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Special Issue on Population

Editorial

This issue of Medico Friend Circle Bulletin is devoted to an exploration of some issues related to the population policies announced by several states are in the country, while several other states are in the process of finalizing their own policies. Given the openness with which public policy documents are prepared in the country, it is not surprising that a vast majority of persons involved as academics or activists in health and population issues were taken surprise as state after state announced population policies. One fundamental reason is of course that these states had never before felt the need, and indeed do not do so even now, to formulate health policies with which population policies may resonate. The second is that in very fundamental manners, many of these state policies late the letter and spirit of the National Population Policy.

Not only are these policies divorced from health policies, but they are also divorced from issues that profoundly impinge of both health and population. Indeed way back in 1980 the Working Group on Population Policy[1] arguing that population and development are two sides of the same coin, identified employment, income, food security, r supply, sanitation, literacy, female empowerment, health services and the security of children's lives as factors fundamental to a population policy.

Even as macro-economic reforms are eroding the necessary conditions for health and well-being of the majority of people, the population policies with their incentives and disincentives further we the scope of the welfare services that the poor are entitled to as citizens. The irony of course never before has the discourse of rights been as popular as they are today. Indeed it is in this very framework of reproductive rights that the narrowly focussed health package is being framed. Leela Sami provides a summary of some of the state population policies. I provide a brief comment on them. The UP-Bihar Health Watch group has done some excellent work mobilizing against the UP state policies. Jasodhara Dasgupta provides an insight not only into their concerns but equally into how they went about their activities. The Gujarat, a group of activists and academics, mobilized against a two-child norm that was proposed to be introduced in Gujarat. We reproduce here their statement. Another piece on the Gujarat policy is by Renu Khanna who situates it within the feminist discourse on population. Sheela Prasad and Veena Shatrugna write on the Andhra Pradesh's population policy, while Jaya Velankar analyses the Maharashtra's population policy. Unfortunately we were unable to get comments on the population policies of Madhya Pradesh and Rajasthan within the time constraint this issue was put together.

These may be considered papers to commence a wider debate in the Bulletin, *including of course various strategies of mobilisation.*

Mohan Rao

I Government of India (1980), Report of the Working Group on Population Policy. *Ministry of Health and Family Welfare, New Delhi.*

Dr. Mohan Rao teaches at the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

A Summary of the National Population Policy and the State Population Policies of Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra, and Andhra Pradesh

Leela Sami

This paper seeks to summarize the population policies of five Indian states; namely, Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra and Andhra Pradesh. In the year 2000, the Government of India released the National Population Policy (NPP) document which made an explicit commitment to" voluntary and informed choice and consent of citizens while availing of Reproductive and Child Health (RCH) services and continuation of the target free approach in administering family planning services."

The NPP also acknowledges a "need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of RCH services by government, industry and voluntary NGO sectors working in partnership."

The NPP lists its objectives in terms of three time frames: its immediate objective is to address unmet needs for contraception, healthcare infrastructure and health personnel and to provide integrated service delivery for basic reproductive and child health. The medium term objective is to bring the TFR back to replacement level by 2010, through vigorous implementation of intersectoral operational strategies. The long- term objective is to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

In pursuance of these objectives, the NPP lists fourteen socio-demographic goals to be achieved at an all-India level by 2010. These include addressing the unmet need for basic RCH services, supplies and infrastructure, increasing access to schooling, reduction in Infant Mortality Rates (IMR) and Maternal Mortality Ratio (MMR), universalisation of immunization, delayed marriage for girls, universalising delivery by trained personnel and increasing the number of institutional deliveries, achieving a delayed average age at marriage for girls, increased access to information and counselling, universal registration of vital events, control of communicable diseases, convergence of RCH programmes and Indian Systems of Medicine and Homeopathy (ISMH), and convergence of different social sector programmes.

The NPP stresses the need for decentralised planning, the empowerment of women for population stabilisation, child health and survival, collaboration with the voluntary and NGO sector, and encouragement of research in contraceptive technology.

In order to promote the policy, it lists a number of measures. These include rewarding of Panchayats and Zilla Parishads for exemplary performance in Family Welfare and maternity benefits for mothers who give birth to their first child after the age of nineteen. Also, a family welfare-linked social insurance is to be given to couples below the Poverty Line with two or less children who undergo sterilisation. The government proposes to reward couples who marry after the legal age at marriage, register their marriage, have their first child after the age of 21 years, accept the small family norm and adopt a terminal method after the birth of their second child. It is also proposed to have a revolving fund for income generating activities by village level self help groups who provide community health care services, the establishment of crèches and child care centres in rural areas and the urban slums, a wide choice of contraceptives, facilities for safe and legal abortion, and vocational training for girls.

One of the central features of the policy is a commitment to a target- free approach and a refusal to use disincentives or coercion in order to achieve the demographic goals set by the state. The NPP also stresses the need for involvement of local bodies at the lowest level- i.e. the Panchayati Raj Institutions (PRI's)-in the achievement of the goals that make for population stabilization. It suggests the devolution not only of rights, responsibilities and powers to the PRI's but also of funds and resource generation. This latter is extremely critical in order for decision making to be truly decentralised. In doing so, the NPP extends the scope of population policy to a broader notion of democracy and welfare.

With the NPP as the background, we move on to examine the state level policies.

