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INTRODUCTION

Reproductive Health policies are closely related to Population and Family Planning policies. India is well known as the first country to have started a state-sponsored Family Planning programme in 1951. Since the beginning the programme had a strong concern for controlling India's rapidly growing population. Side by side with the Family Planning programme evolved the Maternal and Child Health (MCH) programme, which was concerned with the health of mothers and their children. Among the two programmes the Family Planning programme was pursued far more vigorously and women became its primary targets. Maternal health programs received less attention and despite the rhetoric of caring for mothers the maternal mortality rates even today continue to be unacceptably high. But this state of affairs was not unique to India. In many countries around the world, women's health issues were largely ignored and their Reproductive Health functions were controlled by different policies pertaining to family planning or to abortion.

Women health activists all over the world soon realized how state policies militated against the health of women. A movement slowly built up to challenge this neglect of women's health, especially their Reproductive Health. The culminating point of this dialogue between the women's health activists and states took place at the UN-sponsored International Conference on Population and Development at Cairo in September 1994. The resultant Programme of Action is the commitment of all signatories (states) to slowly change their country's policies relating to Reproductive Health. A change in Indian policies relating to population and reproductive health is also the result of this process.

Changes that have taken place in our country's laws, policies and programs have not always been a result of a benign and concerned government. There has been a long history of people expressing their concerns and engaging with the government for initiating social reforms. The poor socio-economic status of women has always been a major reason for social movements in the country. Some of the first successful advocacy efforts for securing women some rights had been those against *sati* (burning widows on the funeral pyres of their husbands) or for widow remarriage, which took place through legislation over 150 years ago. Other successful efforts in more recent times have related to legislation concerning the minimum age at marriage and for dowry related violence. Unfortunately, the social forces, which perpetuate many of these inequitable systems within society, are very strongly entrenched, and even legal measures have often not been very successful. Advocacy efforts towards Reproductive Health and rights also need to be seen in this context.

This section of the Resource Pack will present the changes that have taken place in the evolution of policies concerning Reproductive Health as well as

how advocacy efforts both in the international sphere as well as within India have affected these processes.

SECTION ONE

Understanding The Evolution Of Reproductive Health Related Policies

The need for change from Population control and Maternal Health

If one considers the situation in India, programmes and policies for population control and maternal health have been in place for over fifty years. Even if these did lead to some decline in population growth rates, their impact on women's health was negligible. In fact it can be successfully argued that these have adversely affected the health and status of women. In India, despite such programmes, the Maternal Mortality Ratios (MMR) remain as high as over 400 per 100,000 live births. In countries like Indonesia, MMR was as high as 450 despite the fact that contraceptive prevalence was over 50% of all married women. Besides, these narrow programmes failed to address the many Reproductive Health problems of women. Table 1 provides a summary of the principal health concerns of women.

Table 1

Category of health problem	Numbers worldwide/year
Unwanted pregnancies	80 million
Unsafe abortions	25 million
Severe maternal morbidity	20 million
Maternal deaths	585 thousand
Women with invasive cancers	2 million
STDs	50 million
Maternal anaemia	58 million
Beating by male partner	20 – 30% of women
Depression	2 to 3 times more frequent in women

(Source : Sen, Germain, Chen eds – Population Policies Reconsidered and ARROW Resource Kit , 1996)



It is clear from this table how little can actually be addressed by programmes focussing on population control and the limitations of only having a maternal health focus. In addition to ignoring some of the most important women's health problems, there is something wrong with the whole approach. The conventional approach, which to a great extent is true even now, had

a very bio-medical understanding of health meaning health was viewed as a result of factors like nutrition, susceptibility to disease, physical, chemical or biological factors and so on. Having understood health in bio-medical terms, the solutions consisted of bio-medical interventions as well. Thus anaemia was considered a result of iron–folic acid deficiency. Green leafy vegetables were considered the answer. This approach totally misses out on the number of economic, social and cultural factors which influence health. Any one who has tried to tackle anaemia in the village by dispensing advice on green leafy vegetables and iron tablets will appreciate how difficult this can be. This simple advice does not take into consideration essential factors like availability of vegetables, women’s social position, financial status of the family, and the prevalent myths and beliefs around women’s diet. Among the different cultural factors, one of the most important is gender roles and relationships (and power distribution) between men and women.

This understanding that health is also determined by socio-cultural factors has slowly emerged over the years. Reproductive Health is one area where socio-cultural factors are even more predominant, and gender roles and power relationships very clearly defined. In such a situation a population control and maternal health approach becomes very inadequate to address the actual health concerns of women.

Adverse effects

Some of the consequences of having a population control oriented policy and programmes:

- Pressure for undergoing sterilisation, undermining human rights
- Health repercussions of hastily done sterilisation operations in makeshift camps – infections, intestinal adhesions, high failure rates, even death
- Inadequate attention to contraceptive safety- inadequate screening and follow-up
- Health services do not have provisions to deal with women’s genuine health problems
- Poor quality of curative services

Women and Family Planning

Family planning interventions have affected the lives and health of women very deeply because women are seen as the main party in procreation or adding to population. Thus almost all family planning strategies have hitherto been focussed on women as targets of contraceptives- pills, IUDs, sterilisation operations and so on. Women are also perceived as soft targets and this has often led to very coercive situations in different parts of the world. The attention that women have received as potential or actual mothers is in sharp contrast to the attention that women’s health *per se* has received. Thus we have a situation in our country where while Couple Protection Rate

has consistently increased over the years while the number of maternal deaths has also increased. Focussing on women as the predominant target of family planning and contraception, not only adds a morbidity burden on women but ignores an essential element of reproductive decision making. Men who primarily make all reproductive decisions are thus spared from taking contraceptive responsibility. What initially seems an easy and practical way in the end reinforces gender inequality between men and women in society.

The International Women's Health Movement

The change in the population control mindset to a broader Reproductive Health framework was, to a large extent, due to the continuous critique of established policies by the international women's health movement. The international women's health movement started in the late 1970's challenging the basic premises of population control. The central logic of the challenge was that individual women's health and rights were of concern rather than population control in the so-called greater interest of society. While there was no one international women's health movement -- it developed in the different regions of the world differently -- there were (and still are) many common platforms where women's health activists join together in expressing their common concerns.

The development of the international women's health movement has to be seen in conjunction with the larger women's movement. The Universal Declaration of Human Rights (1948) unequivocally affirmed the equality of the sexes. In 1968 at the International Human Rights Conference in Teheran, the concept of human rights was applied to the issue of family planning. Women's situation and condition became a central issue of international debate after the launching of the women's decade in 1975. All the while, feminists were critical of the narrow population control mindset and policies. The International Women's Year Conference at Mexico City (in 1975) was an opportunity for women to place their reservations on the international stage. In 1979 the Convention for Elimination of all forms of Discrimination Against Women (CEDAW) was also ratified.

The initial impetus for a separate movement for women's health started in Europe and North America in the '70s. In different places, women had started feminist information centres, women's health centres, publication of specialised women's health-related books and materials, campaigns against sterilisation abuse and abortion rights, and against baby food producers and so on. The first International Women and Health Meeting was convened by European and North American women but subsequent meetings have all been attended by women from developing nations in great numbers.

These meetings allowed women from all over the world to debate on a wide variety of issues and also to join together into a united political force. Women

from the developing nations have been playing an increasingly important role in all the deliberations regarding women's health and rights. DAWN (Development Alternatives with Women for a New Era), a network of women researchers and activists from the developing nations has been at the forefront of the international women's health movement for a long time. Other influential networks included the International Women's Health Coalition (IWHC), WGNRR, WEDO, LACHWHN and so on. Today there are a large number of organisations and networks at the national (in many countries), regional and international levels and they are working in synergy to enable women around the globe achieve their health potentials and rights.

While the actual situation of women's health is different in different countries, the common thread that unites their different situations is the lack of control women have over their health, their sexual lives, their own bodies. This external control takes many forms. Thus in India women had to face forced sterilisations, in other countries it is the pressure of pro-natalist (against contraception or abortion) policies, while in still others forced marriages and honour killings make a mockery of women's rights. The basic message of the women's health movement is the same everywhere and includes- access to quality healthcare services, particularly Reproductive Health services; safe and effective contraception and abortion services; and respect for women's Reproductive Rights. The final demand is that the design and implementation of all services should be done keeping in mind women's health needs and demographic objectives. Women's health activists have raised these issues persistently at various international fora including UN conferences. It may be argued that as a result of these persistent advocacy efforts, a large number of these demands have been met through the Programme of Action adopted at the International Conference on Population and Development at Cairo in 1994.

