Editorial

India became a signatory to the International Conference on Population Development (ICPD) Programme of Action (POA) in 1994 and advocated a paradigm shift by removing the target approach and affirmed its commitment to “voluntary and informed choice and consent” of citizens while availing reproductive health care services.

The Coalition Against Two-Child Norm and Coercive Population Policies hosted by Centre for Health and Social Justice (CHSJ) is a group of individuals and organisations interested to raise awareness among different stakeholders about coercive nature of different population control policies and to advocate for their removal from policies and programmes at the state and the central level.

The introductory article by Leena Uppal reflects an overview of the civil society review of ICPD+15 undertaken in the year 2009-2010. She briefly outlines the objectives of the last ICPD review process in India and expected outcomes of the review process of ICPD+20 that is currently going on in India.

Frederika Meijer, the United Nations Population Fund (UNFPA) representative for India, in her interview has highlighted the focus on young and adolescent people and has emphasized that this time the ICPD review would focus on sexuality education, and efforts to expand the range of choice especially spacing methods.

Jashodhara Dasgupta, who has been working in the field of rural women’s health, reproductive rights and maternal health has expressed strong concerns around the way Indian women are left with only one choice for contraception, i.e. sterilisation. The fact that two-child norm still persists in the form of acts and entitlements amply indicate the lack of commitment to promoting women’s right to choice.

Shubha Chacko, director of a Bangalore based NGO- Aneka, in her article focusses on the misplaced vision of women as merely “reproductive machines”. She emphasises that individuals who fall outside this narrow definition such as single women, lesbians, transgender, sex workers, and women living with HIV (who may or may not be married) have been omitted from availing services even at the conceptual level.

Sabiha Hussain is an academician and a researcher at Jamia Millia Islamia University, New Delhi, author of two books, ‘The Changing Half: A case study of the Indian Muslim woman’ and ‘Exposing the Myths of Muslim Fertility’; points out to the need for understanding specific challenges of marginalised communities, while designing the family planning programmes.

Anubha Rastogi, a human rights lawyer, in her article has emphasised how the government and institutions including the judiciary have in various ways reinforced the idea of two-child norm which has unfortunately worked against women making them helpless in an unresponsive health system.

Finally, in a critical analysis by Mohan Rao, Professor, Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi has highlighted the gaps between discourse and reality and the inadequate attention given to women of third world countries.

As we move forward towards the 20th anniversary of ICPD POA, a vigorous civil society review process is needed to address women’s needs and promote decision-making by women and sexual minorities in contraceptives, number of children within the overall context of their economic and nutritional needs, social position, and cultural constraints. This newsletter is a small step towards bringing meaningful change in reproductive justice and population policy.
ICPD+ 15: The National Civil Society Review process

The International Conference on Population and Development (ICPD, Cairo 1994) not only endorsed the idea of rights based approaches in health through the adoption of the concept of ‘reproductive rights’ but also attempted to do away with the earlier ‘population explosion rhetoric’, and included sustainable development along with the need to look at varied populations – the indigenous, the differently abled, migrants, children, the elderly etc.

Fifteen years since ICPD, a civil society review of commitments made at the ICPD was initiated. The process was facilitated by Centre for Health and Social Justice (CHSJ) in the year 2009-10. The review brought together diverse organisations, networks and governments through a series of meetings and consultations that were held at the national and regional levels. Some of the key stakeholders included community based organisations and federations, networks, women’s health and youth groups, organisations working on dalit rights, maternal health, family planning, abortion rights, sexual health and rights, sex workers rights and sexual minorities, HIV/AIDS and so on. International organisations, UN agencies, bi-lateral organisations, governments at the national and state levels, academicians from reputed institutes across India also participated.