Leela Sami is *a research scholar. Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi*

1. Uttar Pradesh:

The population policy of Uttar Pradesh links the growth of population to pressure on natural resources, and declares the inability of the state and its government to improve the quality of life of the people, in the face of this pressure of population growth. It mentions the need to address issues of gender and child development in the attempt to stabilise population growth.

In terms of its specific objectives, the following are mentioned:

The need to reduce TFR from 4.3 in 1997 to 2.6 in 2011 - 2016.

Proportionate increases in use of contraceptive methods by increasing demand for the same.

Increase in average age of the mother at the birth of her first child.

Reduction in unmet need for both spacing and terminal methods.

Reduction in MMR from 707/ 1000,000 live births in 1997 to 394 in 2010 to below 250 in 2016.

Reduction in infant mortality from 85/1000 live births in 1997 to 73 in 2010 and 67 in 2016.

Reduction in incidence of sexually transmitted diseases (STI's) and reproductive tract infections (RTI's).

Increase awareness of AIDS.

The strategies to be adopted to improve RCH include raising the average age of effective marriage, introducing and focusing on adult education, empowerment of women and enhancing the involvement both of the private and voluntary/ NGO sector and the role of PRI's.

The policy lists a number of incentives and disincentives to achieve its objectives, which include some of the following:

Disqualification of persons who marry before the legal age at marriage from eligibility for government jobs.

"Performance- based" disbursement of 10 per cent of the total financial resources for PRI's. Panchayats which "perform" well in the provision of RCH services will be rewarded. While the total 'transfer of funds will amount to only four per cent of state revenue, the PRI's are to be entirely responsible for advocacy, identification of contraceptive needs and recording of vital, events.

The performance of medical officers and health workers is to be based on their performance in the RCH programme. While ostensibly, this would mean more efficient RCH services, it would perhaps place extreme pressure on health workers to reach targets with regard to limiting of family size. Also, linking performance appraisal of individuals to performance in RCH would probably result in lopsided health services provision, leading to an overemphasis on family planning and a neglect of other aspects of primary health care such as control of communicable diseases.

The document also calls for "an active dialogue with the GOI for wider availability of injectables and other new technologies through private, commercial and government channels in the state". The state thus intends to actively push the introduction of these newer technologies.

Finally, the explicit commitment to charging user fees ostensibly to improve the quality of services will place a further burden on the poor to pay for the entire gamut of health services. The decision of the government to disallow those who marry before the legal age and who have more than two children from government service will adversely affect women who may have no say in their age at marriage. In this case, even the implementation of 33% reservation for women in elected bodies and employment will not necessarily result in greater gender equity, except in a narrow sense for some sections of women.

2. Madhya Pradesh

The population policy of Madhya Pradesh stresses the need to curb high fertility and mortality, which impinge upon the quality of life and the balance between population, resources and the environment. The policy document mentions the process of democratic decentralisation underway in the state and speaks of the need to change the thrust of family welfare from female sterilization to include raising the age at marriage for women, provision of RCH services, universalization of education and empowerment of women.

The specific objectives of the MP policy include:

Reducing total fertility rates from 4 in 1997 to 2.1 in 2011.

Increasing contraceptive usage and sterilisation services.

Increasing the age of the mother at the birth of her first child from 16 years in 1997 to 20 years in 2011.

Reduction in MMR from 498 to 220 between 1997 and 2011 through greater registration of pregnant women, increases in proportions of

institutional and trained deliveries and pregnancy testing centres.

Reduction in IMR through increases in immunization, use of Oral Rehydration Solution (ORS) therapies for diahorrea in rural areas, reduction in incidence of Acute Respiratory Infections (ARI's), coverage of pregnant women and children with Vitamin A, Iron and Folic Acid (IF A) tablets.

Increases in levels of HI V testing.

Services for infertile couples.

Universalizing access to primary education by 2005; with a goal of ensuring that 30% of girls in the age group of 14-15 years in 2005 would complete elementary education.

The strategies advocated by the policy document include the need to involve PRI's, and to empower women in the endeavour to reach population stabilisation. A number of initiatives are suggested such as

making men realize their responsibility to empower women.

strengthening local women's groups.

reducing the burden of housework and drudgery on women by providing cooking gas connections and electricity to rural households.

Reservation of 30% of government jobs for women.

However the MP policy also has a number of disincentives. These include

Debarring of persons who marry before the legal age for marriage from seeking government employment.

Persons who have more than two children will be debarred from contesting Panchayat elections.

The provision of rural development schemes in villages will depend upon the' level of family planning performance by Panchayats. The flow of resources to PRI's is also to be linked to performance in RCH. While there is no specific commitment to increasing devolution and control of resources to PRI's, these institutions are to be made responsible for the implementation of the RCH programme.

Performance by Panchayats in family planning is also to be linked to the starting of income generating schemes for women and poverty alleviation programmes.

3. Rajasthan

The population policy of Rajasthan, like those of Madhya Pradesh and Uttar Pradesh, also links deceleration in the population growth rate to sustainable development. It mentions the need to reduce infant mortality, gender discrimination and undernutrition, and to increase household security.

With regard to its specific objectives, it mentions

The need to increase the median age at marriage for girls from 15 in 1993 to 19 by 2010 through education and increasing awareness.