Some important achievements of women's health activists around the world

- ICPD PoA
- Women's Health Policies in Brazil, Columbia and Australia
- Highlighting the morbidity from Reproductive Tract Infections in women
- Abortion law reform in many countries
- Successful campaigns against harmful contraceptives – injectibles and vaccines
- Successful campaigns against sex selective abortions

International Conferences, Population Policies and Reproductive Health

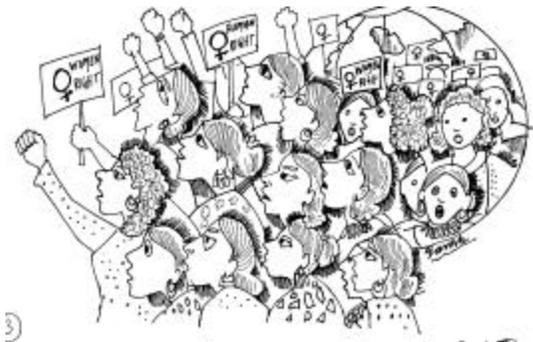
The UN has held a series of conferences which have had an important bearing on the evolution of ideas of Reproductive and Sexual Health and Rights. The first one, which was not strictly on the issue was the International Human Rights Conference held in Teheran in 1968, which introduced the

concept of the rights into the realm of contraception and family planning. The first conference devoted exclusively to the issue of population was the World Population Conference in Bucharest in 1974. In this conference the dominant view was that development was the best contraceptive and importance was given to socio-economic development as a major force in reducing population growth. The next population conference was held ten years later in Mexico City. By this time women's health activists managed to include some women's issues within the World Population Plan of Action – emphasising linkages between high fertility and lack of education, health care and employment opportunities for women and their low status. But this document also stated that government should make family planning measures widely available, shifting the focus to family planning programmes.

International Conference on Population and Development

The International Conference on Population and Development held in Cairo in September 1994. Delegations from 179 nations took part in the negotiations which finally led to the adoption of the Programme of Action (PoA) on population and development for the next 20 years. This document endorsed a new strategy which emphasised the linkages between population and development and focussed on meeting the needs of individual women and men rather than on achieving demographic targets. Empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment were key features of this new approach. The ICPD PoA stressed the importance of reproductive rights and reproductive health for men and women and emphasised the need for equity in gender relations, responsible sexual behaviour, and the need to enhance access to appropriate information and services. Special efforts were also to be made to emphasise men's shared responsibility and active involvement in responsible parenthood and sexual and reproductive behaviour. The PoA also highlighted the nature of state action and International support that would be necessary for it to succeed.

The period between 1984 and 1994, when the ICPD was held, was a period of great challenges to the traditional thinking on population. Women's health activists all over the globe drew attention to the effect of these programmes on women's health and their presence in large numbers in Cairo ensured that the Cairo Programme of Action reflected many of their concerns. The change in thinking that the Cairo process has brought about is being hailed as a 'paradigm shift'-- the shift from population control to individual well-being which has been outlined earlier.



These International conferences have played a major role in the way countries' population policies are framed. While the discussions and debates in these conferences reflect those which are going on in official circles within different countries, the parallel NGO meetings are increasingly providing spaces to activists to react and interact with official delegates and get their concerns heard. Once the official document/recommendations gets ratified, individual countries are expected to change their own policies in line with the principles of this agreement. In case of the ICPD, the document is known as the Programme of Action (PoA) and it is to form the guidelines for countries for the next twenty years. Some of the major goals from the ICPD PoA are as follows:



- By 2015, the PoA advocates for a universally available Family Planning programme for everyone in the world
- By 2005, all countries should attain life expectancy at birth greater than 70 and by 2015 all countries should attain life expectancy at birth greater than 75
- By 2015, all countries should achieve infant mortality rate below 35 per 1000 live births
- By 2005 those countries with intermediate levels of maternal mortality should achieve a maternal mortality rate below 100 per 100,000 live births and below 60 per 100,000 live births by 2015
- By 2005 those countries with the highest levels of maternal mortality should achieve a maternal mortality rate below 125 per 100,000 live births and below 75 per 100,000 live births by 2015

Alongside the UN Conferences on Population were the conferences on women- Mexico City 1975, Nairobi 1985 and Beijing 1995. These conferences too have made important recommendations about the status of women, including their health. Some of the important principles which these two conferences (Cairo 1994 and Beijing 1995) upheld were-

- Gender equality and equity and women's empowerment are essential
- National strategies have to be developed to ensure universal access to all individuals of a full range of Reproductive and Sexual Health services
- Sexual and Reproductive Health has to be considered within a primary health care context
- All barriers to women's access to health services have to be removed
- Reproductive Health interventions have to be redesigned taking into

consideration women's multiples roles

- Male responsibility and equal partnership has to be promoted
- Efforts to increase women's awareness of their rights – including sexual and reproductive rights -- have to be supported
- Transparency and accountability has to be ensured

The interested reader will find details of the recommendations of the two relevant conferences – Cairo and Beijing and their followup in many interesting documents, some of which are mentioned later.

Other Factors Influencing Reproductive Health Population Policies

Religions - Religious doctrine and religious leaders are often serious critics of many population or Reproductive Health policies. On the one hand religions are often adverse to artificial forms of contraception, while on the other they also try to stall any form of deviation from their accepted codes of reproductive and sexual behavior. The position of women is also very clearly delineated in most religions and attempts at changing this status are sometimes seen as an attempt to undermine religion. Most religions tend to take a natalist, anti-abortion stance and this seriously hinders policy formulation and implementation in many countries. The Roman Catholic Church has played a particularly unhelpful role in the entire ICPD and its follow-up process. The Vatican has an observer status in the UN and uses this official position to stall debates and discussions which it perceives as being against its teachings. Other religions play significant roles within individual countries.

International Agencies and Donors - UN agencies usually follow the agenda that has been outlined at the different UN conferences and this dictates the funding they provide to countries. Other international agencies/donors like World Bank, USAID and even Population Council are also known to influence Reproductive Health and population policies in our own country. Examples from India include the Reproductive and Child Health Programme which was designed with the assistance of the World Bank.

Political Parties and Leaders - The role of national political parties and leaders in the framing of national policies is obvious. Very often, political will decides what kinds of population policies are in place within a country. For examples within India one has to consider the Emergency period forced sterilisation and the target-oriented regime of India's Twenty Point Programme. Even today the lack of political will makes a mockery of the provisions of the Community Needs Assessment Approach and the Reproductive and Child Health Programme.

Comparing Women-Centred RH and Population Control/Family Planning Approaches

The change that the two UN conferences recommend has to be

operationalised in terms of an effective approach. The table below gives a comparison between the conventional Population Control mindset and the newer Reproductive Health approach in terms of the conceptual understanding and assumptions.

Area	Population Control/FP Approach	Women-Centred RH Approach
1- Rationale	<p>The most important aspect of women's health is pregnancy, childbearing and fertility. Women's health is very important as it affects the health of children</p> <p>When women have fewer children who are better spaced, women's health and status will improve</p>	<p>Women's health has not automatically improved by focusing on contraception and maternal health- maternal mortality rates can still be high even though use of contraceptives has risen</p> <p>With a narrow family planning and maternal and child health care focus, women's other health problems are neglected (e.g. unsafe abortions, RTIs, STDs, cancer and health effects of violence against women.</p>
2- Definition of women's reproductive health	<p>A narrow bio-medical meaning of maternal health or the health of women of reproductive age, focusing on birth/child bearing without death or disease, and on contraception</p>	<p>A broad understanding which is centred on the right of women to make their own autonomous choices about reproduction and sexuality, and the right to provision of services of a high standard which are women-centred (based on women's experiences and needs)</p>
3- Goals	<p>Demographic reduction of increase of fertility and population</p> <p>Improve women's and children's health and family welfare (secondary goal)</p>	<p>Improve women's health including their Reproductive Health</p> <p>Increase women's control over their bodies and ultimately their lives</p> <p>Change socio-economic conditions which are barriers to the exercise of reproductive rights (e.g. women's legal status, education, poverty level,</p>
4. Ethics/values		

Reproduction is primarily a social function	decision making power in the household, choice of whether and when to marry)
Demographic goals of a country are more important than the human rights of individuals	Women have the individual rights and the social responsibility to decide whether, and how and when to have children and how many to have: no woman can be compelled to bear a child nor be prevented from doing so against her will
	Women have the right of choice within a human rights framework
	Men also have a personal and social responsibility for their own sexual behavior and fertility, and for the effects of that behavior on their partners and their children's health and well-being
	The fundamental sexual and reproductive rights of women cannot be subordinated against a woman's will, to the interests of partners, family members, policy makers, the state or any other actor
5. Underlying assumptions	Due to biology and gender role and responsibilities, women have a greater right to make fertility-related choices
Population size/growth is the main determinant of poverty, under-development and environmental sustainability	Women can be trusted and must be respected to make their own reproductive decisions when fully informed
Population control will reduce fertility	Poverty is due to the economic growth model of development. Focus is on meeting basic needs and not on population control

Improving women's status and providing quality Reproductive Health programmes will help to reduce fertility

(Source: ARROW 1996: *Women-Centred and Gender Sensitive Experiences*: Changing our perspectives, policies and programmes on Women's Health in Asia and the Pacific. Resource Kit)

Population Policies and Reproductive Health

The concept of Reproductive Health emerged as a reaction against the narrowness of the population control mindset and its operationalisation. Now that Reproductive Health has established itself as an idea whose time has come, one needs to define the relevance of population policies. These two concepts seem fundamentally opposed to each other in some ways - population control is defined in terms of social significance while Reproductive Health is concerned with enabling the individual. For many, the meeting point of the two is Family Planning, which is a central idea in population control, and an important idea in Reproductive Health. The difference lies in how it is viewed. Population control is concerned with reducing fertility and population growth while Reproductive Health is concerned with individuals and their choices and health. Thus for this point of view, the challenge for population policies is to enable individuals to achieve their reproductive intentions.

