

INDIA

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CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION AND OBJECTIVES

METHODOLOGY AND COUNTRY TEAM

Constraints in Field Research
Country Context

PROGRESS IN ACHIEVING ICPD GOALS AND OBJECTIVES

Policies Relevant to ICPD
Maternal Health and Reduction of Maternal Mortality and Morbidity
Neonatal, Infant and Child Mortality and Morbidity
Gender Equity, Equality and Women's Empowerment
Family Planning and Contraception
Missed Opportunities: The Reversal of ICPD in India

BARRIERS AND FACILITATING FACTORS

Maternal Mortality Reduction
Safe Abortion Services
Neonatal Health and Reduction of Infant Mortality Rate and
Neonatal Mortality Rate
Prenatal Diagnostic Techniques Act
Gender Discrimination
Contraception and Family Planning,

CHALLENGES

Patriarchal Structure and Ideology
Early Age at Marriage and Early Pregnancy
Building a Culture of Work, Responsibility, Commitment and Accountability
in the Health and Family Welfare Departments
Enhance Political Will and Political Stability
Social Inequity and Equality
Fundamentalism
Steady Trend toward Privatisation, Liberalisation and Globalisation
Low Levels of Literacy and Awareness among the Community,
especially Women

RECOMMENDATIONS

Recommendations to Government
Recommendations to UN Agencies, World Bank and Funding Agencies
Recommendations to NGOs

REFERENCES

ABBREVIATIONS / ACRONYMS

NOTES

Executive Summary

India was the first country in the world to implement a national family planning programme that over time, expanded so much that it sidelined not only maternal and child health but all other health programmes. The fear of a population explosion ensured that fertility control became the core of health care planning. Family planning targets were set and enthusiastically implemented. Alongside, health care infrastructure and manpower increased tremendously, particularly during the last three decades. Despite this, the population continued to grow and there was no improvement in maternal health. Recent years provide evidence that maternal mortality has not gone down and infant mortality has remained stable.

The ICPD brought a new perspective and new hope to the proponents of population stabilisation and primary health care. A rights-based development approach was adopted and the RCH programme was launched afresh on the basis of new concepts. This study aims to evaluate the progress, if any, of this new approach and to monitor the achievements and shortfalls in the Indian Government's commitments to the ICPD agenda. It is based on a number of critical indicators:

- Maternal health and maternal morbidity and mortality, age at marriage, childbirth assistance, emergency transport, and safe abortion services.
- Newborn health, neonatal deaths, and infant care programmes
- Gender equity and women's empowerment including violence against women
- Contraception, family planning and male participation.

The study uses both primary and secondary sources. The former include in-depth interviews with different stakeholders and interactions with national level experts. Secondary data include reviews of documents, policies, programmes, and Acts, reports, studies and articles related to ICPD and its implementation in India.

Indian participation in ICPD took place in a positive spirit and was supported by a strong and united NGO lobby within the country. Delegates took active part in the deliberations and pushed forward the reproductive health agenda that the Government was already set to begin. After the ICPD, the Government took some key steps in implementing this agenda. Family planning targets were removed, a community needs assessment approach was introduced and a reproductive and child health programme was launched. The RCH programme and the population policy adopted the language of reproductive health even though its content remained rooted in demographic concerns.

This report highlights a number of issues. First, there has been no major change in the implementation of ICPD goals where maternal mortality is concerned. The monetary incentives, benefits and schemes launched for improving pregnant women's access to health services have remained under-utilised because of gaps in implementation of the programme. For example, women find it difficult to use round-the-clock PHCs and CHCs for institutional deliveries because of problems of location, distance, lack of transport and the non-availability of staff and facilities. Then, while antenatal care has improved, postnatal care is almost non-existent and this has an impact on the mother and the newborn. Although newborn survival is given high priority the mechanisms for implementation at the home level are poor; efforts have not been made to increase the number of service providers at the grassroots level. Further, there is no evidence of expanded abortion services. Mid-level providers have not been included and their number remains limited.

Where family planning and contraception are concerned, the report shows that the target free approach was introduced hastily and without adequate preparation; it was seen as a failure within its first year and had to be withdrawn. Another problem was that decentralised participatory planning could not take off due to inadequate understanding of the process at all levels. The stakeholders at different levels, especially grassroots service providers who were responsible for implementation, were not trained and sensitised about the new approach. As a result the privileging of sterilisation continues with some states taking stronger measures than others to achieve targets. The unmet need for spacing methods has not been seriously considered.

Gender concerns have not been addressed as part of the RCH programme. This has resulted in continuation of the existing discrimination in health services at all levels. The two basic issues that impinge on reproductive health – low age at marriage and first pregnancy – have also not been addressed. Discussions on male participation are often limited to men’s role in accepting vasectomy. The broad role that men play in all aspects of maternal and child health - including reproductive decisions - is not considered.

The main barriers to implementation of the ICPD agenda are: a lack of political will and an inadequate understanding of the agenda even among policy makers. The elite group of policy makers and programme managers have a strong resistance to changing the existing target-driven approach because they firmly believe in the population problem and also fear the consequences of disturbing the status quo.

Some challenges to taking the ICPD forward are:

- The patriarchal nature of Indian society, which is responsible for gender inequities. A change in this deeply embedded structure will require sustained effort.
- An unhealthy work culture with low commitment and accountability, which means that people are denied quality services. This will require a strong political will to change.
- Social inequities and low levels of literacy and awareness among people all over the country which make it difficult to implement programmes that require people’s full participation. Unless NGOs and the Government make strong efforts, people will not be empowered to exercise their rights.

Recommendations

This report recommends that the Government of India and donors make consistent efforts to ensure that the reproductive health and rights agenda is part of its key policies and that there are clear-cut guidelines for implementing it. It is further recommended that the public health system is made accountable to people, and NGOs need to remain focussed on their observer and change agent roles. They have a critical part to play in empowering people to demand services and in making governments accountable to people.

Introduction and Objectives

Health and family planning policies in India were shaped by the population panic that caught virtually the whole world during the post War years. In India, the post Independence decades witnessed a rapid decline in death rates, giving rise to concerns about excessive population growth and its social and economic ramifications. The implementation of a centrally conceived and controlled National Family Planning Programme (NFPP) in 1952 -- that gained the distinction of being the first national level programme for family planning in the world -- was the direct result of this. The NFPP initially followed a cautious approach but gradually became aggressive, setting itself increasingly high targets, expanding its focus on terminal methods and finally pinpointing female sterilisation. These target-oriented population control measures did not focus on long-term human development but gave a priority to quick-fix methods. Sexuality, sexual and reproductive health and rights were not part of the health and family planning programmes.

The maternal and child health (MCH) programme that began as a vertical programme along with other disease control programmes later became integrated into the family welfare programme. Between the seventies and the nineties there was a phenomenal growth of infrastructure at the peripheral level. The number of primary health centres grew from 5131 in 1971 to 22,243 in 1991. The number of sub centres grew from 27,929 in 1971 to 131,098 in 1991. But despite the large infrastructure and considerable investment in human resources, overall primary health care did not improve. Because of the excessive emphasis on family planning, the focus of primary health care was directed towards meeting sterilisation targets, with some action in the area of immunisation and antenatal care. The quality of care, basic primary health care, maternal health, community participation and attention to gender and rights got lost in the enthusiastic efforts to implement birth control measures.

Within this context the ICPD became a central framework around which a new public health perspective could be rebuilt. India played a key role at the ICPD, both in setting the agenda as well as in the deliberations. During the conference, India was open, mature and progressive in its approach and discussions because it had the advantage of having prepared well and held a number of consultations in the run-up to the conference. Government officials and civil society members worked in close collaboration with each other.¹

In Cairo India took the stand that the Conference should focus on poverty alleviation and supported the recommendation that 20 percent of national public sector expenditures and 20 percent of development assistance should be devoted to the social sector. Asking that macro economic policies be introduced for social development, India welcomed the role of NGOs in promoting community participation, education and communication. Some concern was expressed about the content and process at ICPD in relation to the sexual and reproductive health needs of adolescents, labour laws, discrimination against women and the transfer of resources to NGOs; India wanted the inclusion of unsafe abortion and cancers of the female reproductive system, multiple pregnancies, early birthing and HIV in the list of priority health hazards.

A monitoring mechanism was also set in place. The NGO, Health Watch (HW) and its partners conducted a series of regional consultations with support from UNFPA and in collaboration with the Government of India (GOI) in 1996 to gauge field realities after the introduction of the Target Free Approach (TFA).² Health Watch partners wanted to assess the extent to which ICPD concerns and content had percolated to the field level. The findings from the regional consultations were presented at a national meeting. They showed that grassroots functionaries were

confused about the policy of a target free approach since their performance was still linked to the achievement of family planning targets. The newly introduced concepts of the life cycle approach, such as the quality of care, community needs assessment, gender orientation and male participation were not clearly understood.³

Apart from Health Watch, the Family Planning Association of India (FPAI) facilitated NGO consultations all over the country on critical issues related to implementation of the ICPD agenda. The findings were shared at a national consultation coordinated by CHETNA, Health Watch, the Population Council, the Voluntary Health Association of India (VHAI) and Working Women's Forum and funded by UNFPA.⁴ These consultations largely focussed on the NGO role in ensuring implementation of the ICPD agenda and how it could be strengthened in relation to government and donor agencies.