Given the diversity of stakeholders, the overall objectives of the review process were as follows:

- To conduct a review of key gains and challenges that have emerged in the last 15 years since ICPD in the context of health related policy and programming in India.
- To raise awareness among multiple stakeholders, including the state, about the significance of reproductive rights in the context of existing health conditions of specific vulnerable groups
- To push the boundaries of conceptual thinking around sexual and reproductive health and have a dialogue with different groups and movements within civil society to create synergy.

ICPD at 20:

As the 20th anniversary (2014) of the ICPD POA draws close, government’s commitments to its people in India are under review; UNFPA organised a consultation process in the month of November 2012 towards the new sustainable development goals at the global, regional and the national level. This consultation provided an avenue for civil society partners to share their views on the progress made in the country with regards to ICPD POA; and how civil society can feed India’s views into the global processes and take advantage of the opportunity to discuss processes to leverage actions within India for greater congruence with the spirit of the ICPD POA.

September 2014 marks 20th anniversary of ICPD. The UN General Assembly passed resolution A/65/234 (2010) as a follow up to the vision of ICPD, beyond 2014

An ICPD+20 review of the ICPD (POA) is in process, a key outcome of which will be a special report with recommendations for action from the UN Secretary General to be presented to the UN Conference on Population and Development in 2014

India ratified the 20-year ICPD POA, and pledged to promote gender equality, eliminating violence against women and provision of comprehensive sexual and reproductive health services as cornerstones of population and development policies

The review process in India at ICPD+15 brought forth a strong need for state level coalition building to counter coercive population policies as a prerequisite for achieving the ICPD Programme of Action

The focus of these meetings was to take forward the review of achievements, gaps and challenges in delivering the promise of Cairo. Global discussions and partnerships between women’s organisations, parliamentarians, governments, young people’s organisations and UN agencies are taking place to push for strong and successive frameworks of ICPD and MDGs and beyond. One of the key concerns that emanated during these meetings was the need for civil society organisations to take greater interest and feed learnings into the different processes, and to come up with coordinated messages to ensure sexual and reproductive health and rights is at the heart of the new framework and national policies and programmes.
Describe UNFPA’s involvement with the ICPD beyond 14 review process in India?

UNFPA believes in the ICPD and strongly feels there is no need to renegotiate on what all has been agreed to in the ICPD POA; however, there is a need to review the progress made since. We are trying to link the ICPD with the post 15 agenda looking at sustainable development and also primarily working with the young people to see what should be the new sustainable development goals. UNFPA believes strongly that this time the review would focus on sexuality education and efforts to expand the range of choices especially spacing methods.

UNFPA has continuously been examining if young people have the information to make informed choices and whether the services ensured within the National Rural Health Mission in India are really adolescent friendly. UNFPA also has a special interest in the roles that Accredited Social Health Activist (ASHA) are playing in counseling because even today young girls are bearing children too early, which is hampering their own development. UNFPA has been working closely with the government on an adolescent health strategy and engaging with different ministries including the Ministry of Health, National Council of Education Research and Training (NCERT) and the Ministry of Human Resources to bring in the adolescent focus agenda.

What is the role of UNFPA for women’s free choice in family planning decision making?

It is important and encouraging that the government of India has made the ICPD review process open to the public and has put up the ICPD questionnaire for civil society review on their website. The government recognises the gaps which are in the health programmes, but we do need a strong community voice. UNFPA does not support coerced sterilisation operations. In a scenario where the Supreme Court has mandated that the Ministry of Health and Family Welfare (MoHFW) guidelines on sterilisation for men and women need to be followed in the states, the vigilant role of civil society organisations to eliminate flouting of rules and guidelines assumes greater importance. UNFPA is concerned and is working with the government to ensure that quality assurance takes place and women exercise free choice.

A lot of work needs to be done in strengthening the implementation of NRHM. UNFPA is continuously involved in screening the state and district NRHM activities. An area which needs further strengthening is community monitoring. There also needs to be interstate learning exchange of good practices in quality assurance, e.g. in Maharashtra UNFPA has worked closely with the state government on strengthening quality assurance system.