But there is another point of view which sees population policies in an entirely different light in the new Reproductive Health and Rights framework. Here population policies are not concerned with the reduction or augmentation of numbers but in the quality of life of all segments of population – especially the marginalised communities.

No matter what the point of view, the challenge of population policies is to ensure that certain principles are incorporated, some of which are given below-

- The principle of equity and social justice
- The principle of autonomy and self-determination of the individual - women and men
- Those individuals have individual rights and social responsibilities - women and men towards each other and children's health and well being.
- The principle of participatory democracy - engage the most marginalised in the decision-making process.
- The principle of accountability and transparency.

Framers of population policies also need to seriously question the assumption that population growth is not the only or most important determinant of

poverty and environmental or resource depletion. Reduction of fertility rates cannot take place without concomitant improvement in other social development indicators like education and general health and gender relations. And it must also be remembered that Reproductive Health in its true essence goes much beyond just adding some additional services to existing Family Planning and MCH programmes.

Is Reproductive and Sexual Health and Rights an idea which has been imported?



There is often a tendency to label the Reproductive and Sexual Health and rights-related discussions as alien to our own culture and as being imported by feminists from the west. The reason given is that where people do not have enough to eat, this kind of discussion draws attention away from the many other immediate needs for survival. This argument does not hold much water as Reproductive Health is at the core of survival. The other thing that needs to be kept in mind is that while survival may be important, the right to life also

qualifies the quality of life that the surviving person is entitled to. Reproductive Health and Rights of women are a significant aspect of that quality of life. And thus in no way is a discussion on this subject less important than one on food security.

While it is true that Western ideas have played a role in drawing attention to what should be women's entitlements in terms of health and on her body at large, women from the developing countries have contributed equally with their own ideas and analyses, and played their own roles in the entire struggle. The most important "western" idea is the idea of or the primacy of 'self' or the individual identity which is central to the debate of rights (bodily integrity). In cultures like ours, women are socialised from early on about self-denial, and this way tend to accept all forms of privations as *fait accompli*. Women's activists from the developing countries have developed the concept of 'self' or individual entitlements further to include the notion of social and economic needs and conditions which enable individual poor women to access their health, and rights to decision making. The entire debate of Reproductive Health and rights becomes extremely relevant in India when you consider the following situation of women as it prevails in our country -

- Sex pre-selection and aborting of the female foetus
- Lack of proper nutrition or education for the girl child
- Early marriage and child-bearing

Shame and pollution around reproductive organs and processes like menstruation

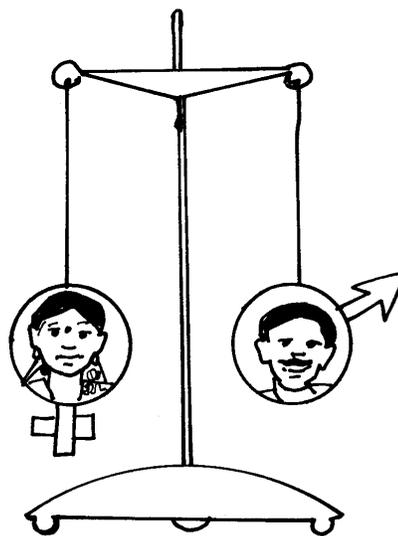
- Frequent pregnancies and childbirth
- Harmful customs and practices around pregnancy, childbirth and puerperium
- Lack of quality ante-natal, intra-natal and post-natal services
- Lack of safe abortion services
- High incidence of maternal mortality
- Lack of negotiating power in sexual relationships
- Unwanted and forced sterilisations
- Lack of information or choice in contraception
- Lack of health services
- Lack of decision-making and financial autonomy for healthcare-seeking
- Domestic violence
- Sexual violence

There will be few who will argue that the entire list has been fabricated. If this list even in parts reflects the situation of women's health, as it exists in India, can the concepts of reproductive and sexual health and rights be alien?

Going beyond Reproductive Health - Developing a women's health policy

Primary Health, Reproductive Health, Women's Health - What do these terms mean? How are they different? First there was the Alma Ata conference which talked of universalisation of primary health and raised the slogan of "Health for all by 2000 AD". The Cairo conference firmly set forth Reproductive Health goals to be achieved by the year 2015. Is something missing that we need to discuss Women's Health separately? Many activists agree that while the Cairo and Beijing conferences have put the issue of gender as a determinant of health rights in the forefront, just discussing Reproductive Health is not enough. Also, Reproductive Health has developed from the population perspective, and not from the health side.

In order to enable women enjoy the best possible health (physical, mental, social) it is essential to discuss a separate women's health perspective which, while including Reproductive Health, will not be restricted to it. There are many other health problems of women which are brought on by the fact that she is a woman (gender roles and biology) and policies need to be framed in order to address these. There are a few countries in the world which have already framed such policies - Brazil, Columbia, Australia and South Africa are in the process of doing so. Activists in India are also trying to put together a process which calls upon the Government to do so. But it is not going to be an easy task



and will need the concerted efforts of a dynamic women's movement together with a favorable political climate in order to do so.

SECTION TWO

Family Planning and Reproductive Health Policy in India

Evolution of Population related Policy and its changes in India

In the Pre-Independence period - A concern for the country's growing population was articulated by Indian leaders well before Independence. Till 1921, India's growth rate was negligible and started rising after 1921. Immediately afterwards, there were many local initiatives for arresting this growth. In Pune the first Family Planning clinic was started in 1923. In 1928, a neo-Malthusian league was formed in Madras, and in 1930 a Congress Government-run Family Planning clinic was started in Mysore. In 1938, the Congress party started its National Planning Council and it had a special subcommittee looking into various aspects of India's population problem. In 1949 the Family Planning Association was started. It is but natural that with such a growing concern in all parts and sections of the country Family Planning become part of the national agenda soon after independence.

Family Planning - Early Years - The Bhole Committee recommended in 1946 that population growth would be a problem and that the Government should promote birth control. The Planning Commission soon after it was set up recognised the need for a population policy. In the draft of its first Five-Year Plan it recommended that a population policy was essential for planning, and Family Planning was necessary for improvement of health of mothers and children. It also accepted that the state should provide facilities for sterilisation. Clinics were considered the main vehicle for providing services. Sterilisations were accepted as a method in 1959, and in the same year incentives were given for the first time in Madras. Vasectomy was the method promoted.

During the second and third Five-Year plans, suggestions were also made to include sex education, family life education, and child guidance to promote welfare of the family. By the late fifties it was becoming clear that the clinic-based approach was not able to reach most of the families in the country, and in 1963 the Government proposed that Family Planning should be promoted using the extension approach- or visiting women at their homes. Auxiliary Nurse Midwives (ANMs) were now trained to do this. In 1966-67, time-bound targets were first introduced to enhance the decline in birth rates. These targets were set by the Central Government and in turn passed on to lower levels- state, districts, primary health centres, sub-centres and functionaries.

Tyranny of Targets - The Fourth Plan (1966-74) period marked the intensification of the Family Planning efforts. On one hand the Ministry of Health was renamed as the Ministry of Health and Family Welfare, and a separate department of Family Welfare with a Secretary in charge was set up. On the other hand the 'cafeteria' approach started broadening the range

of contraceptives offered (pills and IUD), mass sterilisation camps started and the MTP Act was passed. However, the ambitious target of reducing birth rates was not achieved. In the Fifth Plan, the Minimum Needs Programme was integrated with the Family Planning Programme but this was



also the period of apparent anomalies. While the Indian Health Minister raised the slogan of “Development is the best contraceptive” at the Bucharest conference, forced sterilisation camps were conducted at the behest of Sanjay Gandhi during the Emergency. As everyone knows the

Emergency excesses in the field of sterilisations were one of the main reasons which brought the Government down. After 1977, Family Planning (now the department was renamed as Family Welfare) became a low-key activity but soon after Mrs Indira Gandhi came back to power the voluntary sterilisation camps re-started with the new technology of laparoscopic sterilisation. Women now were the main targets for contraceptives - especially sterilisations - and vasectomy figures became negligible. Method-specific targets were also introduced for the temporary methods but there were incidences of gross mis-reporting because these figures were difficult to follow-up. Performance in Family Planning programmes also became a key indicator of ranking states and districts and it was included as an important feature of the Twenty Point Programme.

Changes in the approach to Family Planning service delivery since ICPD

The International Conference on Population and Development (ICPD, Cairo, 1994), marked a radical shift in thinking and action around population and development issues. Family Planning lost its pre-eminent place in service delivery to the concept of comprehensive reproductive health services across the life cycle. As a result of ICPD PoA the focus of family planning programs shifted from fulfillment of national demographic goals to fulfillment of reproductive goals of individuals and couples. The respect for human rights, the concern for gender equality and equity and the need for universal access to services which enable the enjoyment of the highest quality of physical and mental health were now the key guiding principles for reproductive health related service delivery. In concrete terms these translated into the following

- Voluntary and Informed Choice
- Addressing unmet needs

- Improve range and quality of services available
- Removal of Demographic goals and targets
- Increased participation of men
- Women's Participation in management
- Prevention and control of abuse by program managers and providers

Governments and the international community were urged to take all possible steps to ensure that these principles were built into actual service delivery.

