1995).

##### 7. What has been the impact of the two-child norm policy on society?

- The scale of disqualifications in panchayats where the two-child norm is applicable, is noted to be huge.
- Panchayat representatives hailing from socially disadvantaged groups (SC, ST and OBC, mainly women) who are negatively impacted by the two-child norm are noted to be disproportionately higher in number.
- Enforcement of the two-child norm on panchayat representatives has been identified as a factor leading to increased discrimination against the girl child and worsening the already declining child sex-ratio in India.
- It is claimed that there are direct linkages between negative outcomes for women and the two-child norm including forced abortions, desertions and disowning of the third child, etc.
- Concerns of corruption and caste politics because of the two-child norm have been raised.
- This norm has created complexities and confusions. As for example, in some cases whether twins should be considered as two children or as a single unit, is left to the subjective interpretation of the state.



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