“It is known by now that there are certain countries who want to push back on gender equality. India in the ICPD 1994 played a very important role and it should continue to keep the momentum else the world would go back. All of us playing different roles- media, government, civil society and UNFPA with its global experiences need each other to bring forward the whole population agenda.”
Rights based approach and empowerment of women through ensuring their ability to control their own fertility is the cornerstone of population and development related programmes. How far do you think we are from this approach?

Almost 20 years ago we agreed to the principles of empowerment of women and rights based approach. It is sad that even after 20 years, we have moved only on paper because the policy making circles continue to emphasise female sterilisation as a key measure for fertility control. Recently an analysis of Programme Implementations Plans (2011) of different state governments conducted by CHSJ revealed that the budgets and activities relating to family planning under the National Rural Health Mission (NRHM) clearly focus on female sterilisation. If only one contraceptive is offered to women, where are the elements of choice and planning? Women need contraceptives and they accept what is being provided to them, sterilisation neither gives women time to plan nor does it imply that they have a choice.

The data from Health Management Information system (HMIS) report of NRHM available on the website implies huge differentials between male and female sterilisation operations. Governments continue to track only permanent methods of family planning and within that gender sensitivity is a huge concern. It is clearly visible that community needs assessment approach that was brought in, by the government itself around 1997, has been dropped off as the policy makers do not seem to have an understanding of how it could be done. We know that many women are forced to become pregnant; women face marital rape and forced sex. Given these realities, maternity benefits are made conditional based on number of children, which means victimising women and denying them their rights.

Recently in the international platforms including the London Summit 2012, issues like safe abortion, freedom of choice in contraceptions were not explored and thought through in detail. How do you think such a position will impact the policy planning with regard to comprehensive reproductive rights and health for women in India?

In London Family Planning Summit (2012) a major intention was to ensure that world market for sale of contraceptive products flourishes and remains well funded. The fact that India at this summit committed to play a key role towards promotion of contraceptive products among millions of women in India, is indicative of the fact that Indian policy and programme planners continue to place family planning outside the realm of women's reproductive rights and choice. With this logic, India will commit bigger budgets to family planning commodities and there will be complete lack of attention to reproductive rights and empowerment and issues like safe abortion and choice of contraceptives will remain neglected.

India submitted its status report for the second cycle of Universal Periodic Review (2012-2016), which is a new and a unique human rights mechanism of the UN Human Rights Council, aiming at improving the human rights situation on the ground of each of the UN Member State. Under this mechanism, the human rights situation of all UN Member States is reviewed every 4

For women’s reproductive rights and advocacy
Jashodhara Dasgupta

Interview by Leena Uppal

Jashodhara Dasgupta has been working since 1986 to promote rural women’s maternal health, sexual and reproductive health and rights and human rights. She is currently the coordinator of SAHAYOG, and is on the steering committee of civil society platforms such as the National Alliance on Maternal Health and Human Rights (NAMHHR, India), the Women’s Health and Rights Advocacy Partnership in South Asia and the International Initiative on Maternal Mortality and Human Rights. She has served on a high-level expert group on Universal Health Coverage (2010-11) and is serving on various government committees. She is currently the vice-chairperson of the Commission on Global Governance for Health set up by the University of Oslo and the Lancet (2011-13).
years (48 states are reviewed each year during three UPR sessions dedicated to 16 states each). The Council has recommended that India has to move towards gender sensitive and comprehensive contraceptive service planning and implementation. India now has to take steps towards fulfilling these recommendations and in the next four years India will have to show what steps have been taken with regard to these comments. It is critical that these recommendations are put into action as many of us would be keen to see these recommendations turn into action.¹

What in your opinion are the key areas of public health that the government need to re-look at and align with the principles of ICPD.