Changes in the Family Planning policies and program – the case of India

The decade of the 1990's was marked by many changes in the way the National Family Welfare programme was designed and delivered. With release of the Eighth Five Year Plan in 1992, the family welfare programme entered into a reflective phase. The plan document expressed concern about the poor realization of family welfare goals and questioned the wisdom of centralized planning and target setting.

Table 2
Changes in Approach and Delivery of Family Welfare Programme in India
1991-92 - Removal of targets in Tamil Nadu
1992- Eighth Five Year Plan – calls for review of targets
1992-93 - Child Survival and Safe Motherhood Program
1994 – ICPD , Cairo
1995 – Removal of targets in 1 or 2 districts in all states
1996 – TFA announced
1998 – RCH programme launched
1999 – TFA re-christened as the Community Needs Assessment Approach (CNAA)
2000- National Population Policy announced

Early experiments in withdrawing targets were started in Tamil Nadu in 1991- 92 and Auxillary Nurse Midwives (ANM) were strengthened to provide services. This experiment was successful in raising the contraceptive prevalence of all the four common methods. India was very quick in implementing some of the recommendations of the Cairo Conference notably the withdrawal of contraceptive targets. In 1995 contraceptive targets were removed in one or two districts in all states and in April 1996 the entire country entered into a new era of the Target Free Approach (TFA) to Family Planning. Subsequently the Reproductive and Child Health Programme was launched and in 2000, India announced in National Population Policy. The new approach which was adopted included very laudable components like - quality of care, bottom-up planning, community-need based service provision which are all in line with the ICPD recommendation and also genuinely addressed the existing lacunae in the Family Welfare Programme.

The National Population Policy (NPP 2000)

The NPP 2000 was announced in March 2000. It is the articulation of India's commitment to the ICPD agenda, and forms the blueprint for population and development related programmes in the country. The overriding concern of

the National Population Policy is economic and social development and human well being. A cross cutting issue is the provision of quality services and supplies, information and counselling, besides arrangement of a basket of choices of contraceptives, in order to enable people make informed choices and enable them to access quality health care services. The immediate objective is to address the unmet needs for contraception, health care infrastructure , and health personnel and to provide integrated service delivery of basic reproductive and child health care. The medium term objective is to bring the TFR to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long term objective is to achieve a stable population by 2045, at a level consistent with the requirement of sustainable economic growth , social development and environmental protection.

Goals of the Policy for 2010 – Some of the goals of the NPP 2000 include

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure
- Achieve universal access to information/counselling, and services for fertility regulation and contraception with a wide basket of choices
- 100 percent registration of births, deaths , marriage and pregnancy
- Reduce infant mortality rate to below 30 per 1000 live births and reduce maternal mortality ratio to below 100 per 100,000 live births
- Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons
- Achieve universal immunisation of children against all vaccine preventable diseases
- Promote delayed marriage for girls , not earlier that age 18, and preferably after 20 years of age
- 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

State Population Policies- Incentives, disincentives and coercion

The National Population Policy favours voluntary informed choice for contraceptive acceptance. However some states have provisions for incentives and disincentives, notably – Andhra Pradesh, Madhya Pradesh, Rajasthan, Uttar Pradesh, Orissa and Himachal Pradesh. When disincentives are applied at the level of the health service providers, the health functionaries start applying pressure on the community, and engage in coercion. The quality of family planning services which is not too good to start with becomes worse. This poor quality has tremendous implications in terms of core health concerns like maternal mortality and morbidity.

When disincentives are applied to the community, the impact is squarely upon the women. Men persuade or force women to undergo sterilisation operations. The woman also stands to be deserted if she has a third child. If a

woman with three children becomes a widow she could have to face the burden of disincentives (no job, no loans etc.) even though she is already extremely vulnerable. The impact of disincentives is also disproportionately borne by the dalits, OBCs/ STs who are already vulnerable- because they have more children. So instead of creating opportunities for the vulnerable which is the mandate of the state (according to the Indian Constitution) a scheme of disincentives ends up doing just the opposite!

The impact of incentives is a little more complex to understand. Most incentives that are being provided are linked with undergoing sterilisation after two children. This is similar to promoting a two-child norm, in a less coercive way. The impact of such an incentive could be promoting sex selective abortion, as well as the pressure on the woman



to undergo sterilisation operation. At another level when people are economically very vulnerable incentives themselves become coercion because the people cannot afford to refuse the incentive. This point of view has been clearly elaborated by the Supreme Court. It is clear that whichever way one looks at it incentives and disincentives end up being disadvantageous to women.

A selection of incentives and disincentives in different state population policies

- Better performing villages and districts to be provided more funds under different government schemes
- Cash and other prizes and medals to individuals who opt for permanent methods after a specific number of children, including girl children
- Preference in schemes such as allotment of land, house sites, IRDP, TRYSEM etc, to sterilisation acceptors including vasectomy, after a specific number of children
- Limiting educational and travel concessions to two children only
- Disbarring persons from participating in election to local bodies if having more than two children
- Disbarring persons marrying before the legal age from Government jobs.

Review of key areas in which changes were desired

Providing contraceptive services to a population of a few hundred million adults is a daunting task and the Family Planning programme in India has been able to achieve considerable success in bringing about changes in many demographic indicators. The total fertility rate has come down from 6 children per woman to less than 3 in 1998-99. In the ten year review report of its programme since ICPD, provided by the Government of India to the Commission on Population and Development, seven key areas of change were identified. Four of these changes viz. abolition of contraceptive targets, informed choice, focus on public-private partnerships and larger role for NGOs, and reforming management systems to increase accountability at all levels relate directly to the design and delivery of family planning and reproductive health services. The following section presents the changes and challenges in the area of Reproductive Health service delivery around five key areas.

- Abolition of contraceptive targets
- Decentralised client centred approach
- Increasing choice of spacing methods, provision of informed choice
- Improve range quality of services
- Increase accountability of providers at all levels

Abolition of contraceptive targets – One of the earliest changes in the family planning programme as mentioned earlier was the removal of centrally determined contraceptive targets. However there was a fear that TFA was going to be interpreted as ‘work free’ approach and not being sure that the approach would not be reversed in a number of states health managers continued to impose targets at their own levels. At an aggregate national level the performance of the department dropped in the first few years and states like UP, Haryana and others re-introduced contraceptive targets. Rajasthan went a step forward and adopted a Population Action Plan in 2003 in which contraceptive targets were reintroduced for educational workers at the village level.

Table 3 : Contraceptive Service provision

Year	Sterilisation #	IUD	Oral Pill	Condom	Total
1994-95	13.5 (96.9%)	19.8	52.3	14.4	8,339,000
1995-96	13.1 (97.2%)	20.4	51.4	15.1	8,235,000
1996-97	12.1 (98.1%)	17.7	53.8	16.4	7,303,000
1997-98	12.6 (98.3%)	18.4	50.0	19.0	7,940,000
1998-99	12.1 (97.6%)	17.5	50.3	20.0	7,976,000
1999- 2000	12.5 (98.1%)	16.9	49.4	21.1	8,530,000
2000- 01*	12.9 (97.7%)	16.6	49.7	20.8	8,518,000
2001- 02*	12.8 (97.7%)	16.8	47.2	23.3	8,723,000

* Provisional figures # Figures in bracket indicate proportion of tubectomy

It is clear from the table that while there was a drop in the number of Family

Planning acceptors in the three years following the adoption of TFA, these figures exceeded the pre TFA years thereafter. These changes have to be interpreted in the light of the feeling among many that the reduction in numbers after TFA was not just because the number of acceptors went down but the reporting also became more honest.

Incentives and disincentives related to contraceptive use have always been closely associated with contraceptive targets. The National Population Policy places emphasis on voluntary informed choice and steers away from disincentives. However a number of states have instituted a series of disincentives starting from disqualification from local elected office to participation in Government schemes.

Decentralised client centred approach – The TFA was supposed to remove contraceptive targets as well as introduce decentralized health planning at the same time. The name was also changed to Community Needs Assessment Approach (CNAA) to spell out the true intention of this change. However the results are not completely satisfactory. In many places simple mathematical calculations using population parameters and expected rates (like Crude Birth Rate) were made to arrive at targets for the whole range of services – antenatal tetanus toxoid coverage to contraceptive service delivery. Mahila Swasthya Sanghs and the Panchayat mandated Swasthaya Samiti remain confined to paper in many places.

Increasing choice of spacing methods, provision of informed choice – The objective of FP programmes over the years has been to reduce the fertility for women across the country to the replacement level of 2.1. However, unmet needs continue to be high in many states. The quantum of unmet needs remains as high as 25 to 30% in states like UP and Bihar and in the northeastern states. The participation of women in decisions relating to family planning is also poor and overall less than a fifth of all women discuss this issue with their husbands. Though in the last few years efforts have been made to introduce a number of new methods in the country – namely long acting injectable contraceptives, implants, emergency contraceptives, the diaphragm and the female condom.