The South and South East Asia Regional office of the Population Council conducted consultations in January 1999 to discuss the initiatives taken to implement the ICPD agenda in India. The objectives were to identify best practices, and constraints and to list the critical steps that needed to be taken in the next five years. The consultation concluded with the following words. "The enabling policy environment now exists for making the public health system more client oriented and accountable to the community. To ensure that these concerns are not lost in implementation, civil society needs to be made aware of its rights and empowered to demand services".⁵

In its report to the ICPD+5, the GOI stated that ICPD gave a "fresh direction to population and development strategies and goals" in India. In its introduction it agreed that though India had made several strides, its adverse sex ratio, continuing discrimination towards girls and women and high maternal mortality were still matters of concern. The Country Report focussed on the following achievements: withdrawal of financial incentives to providers with the objective of improving the quality of care; introduction of an essential reproductive and child health (RCH) programme including family planning (FP), safe motherhood (SM), child survival (CS) and management of reproductive tract infection/sexually transmitted disease (RTI/STD) services; direct financing of states through SCOVA, the State Committee of Voluntary Agencies, with the objective of avoiding delays in implementation because of budgetary constraints; involvement of NGOs and the private sector in the delivery of services in the public sector; involvement of ISM (Indian System of Medicine) practitioners in delivery of RCH services to improve access, especially in rural and tribal areas. The GOI also reported the introduction of the Community Needs Assessment approach, district specific interventions, special strategies for urban and tribal areas; and, special strategies for adolescents that include information and services.⁶

Initiatives for monitoring ICPD at Ten implementation began in late 2003 when UNFPA, with the approval of GOI, initiated a monitoring exercise and gave funding to the Population Foundation of India to conduct discussions and consultations on ICPD related issues. A series of national and regional consultations were planned and conducted. Interestingly, both HW and the FPAI, who had played active roles in monitoring progress during ICPD+5 and Beijing+5, did not seem to be as centrally involved in monitoring commitments and achievements at ICPD at Ten. However, there were other surveys and assessments that contributed to the monitoring exercise.

As part of the RCH programme the Ministry of Health and Family Welfare (MOHFW), GOI undertook facility surveys in all districts in two rounds (1998 and 1999), to assess the availability and utilisation of health facilities and services in all government health care establishments in the districts. They checked the

reliability of performance statistics furnished by the family welfare departments of the states through interaction with beneficiaries. The two nationwide studies (NFHS I and NFHS II) revealed trends in maternal and child health, contraception and access to services, among other issues, and helped to assess the impact of the paradigm shift.

The purpose of this monitoring study is to assess progress and achievements in commitments made by the GOI during the ICPD in 1994. The critical indicators monitored in the four states were:

- Maternal health, maternal morbidity and mortality, age at marriage, childbirth assistance, emergency transport, and safe abortion services.
- Newborn health, neonatal deaths, and infant care programmes
- Gender equity and women's empowerment including violence against women
- Contraception, family planning and male participation.

Methodology and Country Team

CHETNA and ANS, two organisations experienced in health research and interventions, took the responsibility for conducting the India Country Monitoring Study. The study design was worked out during a planning meeting organised by Arrow in June-July 2003 at Kuala Lumpur where the critical indicators to be monitored were decided and a broad framework for monitoring was developed. The design and processes of monitoring and reporting were further developed at a workshop in Hyderabad (January 20-22, 2004). This workshop helped to finalise the list of critical indicators, sources of data, tools to be used and allocation of work. The objectives and processes of national level interactions, document review and secondary data analysis were discussed and finalised. A compilation workshop was held in Ahmedabad (March 12-14, 2004) where primary and secondary data collected at state and field level were discussed, compared and compiled.

In addition to the national level monitoring, four states were taken up for monitoring ICPD implementation at state and community levels. These are Andhra Pradesh, Gujarat, Karnataka and Rajasthan. The selection of the states was based on familiarity with the situation and access to information. From each state, two districts (16 PHCs, four urban health centres, 16 sub centres and 32 villages) were selected to assess whether reproductive health information and services had reached the furthest corners of the state. However, the findings of the state level studies are not included in this report except to highlight a particular issue or provide ground level examples.

All available documents between 1994-2003 such as RCH (I and II) documents, national and state population policies and other project and training documents were reviewed for changes that had taken place in terms of reproductive rights, health, youth, gender equity, male participation, etc. The list of documents reviewed/referred to is given in Annexure 1. The sources of data were grouped into the following: a) Statistics indicating current, past trends and changes (census, studies, surveys), and b) Policies, draft policies, Acts, draft legislation, modules, IEC materials.

A wide range of sources and informants helped in compiling data on the critical indicators at the national level and in the four selected states. Primary data were collected at policy and programme level, implementation level and community level. In-depth interviews and focus group discussions were the main methods of data collection. The chart below summarises the sources of data used to collect the information.

Level of information	Resource persons and sources of data
National policy and programme	Interviews with resource persons, experts, government officials, donor agency representatives
State policy and programme	Interviews with policymakers or their representatives in four states - Andhra Pradesh, Karnataka, Gujarat and Rajasthan.
Service provision at district and health centre level	Eight district hospitals (Anathapur, Medak, Bidar, Kolar, Banaskantha, Dang, Bharatpur, Tonk), eight CHCs, 16 PHCs, 32 sub centres were visited to assess facilities and services available.
Donor level – national and international	Representatives of organisations that played a facilitating role in ICPD and its implementation in the country and the states were interviewed and their documents were reviewed.
NGO perspectives	Representatives of NGOs that played a key role during pre and post ICPD periods for reproductive health and rights.
Community level	Focus group discussions in 32 rural and four urban areas

The India Country Monitoring Team ICPD + 10 consisted of two researchers (Dr M Prakasamma and Ms Indu Capoor) with support from two programme coordinators (Ms Shanthy and Ms Jothi Gade) and a consultant, Dr Francis Raj. A team of research assistants and NGOs in the four states helped to collect and compile information.⁷

Constraints in Field Research

- Problems were faced in getting appointments to interact with people especially at the national and state levels because they were busy in administrative activities and also programme priorities such as the Pulse Polio programme.
- Data were not available for several indicators such as maternal mortality and gender equity for different levels.
- Due to transfers and recent postings, full information related to the facilities or the trends within the last ten years could not be obtained. Further, in order to observe facilities and interview all staff, it was necessary to make repeated visits based on the availability of relevant staff.

Country Context

India is a union of 28 states and seven union territories. It is a country of 1,027,015,247 people living in about 500,000 villages, towns and cities. The population is predominantly rural with 72.22 percent of the people living in rural areas (741,660,293). Each state is divided into administrative units called districts with a population of two to three million on an average. There are 593 districts in the country. Each district is further divided into two or more sub divisions that comprises of two to three thousand villages.

The *Panchayati Raj* system is a three-tier structure of local self-government at village, block and district levels and acts as a link between the village and district administration. A local self-government body called the *Panchayat* does the local governance and programme implementation. As local welfare bodies, all development in the district is channelled through these bodies.



Source: Office of the Registrar General, India, 2001.

States enjoy constitutional autonomy in the area of health to a great extent since health is on the concurrent list. This means that the responsibility of the central government is to formulate policies, plans and guidelines, and guide and help state health ministries. As well, each state has the freedom to develop its own health system according to its needs and resources. However, this does not usually happen as funding for several health programmes is controlled by the central government.

India's health infrastructure comprises an extensive network of hospitals, dispensaries and health centres. As on 31 March 2001, there were 3,043 community health centres (CHCs), 22,842 primary health centres (PHCs) and 137,311 sub centres spread over the country. Each sub centre covers an average population of 4579, each PHC covers a population of 27,364 and each CHC covers a population of 214,000.⁸

The number of hospitals and hospital beds showed only a slight increase from 1971 to 1998 (hospitals rose from 0.7 to 1.6 and hospital beds rose from 63.6 to 92.5 per 100,000 population). There were wide differences across the country in the availability of hospitals and hospital beds. For example, the small southern state of Kerala, had 6.7 hospitals and 309.36 beds while Bihar had only 0.4 hospitals and 33.12 beds per 100,000 population in 1998.

Financial outlays for health and family welfare programmes have gone up steadily since 1952. The annual outlay for 1991-92 was Rs 749 crores (approximately US\$ 17 million) whereas the annual plan outlay rose to Rs 2720 crores (approximately US\$ 604 million) in 1999-2000. However, the health budget is less than five percent of the entire budget, something that identifies health as a low priority sector.

The Bhore committee⁹ laid the foundation for public health in India with an emphasis on health services being as close to people as possible. Though some of the infrastructure goals have been met, most of the service goals recommended by the Bhore Committee are far from being achieved even today. For example,

the Committee recommended that there should be one hospital bed for every 175 people, one doctor for every 1600 and one nurse for every 600 people. Subsequent health committees tried to make changes in the ideals set by the Bhore Committee according to the situation. The decline in availability of services 'closest to the people' started within the first decade after independence and steadily continued. For example, the Mudaliar Committee¹⁰ stressed hospital strengthening and mobile services with one PHC for 40,000, one bed for 1000, and one doctor for 3000 people. The Kartar Singh Committee¹¹ recommended retraining ANMs (Auxiliary Nurse Midwives) and Malaria workers as multipurpose health workers and setting up one PHC for 50,000 people. A bold step to build a cadre of village health guides was started in 1977 but gradually faded within a decade due to programmatic problems and withdrawal of professional and political support.

After the Alma Ata Declaration a joint high-level committee of the ICMR-ICSSR (Indian Council of Medical Research and Indian Council of Social Science Research) tried to bring public health and primary health care back into focus.¹² They tried to reorient services to people's needs and recommended formation of village health units at 1000 population as well as an increase in the health budget. Following on this, the National Health Policy¹³ stressed the provision of universal comprehensive primary health services in the spirit of the Alma Ata Declaration and the transfer of health knowledge to village based health workers. These principles however did not get translated into action and population control measures were the highest priority during the 80s and 90s.

The last decade of the century witnessed the introduction of policies meant to strengthen democratic processes both due to international prioritisation and national reconsideration. Democratic decentralisation started with the revitalisation of the *Panchayati Raj* Institutions (PRIs) and *Nagarpalikas* (town municipal organisations) in 1992. The importance of sustainable development was widely recognised.

Towards the 1990s NGOs put pressure on the government to move away from targets and thus played a vital role in shaping India's health policy. As Pachauri said, "Well before the Cairo conference -- at least a decade earlier -- several NGOs, researchers, women's groups, and donors in India, had sought to change programme direction by moving away from demographic targets and numbers and focussing on how to address the needs of clients, especially women. NGOs and feminists who had formed pressure groups were in the forefront of advancing this agenda".¹⁴

Even within the government there was growing agreement for non-coercion in the family planning approach. The 1991 Census clearly pointed to the failure of the National Family Planning programme in curbing population growth, and this strengthened the move towards reviewing the programme. The government now began to discuss the need for a national population policy with a reproductive health approach rather than a demographic one.