The government of India tried to bring in the principles stated under ICPD when they brought in the RCH I and II. However, with the new vertical programmatic focus in the NRHM, e.g., institutional delivery and sterilisation, the reproductive rights and reproductive health approach got sidelined. Government needs to go back to the broader approach that has been specified under the RCH programmes which looked into adolescent issues, reproductive infections, reproductive health problems of women and focus on neglected populations including tribal and slum populations. The current focus on adolescent health is limited to population explosion and prevention of HIV/AIDS. Sexuality education, gender based violence, menstrual hygiene for poor girls and gender equality are important aspects of public health.

Though we want reproductive health and rights now which have been ensured in the ICPD POA, we are still grappling with the problems related to lack of basic facilities to people. Huge gaps in basic health care provision still prevail resulting in high levels of malnutrition among women, anemia and lack of safe drinking water and sanitation facilities.

¹ Recommendations are available in the Human Rights in India, status report 2012 available online: http://www.wghr.org/pdf/Status%20report%202012.pdf
Rights, resistance and redefinition
Sex workers and sexual and reproductive rights - Shubha Chacko

Shubha Chacko is currently the Director of an NGO called Aneka which focuses on issues of sexuality, gender and women. She works closely with working class sexual minorities, sex-workers and people living with HIV. In her article she unfolds how sex workers are still at the edge of the government services and programmes.

“The doctor I went to, conducted an internal examination, wrote out some medicines and told me not to have sex with my husband for the next three weeks. How was I to tell her that I was a sex worker? That it was not just about having sex with my husband. So I nodded and went away. I am still suffering with excessive white discharge…”

Rani, 35 year old home-based sex worker

“When I went to the hospital they immediately asked me to go for an HIV test, because they knew I am a sex worker. I was not even allowed to speak. What I wanted to tell them was that I was suffering from great pain during my periods. I left immediately.”

Rahima, 30 year old street-based sex worker

Scores of people who fall outside this narrow definition, including single women, lesbians, transgender women, sex workers, and women living with HIV (who may or may not be married) are omitted even at the conceptual level.

The two anecdotes narrated above amply demonstrate that approach to the issue of sexual and reproductive health rights is modelled on the presumed needs of a heterosexual married woman. Such presumptions indicate that the problems of sex workers and sexual minorities remain outside the purview of sexual rights.

The notion of sexual health and rights was legitimised in the ICPD POA and “sexual rights” was written, for the first time. Since the Cairo Conference in 1994, important strides have been made in terms of reshaping the population and development debate in the direction of a gender, health and human rights frame. But confusions, ambivalences and resistance with respect to sexuality have not vanished. By and large sexuality discourses related to ICPD tend to be constructed in connection with violence and disease, and not so often framed on the basis of freedom and rights.

The idea of population stabilisation still shapes most of the efforts of the government. ‘Reproductive rights’ which the ICPD underlined, are taken to mean a programme to be implemented with certain women, rather than as a set of principles, entitlements or claims that have to be interwoven into all programmes. Therefore, the interventions that are rolled out on the ground reinforce the vision of women merely as reproductive machines, to the exclusion of their other roles and aspirations.

The new language that emerged out of the ICPD was that of needs of the beneficiaries, of overall health and even choice. A major point of departure was the Reproductive and Child Health Programme, which was launched in 1997, to focus on ‘client satisfaction’. Many other policies followed closely including the National Population Policy (NPP), 2000, sections of the Tenth (2002-07) and Eleventh Five Year Plan (2007-2012).

At the national level, large-scale HIV prevention interventions have, without doubt, specifically focused on sex workers and have helped draw some attention to their situation. However, the objectives of these interventions remain primarily to contain the spread of HIV. This means that the benefits to sex workers are secondary to the public health concerns of the ‘general population’. The outreach work carried out is geared towards imparting information on condom use and early testing for Sexually Transmitted Infections (STIs) and HIV.

Lack of attention to women’s sexual and reproductive rights increase their vulnerability to HIV/STI infections and the impacts of HIV and their HIV status increases their vulnerability to sexual and reproductive rights violations.