Introduction of new contraceptives have been a seriously contested space between women's health activists on the one hand and international organisations and the government on the other. The argument of the women's health activists has been that many of these contraceptives have been inadequately tested in India, their introduction requires a stronger and more committed health delivery system and that many of their contra-indications are being downplayed. These groups have also argued that the Government has not made sufficient investment into women controlled methods like the diaphragm and the female condom. A Public Interest Litigation (PIL) was filed in the Supreme Court which has disallowed the adoption of injectable contraceptives in the government program while allowing for their controlled

use in the private sector. The use of quinacrine (an anti-malarial drug which if introduced as a pellet into the uterus causes tissue scarring leading to chemical sterilization) has been disallowed. Among the other contraceptives, emergency contraceptives have been introduced into the national program, production of female condoms is planned locally and some women's organisations are involved in distributing the diaphragm on a very small scale. In order to provide increased access to vasectomy a large number of surgeons have been trained in non-scalpel vasectomy.

It is interesting to note in Table 3 that despite the reduction in over all numbers and the subsequent upward trend, the proportion of different contraceptives remains the same across the years. The contribution of vasectomy to overall sterilization also remains the same throughout this period. This does not provide any evidence for increase in options provided by the providers or for increased information on spacing methods.

Informed choice, increased choice and availability of contraceptives were among the principle changes recommended by the ICPD PoA. A number of studies that were conducted in the early and mid 90's prove ample evidence that many of these aspects were found wanting in the different states. The providers often promoted one method over another rarely keeping the women's convenience in consideration. Supplies were also found to be irregular and inadequate in places. A five-state study commissioned by the Ministry of Health and Family Welfare came up with similar findings in 2003. Tubectomy continues to be the most prevalent method for contraception. Even the more progressive women in the community lacked knowledge and awareness about side effects and contraindications of different methods.

Improve range and quality of services – The reproductive health needs of women is not limited to contraception. Maternal health continues to be a major problem in India and over 125,000 women die each year from causes which are related to maternity and this number has remained stagnant for over a decade. However the government programme in most states, especially the so called poorly performing states remains driven by the family planning programme.

Over the decade the one answer that is being repeatedly proposed to reduce high maternal deaths is institutional deliveries. Studies have shown that roughly sixth of all deliveries can develop complications and need expert supervision and care. This means that all deliveries do not need to come to institutions but there needs to be a very effective system of screening before the onset or during labour and an efficient means of referral. Today if all women from the villages of the poorly performing states started approaching their local PHC for delivery services they would most probably be faced with absent doctors, unavailable beds, dysfunctional labour-rooms, no ambulance facility for referral to the Emergency Obstetric Care if necessary.

The need to promote contraceptives is not as important as it was earlier and in many places the demand actually exceeds supply. However the challenge of providing reproductive services of acceptable quality is emerging as a very important area of concern. The debate and discussion around quality of care of contraceptive services is of comparatively recent origin. A number of studies were conducted in different states in India in the early and mid-nineties to understand quality of care in Family Welfare services. These studies covered many of the major states including poorly performing states like Uttar Pradesh and Bihar to the better performing states like Maharashtra, Gujarat and Tamil Nadu. Being concerned about the poor quality of sterilization services the Ministry of Health and Family Welfare through its research and standards division released a set of guidelines on quality of care standards for female and male sterilization. Though tubectomy is the preferred method for the health providers the provisioning of services continues to be inadequate.

Services for Reproductive Tract (RTI) and Sexually Transmitted Infections (STI) were supposed to be one new service that was to be provided through the new RCH programmes. However the services for RTIs remains poor though training of providers has begun. Services for STI have received some fillip because of its close relationship with HIV/AIDS.

Increase accountability of providers at all levels – A very large network of Auxillary Nurse Midwives (ANM) , Lady Health Visitor (LHV), Medical Officers and Gynecologists are involved in providing Reproductive Health services in the public sector. Community Based Disbursement (CBD) workers of NGOs , small shopkeepers and entrepreneurs in Social Marketing programs and nurses and doctors of NGO and private sector organisations are also involved in providing contraceptive services.

The aggressive manner in which the Family Planning programme was implemented up to the 1980's has been documented¹. The ICPD PoA clearly warns against administrative excesses and abuses. However no clear mechanisms have been instituted to guard against these. The private sector which provides a significant proportion of contraceptive services continues to be poorly regulated in India. A set of guidelines were issued for ensuring quality of care of sterilization services, however no directions were given regarding what should be done if these were being followed. The performance audit review conducted by the Comptroller and Auditor General noted that only 9 states have reported a total of less than eight hundred contraceptive failures and no procedures existed to deal with these. Using the most conservative estimates (0.5%) roughly 22,000 women face contraceptive failure each year, though local studies indicate a much higher rate of failure.

¹ 'Something like a War' documentary film by Deepa Dhanraj

The National Population Commission was established within the Planning Commission, but this commission has not been provided with any clear mandate for monitoring accountability. However, the National Human Rights Commission (NHRC) and the National Commission of Women (NCW) have initiated some action to monitor accountability. The NHRC organized a national colloquium in January 2003 and NHRC Declaration "notes with concern that population policies framed by some State Governments reflect in certain respects a coercive approach through use of incentives and disincentives, which in some cases are violative of human rights." The NCW has initiated a process of Public Dialogues (Jan Sanwad) around Family Planning this year.

The Supreme Court has been involved in a number of reproductive related accountability cases in the last couple of years. The most well known among these is Public Interest Litigation (PIL) concerning the non-implementation of the Pre Natal Diagnostic Techniques (PNDT) Act. The Supreme Court has taken state governments to task and issued strict orders and guidelines. In a case of sterilization related death the Supreme Court has ruled that the Government is responsible for the action of its doctors and held it liable for the negligence. In another case the Supreme Court has awarded compensation to woman who conceived after undergoing tubal ligation. The Supreme Court delivered its judgement on a PIL against introducing long acting injectable contraceptives in the country and a PIL on the non implementation of the quality of care related standards is currently being heard in the Supreme Court.

Challenges

A closer examination of the situation in India reveals that despite the overall achievements in the ten years since ICPD, many new concerns have emerged. There is also a deep seated reluctance and resistance to change among program managers. Some of these concerns are highlighted below.

Population control mindset – The re-introduction of targets in many states in India, the continuing emphasis on the two child norm clearly indicates that the fear of a rapidly growing population and the need to control it somehow, dominates the thinking of many people in power. This is contrary to national and international evidence as well as population and development related theory. It is not surprising that this mindset still dominates because this mindset was inculcated systematically over the last 50 years and there have been no similar efforts to challenge it with recent evidence and understanding.

Lack of respect for clients – The ICPD PoA is not only about increasing the number of contraceptives available to a couple but it is deeply embedded in the concept of human rights. However government departments as well as individual service providers grow up in a culture of hierarchy and power. Informed choice implies a degree of humility in the providers and flexibility in

the manager, which will allow the system to provide adequate information to large number of non-literate persons and then support them in making a choice. Nurses, doctors and managers are not familiar with a client-centred culture.

With private institutions and NGOs playing an increasing role in the delivery of services it may be expected that there will be a slightly improved respect for clients because private institutions will recover a fee for service and NGOs have a closer community support. However for family planning programmes to remain committed to the principle of informed choice, reproductive rights and gender equality, it is essential to have clear programme inputs to ensure that these principles are incorporated into communication and service delivery strategies.

Ensuring adequate supply and access to a variety of contraceptives –

Unmet needs continue to be high in many places both at the level of a country and in specific provinces within countries. This is partly due to the inability of the health system to respond to the needs of couples. Knowledge of contraceptives is uniformly high across the region, but the needs of couples vary at different times in the union. However the emphasis on particular methods makes it difficult for couples to practice contraception at many points in their reproductive lives. Ensuring uniform contraceptive supply is essential for the success of spacing methods. In contrast to the earlier point relating to informed choice, regular supplies relates to management rather than programme and provider perspective.

Lack of knowledge of quality of care parameters – Though technical training is provided to service providers from time to time, there is lack of knowledge and concern relating to the quality of services provided. While this could reflect genuine ignorance it also relates to the attitude of providers towards their clients, especially poor rural clients who form the bulk of family planning service acceptors in the public sector.

Inadequate monitoring and accountability systems – The success of family planning programmes continues to be measured by contraceptive acceptance. Comparison of outcome studies like the National Family Health Survey in India bring out the huge discrepancy and over reporting that is inherent in service statistics. However these statistics continue to be measure of failure or success. Besides the problem of over-reporting the reliance on numbers reduces the importance of looking at quality parameters. It is a matter of grave concern that while contraceptive prevalence rates have increased over time, maternal mortality related rates have increased in the same places and over the same period of time. Despite the universal knowledge of failure rates and complication rates, there are absolutely no mechanisms in place to either trace or to provide for these individuals.

The times are long gone when it was necessary to count how many people

are interested in and are using family planning methods. Communities no longer need to be convinced about the need to use contraceptives. The question is whether the service delivery system is geared to provide them with the appropriate service which is of high quality. The program planning and monitoring indicators need to be so designed that they capture this aspect of service delivery.