The flurry of activity just before the ICPD demonstrated the proactive steps to shift focus from contraceptive targets to development goals. For the first time 'human development' was mentioned as an objective in the Eighth Five Year Plan and it emphasised that health facilities must reach the entire population by the end of the Plan. The Plan also identified peoples' initiative and participation as key elements.

The Planning Commission¹⁵ recommended that, “a National Policy of Population should be formulated by the Government and adopted by parliament.” A high level expert committee headed by Dr MS Swaminathan, was commissioned in 1993 to prepare a Draft National Population Policy with a shift away from fertility reduction per se to an approach based on human development. The Government wanted a policy that would be, “pro-nature, pro-poor and pro-women”. The Committee was composed of experts from diverse fields and held a series of consultations.

The Swaminathan Committee produced the first report just before the ICPD in 1994 and a revised report in 1996. The report advocated a holistic, multisectoral approach towards population stabilisation with no method- specific targets but a national goal of TFR 2.1 by 2010. Other proposals of the expert group included (a) removal of method specific targets down to the grassroots level (b) an emphasis on improving the quality of services (c) a removal of all incentives in cash or kind and (d) setting up a National Commission on Population and Social Development under the chairmanship of the Prime Minister.

Within this introspective and proactive atmosphere during the 1990s, ICPD encouraged the GOI to look at population problems from a human development and rights perspective. The presence of an open and supportive government even before going to Cairo helped to facilitate the process of change. Women’s groups, feminist organisations and NGOs participated actively in moving forward the pre-ICPD discussions. The UNFPA supported NGO consultative processes all over the country. Various meetings were organised by NGOs to build a dialogue and discuss critical reproductive health issues as inputs to national policies and the ICPD Programme of Action. They discussed what women wanted and needed as opposed to what the family planning programme offered.¹⁶

The UNFPA and the Ford Foundation played a major role in ensuring the right mix of NGO participation at Cairo. The NGO group was clear, knowledgeable and united, and people’s voices had a real opportunity to be represented. NGO activists also worked hard to ensure that Government inputs into ICPD used the right language and approach, and to this end, there was a regular and continuing interaction between NGOs and the Government.

This contact was maintained in the months following ICPD. Shortly after the meeting, all participating groups were invited by the GOI to share their experiences and views. And before the year was out, India moved to translate Cairo recommendations into reality. The move away from targets came in 1996 with non-coercive target free approaches in family welfare programmes initially being adopted in one district in each state, and later in all parts of the country. The introduction of the Target Free Approach (TFA) also meant that all incentives and disincentives were removed from the family planning programme.

Progress in Achieving ICPD Goals and Objectives

This section discusses relevant government policies and projects and the progress made by India in achieving ICPD commitments on three critical indicators: maternal health, morbidity and mortality; newborn health, morbidity and mortality; gender equity and women’s empowerment and contraception, family planning and male participation.

Policies and Schemes Relevant to ICPD

In the decade following Cairo, India initiated several policies and programmes in order to implement ICPD commitments. The major move has been the attempt at bringing about a qualitative shift from the demographic based target approach to broad-based client-centred services. Not only was a wider range of services introduced, they were also increasingly decentralised. The table below lists some of the policies and plans that have relevance to the ICPD agenda and that were introduced in the last decade.

Table 1. Goals Set Under Different Policies and Programmes

	Current status	Tenth 5 Year Plan 2002-07 Goals	RCH II – Goals by 2004-2009	NPP Goals by 2010	Millennium Development Goals
MMR	540 (WHO, UNICEF and UNFPA, 2000)	2/1000	150/100000	100/100000	Reduce by 3/5 between 1990-2015
IMR	70 (1999) (GOI, 2004)	45/1000	35/1000	30/1000	---
0-5 MR	94.9 (NFHS II)	---	---	---	Reduce by 2/3 from 1990 levels
Population growth rate	21.34 (Census, 2001)	16.2% (2001-11)	16.2% (2001-11)	---	---
TFR	3.3 (SRS, 1997)	2.3	2.2	2.1	---
CPR	44.0 (NPP, 2000)	65%	65%	Meet 100% Needs	---

Designed by the Planning Commission, India's Five Year Plans are critical to the country's policy and planning exercises. They are prepared in consultation with the highest level of policymakers and set the tone, content and budget allocation for programmes within the plan period. The Eighth Plan (1990-95) introduced the concept of human development into the planning process. The Government recognised that innovation and dynamism were missing in the NFPP. "The Family Welfare Programme has essentially remained a uni-sector programme with centralised target-setting, lack of pre-service and in-service training, and a monitoring mechanism that is incapable of identifying roadblocks or applying timely correctives" (Eighth Five Year Plan 1992-97, Planning Commission of India).

The focus of the Ninth Five Year Plan (1995-2000) was on reduction of population growth and achieving desired levels of fertility. The Tenth Plan¹⁷ demonstrated a conceptual shift in family planning with a focus on need based, client centred, demand driven RCH care, strengthening of infrastructure for service delivery, additional assistance to poor performing districts, supply of essential drugs and contraceptives and promotion of male participation in planned parenthood. The main objectives of the Tenth Plan are reduction of the decadal rate of population growth, reduction in IMR to 45 per 1000 live births by 2007; and reduction in maternal mortality ratio to 2 per 1000 live births by 2007 and to 1 by 2012. The

Government also constituted a National Resource Centre to facilitate formulation of population policies at state level in keeping with the spirit and letter of the NPP, 2000.

A review of the Five Year Plans shows that though there is considerable rhetoric about reproductive health and rights, the stress on RCH components is limited and the major focus is on population stabilisation. Within this wider planning process, the swinging back and forth from targets to human development measures and population control is evident. There is talk about development but this is dominated by demographic goals. The alarm over uncontrolled population growth has not abated among the elite policymakers. This confusion among policymakers and planners finds its way to grassroots service providers resulting in some structural changes but very few conceptual shifts.¹⁸

Responses to the ICPD paradigm shift were visible immediately after ICPD in India. Before ICPD the total fertility rate (TFR) and the contraceptive prevalence rate (CPR) were used to fix family planning targets and assess the success of the programme. ICPD replaced them with quality of care, informed choice, a gender focus, women's empowerment and accessibility to a whole gamut of reproductive health services. These initial responses were seen as a welcome departure from the earlier target oriented demographic approach.

India decentralised the planning process at the grassroots level with participatory processes based on a bottom-up approach called Community Needs Assessment (CNA) to design family welfare programmes according to community needs. For the first time the Government planned to provide need based health services to individuals, making the village a unit for providing health services. A manual on decentralised participatory planning was prepared and sent to states.

The Reproductive and Child Health (RCH) Programme was launched in October, 1997 in response to the changed paradigm on population, development and public health and was based on a client-centred, demand-driven, quality service approach as opposed to the previous provider-centric target-based approach. The RCH agenda was based on the *lifecycle* approach. Its main objective was to strengthen reproductive and child health services in the country with the aim of reducing maternal and infant mortality and creating a greater awareness about client rights.

The GOI document on the RCH programme tried to follow the RH concepts and definition as stated in the ICPD document. The RCH approach was defined thus: "People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and childbirth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being, and couples are able to have sexual relations, free of fear of pregnancy and of contracting diseases".¹⁹

The vision of RCH Phase II is to ensure progress in reproductive and child health and population stabilisation through participatory programmes to meet the unmet needs of the target population, and delivery of assured, equitable and responsive quality services. The RCH II vision is to bring about outcomes as envisioned in the National Population Policy 2000, the Tenth Five Year Plan document, the National Health Policy 2002, Vision 2020 of India and the Millennium Development Goals. The goal of RCH Phase II is to reduce MMR to 150 per 100,000, reduce IMR to 35 per 1,000, to maintain a population growth rate of 16.2 percent, reduce TFR to 2.2 and increase the couple protection rate (CPR) of 65 percent. The RCH programme is being formulated for implementation with funding from Government of India, World Bank, DFID, European Commission, UNFPA, UNICEF and other bilateral

donors. At the time of writing this report, the central and state governments were actively involved in finalising their project documents. Consultation and discussion with civil society groups and individuals took place to some extent and varied among states.

National Population Policy, 2000

India's commitment to ICPD principles and recommendations of the PoA was further affirmed in its National Population Policy (NPP) released in February 2000 which asserts the centrality of human development, gender equality and equity, and adolescent reproductive health among other issues, to stabilising the country's population.²⁰ The NPP states, "stabilising population is not merely a question of making reproductive health services accessible and affordable, but also of increasing the coverage and outreach of primary and secondary education, extending basic amenities like sanitation, safe drinking water and housing, empowering women with enhanced access to education and employment." A high level National Commission on Population (NCP) was constituted on 11 May 2000, to oversee implementation of the NPP. The Prime Minister heads the Commission, with chief ministers, central ministers in-charge of the concerned departments, demographers, public health professionals and NGOs as members. The main goals of the policy are to reduce IMR to below 30 per 1,000 live births; reduce MMR to below 100 per 100,000 live births; achieve universal immunisation and promote a delayed age of marriage for girls.

National Health Policy, 2002

The National Health Policy attempts to set out a new policy framework for the accelerated achievement of public health goals in the socio-economic circumstances currently prevailing in the country. Its main objective is to achieve an acceptable standard of good health among the general population. Overriding importance is given to ensuring more equitable access to health services across the social and geographical expanse of the country. The contribution of the private sector in providing health services is to be enhanced, particularly for the population group that can afford to pay for services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through an increased sectoral share of allocations. Within these broad objectives, NHP-2002 endeavours to achieve an MMR of 100 per 100,000 live births and an IMR of 30 per 1000 live births by 2000-2015.