While STIs do merit some attention in the ‘Targeted Interventions’ aimed at preventing HIV infection; a range of health needs of sex workers including those related to sexual and reproductive health have been neglected both in research and public health interventions.

The state indulges in ‘doublespeak’ vis-à-vis sex workers. One arm of the state (National Aids Control Organisation) is designing interventions to encourage sex workers to use condoms or access screening services (both major determinants of the prevalence of sexually transmitted diseases), the other (the police and the courts for example) work hard to hunt, penalize
and punish sex workers. Yet others (The Department of Women and Child Development and the National Commission of Women) are involved in rescue and rehabilitation.

The fact that sex workers overwhelmingly work outside the law has implications for their health that are hard to quantify. In one Australian study carried out in 1998, the prevalence of sexually transmitted bacterial infections was 80 times greater among illegal street sex workers than in their legal brothel counterparts.

On the ground their complex legal status, coupled with views that they are ‘immoral’, ‘bad’ and ‘unworthy’ translates to a systematic denying to them a clutch of fundamental rights including those related to health and well-being. Female, male and transgender sex workers can come from all walks of life, but in India (as in most developing countries), they are more likely to come from poor and marginalised communities and already face considerable discrimination and stigma. The added stigma associated with selling sex, “the whore stigma,” and the fact that their activities are largely criminalized greatly accentuates their vulnerability. Sex workers therefore have limited access to information and to health services, and operate under personal, structural and socio-cultural constraints. Many in need avoid accessing services even in an emergency situation. Those who do access services, tend not to disclose their identity which increases their chances of inadequate or inappropriate responses from the health care personnel.

**The way ahead - Recognise the rights of all sex workers**

While both health authorities and sex workers stress the importance of access to HIV and STI testing and condoms as the key to good health outcomes, sex worker rights activists place equal or more emphasis on the ability to work in safe, clean and fair workplaces; and accessible and effective health programmes and equitable policy.

The social stigma attached with fear of exposure and health worker discrimination and judgmental behaviours appear to be the major barriers to seeking health services

Some features of that can be:

- ‘Education’ to usher changes in individual behaviour, health worker and community perceptions, as well as the training of the health workers to serve without discrimination.
- Rolling out specific programmes for sex workers’ health and human rights.
- Supporting sex worker involvement and leadership in all programmes including those addressing SRH and HIV prevention.
- Reforming laws and stopping police repression.
- Stopping raids and involuntary “rescues”.

To conclude, it is worth recalling the Sex Workers’ Manifesto from the First National Conference of Sex Workers in India, 1997; which explored how patriarchy and morality intersect in understandings of sexuality. It rejects the idea of sex as simply an instrument of reproduction which, in their analysis, leads to compulsory heterosexuality, supposed monogamy and false morality all aimed at curbing women’s sexual freedom.
Breaking stereotypes around Muslim fertility
Sabiha Hussain

Sabiha Hussain, Associate Professor, Dr. K R Narayanan Centre for Dalit and Minorities, Jamia Millia Islamia University. She completed her M.A, M.Phil and Ph.D from the Centre for the Study of Social System, School of Social Sciences, Jawaharlal Nehru University, New Delhi. She was a fellow at the Centre for Women’s development Studies, New Delhi and has worked extensively to highlight the problems and issues of Muslim women in India from a gender perspective.

Muslims in India account for 13.43 percent of the total population (2001 Census). Muslims are virtually lagging behind all other communities in education and are facing relative deterioration in almost all spheres of day-to-day life, including their reproductive health (refer to the Sachar Committee Report). Fertility among Muslims is not considered by society or the ‘State’ as a matter of equality and reproductive justice.