Increase institutional deliveries from 8% in 1995 to 35% by 2016 and assistance by trained persons in child delivery from 35% in 1995 to 75% in 2010.

Educate all women in the reproductive age groups about antenatal services and on establishing linkages between female health workers, Anganwadi workers and trained dais at the village level.

Improved child health is to be achieved through assuring better quality ARI care, strengthening links between ICDS and health workers, and coverage of all children for immunization and Vitamin A dosage.

With regard to operational strategies, it mentions the need to encourage men to use low-cost sterilization services, and recognizes that quality of the sterilization and spacing methods need to be improved. While the thrust of the policy is on provision of RCH services, improvement of management of service delivery systems, encouraging involvement of PRI's, NGO's the private sector and co-operatives, and on information, education and communication (1EC).

There are, however, a number of incentives and disincentives mentioned, which include the debarring of persons with two or more children from contesting elections. It is also mentioned that "the same provisions can be considered for other elected bodies like co-operative institutions and as a service condition for state government employees." The policy also states that "the legal provisions barring people with more than two children from election to panchayats and municipal bodies is a testimony of the firm political will and commitment to population control."

The policy is cautious on the question of introducing new reproductive technologies, although the policy draft mentions that" new contraceptive methods, as and when approved by the GOI will be introduced to make new technology accessible." Finally, it mentions the need to address issues of infertility. RTI's and female literacy.

4. Maharashtra

The population policy of Maharashtra begins with a statement of the need to bring down the rate of population growth. Its specific objectives include:

Reducing TFR to 2.1 by 2004.
Reducing CBR to 18 by 2004.

Reducing IMR to 25 by 2004.

Reducing neonatal mortality to 2 by 2004.

The policy extract lists a number of measures in order to achieve these objectives. These include:

The provision of subsidies and perquisites to government employees is to be linked to acceptance of the small family norm or permanent methods of family planning by couples.

Service in government jobs is also to be dependent on the acceptance of the small family norm.
Provision of village health schemes will also be inked to the performance of panchayats in the RCH programme.

Assessment of medical officers will depend upon their level of performance in the RCH programme.

Persons having two or more children will be debarred from contesting panchayat elections.

Other schemes include cash incentives to couples undergoing sterilization after the birth of one or more daughters, training of dais, and strict enforcement of the Child Marriage Restraint Act, the ban on prenatal sex determination testing, etc. Also, women's self- help groups are to be set up at the village level.

Funding of PRI's will depend upon performance in the RCH programme.

The policy makes no provision for the representation of women in elected or other bodies. It also does not mention the devolution of resources or decision-making powers to PRI's.

5. Andhra Pradesh

The Andhra Pradesh population policy links population stabilization to improvements in standards of living and quality of life of the people. It states that "production of food may not keep pace with growing population....pressure on land and other facilities will increase further, resulting in social tension and violence...housing in both rural and urban areas will become a serious problem...there will be an increase in unemployment....there will be serious pressure on the country's natural resources causing deforestation, desertification and more natural calamities."

The demographic goals as stated in the policy include:

Reduction of natural growth rate from 1.44 in 1996 to 0.80 in 2010 and 0.70 by 2020.

Reduction in CBR from 22.7 in 1996 to 15.0 by 2010 and 13.0 by 2020.

Reduction in CDR from 8.3 in 1996 to 7.0in 2010 and 6.0 in 2020.

Reduction in IMR from 66.0 in 1996 to 30.0 in 2010 and 15.0 in 2020.

Reduction in MMR from 3.8 in 1996 to 1.2 in 2010 and 0.5 in 2020.

Reduction in TFR from 2.7 in 1996 to 1.5 in 2020
Increase in Couple Protection Rate from 48.8 % in 1996 to 70 % in 2010 and 75 % in 2020.

These objectives are to be attained by:

(a) The promotion of spacing, terminal and male contraceptive methods.

(b) Increasing the coverage of pregnant women for IT inoculation and provision of IFA tablets.

(c) Increasing the number of trained and institutional deliveries.

(d) Strengthening of referral systems and equity in accessibility of services.

(e) Eradicating polio, measles and neonatal tetanus by 1998.

(f) Reducing diahorreal deaths, deaths due to ARI's and incidence of low birth weight babies.

(g) Increasing female literacy levels, increasing the median age at marriage for girls and reduction in severe and moderate malnutrition among children.

(h) Reduction in the incidence of child labour.

The policy lists a number of operational strategies relating to promotion of terminal and spacing methods, ensuring safe deliveries as well as safe abortions, prevention and management of RTI's and SID's, increasing the average age at marriage of girls, and increasing female literacy and child survival. It also mentions a role for NGO's and the private sector in social marketing of contraceptives and delivery of health care.

The document explicitly lists a number of incentives

to be used in the achievement of its objectives.

These include the following:

1) At the community level, performance in RCH and rates of couple protection will determine the construction of school buildings, public works and funding for rural development programmes-.

2) Performance in RCH is also to be made the criterion for full coverage under programmes like TRYSEM, Weaker Section Housing Scheme, and Low Cost Sanitation Scheme.

3) Funding for programmes under the DWCRA and other social groups will be dependent on RCH performance.

4) At the individual level, cash prizes will be awarded to couples adopting terminal methods of family planning.