The National Policy for the Empowerment of Women, 2001

The National Policy for the Empowerment of Women was adopted to eliminate all forms of discrimination against women, ensure gender justice and empower women both socially and economically.²¹ The policy directs central and state ministries to create time-bound action plans for implementation. The plans include the goals to be achieved by 2010, identification and commitment of resources, assigning of responsibilities for implementation of goals, monitoring, reviewing and assessment mechanisms and introduction of gender perspectives in the budgeting process.

The Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse - PNDT) Act, 1994

The PNDT Act, 1994 was brought into force by the Government of India with effect from 1996 in the backdrop of a declining sex ratio and for containing the

practice of sex selective abortions.²² The PNDA (Juvenile) Amendment Bill to the PNDA Act 1996 was passed in 2002. The amendments bring the technique of pre-conception sex selection and use of ultrasound machines within the ambit of this Act. Punishments prescribed under the Act have been made more stringent and the appropriate authorities are empowered to conduct search and seizure operations, and seal machines, equipment and records of the violators of law.

The Medical Termination of Pregnancy Act, 1971 and Amendment 2003

The MTP Act facilitates the recognition of MTP centres by decentralising the authority to the district health officers. In addition, specific punishments for conducting illegal abortions by unqualified persons and places not approved by concerned authorities have also been included. Rules and Regulations for the MTP Act were made in 2003. The Government took several steps to expand and strengthen safe abortion services under the RCH programme by (a) increasing the availability and accessibility of abortion services, (b) procuring MTP equipment centrally and providing it to district hospitals, CHCs, PHCs and wherever else it was required (c) addressing the shortage of trained personnel in PHCs/CHCs and other hospitals by engaging the services of consultants to visit these facilities (d) providing free training in MTP techniques to recognised MTP centres in the non government sector (e) increasing the number of specialised MTP training centres to provide MTP training and (f) pilot testing the manual vacuum aspiration (MVA) technique and implementing it in rural areas in eight states in India.

The proposed Constitution (Seventy-Ninth Amendment) Bill, 1992 envisages that a person would be disqualified from being chosen, and for actually being, a member of either house of legislature of a state if he/she has more than two children. However these provisions will not apply to those who had more than two children before the commencement of the Act or those who beget additional children within one year of the commencement of the Act.

Involvement of Panchayati Raj Institutions in the Health and Family Welfare Programme: The department of family welfare, Government of India is encouraging the involvement of village communities in the national effort to stabilise population and improve the health profile of the population. The scheme envisages the achievement of lower fertility and mortality rates by inculcating the practice of registration of births, deaths, marriages and pregnancies, as these will provide information for close monitoring.

Special Schemes and Projects

Janani Suraksha Yojana Scheme is in final stage and will be implemented under RCH II from 2004 onwards to deal with the referral of women in labour. Under RCH II it is proposed to provide training to MBBS doctors in anaesthetic skills for four and half months for providing emergency obstetric care in coordination with Federation of Obstetrics and Gynaecologists Society of India (FOGSI).

Essential Obstetric Care Scheme intends to provide (a) basic maternity services to all pregnant women through early registration of pregnancy (b) provision of a minimum of three ante-natal checkups to monitor the progress of the pregnancy and to detect any risk or complications so that appropriate care including referral can be given on time (c) promotion of institutional delivery and provision of safe delivery at home (d) provision of postnatal care to monitor the postnatal recovery of women and to detect complications, which include appropriate referral.

Emergency Obstetric Care Scheme was introduced to prevent maternal morbidity and mortality under the CSSM programme of the RCH project. Under this scheme Government strengthened FRUs through the supply of drugs in the form of emergency obstetric drug kits and skilled manpower on a contractual basis. Sub district hospitals, CHCs and FRUs are entitled to hire services of private anaesthetists for conducting emergency operations for which they are paid Rs 1,000 per case.

24 Hour Delivery Services at CHCs/PHCs: To promote institutional deliveries provision has been made under the RCH programme to give an additional honorarium to the staff to encourage round-the-clock delivery services at PHCs and CHCs. As part of this scheme, it is envisaged that at least one medical officer, nurse, and cleaner are available beyond normal working hours.

Vandemataram Scheme: On 10 February 2004 the Union Health Minister launched a new private-public partnership for maternal health care named Vandemataram (literally, respect for the mother/motherland) to engage the services of experienced private gynaecologists to render a day's free service on the ninth day of every month to poor pregnant women.

Referral Transport: The Government made provision to assist women from poor families to avail of emergency transport for complications related to childbirth. This programme has been in existence since 2000-2001 under the RCH programme. It provides a lump sum corpus fund to panchayats.²³

Dai Training scheme: The *dai* (midwife) training programme had initially received a setback under the RCH I programme. However it was re-introduced during 2000-2001 and training was permitted in selected government institutions and through some NGOs. The scheme is implemented in 156 districts with safe delivery rates of less than 30 percent. RCH II does not give further support to dai training and promotes institutional delivery. Across the country, NGOs and health activists have questioned the policy considering the poor outreach of public health services to women in remote rural areas. A National Consultation was coordinated by CHETNA and Academy for Nursing Studies on 5 May 2004 at Ahmedabad to deliberate on the role of the dai in safe motherhood and neonatal health.

Parivar Kalyan Avam Swasthya Mela: In order to improve access to services of specialists like gynaecologists and paediatricians for people living in remote areas where the PHCs are inadequately staffed, mini melas (fairs) in the form of RCH camps have been initiated in 23 states.

Non-Scalpel Vasectomy: The Government of India has made a consistent effort to propagate the use of non-scalpel vasectomy to increase male participation in family planning.

Health Insurance Scheme: The Government introduced a health insurance scheme for the poor where it will pay a modest premium amount for in-patient care for an assured amount of health care. However, the benefit was linked to the acceptance of sterilisation, with acceptors and their children getting access to quicker medical treatment. This shows a clear preoccupation with population stabilisation rather than with comprehensive health coverage. Several state governments are proposing to introduce health insurance and some have already done so for a limited number of poor families.

RCH Camps were introduced in 2001 in 102 districts in seven states with poor performance in maternal health care. The aim is to provide reproductive and

child health services and improve maternal and child health services to people living in remote areas.

Integrated Financial Envelope provides flexibility to five better performing states (Tamil Nadu, Kerala, Maharashtra, Punjab and Andhra Pradesh) to design interventions to address maternal health care problems specific to the states instead of tying these states to national schemes.

Under a scheme called the SWAP scheme, the GOI took over the financial responsibility for ANMs at sub centres throughout the country from the states. This included the maintenance expenditure of all sub centres as per the 1991 population. In exchange the GOI transferred 5435 rural family welfare centres and post partum centres to state governments

Maternal Health, Reduction Of Maternal Mortality And Morbidity

The problem of high MMR continues into the third millennium in India despite huge increases in health infrastructure and manpower after India's independence. There is no clarity about the magnitude of the problem, and estimates vary, depending on the methods used and the organisation's standpoint. While international agencies and surveys give figures, individual states quote very low rates. There is a disagreement between surveys, national registration systems and individual researchers. The NFHS I reported MMR as 424 in 1992-93 in India, but the NFHS II reported that it rose to 570, whereas WHO reported an MMR of 437 in 1995.²⁴ Due to the difficulty in studying and calculating accurate MMRs, there are huge disparities in the reported MMR figures in India.

However, despite this, health officials, NGOs and programme managers in India are in agreement that MMR is high. There is also agreement that there has been no decline in the last decade. Reduction of maternal mortality was a critical goal in several plans and programmes (HFA, RCH, NPP) and is also part of the Millennium Development Goals.

Major factors for the persistently high MMR are: low awareness of risks among women and families and low access to resources. The failure of the public health system, at the grassroots level, to provide a skilled birth attendant for every childbirth is a critical factor in the high maternal mortality rate. In addition, the gradual but steady withdrawal of skilled services and service-providers from the community to more centralised urban areas has reduced access to qualified care.

Deliveries attended by health professionals and those conducted in institutions rose only marginally between 1992-93 and 1998-99. While health professionals attended 34.2 percent of births in 1992-93, there was a slight increase to 42.3 percent in 1998-99. Deliveries in institutions were only 25.5 percent in 1992-93 and rose to 33.6 percent in 1998-99.²⁵ Surveys show that the percentage of women receiving antenatal care went up from 49.2 percent in 1992-93 to 65.4 percent in 1998-99. But only 43.8 percent of women received three or more antenatal checkups in 1998-99 (NFHS I and II) and only 20.0 percent of pregnant women received all recommended types of antenatal care in 1998-99.

The numbers of normal deliveries are indicative of the general health and awareness of the country and the efficiency of its public health system in prevention and promotion. More normal deliveries indicate that more women have better nutrition, less anaemia, better access to primary health services and higher level of information about high-risk deliveries. According to government reports normal vaginal deliveries were 91.1 percent in 1998. But data reveal

that nearly 80 percent of women suffer from anaemia and that 15 percent of pregnant women generally face complications. This indicates the discrepancy in presence of risk and referral and treatment and the difficulty of providing one explanation for the high maternal mortality.²⁶ There is, however, no major change in the causes of maternal deaths in the last decade, except that toxemia related deaths have reduced.

Unsafe Abortions

The estimated number of abortions in India was 10.1 million in 1991, which reduced to 8.5 million in 1997. Spontaneous abortions stood at 3.4 million in 1991 and 3.2 million in 1997. The total number of induced abortions in 1991 was 5.1 million, and this figure went down to 4.8 million in 1997. There were 0.58 million medical terminations of pregnancy (MTP) in 1991 and 0.54 million in 1997. The total number of illegal abortions in India in 1991 was 4.5 million and 4.3 million in 1997. The total number of legal abortions in India in 1990-91 was 5,81,215, which reduced marginally to 5,38,075 in 1997.²⁷ The number of registered abortions in India were 5,80,744 in 1990-91.²⁸ These increased to 7,23,142 in 2000-01. The percentage of deaths due to abortion was 11.8 in 1990 and 17.6 in 1995.²⁹

Maternal Mortality

Maternal mortality did not receive the same stress as family planning even after ICPD and RCH. Policies and programmes emphasised FP and immunisation indicators and not maternal indicators. There was no compulsion for ANMs to conduct deliveries. The stress on vertical programmes also drew attention away from maternal and women's health problems. The introduction of Universal Immunisation Programme (UIP), Child Survival and Safe Motherhood (CSSM) and Pulse Polio took away the focus on maternal health. Maternal health has always been given a lower priority in health care policies and programmes. In the initial MCH programme, questions were raised about the low priority to the maternal component, while immunisation within the child health component was given high focus. Maternal health as part of an integrated family welfare programme always came after family planning and very often after immunisation.