She notes strongly that the reproductive needs of Muslim women are no different than those of Hindu women. Her vast experience of working with Muslim women in rural and semi urban communities goes to show that health is a priority among Muslim women too and most of them want to come out of the cycle of repeated pregnancies and want to use various spacing methods both for the better health of the child and themselves. But the fate of women’s rights crucially hinges upon the outcome of debates on gender equality, access to services of reproductive health including contraceptives and follow up services and misconceptions about Islamic prescriptions related to health, hygiene and reproduction both within the community and outside the community.

The level of unwanted fertility is highest among Muslims due to various structural and programmatic laps. Female sterilisation is the dominant contraceptive method promoted by the government and Muslim women are much less likely to opt for sterilisation. The influence of religion is seen as a barrier to the adoption of sterilisation among Muslim women as well as in termination of pregnancies especially after first trimester. However, this approach in family planning focusing on sterilisation programme continues to advance even after India was one of the first countries at the ICPD, to make a conscious attempt to ensure people’s right to decide freely and responsibly the number and spacing of their children. The government has little focus on providing choice of contraceptive methods to Muslim women or reproductive health and rights of young adolescent Muslim girls along with the biased attitude of the service providers who have stereotypes about Muslims as non-practitioners of contraceptives.

The programme implementers should attempt to clarify religious misconceptions about Muslim family planning practices and also seek active collaboration and support of religious leaders and NGOs working on the issue of reproductive rights to raise awareness about women’s health and reproductive rights. Muslim localities are left un-served by health and family planning providers because of the misconceptions and stereotypes and the targets to meet and the targets they have are those of female sterilisation. Use of a contraceptive method depends upon the mutual choice of both the partners and the availability. Literacy campaigns should focus specially on male involvement in responsible contraceptive behaviour. There is little focus on male responsibility in our policy and programmes of family planning or for that matter little focus on progressive interpretations of Islamic prescriptions by the Muslim leaders. There is a need to look at the issue of fertility and contraception from a gender and programme perspective and not be interpreted from a religious viewpoint.

A Muslim woman’s identity is further subsumed under Muslim community identity. It is a general misconception that Muslims are against use of family planning methods and that they are ‘child producing factories’ bound to their religious duty and polygamy.
Every time the evening conversation at any social gathering begins with the traffic and the conditions of the roads, it invariably leads to the growing population of the country and how we are in competition with China and that there are just too many people on the streets.

Slowly, but surely, the conversation moves towards who really is the problem in this population explosion and there you have it, the poor, the religious minorities, the lower class uneducated urban and rural poor. Never will be a family belonging to the middle class or the upper middle class be targeted. It’s alright to have more than 2 children if you are a politician, not at the panchayat level mind you, or a judge or a business man. Very clearly the belief that ‘they’ are too many gets established, without a single thought being given to the lack access to information, education and choice that ‘they’ have.

The government consistently maintains that there is no coercion in the two-child norm policy, but on closer examination one will find that the two-child norm is linked with a number of public welfare policies like schemes for food (ration cards), education (admission to schools and fee waivers), and livelihoods (jobs, promotions, irrigation and other facilities for farmers), health (provision of public health facilities including maternity benefit schemes), and political empowerment (eligibility to contest in panchayat elections).

From a legal point of view, the two-child norm is a clear violation of the rights guaranteed under Part III of the Constitution of India. Whether one looks at this from the point of view of the mother/couple who is being coerced into limiting the number of children that she/they have or from the point of view of the third and subsequent child that is born who is de-incentivised, the story remains the same. The right to life guaranteed under Article 21 includes right to live with dignity, right to health and access to health services. By bringing in the coercive policy of the two-child norm the state takes away choice and the responsibilities that the state is expected to fulfill. These include access to and information about limiting and spacing methods are conveniently ignored.