5) Allotment of surplus agricultural land, housing sites, as well as benefits under IRDP, SC Action Plan, BC Action Plan to be given in preference to acceptors of terminal methods of contraception.

6) Special health insurance schemes for acceptors of terminal methods of family planning.

7) Educational concessions, subsidies and promotions as well as government jobs to be restricted to those who-accept the small family norm.

8) Cash awards on the basis of performance to service providers.

9) An award of Rs. 10,000 each to 3 couples to be selected from every district on the basis of lucky dip, from the following categories: (a) 3 couples per district with two girl children adopting permanent methods of family planning (b) 3 couples per district with one child adopting permanent methods (c) 3 couples per district with two or less children adopting vasectomy.

The policy document mentions the need for involvement of people's representatives, religious leaders, professional social bodies, professionals, chambers of industry and commerce, youth, women and film actors and actresses. While it underscores the need for delegation of rights to PRI's, there are no provisions for delegation or devolution of resources to the panchayats.

To summarize, the National Population Policy lays the groundwork for a policy of population stabilization based on the premise that the provision of health, safety, security and protection of vulnerable groups is a precondition for population stability. It also affirms the need for a policy based on the ethics of informed choice and consent. In doing so, it eschews any measure that would be ethically hazardous or coercive. However, the state policies all suggest some measure of disincentives in order to achieve their targets.

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development processes have a direct impact on poverty and community health, giving rise to a host of unmet needs. We would, for example, posit that toilet facilities, systematic garbage remove facilities should intrinsically be part of the population policy. Because the lack of these creates the conditions for worsening health conditions.

7. Given the fact that Gujarat has had an abysmal record with regard to girl child infant mortality rates between girls and boys in the age group 0-4. Special care needs to be expended on programmes that will plug the shocking gap between the deaths of boy child and the girl child. This will include social awareness programmers as part of the population policy. It is important to realize that these social awareness programmers should aim al discussions with men as well as women.

Anti-People State Population Policies

Mohan Rao

In February last year; rile Government of India adopted the National Population Policy 2000. This policy is weak on many counts: population is not integrated with health, it has population stabilization rather than the health and well being of the population as a goal and so on. Yet one aspect on which the policy is to be hailed is that it resolutely affirms the "commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services". It is thus surprising that several state governments have announced population policies, which, in very significant manners violate the letter and the spirit of the National Population Policy. Equally distressing is that several private members bills are pending in Parliament that seek to reinforce a punitive and anti-democratic approach to issues of population.

Before considering why these measures are anti-democratic, it might be pertinent to recall some of the measures proposed by the states. The Uttar Pradesh policy, for instance, disqualifies persons married before the legal age of marriage from government jobs, as if children are responsible for child marriages. Further, 10 per cent of financial assistance to Panchayats is to be based on family planning performance. Indeed, frightfully recalling the Emergency, the assessment of the performance of medical officers and other health workers is linked to performance in the Reproductive and Child Health (RCH) programme, the new avatar of the family welfare programme. The policy also recommends User Fees for government health services when it is widely accepted that these are inaccessible to the poor. And in a daring departure from other states, the policy recommends the induction of contraceptives such as injectables and implants which are both unsafe and dangerous to the health of women.

Madhya Pradesh, besides debarring persons married before the legal age at marriage from government jobs, also forbids them from contesting Panchayat elections. As in the case of U.P., disbursement of resources to PRIs is linked to family planning performance. In a piquant twist, the provision of rural development schemes, income generating schemes for women, and-indeed poverty alleviation programmes as a whole, are all linked to performance in family planning. Rajasthan, besides debarring persons with more than two children from Panchayat elections, also bars them from other elected bodies like cooperative institutions. It makes adherence to a "two-child norm" a service condition for state government employees.

In addition to many of the above, the Maharashtra government in an Order announced the two-child norm as an eligibility criterion for a range of schemes for the weaker sections, including access to the public distribution system and education in government schools. The Andhra Pradesh government's fervour is exhibited by the fact that performance in RCH and the Couple Protection Rate will determine construction of school buildings, public works, and funding for rural development. Performance in RCH is also a criterion for coverage under programmes like TRYSEM, Weaker Section Housing Scheme, Low Cost Sanitation Scheme and DWCRA. Allotment of surplus agricultural land, housing sites, benefits under IRDP, S.C. Action Plan and B.C. Action Plan are to be given in preference to acceptors of family planning. Further, educational concessions, subsidies, promotions and government jobs are to be restricted to those accepting the small family norm. In a macabre metaphor of the lottery that is the life of the poor in the country, awards of Rs. 10,000/- each are to be given to three couples per district chosen by lottery. Eligible couples comprise those with two girl children with the mother sterilised, those with one girl child with the mother sterilised and couples two children or less with the father sterilised.

Newspaper reports indicate that Gujarat, that crucible of Hindutva politics, has unveiled a population policy that, besides carrying a range of disincentives, also explicitly makes a two-child norm mandatory for all communities.

These state policies are thus in complete disjunction with the National policy and indeed with commitments made by the Government of India at .the International Conference on Population and Development in Cairo. Policy makers so anxious to control numbers need to be reminded that such policies are unnecessary as a significant demographic transition is underway in large parts of the country. Areas where this transition has lagged behind need assistance towards strengthening their health and anti-poverty programmes and not measures that punish the poor. As the NPP itself points out, there is a large unmet need for health and family planning services. In such a situation, without meeting this unmet need, to propose punitive measures is both irrational and absurd.