During the Eighth Five Year Plan maternal health programmes were integrated along with child health into the CSSM programme. Here too, the child survival component received a higher priority in implementation and safe motherhood was mainly limited to antenatal coverage. During the Ninth Five Year Plan all interventions under the CSSM programme became part of the RCH programme. Maternal health received attention within the framework of emergency obstetric care and development of First Referral Units (FRUs). Support to community based traditional birth attendants was withdrawn since they did not contribute to reduction of maternal mortality. The low stress on maternal health was thus a major factor in the persistence of high maternal mortality in the country.

Instead of designing a programme for systematically overcoming problems in accessing maternal health care with a long-term goal, the Government has introduced several short-term schemes and projects with a myopic perspective. These short cuts to deeply rooted social problems are often populist schemes with little comprehensive coverage. Selected targeted interventions such as antenatal registration, administration of Tetanus Toxoid injections and distribution of iron and folic acid tablets are perceived as antenatal services and institutional deliveries are equated with low maternal deaths. Adequately trained and empowered SBAs supported with equipment and linked to referral hospitals can manage and prevent a large chunk of the 15 percent life threatening complications that pregnant

women are likely to face. While neighbouring countries tried to develop midwifery service providers, India lost the skilled auxiliary nurse midwives (ANMs) when the MPHWS scheme was started. The number and quality of Skilled Birth Attendants (SBAs) functioning in the periphery have not increased. The introduction of the multipurpose schemes has systematically deskilled the ANM in the last 20 years, the over-emphasis on sterilisation further eroding her midwifery skills. Hence, though there are more than 150,000 ANMs in position, only a small percentage assist during childbirth. The training under RCH I did not improve their skills. Debate over the low impact of TBAs on reducing MM initially caused confusion but gradually resulted in withdrawing support to TBA training. The combined effect of dilution of ANMs' skills and withdrawal of support to TBAs created a void in childbirth services in villages.

One reason for MMR being very high in India is that the Public Health System lacks adequate facilities for caesarean sections for women facing childbirth complications. Women with complications have to travel far and long to access treatment. Caesarean section deliveries accounted for 6.6 percent of all deliveries in 1998. More caesarean section deliveries take place in private hospitals than in government hospitals resulting in high cost and poor access.³⁰

However, there are some positive aspects. Consistent advocacy from different angles has resulted in some attention. Several NGOs and networks brought up the issue of high maternal mortality during government meetings. The White Ribbon Alliance of India (WRAI) organised a march to Taj Mahal in April 2001 and created high visibility for the issue.³¹ Groups in other parts of the country took up similar initiatives.³² The Government of India announced 11 April 2003 as National Safe Motherhood Day. Since then committed organisations and networks have been using this day for creating higher awareness and visibility on this critical issue. Various projects have been taken up in different parts of the country with the objective of reducing maternal mortality. The project on averting maternal death and disability – which is being implemented with support from Columbia University - is one such example.

Neonatal, Infant and Child Mortality and Morbidity

The infant mortality rate reduced only marginally during 1991-99, in India (from 77 to 70). Under-five mortality declined remained the same. The ratio of full-immunised one year olds was 35.4 percent in 1992-93 and 42.0 percent in 1998-99.³³

Gender differentials were observed time and again while analysing fully immunised children less than 12 months old. In 1992-93 the male-female percentage ratio in this age group was 36.7: 34.1 and in the year 1998-99, it was 43.1: 40.9 for one year olds.

The reason for the slow decline in IMR is the high neonatal mortality. Programmes designed in CSSM and RCH focused on immunisation and childhood illness such as ARI and diarrhoea and were, therefore, successful in reducing child mortality but did not touch NNM. Neonatal mortality and maternal health are closely linked. Postnatal care and education are effective in reducing neonatal mortality and morbidity.

Gender Equity, Equality and Women's Empowerment

The critical issues related to gender are trends in sex ratios, gender sensitivity among service providers and government initiatives to empower women. Among the one billion people in India, ideally there ought to be 518 million women if there

was gender equality and equity (about 105 women to 100 men in an equal society). But there were only 489 million women resulting in about a quarter million women missing. This indicates that women face discrimination and adverse situations at every stage in their lives and the discrimination is so large that it becomes visible in national statistics.³⁴

The decade 1991-2001 witnessed a slight progress – an increase from 927 to 933 girls for 1000 boys) - in the overall sex ratio. However in some states such as Gujarat it declined by 13 numbers (from 934 in 1991 to 921 in 2001).³⁵ But examining the figures more closely discloses that the juvenile sex ratio (below six years) has shown an adverse trend. There were 945 girls to 1000 boys in 1991 but this reduced to 927 per 1000 boys in 2001.

Gender discrimination is clearly visible in infant and under five mortality rates, too. In 1999, the female IMR was 71 compared to the male IMR of 70 per 1000 live births.³⁶ This shows discrimination since it is well known that the female infant, especially in the newborn period, is sturdier than the male infant. The adverse social effects of discrimination against girls become stronger as girls grow older, resulting in stark differences in mortality rates in the under-five age groups. NFHS data (1998-99) show that 105.2 girls compared to 97.9 boys (below five years) died among 1000 live births.

Figures of life expectancy also reflect gender discrimination. On an average a woman is expected to live about five years longer in a society that is based on gender equality and equity. However, though life expectancy has risen over the years and women today live for 63 years compared to 32 years in 1951, the sex differential in life expectancy is much lower than expected. The excess of female over male life expectancy is only one year in India compared to 4.5 years in Sri Lanka and 6.0 years in Canada. Within the country there are many regional differences, with a woman in Madhya Pradesh who can be expected to live for 57 years compared to a woman in Kerala who has a life expectancy of 75 years – on par with developed countries.³⁷

The overall age at marriage for females marginally increased from 17.2 years in 1971 to 18.4 in 1981, and 19.3 in 1991. According to NFHS II the average female age at marriage was 19.7 in 1998-99. However, there are wide differences across the country. In some states (Andhra Pradesh, Karnataka, Tamil Nadu) there is no difference in the nearly ten years between 1991 and 1998. The lowest age at marriage is in Andhra Pradesh and Rajasthan (18.3 years). Manipur and Goa have the highest age at marriage of about 25 years.

Nutrition indicators also reveal the effect of gender discrimination through life. In the year 1998-99, 13.2 percent women were below 145 cm and classified as nutritionally at risk. In addition, 35.85 percent of women were below 18.5 kg/m below BMI and classified as malnourished. NFHS data show that in 1998-99, 51.8 percent had any anaemia, 35.0 percent had mild anaemia, 14.8 percent had moderate anaemia and 1.9 percent suffered severe anaemia.³⁸

Existing differences in immunisation between girl and boy infants have not reduced over the last decade. According to NFHS I, the male-female percentage ratio of fully immunised one year olds was 36.7: 34.1. In 1998-99, the average percentage of fully immunised infants went up but the gender differences remained. While 43.1 percent male infants were fully immunised the fully immunised female infants were only 40.9 percent.

Violence Against Women: Based on reports of violence and rape, it is clear that women aged 18-30 years are more often victims of rape than older women. Among 10,197

reported crimes of rape during 2001, 7881 of the victims were between the ages of 18-30 years, 2248 were between 30-50 years and 68 were above 50 years.³⁹ Among the perpetrators of rape, in 13,504 cases the offenders were known to the victim. Among these 439 were family members, 851 were relatives, 4324 were neighbours while 7890 were other known persons.

Policies and Programmes to Promote Gender Equity: The Constitution of India not only grants equality to women but also empowers the State to adopt measures of positive discrimination in favour of women for neutralising the cumulative socio-economic, educational and political disadvantage faced by them.

The major impact of ICPD and Beijing has resulted in mobilising women from hitherto non-accessed regions of the country. The creation of NAWO (National Association of Women's Organisations) has brought a new network onto the scene. The main advocacy emphasis in the country has been on political empowerment: building the capacity of elected women representatives in local and municipal government bodies; pushing for a quota for women in the Parliament; and engendering the Indian census.

Gender awareness and training programmes were given a boost after ICPD by NGOs and international agencies. UNIFEM, UNFPA and DANIDA supported several projects in this area. Two-day residential workshops on gender sensitisation were organised for middle level officers of the Department of Health and Family Welfare with the help of UNFPA in 2002 in some states. Initially, government departments did little in this respect.

The box below lists some policies, programmes and activities for women's empowerment and equality. The GOI took up various measures in order to fulfil the ICPD commitments to equality and equity for women and to enhance women's involvement in decision-making at all levels.

- A National Policy on Empowerment of Women was released in 1999 (mentioned earlier).
- The year 2001 was announced as the year of Women's Empowerment and a series of activities were taken up to enhance the role and status of women.
- The Ninth and Tenth Five Year Plans recognised empowerment of women as a major objective and proposed to create an enabling environment with requisite policies and programmes, legislative support.
- A new initiative to engender the 2001 census was taken up.
- The Swashakti (self empowerment) Project initiated in seven states of India resulted in formation of thousands of Self Helps Groups (SHGs) all over the country.
- As a result of the amendment passed against sexual harassment of women at workplace it became compulsory and organisations to have committees to support the victim emotionally and legally in all government departments.
- The amendment to ensure 33 percent participation of women in governance at district, block and village level gave rise to a large number of female leaders at the local level who gradually rose to political power at district and legislative levels. But, in many instances, power continued to be wielded by male family members.
- The RCH training modules included a section on 'gender sensitivity' to provide inputs into gender concerns among service providers.
- Implementation of Sarva Shiksha Abhiyan (Education for All) programme increased the enrolment of girls in primary schools and their retention in secondary schools.