The emphasis on numbers has also led to a wholly inadequate accountability mechanism. Community level providers are held accountable only on the basis of their numerical performance. Instead of improving service delivery this leads to dishonest record keeping. The recent legal activities around family planning service quality indicate that the community is no longer willing to accept poor services.

SECTION THREE

Advocating for Reproductive Health and Rights in India

What is Advocacy ?

Advocacy is an important component of the rights based approach. Policy or public advocacy is different from legal advocacy in the sense that it does not necessarily involve courts or the judicial system. However it is closely concerned with the rights of the underprivileged or the marginalised. Public or policy advocacy involves the creation of public pressure for influencing policy formulation, programme implementation in the interest of the poor, underprivileged or the marginalised. Such advocacy efforts are usually directed towards those groups or individuals who are in decision making positions and could include policy makers, legislators, senior program managers and so on. The advocacy initiatives can be taken by the affected groups themselves or by other members of civil society who are concerned. Advocacy thus links grassroots activism to macro level policy action. Advocacy activities are non-violent and usually involve democratic spaces for debate, discussion, protest and civil disobedience. The objective of advocacy is to ultimately increase the participation of the underprivileged groups in decision making processes which affect their own lives. In a democratic country like India, advocacy can be seen as a process aiming at improving citizenship of the poor and backward groups. Women are among the most underprivileged of all groups.

Advocacy is - A value driven political process, embedded in the respect for human rights

Advocacy involves – Deliberate, planned and organised action

Advocacy aims - To effectively influence public policies and get them implemented

In order to – Advance social justice and human rights

Make the governance accountable and transparent

Policy Advocacy

Bringing about policy change through

- *Creating policy where they are needed and none exist*
- *Reforming ineffective and harmful policies*
- *Improving policy implementation*

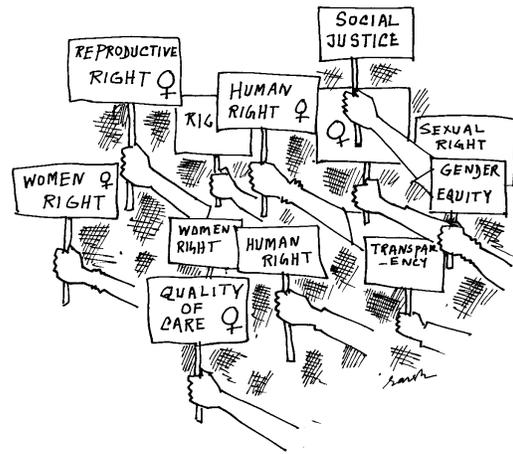
This may involve dialogue, negotiation, protests or confrontation

What is the need for Advocacy ?

India is a socialist, secular and democratic country where every individual born regardless of age, sex, religion, caste place of residence, educational status is a citizen, and after attaining majority has the right to participate in selecting the governments. The governments, which are elected by the people

are meant to serve the interests of the citizens and the Constitution of India has made express commitments to serving the needs of all persons to secure social, economic and political justice for all.

However a large portion of the population, notably women continue to live their lives without dignity, and have to face numerous privations – social, economic and political. In the realm of health care, women have special



health needs, however despite the focus of maternal health services since independence maternal mortality figures remain unacceptably high. Sub centres are often closed; women doctors are not available at the Primary Health Centre; Emergency Obstetric Care services are still not available at all First Referral Units; and the result is that there is very little health service available for women. This is

despite the fact that over the last six to eight year's new policies and programmes have been designed and implemented. It is in the interests of the women that the policy makers and programme planners become aware of grass-roots reality. It is in the interest of achieving the very laudable programme objectives and outputs that women become involved in monitoring the programmes that are supposed to be providing them valuable and much needed services. The process of informing policy programme planners about the grass roots reality and the experiences of women so that programme formulation and implementation can be done in the interest of women needs advocacy. The process of getting women to become parties in the programme formulation and monitoring process involves advocacy. The process of increasing grass roots democracy and citizenship includes advocacy.

Reproductive Health and Cultural and Political Challenges to advocacy in India

In the recent past, much ground has been gained in getting gender, empowerment of women and Reproductive Health and rights incorporated at the policy and programme level of the government and that of international development organisation, but in reality many of these changes remain restricted to paper. Poor rural women continue to suffer



multiple oppression. The international changes have been successful in changing the language of the discourse but as far as the state is concerned, a lot of doubt remains about its intentions. There is the fear that the state has adopted the rhetoric without adopting the substance. Experiences over the last couple of years with regard to the implementation of programmes by the different authorities strengthen this doubt.

The other challenge in enabling women to achieve their potential reproductive health does not lie in not having effective policies or programmes, but in their implementation. It is with regard to this hurdle that one has to consider the cultural traditions and biases existing in different parts of our country. Patriarchy is by and large practised in most parts of the country (except some notable exceptions), reproductive organs and functions of the women's body are considered polluting and shameful, there is a great degree of hypocrisy surrounding matters relating to sexual behaviour. Added to this there are numerous beliefs and practices concerning the smallest aspect of women's lives, especially menarche, pregnancy, childbirth, childrearing, infertility, and women's health (especially Reproductive Health problems). In such a situation, enabling women to achieve a state of health is not just a simple matter of providing services and designing IEC programmes. The challenge is to somehow change the deep-rooted centuries' old traditions. Unless we realise this, most efforts will not be successful.

The problem of cultural biases is prevalent not only within communities at large and within the women themselves, but also within the service providers who are supposed to provide different social sector and health services to the community. In such a situation, just assuming that a change in programmes will affect their behaviour is being very naive. There is enough evidence over the last three years to show that much of the changes that have been brought about by programmes are not being implemented in the spirit intended. Advocacy efforts at the community level to change community attitudes and perceptions become very important in this context.

Strategies for Successful Reproductive Health Advocacy

Advocating for Women-centred Reproductive Health is not just a matter of getting the Government to formulate the politically appropriate programmes. It is a complicated issue of building bridges with the Government, service providers, media, community leaders organising communities and creating a widespread understanding and consensus on sensitive issues like women's position in society, her rights and entitlements, male responsibility and participation and so on. Engaging in all these activities is not possible for any one actor and so it is essential that interested parties themselves engage in broad-based coalition building, so that different people can focus on activities they are best skilled at. While advocating and lobbying with the Government authorities for both programme implementation and policy formulation has been visible, the other important task of mobilising communities for demanding their rights has not received much attention in the sphere of Reproductive

Health and Rights. Some of the important areas around which advocacy is important are :

- Broadbased alliance-building within activists, NGOs and other concerned actors
- Community-based research and wide dissemination of the results
- Changing mindset of the bureaucrats and healthcare service providers
- Open avenues for dialogue and partnership between government bodies and NGOs and with the community
- Increase in bottom-up planning, ensuring accountability and transparency; involving panchayats, especially women representatives
- Increased investment in training, involving social sector experts in training; skill upgradation of health personnel;
- Improving working conditions of ANMs and rationalising their workload
- Developing a strategy for involving men
- Generating a demand from women and the community for Reproductive Health services and rights

Different Kinds of Advocacy Action

Media Advocacy

Using the print media – Press release; Media advisory, letters to the editor, writing Op- Ed pieces, inviting media persons to events, exclusive stories etc.

Electronic Media – radio and television- Media coverage to events, human interest stories, participating in discussions and talk shows etc.

Public Education

Public meetings and film shows, Signature campaigns, Wall writing, Posters, Street Plays and other popular or folk media etc.

Preparing reports, briefing kits, booklets, fact sheets and other written material

Opinion polls and focus groups

Dialogue and Negotiation

Individual meetings and face to face interaction; Consultations; Written memoranda

Policy/ Programme Monitoring

Facility visit ; Implementation mapping; Social Audit; Interviews with clients and community

Legislative Advocacy

Meeting with leaders of political parties, preparing and presenting briefing kits

Asking politicians to put up questions before the legislative assembly/ parliament

Meeting with leaders of political parties around their election

manifestos

Meeting and briefing politicians associated with committees associated with the legislature or during a law making process

Legal Advocacy

Filing cases around cases of individual violation of rights in the court of law

Filing Public Interest Litigation in State High Court or Supreme Court

Public Hearing, Tribunals and Commissions

Internet based Advocacy

Email based mass mailing, action alerts, signature campaigns

Building issue specific websites and portals

Direct Action

Protest March and Rally; Sit-in and Demonstrations ; Hunger strikes

A Review of Current Advocacy Effort for Reproductive Health

There is a long history of social movements in seeking a better social status for women in our country. Close on the heels of social movements has also been a history of legislative reforms. In recent times, dowry deaths have given rise to strong voices within the women's movement decrying this inhuman practice. In the case of contraceptives there have been struggles against the introduction of long-acting hormonal contraceptives. In the case of Reproductive Health the demands have been much more muted. In the period before ICPD, NGOs and women's groups organised a series of parallel



consultations across the countries trying to take on board concerns of activist and grassroots workers. After ICPD there were efforts to help the Government fulfill its commitment. In the last few years there have been occasions when there have been efforts to go back to the population control agenda. This has brought together a large number of groups together. Implementation of the PNDT Act and the declining juvenile sex ratio has been one issue around which there has been

consistent advocacy in recent times.