The disincentives proposed do particularly anti-poor, anti-dalit and anti-adivasis, with these weaker sections have to bear the brunt of the withdrawal of a range of subsidies and measures to mitigate poverty and deprivation. The National Family Health Survey for 1998.-99 shows that the Total Fertility Rate (TFR) is 3.15 for S.Cs, 3.06 for S.Ts, 2.66 among O.B.Cs and 3.47 among illiterate women as a whole. In contrast, it is 1.99 among women educated beyond Class X. Significant sections among these already deprived populations will thus bear the brunt of these policies of disincentives. In addition to privatisation that de facto deprives S.Cs and S.Ts of jobs in the organised sector, these explicit policy measures will further curtail the meager employment opportunities available to them. Indeed this measure is pregnant with pro-natalist possibilities.

The disincentives are also anti-women since women in India seldom decide the number of children they wish to bear, when to bear them and indeed have no control over how many will survive. By debarring such women from contesting elections makes a mockery of policies to empower women. Further, they will provide an impetus to some women to resort to sex selective abortions and female feticide, worsening an already terrible sex ratio in the country.

The proposals are also anti-minorities since they ignore the fact that the somewhat higher TFR among some sections of these communities are a reflection of their poorer socio-economic situation. It need hardly be stated that just as the Hindu rate of economic growth is a chimera, so is a Muslim rate of population growth.

Finally, the proposals are deeply anti-democratic and violate several provisions of the Constitution (the right to livelihood, the right to life, the right to privacy, among others) and several International Covenants that India is signatory to, including the Rights of the Child.

The fact that structural adjustment policies have led to the collapse of a weak and underfunded public health care system, and that these same policies have also led to an increase of infant mortality rates in ten 'of the fifteen major states of the country, do not seem to concern our policy makers. So singleminded are they in their short-sighted policies that they do not realise the appalling fact that it is the fearsome pursuit of family planning programmes that has led to the distrust of the health system among the poor. The fact too is that it was these same people who brought down a government for the "excesses" of family planning not too long back. Is the fear of the poor so strong among our legislators and policy makers that their memories are so short?

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e-forum: It was pointed out that of late, several postings on the e-forum were from sources unknown to most members and of no interest to most. This seems to have happened since the eforum has been an open e-list, which could be subscribed to without a reference to any MFC member.

The question of whether this was appropriate was debated and it was resolved that since the e-forum was essentially an organizational forum, membership be restricted to those who are members of MFC in the broad sense, and those recommended inclusion by MFC members. Mode of access should accordingly be modified. A list of e-forum members can be regularly posted by the moderator, and postings not of common interest can be discouraged.

'MFC Revival': Over the past two months, a few members had expressed on the e-forum strong feelings about the apparent decline in committment of MFC members in taking up organizational responsibilities, and had questioned the justification of the organization running on the efforts of a few individuals. This was discussed at the MAM, although members who had expressed their views strongly on the e-forum were not present at the meet. It was felt that raising such issues in this manner also discourages those who are working for the organization any way, and who will keep working despite all odds.

The problem of fluctuating commitment was, however, acknowledged. The problem may not precipitate matters in the near future, since at least the run up to the next meet is gaining momentum, and good participation can be expected at the annual theme meet in January. The matter can be further discussed at the next AGM.

The next Annual Meet: The next Annual Meet will be held on 24-26th Jan, 2002 (Thursday-Saturday), at Sevagram as planned, of which the theme discussions will take up the first two days, and the AGM will be on the 26th. The venue booking has been confirmed. A detailed report of the discussions in preparation for the annual meet has been posted separately.

Report of the Women & Health Cell Meet, July 12-13, 20Ot:

Main Points arising out of the discussion on the theme of Nutrition and Food security: The discussions on the above theme were not just wide ranging but also quite substantive. Participants were asked to reflect on their current work, express

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Safegaurding Women's Health and Rights; Advocacy in Uttar Pradesh on the Population Policy 2000

Jashodhara Dasgupta.

Background to the formulation of the Uttar Pradesh Population Policy

The International Conference on Population and Development (ICPD) in 1994 looked at the population question anew from the aspect of sustainable development and reproductive rights and health. It announced a clear shift from the population control paradigm, advocated women's empowerment, and stressed the need for changing unsustainable patterns of consumption that destroyed our environment. According to the ICPD Programme of Action, individual countries had to make policy, programme and paradigm shifts that enabled them to attain the ICPD goals of health, rights and development.

At the International UN Conference on Population and Development (ICPD, 1994), it was recognised that merely focusing on reducing numbers will not lead to a better quality of life for the poor, or better health for women. Trying to reduce numbers through discrimination, force and violence is violation of human rights.

The Government of India (GOI) responded by announcing a shift in the Family Welfare programme in 1996 called the Target Free approach, and widened the scope of health services through the Reproductive and Child Health (RCH), programme. In February 2000, the Government of India announced its National Population Policy. It also recommended that the states should also formulate their own policies. It was not made clear how the policies at two levels would intersect, and whether there were any minimum guidelines for the state policies.