- Programmes such as Mahila Samakhya (women's empowerment), which existed even before the ICPD, laid the foundation for mobilising grassroots women, and focussed on campaigns to foster women's awareness of their legal rights, rights within their families etc.

Family Planning and Contraception

The NFPP, with its aggressive IEC campaigns, has been successful in increasing awareness about contraception, especially the female terminal method. However there is limited choice as the government programme provides only five contraceptive methods – male and female sterilisation, intra-uterine devices, oral pills and condoms. Among these, the Government has an aggressive campaign and services backed by strong monitoring for female sterilisation. Providers do not offer complete information about the variety of methods available even within the NFPP and therefore men and women do not have an opportunity to exercise their right to contraceptive choice.⁴⁰

According to reports in NFHS II, 99 percent of currently married women aged 15-49 years were aware of any modern contraceptive method and 49.3 percent had ever used any modern method. There was a marginal increase in awareness and use of contraceptive methods between the six years of NFHS I & II. The predominant method of contraception is female sterilisation both in 1992-93 (27 percent) and 1998-99 (34.2 percent) with other methods accounting for only a small percentage of contraceptive coverage. In 1998-99, the NFHS II showed that oral contraceptive pills (8.4 percent), IUDs (5.6 percent), condoms (7.9 percent) and male sterilisation (2.0 percent) contributed very little to overall contraceptive prevalence. The same report showed that 65.2 percent of currently married women said that they preferred to use female sterilisation. The fact that women preferred a terminal and provider-controlled method of contraception as compared to women-controlled reversible methods shows to what levels the NFPP has reached in shaping women's reproductive choice. The situation is aggravated by poor quality services and lack of information.

The age at sterilisation indicates doubts over the exercise of choice and decision-making among women in an environment of active promotion of female sterilisation by the Government. According to NFHS II (1998-99) nearly half the users who underwent female sterilisation were 25 years with 7.3 percent undergoing a permanent method before the age of 20 years. This also indicates the young age at marriage and the low use of spacing methods, adding to problems of maternal and neonatal mortality and morbidity.

Contraceptive use is lower among women with less education, a low standard of living and those belonging to lower caste groups such as Scheduled Castes (SCs) and Scheduled Tribes (STs) indicating that information and services have not reached underprivileged groups. Son preference seems to dominate the scene of contraceptive use and female sterilisation acceptance in the country irrespective of caste, class, religion, region or education. While 66.8 percent of women with two sons used contraception, only 58.9 percent women with one son used contraception and only 39.7 percent with no sons used contraception.

The NFPP is laden with limited choice, gender inequalities and low male involvement in contraceptive use. The programme and methods are heavily targeted at the female. Though the Government and the RCH programme recognise the critical and powerful role played by men in sexual and reproductive behaviour, male participation in contraception is not clearly defined in the new programme. Several states have limited the participation of men to the acceptance

of male sterilisation. Their broader role in the health of women and children has not been addressed despite there being a large cadre of male health workers.

Missed Opportunities: The Reversal of ICPD in India

Ten years after the commitment at ICPD, the NFPP has still not been successful in changing the old paradigm. Within the first three years the clarity of goals, the framework and the partnership at the ICPD were lost. Method specific targets, incentives and disincentives were reintroduced as a result of the failure of the TFA. There were many missed opportunities and some reversals in achievements in reproductive health. Some of these are given below.

Return to targets: The target-free approach (April, 1996) was discontinued – after a trial in one district in each state - due to panic over the logical decline in sterilisation figures after introduction of the TFA. The TFA was renamed the Community Needs Assessment Approach (CNAA) from 1997 onwards because, as policymakers and programme managers put it, ‘target free’ was misunderstood as a ‘work free’ approach at the field level. The CNA approach too was not adequately explained to field staff and therefore not carried out with the kind of community participation that had been envisaged. Had the fieldwork been done in the spirit of decentralised participatory planning, this approach could have brought in active community participation.

Low participation of NGOs and civil society in policy making: The openness and mutual support that was evident between NGOs and government during the ICPD days gradually declined, and the regular meetings that had been held before and immediately after Cairo, became rare. The RCH I programme used NGOs as implementation agencies and brought in the larger and better-known NGOs as coordinators thereby creating a hierarchy among them. Participation now meant involvement only in processes and programmes rather than in policy and planning. Even while RCH II is being planned, there is not much evidence of large-scale consultations or an inclusive process in the planning exercises.

Centralised policy formulation: The process used for formulating the NPP itself was criticised as being ‘closed’ and hurried, with non-existent public discussions and a hasty approval from the Cabinet. The earlier draft population policy prepared by the Swaminathan Committee in 1993 was not used even though it put forth several rights based measures.

Clinging to the population stabilisation perspective: The National Population Policy – in which several sections remain unchanged despite ICPD - indicates that the emphasis is still on population stabilisation rather than overall development. In the words of Nanda, “There are some diehard ‘population control’ exponents among politicians, bureaucrats, demographers and other sections of the elite, who have not reconciled to the paradigm shift, and who feel more comfortable with an authoritarian policy regime of quantitative targets, for the sake of achieving soft and quick-fix options.”¹⁴¹

Return of stronger incentives and disincentives: The small family norm is being used at different levels with the objective of fertility control. In some states a large family (more than two children) is being used as a disincentive for entry into political positions. In the words of Gita Sen, “Although it may seem reasonable to expect those who wish to stand for office to abide by the small family norm, requiring this may be unconstitutional and ultimately coercive.”¹⁴²

Lack of accountability: Though policies are formulated and programmes designed for implementation and people are meant to avail of the benefits, the policies do not

clearly state the responsibilities for failure. For example, failure of tubectomy has been known to take place. The policy puts a further burden on the already poor woman to carry the pain of not being able to conceive in case of child death or to carry the burden of pregnancy in case of failure of the operation. Policymakers do not seem to realise these issues when they formulate policies which impinge on rights.

Hasty and unplanned implementation: Hasty decisions and introduction of TFA with very little time for implementation plans and consensus building led to some problems. According to Leela Visaria, a reputed demographer, the announcement of the target free approach, “was rather sudden, abrupt and without adequate preparation”.⁴³ In a flash, a 30-year old policy of centrally driven and forcefully pursued targets was abandoned. Understandably, there was both relief and some scepticism – for how would people schooled in the target approach even begin to understand the changed paradigm?

Low understanding of participatory processes: National technical experts who went from state to state stressing the importance of CNAA were unable to give conceptual clarity and put in place concrete steps for decentralised participatory planning. The uncertainty among those at the implementing end contributed to the slowness with which this alternative strategy was accepted. The low levels of sterilisation achievement during the first year of the TFA were enough for health planners and demographers to reiterate the need for clear targets to guide performance.

Government's narrow perception of RCH: Government policymakers saw RCH as a means to control population growth and not as a right-based approach. The RCH document translated RH narrowly as RCH – an integration of CSSM and FW programmes. In the introductory section the document states that while RH is essential as a legitimate right of all citizens, “RCH is even more relevant for obtaining the objective of stable population for the country”.⁴⁴

Lack of ownership of the ICPD programme by state governments: Health policy and planning in India are largely centralised and state level policymakers are not directly involved in central government policy-making. Because ICPD remained essentially a subject of the Central Government and did not filter down to the states, there was little involvement at that level. Further, because state governments had not participated in ICPD deliberations they considered it as an approach driven by the UN and international agencies rather than the family welfare department of GOI. They did not link the ICPD agenda with the shift in Indian government policies. Nor did they adopt the CNA approach. Policies were conceived at the national level and though the Central Government tried to implement them, programme managers and health workers were confused about the purpose and process of the CNA. Some states came out with even more coercive measures in their policies without adhering to ICPD recommendations.

Lack of continuity: Frequent changes in political and bureaucratic leadership postings led to a loss of continuity in carrying forward the ICPD agenda. The enthusiasm and commitments made at ICPD did not get passed on to new people coming into positions of power, and therefore did not get passed on to politicians for whom the only ‘solution’ was population control.

Lack of proactive role by donors: Though international donors and NGOs helped in facilitating ICPD and in bringing the agenda into the country, they did not adopt a proactive stand while the Government slipped back from its ICPD commitments. Instead of working for a broad health approach they shied away from dissent and implemented projects – as NGOs do – in small pockets. The World Bank, which has great influence over government policy formulation, did not push the ICPD

agenda of rights and community participation. Its policies led to further decline of the public health system and alienated the poor from government facilities.

Lack of indicators for measuring quality of care: The Government has not set clearly measurable quality-of-care indicators to map the progress made in health after RCH I. Instead, it has been setting targets based on hypothetical numbers. There is, therefore, a large gap between the indicators of progress published by government and the ground reality.

Today, ten years after ICPD, women still have no choices. Sterilisation measures essentially target them. The Government has focussed on reducing numbers and achieving quick results through short-cut methods and by compromising individuals' rights and the welfare of the people. Resulting from a reversal of ICPD, targets were once again reintroduced into programme implementation. The RCH programme, which was adopted mainly to improve maternal and reproductive and child health, lost track of its broad objective: the maternal and reproductive health of women was neglected.

Low grassroots involvement: The new approach required a high level of participation from the staff at the grassroots but members of the peripheral health staff were unaware of the purpose and objectives of the programme. They did not get adequate training. District and state level officers used the community needs assessment method as an indirect method of fixing targets and called them 'expected level of achievement' (ELA) rather than targets.

Narrow focus of RCH: Other health problems of women and families, such as infertility, were not addressed in the RCH programme. The UNFPA held one national consultation on infertility but there was no follow up.⁴⁵ The VHAI in collaboration with WAH (Women and Health Programme) and DSE (German Foundation for International Development) conducted a national consultation, "Towards a Comprehensive Women's Health Policy and Programme", in 1999 to bring all issues related to gender, rights and women's health within a basic health framework.⁴⁵ But being a small initiative this was not incorporated into the programmes.