Community based advocacy - In a country like India, social systems are so

strong and well entrenched that women's movements, despite being extremely vocal, have made a greater impact in terms of legal provisions than in changing people's mindset. In such a situation, the importance of advocacy is two fold: raising consciousness among the community to the issue and influencing state systems to enact and implement new policy. Where consciousness-raising efforts are concerned, in the sphere of Reproductive Health, these are primarily pioneered by different community based NGOs working on this issue. Their numbers are few, and they are far outnumbered by those NGOs that are working primarily with either a very Family Planning/Population Control-oriented approach or a maternal and child health perspective.

The challenge for community-based advocates is to help the community, especially women, articulate their own Reproductive Health needs and demand their rights – from their families and communities as well as from service providers and the Government. This, as has been pointed out earlier, is easier said than done, but a number of experiences all over the country prove that this is possible. These community-based efforts incorporate many aspects like, transparency, bottom-up planning, involving men and so on.

Providing the background for change – That the situation of women in our country is bad is well documented, but there are many aspects of women's health and the denial of their Reproductive Health related rights which have not been adequately documented. Many false notions about the status of women's Reproductive Health and Rights persist. Similarly, people in the community accept their situation unquestioningly. The challenge for advocates is to bring to light these situations through thorough documentation to policy makers and implementors as well to the community at large so that they may take stock of their own situation and act accordingly.

That data plays a crucial role in both in identifying the core advocacy issue as well as identifying possible is well illustrated by the role of juvenile sex ratio in the advocacy against sex pre-selection. Juvenile Sex Ratio (proportion of girls for one thousand boys) is a statistic that was never seriously considered in our country. However office of the Registrar General of India has built up a strong movement across the country based on this figure. Similarly data from the National Family Health Surveys, the District Household Survey or the Census can be used to identify and give substance to important issues we know exist on the ground. Smaller scientific studies, both quantitative and qualitative, may be conducted to highlight and substantiate issues that we believe need to be addressed through our experiences on the ground.

Data and research can also be used in identifying and creating solutions. Grass roots interventions implemented by different groups can be carefully documented to identify key issues which led to their success. Research methodology plays a crucial role in substantiating claims with empirical evidence otherwise these claims run the risk of being dismissed as being

anecdotal.

Advocating for policy change with the Government - Besides creating informed community awareness on the issues of Reproductive Health and Rights, an agenda which has slowly emerged is that of advocating for policy changes or for effective implementation of Government programmes. On this count there are three different kinds of efforts which are currently being tried within the country. These efforts are characterised by different approaches but all three are spear headed by activists and NGOs. There are some NGOs which are involved on all three efforts.

The first effort could be broadly termed as **active conformation and litigation**. This has included successfully resisting the introduction of long-term hormonal contraceptives like Depo Provera and Norplant or for Quinacrine. On the other hand, the same groups have also actively lobbied for introduction of legislation banning sex-selective abortions in which they were successful. Many of the activists involved in these efforts belong to what is loosely called the autonomous women's health movement in India.

The second effort could broadly be called **engagement** and is being spearheaded by a network of academics, activists, NGOs and demographers called Healthwatch. This network was formed immediately following the Cairo conference and has the fulfillment of the Cairo PoA as its main objective. Towards this end it has been involved in consultative processes and conducting nationwide studies. The results of these consultations and studies have been regularly shared with the Government. While there has been no explicit acknowledgment of the contribution of Healthwatch in the framing of the new Target Free Approach, Reproductive and Child Health Programme or the Community Needs Assessment Approach, members of the network have been involved in influencing some of the changes in their independent capacities.

A third approach which is being tried is that of **community monitoring and social audit** of programmes and policies. This has included the community initiated and implemented studies of the public health services and subsequent public tribunals or public hearings.

Advocating for Change -Some Experiences

In this section we will introduce different efforts around RHR advocacy in India.

Campaign against Injectable Contraceptives - Women's groups in India have been very vocal against the introduction of injectable contraceptives in the country. The campaign started in December 1984 and is still ongoing, which illustrates its dynamic and sustained nature. During this extended

period, the campaign has included dharnas, sit-ins at the Ministry of Health and Family Welfare and ICMR, gherao of the Drug Controller, public interest litigation, reaching out to the public through posters, booklets, songs and skits and even video. The success of this campaign can be measured by the fact that these contraceptives have not yet been made part of the Family Planning programme. For more information about the campaign please get in touch with Saheli, Women's Resource Centre, Delhi.

Campaign against sex-preselection – Sex pre-selection and abortion of the female fetus has been a negative aspect of son-preference in India. A campaign on this issue started in the 80's in Maharashtra and led to the enactment of a law prohibiting such practice in the state. Later the campaign spread to other parts of the country which led to the enactment of the national Pre-Natal Diagnostic Techniques (regulation and prevention of misuse) Act, 1994. This act forbids doctors from conducting tests to determine the sex of the foetus. However this act was not implemented in most states of the country and thus a group of health activists approached the Supreme Court with a PIL to enforce its provisions. The Supreme Court in a series of orders has directed the states to immediately ensure the implementation of the provisions of the law. The Act has also been amended to include newer technology which enables sex-determination even before conception. The campaign has gained momentum and many more parties have joined in after the Census 2001 revealed that there has been an alarming decline in the juvenile sex ratio all across the country. For more information on this campaign please get in touch with CEHAT, Mumbai.

Campaign against Two child Norm and targeted population programmes – One of the key elements of the new paradigm adopted after the ICPD was voluntary informed choice and a reproductive health approach. However within five years of adopting the CNAA approach there was anxiety within the Government that this approach was resulting in the reduction of contraceptive acceptors. This led to many state governments to continue or impose with a two child norm which provided disincentives for people (young people) with more than two children. Health activists approached the NHRC in 2002 with this issue and the NHRC instructed the state governments to reconsider their policies. However the Supreme Court in a judgement in 2003 (Javed vs Government of Haryana) upheld the two child norm without considering recent population and development related evidence. The United Progressive Alliance has also called for targeted population control in its Common Minimum Programme. A large number of groups are involved in diverse advocacy activities for the withdrawal of these norms. These activities have included consultations, public tribunal, media advocacy, studies and widespread dissemination of these findings, PIL on quality of care of family planning services and so on. For more information on this campaign please get in touch with SAMA, Delhi or Healthwatch UP, Bihar, Lucknow.

WHRAP: Women’s Health and Rights Advocacy Partnership -

WHRAP brings together women NGO partners who are committed to strengthening civil society capacity to effectively advocate for sexual and reproductive health and rights (SRHR) issues. The main issues included are safe motherhood and young people’s SRHR and the advocacy is aimed at the local, national and regional levels. Currently implemented in Bangladesh, India, Pakistan and Nepal. WHRAP is being implemented in India in Gujarat, Rajasthan, and Uttar Pradesh and is coordinated by CHETNA and Kriti Resource Centre, Lucknow.

HEALTHWATCH - This is a national network started immediately after the Cairo Conference by a group of individuals who had attended the conference and wanted to assist in the process of actualising the PoA in India. Today, Healthwatch is very broad-based alliance and includes in its core group activists, researchers, established service delivery and training NGOs, demographers and academics. The network has been involved in creating an understanding and awareness both about the TFA and RCH as well as the post ICPD programme implementation around the country through a series of consultations. It has recently concluded a country wide study on the status of safe abortion in the country.

Women and Health (WAH) Network - The WAH! network has been involved in first developing a clear perspective on women and health and, once that perspective was developed, actively disseminating this understanding through training and advocacy. These training programmes which were conducted in South and West India have now helped in creating a large number of organisations which are committed to this framework. The network is also involved in advocating for a comprehensive women’s health policy for the country. For more information please get in touch with CHETNA, Ahmedabad.

People’s Health Movement - The People's Health Movement (PHM) is a growing coalition of grassroots organisations dedicated to changing the prevailing health care delivery system. The goal of the PHM is to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities. In India, this movement is going on in the form of the Jan Swasthya Abhiyan (JSA). JSA is involved in a series of regional Public Hearings on the Right to Healthcare which were conducted by the National Human Rights Commission (NHRC). JSA was also involved in a People’s Tribunal on the Two Child Norm and Coercive Population Policies. For more information please get in touch with CEHAT, Pune.