One would then ask, in the background of clearly established violations of fundamental rights, why has the two-child norm not been challenged in the courts of law in this country. This is because the Apex Court of India has already given its opinion on the constitutionality of the number of children being a disqualification to contest panchayat elections in Javed & Ors v State of Haryana & Ors (2003 8 SCC 369). When the contention of the two child norm being hostile for women was raised, the Apex Court was of the view that “63. ……. We do not think that with the awareness which is arising in Indian women folk, they are so helpless as to be compelled to bear a third child even though they do not wish to do so…..”

This view, erroneous to say the least, was taken in the year 2003, whether the same was based on any study, research, article or was only the point of view of the bench is not very clear. Even today, 10 years later, the status of access to contraception and spacing methods is not very high and a number of studies ongoing and completed substantiate the need for information and access to be provided not only to the women directly, but also to the health workers who themselves have little or no knowledge about the various spacing methods. Having said that, it is common knowledge that only by creating access to information about contraception and spacing methods or/and access to the methods themselves, the concern is not resolved, because the interplay of decision between the woman and her partner may still leave her at the mercy of the partner’s decision.

This view by the Supreme Court was also reiterated as an observation (obiter) in the order dated 20.11.2007 passed in W.P. (Civil) No 196 of 2001 PUCI v Union of India and Ors, popularly known as the Right to...
food case. This order was passed clarifying the scope of 2 maternity benefit policies namely the National Maternity Benefit Scheme (NMBS) and the Janani Suraksha Yojana (JSY). While the order was extremely beneficial as it clarified that both policies can co-exist and the State cannot replace one policy for the other, it observed in the end the following:

“15. At this juncture it would be necessary to take note of certain connected issues which have relevance. It seems from the scheme that irrespective of number of children, the beneficiaries are given the benefit. This in a way goes against the concept of family planning which is intended to curb the population growth. Further the age of the mother is a relevant factor because women below a particular age are prohibited from legally getting married. The Union of India shall consider this aspect while considering the desirability of the continuation of the scheme in the present form. After considering the aforesaid aspects and if need be, necessary amendments may be made.”

Unfortunately this observation continued the confusion (deliberate or otherwise) about the universal implementation of the two schemes and the central Government moved an Interim Application 98 of 2010 in the pending case asking for clarification. Arguments have been heard on the application and orders are pending.

Another Public Interest Litigation, (MISC. BENCH No. - 446 of 2013) had been heard recently by the Allahabad High Court in which according to the petitioner, majority of problems and ills facing this country, were on account of uncontrolled population of the country. The petition had been filed to seek intervention of the court so that State authorities may be directed to work out a policy for controlling the menace of ever increasing population in India. The High Court dismissed the petition vide order dated 21.01.2013 on the grounds that this being a policy decision, the court is not inclined to intervene. Having said that, the Court was pleased to observe that this is an evil facing the country and is a contentious social problem.

The need today definitely is to establish that a coercive population policy like the two child norm is not only contrary to the democratic system of governance but is against human rights standards. But this cannot be done in isolation as creating awareness on the issues, especially for women, around a policy of this nature is a greater necessity.
You mentioned in an article that issues of women of the third world countries were not adequately addressed at the Cairo Conference? Could you shed more light on this view?

I quote:

“The slogan of sisterhood needs to be placed in the contemporary international situation when the so-called developed First World, led by the USA, wants to impose its agenda on the rest of the world in the name of globalisation...the direct impact was seen in the recent Conference at Cairo...where the agendas of the G-7 group were pushed through and issues concerning Third World women were left unaddressed. For instance in Cairo the issue of abortion dominated the proceedings. The representatives of millions of Third World women in Cairo hoped, while supporting the struggles of Western women for their right to abortion, at least some attention would be paid to their experience. Instead they did not get the support of women representing the First world.