Negative effects of liberalisation: Liberalisation resulted in the public health system further losing its credibility, accountability and responsiveness to poor people's needs and requirements even as the wealthy grew excessively dependent on the private sector. The quality of services deteriorated and the attitude of the health staff became negligent since only the very poor availed of government health services. This, in turn, strengthened the growth of a strong private sector from village to city while the low performance in the government sector led to even the poor seeking the services of the private sector.

In summary, the major policies and programmes after ICPD are lacking in a rights based approach and there is hardly any focus on gender equity and equality. Though maternal mortality reduction seems to have received some attention, maternal morbidity is hardly addressed. Reproductive cancers and other problems of women go unnoticed. Male participation is limited to motivation for vasectomy. Sexuality and sexual health and rights do not find a place in these policies. People's involvement and active participation in health and family welfare is seen only in terms of consultation with a few NGOs and implementation of micro projects under the RCH project.

Barriers and Facilitating Factors

Maternal Mortality Reduction

India's RCH programme was not successful in placing maternal mortality reduction at the centre of programme planning and implementation. There were, however, a number of facilitating factors for reducing MMR:

Facilitating Factors

- The setting of MDGs by the UN.
- The introduction of standards of midwifery practice by WHO, South East Asia Regional Office.
- Promotion of skilled birth attendants by WHO, ICM, UNICEF.
- Research and surveys highlighting the steady figures of maternal mortality.
- The understanding that neonatal mortality is closely linked to maternal health, especially postnatal care.
- Growth of networks advocating maternal health, such as WRAI and other state networks.

Barriers to Achievement

- A myopic perspective that looks at maternal health only with a narrow focus and concentrates on dealing with only one intervention at a time – antenatal registration, tetanus toxoid, iron and folic acid.
- Active encouragement to institutional deliveries but inadequate attention to personnel policies and implementation.
- Local barriers: Though the Government has attempted to improve facilities such as making some PHCs into round-the-clock service centres, women were unable to use them in emergencies because of lack of staff and facilities, as well as lack of transport due to the poor location of PHCs.
- Monetary incentives: Though the Government has initiated several monetary incentives for a woman during the pregnancy cycle, women are not able to make use of these incentives at the right time.
- CHCs do not have blood bank facilities and so caesarean sections are not conducted here.
- Professional bodies such as FOGSI focus more on tertiary care, such as emergency obstetric services, and less on home care.
- A disempowered midwifery profession.
- A low number of skilled birth attendants in the field. ANMs have lost their skills and although nearly ten years have passed after ICPD, the ANM syllabus has not been revised to include new concepts and skills.
- ANMs are overburdened with non-maternal health work. No effort has been made to reallocate responsibilities between male and female health workers.
- Professional bodies are unwilling or unable to take expanded roles. ANMs and midwives are not allowed to perform life saving measures. RCH skill training does not provide skills or empower ANMs and nurses to carry out emergency first aid.
- Traditional birth attendants are not given support, based on the argument that their training had not contributed to a reduction in maternal mortality.
- The Government does not show commitment to reallocate responsibilities or to retrain midwifery service providers.

Safe Abortion Services

The coverage and quality of this service in public health facilities has not yet been expanded though the MTP Act has been amended.

Facilitating Factors

- Sustained efforts by some international agencies such as IPAS to expand safe abortion services.
- Amendment of MTP Act to expand services to PHCs by training medical officers and the inclusion of medical abortion.

Barriers to Achievement

- Abortion care providers not expanded beyond medical doctors even after the new amendment of MTP.
- Midlevel providers not authorised to perform abortions even for simple procedures such as MVA.
- The RCH programme uses a limited concept of safe abortion; post abortion care and follow up is still given low priority.
- No strict measures have been put in place to curb unsafe abortion by untrained providers.
- There is no improvement in the quality of abortion care in public facilities.

Neonatal Health and Reduction of IMR and NNMR

The IMR, and specially the NNMR have remained steady for nearly ten years, despite the RCH and CSSM programmes being intensively focussed on the child.

Facilitating Factors

- UNICEF's sustained efforts to improve the quality of child care.
- Professional groups such as National Neonatology Forum (NNF) and Indian Academy of Paediatrics (IAP) strongly committed to newborn care and survival.
- Increase in the number of thematic and symbolic interventions for newborn care, such as NNF's breast feeding initiative

Barriers to Achievement

- Home care of the newborn is poor since postnatal care by technical providers is almost non-existent.
- An inadequate understanding of the fact that institutional delivery takes care of only some neonatal problems and that enabling and training members of the family is also important.
- Traditionally, training of birth attendants has not included neonatal first aid or resuscitation.
- Gender discrimination in the care of the newborn and infant still continues and very little focus is given to this aspect of post-natal care.

Pre-Natal Diagnostic Techniques Act

Though PNDTs have been discussed widely, there has been no curb on sex selective abortion.

Facilitating Factors

- Legislative support
- Strong and alert activist groups

Barriers to Achievement

- Implementation mechanisms are weak.
- Deeper social problems and perceptions related to gender have not been addressed.

Gender Discrimination

This continues despite the ICPD and Beijing PFA which have brought in some awareness.

Facilitating Factors

- Pro-active steps of UN and donor agencies to ensure gender concerns in all their support activities.
- Introduction of the Women Empowerment Bill.
- Large-scale gender awareness programmes are gradually taken up; development and policy planners have begun to acknowledge the role of gender equity for development.
- More NGOs are taking up gender-related activities.
- Reproductive and sexual rights and sexuality are discussed more openly.

Barriers to Achievement

- The Women's Reservation Bill has not been passed though the issue has been discussed in Parliament three times.
- A lack of commitment among political parties.
- Strongly patriarchal traditions.
- Low awareness of rights and benefits.

Contraception and Family Planning

Nearly ten years after the introduction of the target free approach and decentralised participatory planning, people do not have an opportunity to exercise their reproductive choice but are limited to what the programme provides.

Facilitating Factors

- The mindset is gradually changing even among demographers about the inevitability of growth due to population momentum and the reaching of a saturation point for sterilisation.
- The awareness of HIV/AIDS has increased stress on condom usage for dual purposes.

Barriers to Achievement

- Lack of a political commitment to change the target-oriented approach.
- No effective alternative to targets.
- A strong belief in the necessity of targets among providers and programme managers.

- Elite groups have developed a phobia about the growth of population among the poor and its ramifications on their lifestyle and resources.
- Grassroots service providers have not been trained to provide services for spacing of children.
- The concepts of expanded and informed choice have not been clearly understood.
- There is resistance among providers since choice requires greater interaction with clients.
- The delivery system has not been able to improve the quality of services.

Challenges

Patriarchal Structure and Ideology

Patriarchy is deeply embedded in the minds of the people, and is an age-old legacy that affects the perceptions and lives of both men and women. Changes in women's empowerment cannot be brought about without a change in social perceptions. Although this change has begun, it will take time to become visible. A vigorous, sustained and strategic effort will be needed from all actors, whether government, NGOs, media, politicians, religious leaders, researchers, academicians and the community, to bring it about. Policy and legislation can only facilitate the process.

Early Age at Marriage and Early Pregnancy

The legal age of marriage for girls has gone up slightly within the last decade. However, there remains a large gap between people's awareness of the ideal or legal age and their practices, and even when such awareness does exist, people find it difficult to put this into practice without going against age-old beliefs and traditions. In our research, for example, we found that many people accepted the fact that it would be ideal for the married couple to wait for the first pregnancy. But the traditional emphasis on the importance of childbirth within the first year is strong and the couple are often under intense social pressure to conceive as early as possible. The NFPP's stress on sterilisation does not give importance to this aspect of newly married life. Early marriage and pregnancy are not only major causes of maternal mortality and morbidity but they also increase the powerlessness of the young girl and perpetuate such social practices. Opinion leaders, village and religious leaders and caste heads could help to bring about a change in this attitude since legislation alone has achieved very little.

Building a Culture of Work

This is a major challenge since there is a gradual decline in the work ethos of service providers. An attempt was made to address this by providing different kinds of training, also within the RCH programme. However, commitment does not come with training alone. In fact trainings have failed to bring behavioural changes. It is essential to find ways to ensure that service providers are indeed sensitive and responsive to people's needs, and are available when people require their services.

Enhancing Political Will and Political Stability

All too often, the party elected to power is more preoccupied with trying to ensure its position and its continuity as the ruling power. Very little attention is paid to community development or to the rights of the people. In fact political parties do not want to touch sensitive issues lest these expose them to the risk of losing the power they hold. Political stability is another challenge in India. Individual parties often do not get a majority vote, leading to coalitions, and they are, therefore, insecure about their position. Also, frequent changes of government do not foster steady growth.

Social Inequity and Equality

There is inequality in access to health care and other services. Some groups are unable to access facilities due to their inherent disadvantage. Maternal deaths and newborn deaths are concentrated in pockets where disadvantaged people stay. Society in India is intensely hierarchal. Reservations and special constitutional privileges have not been successful in removing caste-based inequalities even after half a century of planned development. Only social awareness can achieve some amount of success in this field.

Fundamentalism

Religious leaders give top priority to their religious agenda and all other issues get subsumed under this. It is difficult to negotiate gender equity if it goes against the main agenda of a socio-religious political power.

Steady Trend toward Privatisation, Liberalisation and Globalisation

These processes are not beneficial to small entrepreneurs and co-operatives, especially where women are involved. The privatisation of some services is increasing the burden on health.

Low Levels of Literacy and Awareness among the Community, Especially Women

More than 65 percent women are non-literate in India. They do not have much exposure to or awareness about their constitutional, legal and basic rights. So they do not demand these from the Government, society and politicians. Their expectations from the health system are low since they are unaware of the meaning of quality health care. Raising people's awareness requires sustained work at the grassroots.

Recommendations

Recommendations to Government

A serious attempt should be made to enhance people's participation. Micro planning exercises should be carried out in different parts of the country so that programmes are planned according to the different needs instead of having a uniform package for the entire nation. The decentralised planning process that was initiated in 1996 did not take off due to inadequate preparation of peripheral staff. This needs to be reviewed

and revised with greater commitment. The failure of the hastily announced TFA should not be used as an indication that the target approach needs to be revived.