The Government of Uttar Pradesh announced its population Policy on 11th July, 2000. It was 1f~imarily written by consultants of the Policy project, a unit of Futures Group International. The USAID paid US $ 50,000 for its formulation. A consultation" was held for the policy in Lucknow, which had inputs by 'experts' from Mumbai and as attended by the staff of SIFPSA (the state implementing agency for a USAID-funded family planning project), as well as four NGO partners of SIFPSA. A perfunctory presentation was also made later to the larger NGO community of UP, but they were not allowed to have copies of the draft.

About Health Watch Uttar Pradesh Bihar

Health watch is a national group of concerned people who got together to monitor the implementation of the ICPD commitments in India The group has been organising consultations and conducting studies, providing feedback to the GOI and advocating changes in policy and in programme implementation. During one of the earliest consultations, a group of NGOs and networks in Uttar Pradesh and Bihar got together to monitor the situation in these two states especially closely, as they house one fourth of India's one billion population and are prime targets for a coercive approach in population control, violating the right to health. This Health Watch Uttar Pradesh-Bihar (HWUPB) group has today expanded to a large constituency of over a hundred NGOs, as well as women activists, media persons, academics, students and people's representatives. It is engaged in advocacy and monitoring of programmes and policies. The network's Secretariat is hosted by SAHA YOG at Lucknow.

Health Watch UP-Bihar and the UP Population Policy (UPPP)

Identifying the Issue

Initially after the announcement of the UPPP in July, it was quite difficult to get copies of the document. Through the network, a copy was somehow obtained and scanned. The HWUPB Secretariat immediately sent out photocopies to as many partners as possible inviting them to for a consultative meeting in the third week of August 2000. At this meeting, the partners of Health Watch UP-Bihar did a preliminary analysis or the policy, finding several aspects in contravention of the GOI's own parameters, notably the Target Free Approach. No one in UP had information about the policy announcement, including media, people's representatives and NGOs. As such it was decided to do a wider NGO consultation in September.

Getting Stakeholders on Board

In September 2000 Health Watch UP-Bihar organized a meeting with around 40 academics,

media persons, activists, women's movement, health NGOs, networks and service providers. The policy was critically analysed using different parameters. These included international agreements to which India was a signatory, such as the Declaration on Health For All by 2000 (Alma Ata), CEDAW, Cairo ICPD Programme of Action, Beijing FWCW Platform for Action, and national policies such as the Target Free Declaration of GOI, the RCH programme, and the National Population Policy. The UP policy was also analysed from the points of view of sustainable development, women's health as well as the present situation regarding quality of health service-provision in UP. It was disturbing to note that the Uttar Pradesh policy differed significantly from the approach taken by the GOI in earlier policy and programme statements as well as commitments made at UN conferences. The participants felt that the policy was unacceptable in its present form and formulated a collective strategy for advocacy on the policy.

HealthWatch UP-Bihar's Critique of UPPP

The UP Population Policy (UPPP) re-introduces contraceptive targets for Health and Family Welfare department staff as well as other government departments to the extent of 10 lakh sterilisations and 30 lakh spacing method users per year by 2005 which is a complete reversal of the Target Free Approach which the GOI announced five years age. The Policy also declares it will greatly reduce the Infant Death Rate and Maternal Death Rate by ensuring complete healthcare coverage to pregnant women and children. Yet this is to be done through the same Village Nurse-Midwives (ANMs), who can be punished by withholding salaries for as long as six months for failing to fulfil their quota of sterilisation targets. Given the fact that ANMs will be under constant pressure competing with other department personnel, it can be assumed that they will give low priority to safe motherhood, child survival and essential educational work.

The policy will force poor families to negotiate development benefits with government department personnel by giving coerced sterilisation cases.

The policy itself admits that sterilisation camps do not provide quality services and yet plans to promote and intensify the camp approach.

User Charges will be levied in state healthcare facilities which will no longer provide free services for maternal health and family planning. At the same time, the private sector is welcomed as a service provider through special provisions.

Unsafe abortion is one of the factors that cause India to have a high maternal mortality rate. Uttar Pradesh has the highest number of abortions at 67.92 per 1000 women in the 15-44 age group. UP also has the highest Maternal Death Ratio in India. Yet the UPPP is completely silent on the issue of providing safe abortion services

The policy is a gender-blind, and in some cases gender insensitive document, failing to address men's role in family planning and maternal health issues. Neither is it able to increase women's agency in ensuring better health for themselves.

Strategising

Taking into consideration the critique of the policy that had emerged, it was decided that Health Watch UP-Bihar should start a campaign, the objective of which was to mobilize public opinion about the policy and its strengths and weaknesses, and urge the UP government to revise it. Accordingly it was planned to address the government, involve the media and as many NGOs as possible, reach out to the grassroots and enlist community opinions, especially of people's representatives from panchayats, and highlight our concerns through a public event. For this the following strategy was chosen to work for the next six months:

Convey our concerns to the government through an Open Letter and give it to senior bureaucrats, especially in the health and family welfare department.

Share the policy widely with NGOs across the state through a summary version in Hindi, and publicise our critique based on government's own earlier commitments.

Get a statewide opinion poll from at least a thousand community opinion leaders, half of whom must be women.

Collate people's experiences of the Health & Family Welfare system in UP over the last five years, especially of the Quality of Care.