SECTION FOUR

Resource Section

Books for further reading

This is a selection of books and reports we found useful while making this booklet

- Abdullah, R. 2000, *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing*, Asian-Pacific Resource and Research Centre for Women, Kuala Lumpur.
- Alcalá, M. J. 1995. *Commitments to Sexual and Reproductive Health and Rights for All*. New York: Family Care International.
- ARROW. *Changes in Population Policies and Programme Post ICPD* Cairo: A Regional Research Project. Kuala Lumpur: ARROW.
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- Bharat S (2003) , *Social Assessment of Reproductive and Child Health Programme - A Study in 5 Indian States*, MoHFW and DFID, New Delhi
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- Centre for Reproductive Rights. *Cairo+5 (Kit)*. New York: CRR
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- Correa, S. 1994. *Population and Reproductive Rights*. New Delhi: Kali for Women.
- Correa, S.1999. *Implementing ICPD: Moving Forward in the Eye of the Storm*. Suva Fiji: Development Alternatives with Women for New Era.
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- Ford Foundation. 1997. *Advocacy for Reproductive Health and*

- Women's Empowerment in India*. New Delhi: Ford Foundation.
- Germaine, A. and R. K. 1995. *The Cairo Consensus the Right Agenda for the Right Time*. New York: International Women's Health Coalition.
 - Hardon, A. et.al. 1997. *Monitoring Family Planning and Reproductive Rights: A Manual for Empowerment*. London: Zed Books Ltd.
 - Healthwatch UP, Bihar 2002 *Priorities of the People: People Population Policies and Women's Health in UP*, Lucknow, HW UP, Bihar
 - HERA. 1998. *Confounding the Critics: Cairo Five Years On*. New York: HERA.
 - HERA. *Women's Sexual and Reproductive Rights and Health*. New York: HERA.
 - ISIS International. *Women's Perspectives on Population Issues* (Information kit). Phillipines: ISIS international.
 - Jain, A.1998. *Do Population Policies Matter?* New York: Population Council.
 - Kissling, F. 1997. *The Vatican and Politics of Reproductive Health*. London: Catholics for a Free choice.
 - Lombardi, K. and C.S. 1999. *Cairo+5: Telling the Stories*. Washington: The Centre for Development and Population Activities.
 - Ministry of H&FW 2000. *National Population Policy 2000*: New Delhi, Dept. Of Family Welfare.
 - Ministry of H&FW. 1997. *Reproductive and Child Health Programme Schemes for Implementation. India* : Dept. Of Family Welfare.
 - Ministry of H&FW.1998. *Manual on Community Needs Assessment Approach*. India: Dept. Of Family Welfare.
 - Mukhopadhyaya, S. 1998. *Women's Health, Public Policy and Community Action*. New Delhi: Manohar
 - IIPS and ORC-Macro (1999) *National Family Health Survey – 2*, Mumbai, IIPS
 - Pachauri, S.1995. *Defining a Reproductive Health Package for India a Proposed Framework*. New Delhi: The Population Council.
 - SAHAYOG. 1999. *Voices From the Ground*. Almora: SAHAYOG.
 - Saheli Women's Resource Centre.1997. *Quinacrine: The Sordid Story of Chemical Sterilization*. New Delhi: Saheli Women's Resource Centre.
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- World Bank. 1996. *Improving Women's Health in India*. Washington: The World Bank.

Addresses of organisations involved in Reproductive Health and Rights Advocacy

List of Organizations

ACTION INDIA - Delhi

C/o Gouri Choudhary
5/24 Jangpura
New Delhi- 110 014
Phone 011-4314785; Fax 011-4327470
Email- actioni@nda.vsnl.net.in

ARTH- Udaipur

C/o Dr. Sharad Iyengar
39 Fatehpura,
Udaipur-313 004 Rajasthan
Phone 0294- 2451003
Email: arthsoc@sanchar.net.in

MASUM, Pune

C/o Manisha Gupte,
11, Archana Apartments,
163 Solapur Road, Hadapsar,
Pune -28.
Ph-0212-675058, Fax 0212-611749
E-mail- masum@vsnl.com

KRITI Resource Centre

C/o Jashodhara Dasgupta
SAHAYOG
C-1485, Indira Nagar,
Lucknow-226016, Uttar Pradesh
Phone: 0522-2310747, 2341319
E-mail- kritirc@sahayogindia.org

AIKYA - Bangalore

C/o Philomena Vincent
377 Jayanagar, 42nd Cross, 8th Block
Bangalore-560 082(Karnataka)
Phone 080-6645930,8432363
Fax 080-6631565,attn. Aikya

CHETNA- Ahmedabad

C/o Indu Capoor
Lilavatiben Lalbhai's Bungalow
Civil Camp Road, Shahibaug,
Ahmedabad-380004, Gujrat
Phone: (079) 2866695, 2868856,
2865636

Email: chetna@icenet.net

CEHAT- Mumbai

C/o Ravi Duggal
Sai Ashray, Aram Society Road,
Vakola, Santacruz (East)
Mumbai- 400055
Phone-91-022-26673154, 26673571
Email- cehat@vsnl.com

RUWSEC - Tamil Nadu

C/o Dr. Sundari Ravindran
191-A, Nehru Nagar, Vallam Post
Office, Kancheepuram District,
Chengalpattu -603 002, Tamil Nadu
Phone: (04114) 2433216, 2430682
Email: rural@md4.vsnl.net.in ;
kcm_rural@sancharnet.in

SAMA

C/o N.B.Sarojini,
G -19, 2nd Floor,Saket,
New Delhi 110017 India
Telephone: +91-11- 55637633;
Fax: +91-11- 26562401;
Email: sama_womenshealth@vsnl.net

SARTHI – Gujarat

C/o Dr. Giriraj Singh
P.O. Godhar Pashchm 389230
Via Lunawada,
Taluka Santrampur Panchmahal-389
230 (Gujarat)
Phone 02674-239306

SAHAJ- Vadodra

C/o Renu Khanna
1, Tejas Apartments
53, Haribhakti Colony, Old Parada
Road
Baroda-390007, Gujarat
Phone 0265-340223; Fax 0265-330430
Email – sahajbrc@icenet.co.in

Sakhi- Kerala

C/o Aleyamma Vijayan
TC 27/1872,
Convent Road,
Trivandrum- 695035.
Ph- 0471-2462251
Email: sakhi@md2.vsnl.net.in

Prayas, Chittor

B -8, Bapu Nagar, Senth,
Chittorgarh 312 025
Rajasthan
Ph –
Email – prayasct@sancharnet.in

HEALTHWATCH

C/o Vimala Ramachandran
10 B Vivekananda Marg,
Jaipur, 302001,
Ph-0141-2360158

Jan Swasthya Abhiyan

C/o CEHAT,
3&4, Aman Terrace, Plot no.140,
Dhahanukar Colony Kothrud
Pune- 411029
Email – cehatpun@vsnl.com

Healthwatch- UP Bihar

Secretariat
C-1485, Indira Nagar,
Lucknow-226016, Uttar Pradesh
Phone: 0522-2310869; 2310747,
2341319
E-mail- healthwatchupb@yahoo.co.in

VHAI - New Delhi

Tong Swasthya Bhawan,
40 Institutional Area, South of IIT
NewDelhi-110 016
Phone 0116618071,6965871,6962953
Fax 0116853708
E-mail- VHAI@del2.vsnl.net.in

Saheli, Women's Resource Centre

Unit above Shop Nos 105-108,
Defence Colony Flyover Market,
New Delhi-110024.
Emali: saheliwomen@hotmail.com

Forum for Women and Health

C/o Swatija Manorama,
9, Sarvesh,Govind Nagar,
Thane (East),
Maharashtra- 400603,
Ph- 542 3532

Population Foundation of India

B – 28, Qutab Institutional Area ,
Tara Crescent ,
New Delhi – 110016,
Ph .011 – 26867080
Email -

**Lawyers Collective- Women's
Resource Initiative**

C/o Indira Jaising
63/2, First Floor, Masjid Road,
Jungpura Extension,
New Delhi 110014
Telephone; (011) 2431 6925,
Fax – (011) 24321101
E-mail: wri@vsnl.net,

Human Rights Law Network

65, Masjid Road, Jangpura
New Delhi – 110014
Tel: 91 – 11 – 2432/4501,
2431/9856, 2431/6922,
Fax: 91-11-24324502
Email:hrlndel@vsnl.net;
slicdelhi@vsnl.net

Useful Websites :

Advocates for Youth – www.advocatesforyouth.org
Asian Pacific Resource and Research Centre for Women (ARROW) –
www.arrow.org
Center for Development and Population Activities – www.cedpa.org
Center for Health and Gender Equity (CHANGE)- www.genderhealth.org
Center of Reproductive Rights – www.crr.org
Centre for Enquiry into Health and Allied Themes (CEHAT) -
www.cehat.org
Community Partners – www.cp_advocacy.org.uk
Development Alternatives for Women (DAWN) - www.dawn.org.fj
Global Health Council – www.globalhealth.org
Healthwatch UP Bihar- www.sahayogindia.org/hwupb.htm
Human Rights Watch – www.hrw.org
International Center for Research on Women – www.icrw.org
International Centre for Reproductive Health- www.icrh.org
International Women's Health Coalition - www.iwhc.org
ISIS Women's International Cross Cultural Exchange – www.isis.org.ug
Jagori – www.jagori.org
Jan Swasthya Abhiyan – www.phmovement.org/india/index.html
Medico Friends Circle – www.mfcindia.org
Ministry of Health and Family Welfare – www.mohfw.nic.in
National Commission of Women – www.wcd.nic.in/ncw/home.htm
National Human Rights Commission – www.nhrc.nic.in
Population Action International – www.popact.org
Population Commission of India – www.populationcommission.nic.in
Population Reference Bureau – www.prb.org
UNIFEM – www.unifem.org
United Nations Population Fund (UNFPA) - www.unfpa.org
Voluntary Health Association of India – www.vhai.org
Women Living Under Muslim Law – www.wluml.org
Women's Environment and Development Organisation – www.wedo.org
Women's Global Network for Reproductive Rights – www.wgnrr.org
Women's Health and Development Program, Pan American Health
Organisation- www.paho.org

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