Gender sensitisation should be taken up at all levels including among policymakers, programme planners, service providers, researchers and trainers. It is not enough to empower only the client; the service provider environment also must change. For example, grassroots service providers are the least empowered and the most exploited. Administrative and accounts staff also need to develop gender sensitivity in order to deal with women and service providers.

The current trend towards privatisation of services needs to be viewed with caution. The private sector cannot be expected to serve the poorest without a profit motive. Moreover, where the poor are concerned, service providers have little motivation to improve quality since they are aware that their services are meant only for the very poor who may not be aware of their rights. It is very easy to develop a negligent attitude unless there is commitment and a work ethic is developed. Also, the accountability of the public health system has to be viewed seriously. Community based monitoring at panchayat level is critical.

The primary health system should be strengthened. Even if the PHCs are supplied with equipment and facilities under different projects (donor and RCH) there is a need to bring functional efficiency, particularly in terms of staff availability and time convenience. Some PHCs have improved in infrastructure and facilities during RCH projects but no improvements have been made at the sub centre; conversely, there has been deterioration. Sub centres, which are nearest to the people, need to be strengthened and improved particularly.

RCH I withdrew support to *dai* (midwife) training with the intention of providing professional help to all women through institutional deliveries and qualified providers. This shortsighted intervention resulted in women having access to neither the *dai* nor the professional provider. In inaccessible and remote areas, *dai* training should continue in a phased and planned manner with a long term plan for ultimate discontinuation.

The RCH was unable to make any headway in improving referral linkages from the village to the hospital in the case of EOC. CHCs and FRUs are still not equipped to conduct CS, give blood or save the mother and the newborn.

The country has developed thousands of self-help groups in different states. Their activities are limited to savings and credit. Their entry into welfare programmes such as health and education has not been effective. This large resource group can be used for raising awareness about reproductive rights and utilisation.

Scheme-based vertical programmes on specific issues such as HIV/AIDS are again sidelining the concept of holistic and comprehensive health care at the community level. Family planning and maternal and child health should be offered within a strong primary health service structure that is responsive to people's needs.

The Government should adopt a clear policy on male health workers and health supervisors so that this large group is used efficiently.

Recommendations to UN Agencies, World Bank and Funding Agencies

- The World Bank needs to stop its efforts to privatise some health services as such privatisation adversely affects the poor.

- The opportunity for bringing about a change in the health programme from a narrow perspective to a broad perspective is being lost due to the fragmented approach followed by international agencies. The World Bank is in a comfortable position to bring about coordination towards a more broad-based approach.
- UN agencies have made a good beginning in promoting safe motherhood, a client-centred approach, gender sensitisation and quality services especially in the area of maternal and neonatal health and young people's issues. These efforts need to be sustained.

Recommendations to NGOs

- The role of NGOs has undergone a change during the last decade. There is an increasing trend of NGOs undertaking service delivery and being co-opted by the government to take over the management of health facilities. This will create a void in the effective role that NGOs can play as the voice of the people.
- NGOs made history at the ICPD by playing a critical role along with the government, UN agencies and donors. At the same time they were the voice of the people for the PoA. Their role was also clearly visible at the time of introduction of the RCH project and during ICPD+5. They consulted the people and carried ground realities to policymakers. However, their role is less visible now. NGOs need to be cautious and keep their observer/facilitator status rather than getting lost in processes.
- Take proactive and intensive steps to facilitate an enabling environment where women and men can exercise informed choice.
- Disseminating information, creating discussion and empowerment of the people are key roles of NGOs. People should be helped to demand and utilise services, and to make the public health facilities, in turn, accountable to the people.

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Abbreviations /Acronyms

ANM	Auxiliary Nurse Midwife
ANS	Academy for Nursing Studies
AP	Andhra Pradesh
ARI	Acute Respiratory Infections
AWW	Anganwadi Worker (community worker)
BPL	Below Poverty Line
BMI	Body Mass Index
CEHAT	Centre for Enquiry into Health and Allied Themes
CHC	Community Health Centre
CHETNA	Centre For Health Education Training and Nutrition Awareness.
CINI	Child In Need Institute
CNAA	Community Needs Assessment Approach
CPR	Couple Protection Rate
CS	Child Survival
CSSM	Child Survival and Safe Motherhood
DANIDA	Danish International Development Assistance
DFID	Department for International Development
DGO	Diploma in Gynaecology and Obstetrics
DSE	Deutsche Stiftung Fur Internationale Entwicklung (German Foundation for International Development)
DWACRA	Development of Women and Children in Rural Areas.
EICC	Expanded and Informed Contraceptive Choice
ELA	Expected Level of Achievement
EmOC	Emergency Obstetric Care
EOC	Emergency Obstetric Care
ESCAP	Economic and Social Council of Asia Pacific
FOGSI	Federation of Obstetrics and Gynaecologists Society of India
FP	Family Planning
FPAI	Family Planning Association of India
FRU	First Referral Unit
GOI	Government of India
HFA	Health For All
HW	Health Watch
ICPD	International Conference on Population and Development
ICMR	Indian Council of Medical Research

ICSSR	Indian Council of Social Science Research
IEC	Information Education Communication
IFA	Iron and Folic Acid
IMR	Infant Mortality Rate
ISM	Indian System of Medicine
MCH	Mother and Child Health
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MPHW(F)	Multipurpose Health Worker (Female, earlier known as Auxiliary Nurse Midwife)
MR	Mortality Rate
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Extraction
NACO	National AIDS Control Organisation
NAWO	National Alliance of Women's Organisations
NCP	National Commission on Population
NFHS	National Family Health Survey
NFPP	National Family Planning Programme
NGOs	Non Government Organisations
NHP	National Health Policy
NMBS	National Maternity Benefit Scheme
NNM	Neo Natal Mortality
NNP	National Nutrition Policy
NPP	National Population Policy
ORS	Oral Re-hydration Solution
PCI	Planning Commission of India
PHC	Primary Health Centre
PNDT	Prenatal Diagnostic Techniques
POA	Programme of Action (ICPD)
PRI	Panchayati Raj Institutions (Governance)
RCH	Reproductive and Child Health
RGI	Registrar General of India
RH	Reproductive Health
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
SC	Schedule Caste
SCOVA	State Committee of Voluntary Agencies
SHG	Self Help Groups
SM	Safe Motherhood
SRH	Sexual and Reproductive Health
SRS	Sample Registration System
ST	Schedule Tribe
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TBAs	Trained Birth Attendants
TFA	Target Free Approach
TFR	Total Fertility Rate
UIP	Universal Immunisation Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development for Women
VCTC	Voluntary Counselling and Testing Centre
VHAI	Voluntary Health Association of India
WAH	Women and Health Programme
WHO	World Health Organisation ⁶
WRAI	White Ribbon Alliance of India

Notes

- ¹ GO-NGO interaction at ICPD: Prof. Gita Sen represented the NGOs at ICPD. Prominent among NGO representatives at ICPD were: Vimala Ramachandran, Sundari Ravindran, Mirai Chatterjee, Leela Visaria, Pappu, and Indu Capoor. Mr. Sugathan, the then health secretary was open to discussions and interacted regularly with the NGO representatives. Having government delegates and civil society members in the same hotel helped in regular interactions and feedback. Subsequently, the participating government officials helped to move forward the reproductive health agenda of the country.
- ² Health Watch: The Health Watch Trust, a national Network of NGOs working in the area of reproductive health and rights, started immediately after ICPD. Health Watch was born out of the camaraderie and enthusiasm built at Cairo. The purpose of Health Watch is to keep a watch on implementation of ICPD commitments. It operates through a steering Committee of committed individuals and institutions. CHETNA and ANS are HW members.
- ³ Health Watch, 1997
- ⁴ FPAI, 1999
- ⁵ Population Council, 1999
- ⁶ GOI, 1999
- ⁷ Consultations among NGOs and civil society: For example, CHETNA organised a national seminar in May 1994, at which 55 experts, researchers, donors, activists participated. The consultative meeting ended on the note that existing policies and programmes related to reproductive health (before ICPD) were inadequate and insensitive to women's health needs and that they do not address the issue of powerlessness that adversely affects women's health seeking behaviour.
- ⁸ GOI, 2003
- ⁹ GOI, 1946
- ¹⁰ GOI, 1962
- ¹¹ GOI, 1973
- ¹² ICMR-ICSSR, 1980
- ¹³ GOI, 1983
- ¹⁴ Pachauri, 1999
- ¹⁵ GOI, 1992
- ¹⁶ CHETNA, 1994
- ¹⁷ GOI, Planning Commission, 2001
- ¹⁸ Dawn, 1999
- ¹⁹ GOI, 1997 p.3
- ²⁰ GOI, 2000
- ²¹ GOI, 2001
- ²² GOI 1994 and 2002
- ²³ <http://www.keralanext.com>
- ²⁴ WHO, 1995
- ²⁵ GOI, Planning Commission, 2002
- ²⁶ GOI, Planning Commission, 2001
- ²⁷ CEHAT, 2002
- ²⁸ GOI, 2001
- ²⁹ GOI-RGI, 2001
- ³⁰ GOI-RGI, 1999
- ³¹ WRAI, 2002
- ³² ANS, 2003
- ³³ GOI-RGI, 2001 and NFHS 2,1998-99
- ³⁴ Menon-Sen and Kumar, 2001
- ³⁵ GOI-Census of India, 2001
- ³⁶ RGI, 2001
- ³⁷ Menon-Sen and Kumar, 2001
- ³⁸ NFHS 2, 1998-99
- ³⁹ GOI, 2001
- ⁴⁰ Santhya, 2003
- ⁴¹ Nanda, 2004
- ⁴² Sen, 2002
- ⁴³ Visaria, 1998
- ⁴⁴ GOI, 1997
- ⁴⁵ UNFPA, 1999
- ⁴⁶ VHAI, 2000