Do a Public Hearing on the policy after six months and present these experiences.

Implementing the strategy - (i) *publicizing the critique*

Between October 2000 and April 2001, the Secretariat of HealthWatch UP-Bihar (HWUPB) worked in a campaign mode on the components of this strategy, actively assisted by the partners of the network from NGOs, academic world and the media. At first an Open Letter was drafted and shared with other women's health and rights activists in the country, who gave feedback on it. After that a delegation of HWUPB partners met the Chief Minister's Secretary, as well as the Principal Secretary Health and Family Welfare, Governance of UP (GOUP) in December 2000 and January 2001 to hand over the letter, The letter present

the strengths and areas of concern in the policy, gave a set of recommendations, and requested further discussions and consultations. The policy was also widely disseminated to NGOs through a simplified summary version in the HWUPB newsletter Swaasthya Prahari, which also had an article on the critique of the policy. HWUPB also widely disseminated the critique of the policy among media persons through press statements, press conferences, press kits and media briefings. Other health movements like the People's Health Campaign also took up the UP policy as a priority issue for their future activities in the state.

In order to take the policy directly to the people, the salient points were collated and included in the questionnaire for conducting the Opinion Poll. This was especially necessary so that people could give an informed opinion. Between January and March 200 I, there were a series of twelve regional 'workshops in ten districts in every corner of the state, attended by a total of about 200 NGOs, media persons, academics, students, women activists and lawyers from the regions. The UP policy was discussed in the context of the post ICPD approach, and a consensus built on the need for an intervention on the policy. At each workshop, NGOs voluntarily took responsibility to present the policy in the community and conduct the Opinion Poll with ten community leaders of a development block. The questionnaire was discussed and participants were also urged to gather case studies of people's experiences of the quality of state healthcare. Regional media highlighted the policy critique and the campaign.

(ii)The Opinion Poll:

By April 2001, NGO partners had sent in over a thousand opinions of community leaders, half of whom were women. These were collated through computer and analysed and presented at a press conference the day before the Public Hearing. People's opinions were overwhelmingly against bringing targets back: 88.1 per cent felt the target approach did not lead to greater efficiency, and 71.9 per cent opined that government workers should not have targets to fulfil. 61.1 per cent also felt that this approach would not reduce the population .At the same time 81.7 per cent felt that safe abortion services should be included, and 90.3 per cent declared that men must take responsibility for family planning. A substantial 76.5 per cent also felt that the stress on hospital-based delivery was misplaced as it was not possible for common people-to avail of hospitalization for normal deliveries. An overwhelming 87.7 per cent opined that people hardly ever use the government health services, while 16.2 per cent said that they received no government health services at all.

(iii) Experiences of Quality of Care:

In December 2000, two partners of HWUPB, a media person and a women's organization in eastern UP identified the first three cases of coercion and gross medical neglect. A 15-year old girl was passed off by the ANM as a 23-year old mother of three children and forcibly sterilized. A young Dalit woman was persuaded to undergo sterilization by an ANM who had never attended her through all her four pregnancies and childbirths. The doctor at the hospital cut the woman's aorta during the operation and she instantly bled to death. Another young mother of two went to her local hospital for a normal delivery and was given an injection, to which she had a violent reaction. The doctor refused to handle the case, so she died without giving birth. In all the cases, the health department officials refused to take culpability and counter-attacked the victims or their survivor instead.

Soon more cases were identified as other women's organizations and health NGOs followed suit. The HWUPB secretariat sent its own teams as well as young journalists to investigate the cases and document them. In all about 50 case studies were identified, of which 35 were properly documented. They included forced sterilization, sterilization failure and neglect, maternal deaths due to neglect, violations of all medical norms at sterilization camps, abortion complications and deaths. The survivors were asked if they wanted to present their cases at the Public Hearing, and invited to come to Lucknow.

(iv) The Public Hearing:

A major event was the public hearing organized at Lucknow on 25'h April, 2001 on the UP Population Policy and the Quality of State Health Services. The objectives were:

To reflect upon the present quality of services and level of accountability of the government healthcare system in the state of Uttar Pradesh;

To question the state policy's guarantee of safe motherhood and child survival (which are primary health issues);

To indicate that the coercive contraception programme imposed by the state policy further violates the right to health.

ublic hearing was attended by 250 partner NGOs and women's organizations, survivors of state health negligence from the community, grassroots leaders both women and men, media persons and students. The panel of judges included a member of the judiciary, Justice. Y.K. Mehrotra (retired) Dr. Ashish Bose, an eminent demographer, and Professor Imrana Qadeer, a distinguished woman activist and academic. Senior

UP state government officials were invited but did not attend. Key donors like the World Bank, US AID and GOI were also invited. The results of the Opinion Poll had been shared at a press conference the previous day, therefore there was widespread and effective press coverage of the data and the public hearing.

During the Hearing, HWUPB presented its own collective analysis of the UPPP and the results of the statewide Opinion Poll. The survivors came up and spoke about their own experiences of the quality of Health and Family Welfare services, and the gross negligence they had faced. There were also eye-witness accounts of primary health centers, community health centers and camps. There were hair-raising descriptions of the procedures at sterilization camps, euphemistically called "RCH camps". The lack of accountability of the so-called "client-centered" health services was evident. The family planning programme was obviously bent on only terminal methods, that too focusing entirely on women. Women with gross infections or repeated pregnancies after sterilization had nowhere to go, since the acceptors had to sign a form declaring that they would not hold the doctors accountable for any failure.