We strongly believe that where the inequality of nations is increasing, where the development of the First World is in direct proportion to the underdevelopment and exploitation of the Third World, the slogan of sisterhood would mean to protect the interests of poor women in the Third World and to strengthen the global struggle against new forms of colonialism (Towards Beijing: Crucial Issues and Concern: 1995:36)

I subscribe to the view that Cairo in fact imposed the western agenda of reproductive rights without a call for reproductive justice. I consider the Cairo consensus as emanating from the marriage of multinational feminisms with international debt. In my opinion, for India, Cairo meant a rhetorical commitment to reproductive health and rights when basic rights to food, nutrition and health services were being simultaneously eroded by macro-economic policies.

I quote from the position paper of the newly independent Eritrea at ICPD:

“In the case of Africa in particular it is debatable whether reduced population growth will mitigate its marginalisation in the world economic order and accelerate its development. Africa enjoys on the whole considerable comparative advantages in terms of territorial expanse and natural endowments. Its population density even taking into account current rates of fertility is and will remain low in relative terms in the foreseeable future. The appalling poverty and deprivation that stalk the continent are not certainly due to overpopulation and they will not be eradicated if family planning were to be introduced through attractive palliatives and public education programmes. The scourge of ethnic conflicts, massive internal and external displacement and widespread deprivation will not be healed by the most prudent and comprehensive demographic policies.

In the event what is required is a much bolder and holistic approach which addresses and tackles the real causes of underdevelopment. Existing imbalances in terms of international trade must be adjusted to promote rapid and sustainable development in the countries which are lagging behind and in which the economic gap is widening. Furthermore it’s a matter of historical reality that population stabilisation is likely to be achieved as a byproduct of rather than antecedent to overall development. The various programmes associated with family planning and especially the safety nets for the elderly, public education programmes for adolescents, empowerment of women cannot be implemented on a sustainable basis from external funding. Internal development would be essential and indeed a prerequisite for an undertaking of this scale. In brief the answer does not lie in compartmentalised and piecemeal approach but in a comprehensive and innovative approach to the crucial issue of development of the Third World”.

This is something that bypassed the Cairo agenda and over the last 20 years what we have seen is in fact deepening of a health crisis. This is despite the fact
that population growth rates have tumbled in country after country. Health and economic inequalities have sharply increased in the last 20 years.

**Why and how do you think, the progressive policy changes that were made by the Government of India (TFA in Family Planning), after the ICPD were swept away?**

In India, we had the National Population Policy but it did not mean necessarily a paradigm shift! Soon the population discourse entered in the First world nations, not just environmental discourse, but the discourse of population induced environmental degradation, conflict and refugee flows. For example, most American analysts of the Rwanda tragedy seem to attribute it to population and environment. They don’t look at the politics of imperialism and colonialism which were responsible for it.

The securitisation of population issue has become very significant in the last 20 years and it is now an entire American security establishment which has a specific Africa focus and no one is talking of their interest in terms of minerals and oil. We live in neo-colonial times. Look at the statement by Barbara Bush; the US had to invade Afghanistan ‘to protect women’. Whereas actually Afghanistan is a question of not just Cold War politics leftover, it is also a question of molybdenum. Afghanistan has the world’s highest resources of molybdenum. Security discourse argues that West Asia problems are because it’s got a youth bulge, without enough jobs for the large number of young people. There is no reference of course to the politics of oil, or the regimes supported there by the US. One can ask a question why is there a protestant fundamentalism in USA which does not have a youth bulge. Demographic explanations of these sorts are shallow.

**What is your take on the mass sterilisations in India?**

While the National Population Policy has seen no place for targets, it does have incentives; many states have a range of policies which are coercive. There is a certain kind of mindset in the bureaucracy that attributes everything to overpopulation and they are assessed for their performance on family planning.

The members of the National Population Commission have met once in four years, some of us and also the Prime Minister of India said that he is against the two-child norm because he is a liberal at which point at the Population Commission, Sharad Pawar stood up and said that population is a state subject and the centre should have no say in it. This is not true because family planning is in the concurrent list, so the centre does have an important role to play. In my opinion, the government is catering to an upper middle class population which seeks corporate health care. The government is representing the views of this group as what the nation wants.

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