The world’s two population billionaires, India and China, have established national policies to address population growth, though they differ greatly in their details and implementation. Although both countries have substantial regional variation, China’s policy has been strictly enforced nationwide and more effective than India’s in dramatically reducing fertility and slowing population growth. But China’s “success” has also met with international criticism because it limits women’s freedom to bear children. The experiences of these large countries affect and respond to global discussions about population and individual rights.

India
In the 1950s, India launched the world’s first state-sponsored family planning program to slow population growth. From the early 1960s to the mid-1990s, government-determined targets for contraceptive use dominated the management of the program. Between 1975 and 1977, Prime Minister Indira Gandhi’s government promoted male sterilization campaigns that sometimes led to coercion. Public outrage about the reported abuses contributed to the downfall of Gandhi’s government and created a backlash against family planning programs that took years to overcome.1

In the 1980s and 1990s, the government continued supporting the national family planning program with centrally mandated targets for contraceptive use. Although acceptance of family planning was voluntary, the apparent zeal to achieve the targets again met with growing criticism. Critics argued that the overemphasis on reaching annual targets led health workers to worry about meeting numerical goals rather than meeting the needs of the women they served. Two years after the Cairo conference, in 1996, the Indian government made a major policy shift by announcing the “Target-Free Approach” to family planning, eliminating all centrally mandated targets for contraceptive acceptance. Targets remained for planning purposes at the local and state levels, but health workers and administrators were no longer to be reprimanded for not meeting them.2

Studies in the late 1990s showed that the new approach, called the reproductive and child health approach, was being implemented unevenly throughout the vast and populous states of India.3 This is not surprising given the decentralized government and the tremendous economic and social diversity in the country. The 2000 national population policy calls for reducing the average family size from 3.2 in 1999 to 2.1 children per woman by 2010, which would require a rapid decline in birth rates.4 To achieve this goal, the policy calls for meeting the needs for family planning and other health care and for integrated reproductive and child health care services. In India’s largest and poorest states, expanding and improving these services will require substantially greater resources and human capacity.

China
China’s “one-child policy,” introduced in 1979, is unique in its scope and enforcement. The policy is credited with slowing population growth in the world’s most populous country (now about 1.3 billion). It is also notorious for limiting individual rights and for heavy-handed enforcement. Reports of forced abortions and other coercive practices have plagued the program and brought condemnation from the United States and other national governments.

China’s policy generally limits urban couples to one child and allows rural residents two children if the first child is a daughter. Other couples are allowed a second child if certain conditions are met. The regulations have been implemented unevenly throughout China, making enforcement a key political issue.

In 1995, the Chinese government called for reorienting the family planning program to be “driven by the people’s interest” and to emphasize more comprehensive services—a concern sparked in part by the 1994 Cairo con-
The State Family Planning Commission introduced the reforms gradually by selecting pilot counties where family planning services would offer a range of contraceptive method choices, reproductive health care, and counseling. Although local officials still set family planning targets, the concept of “informed choice” has gained acceptance, and an estimated 25 percent of all counties in China have reformed their family planning services to some degree. Though the policy is credited with reducing the total fertility rate from 5.8 in 1970 to less than 2 in 2000 and averting an estimated 300 million births, the government is increasingly faced with the negative side of the changes it brought about. There are fewer children and grandchildren to care for the growing number of elderly people, and limits on childbearing have exacerbated couples’ traditional preference for sons, leading to sex-selective abortions, female infanticide, and a deficit of girls in the country.

Increasing individual freedoms, market-oriented economic reforms, and greater openness to the global community all point toward a more relaxed approach to family planning. But the government’s public stance indicates a continued interest in controlling population growth. It codified its family planning policy into law in September 2002, reaffirming the one-child policy (with a list of exceptions) while at the same time criminalizing coercive enforcement measures.

Common Challenges
In both India and China, the almost universal preference for sons is a major barrier to reducing family size. In cultures where women are subordinate to men and sons contribute more than daughters to families and aging parents, couples may have more children than they would like to ensure they have a son. Some couples in both countries have turned to sex-selective abortions to limit their family size and still have the son they want. While China implements its official policies more effectively than

References