There were some other presentations, including that of a community based study on Maternal Mortality, which showed that the official figure of 707 per 100,000 live births was probably only half the truth (UP already has the highest maternal mortality in India). A "Report Card" of the state of UP's health services showed that around 35,000 women were dying every year from maternity related causes, without any reaction from the government. Around 40,00,000 women go through childbirth every year without trained attendants. About 15,000 women become pregnant every year because of sterilisation failure. Over 30 crore Rupees are wasted every year because of gross over-reporting on use of Copper- T, condoms and oral pills.

It was also clear that primary health services were not available in reality at the community level. Data presented showed that merely 3.2 per cent of women had been visited by any health worker in the last twelve months, and only 4.4 per cent of pregnant women had received complete ante-natal check-up. Only 7.2 per cent women had received a post-natal visit from the health worker (within two months after delivery). This figure is obviously higher than those receiving ante-natal or natal care due to the pressure on health workers to obtain sterilization targets. Further, an assessment of the state's achievements since the UP policy had been announced almost a year ago, showed that there was almost no progress in implementation, despite several achievements being slated for 31st March 2001.

At the end the jury presented their verdict. Dr. Qadeer declared the policy was anti-people, and violated human rights. She condemned the policy for treating people as numbers who had to be controlled, rather than as people whose health, education and livelihood was the government's responsibility. As there was huge funding in UP for health and family planning, there was really no excuse for the non-performance of the government health services. Dr. Ashish Bose said that the injustice of forcing people to undergo sterilisation operations at the hands of unskilled doctors must stop, and a Health Vigilance Commission should be constituted to look into people's grievances against state health care services. Justice Mehrotra advised that monitoring of state healthcare has to be done by people's committees. Those who have been victimized by state health negligence must be able to apply for compensation as consumers. The state of UP must treat the problem of maternal deaths with great seriousness, and safe abortion services must be provided. Sterilisation should not be the first option given to people. There has to be adequate family planning education and awareness, especially for men.

Outcome of the **HWUPB campaign**

Impact

By April 2001, the network had mobilized statewide opinion on the UPPP, including:

130 NGOs and women activists through ten meetings held at different locations across the state;

Over a thousand community opinion leaders from around 30 districts all over UP (half of whom were women);

Fifty families who had been victimized by the very poor quality of care in state family welfare services;

Media people from ten areas of UP (including Lucknow); University students and academics, including teachers of Medical Colleges.

The campaign was also able to get women's groups/ health NGOs in Uttaranchal, Bihar and Jharkhand to start planning for interventions before their own policies are announced. At the national level, a number of key activists, government officials and donors were also informed about the campaign on the UP Population Policy. There was no response to the HWUPB request for further discussions, from the U.P Government, but a question was raised in Vidhan Sabha which is still pending.

Keeping the issue alive

Apart from the question raised in the Vidhan Sabha on the policy in May, demanding clarification on the declaration of the policy, other political actors like the Janwadi Mahila Samiti (CPI-M) carne on board. They led a dharna against the policy at Lucknow in July. A combined delegation of several women's groups also met the governor, protesting against the anti-women intentions of the policy. As the state government planned to implement the policy intent to promote legal age of marriage through a law debarring those married below the legal age from government jobs, HWUPB immediately launched a protest. A statewide signature campaign was started and the governor given a petition.

A seminar on Population was organized on 11th July to re-look at the whole question of "the population explosion theory" with academics, students, activists and media persons. A large amount of information was disseminated to the press, which responded with massive coverage of all the above events. Articles have been written for a local Hindi journal on women's issues AAINA, the newsletter of the national HealthWatch Trust called UPDATE, as well as in the Hindi Pioneer magazine.

The UP campaign is also up linked to the various national efforts on the National and State policies to protest against their anti-women approach, as well as the Constitutional and human rights violations inherent in coercion, incentives and disincentives. Preparations are on for HWUPB to intervene in the state population policies of Uttaranchal, Bihar and Jharkhand.

Conclusion

It is now a year since the campaign started. A very large number of women's organisations, health NGOs, media persons, and community members have clearly understood the direct impact of policies on the health and rights of ordinary people. While the campaign played an important role in linking up the grassroots with policy level decisions, it could not bring about any changes or revision in the UP policy so far. It remains to be seen how far this effort influences other state policies. The post-Cairo paradigm shift is still very difficult for those steeped in the propaganda of the population control establishment. However, the media linkages made have been productive, even on other health and rights issues. We at HWUPB are hopeful that we can he part of a national effort to raise questions on anti-people policies of the state, especially on population issues that impact so brutally on women's health and rights.

Recommendations for the UP Population Policy by Health Watch UP-Bihar

1. We strongly urge the government to withdraw the imposition of method-specific targets in the policy since it leads to coercion, and to provide complete information regarding contraception and high-quality year-round services for birth-control to all women, men and adolescents so that they may make free and responsible choices about their own family size and generate community demand for services.

2.We would suggest that the government reconsider the manner in which the private sector will be involved in the population policy, withdraw the User Charges, and ensure instead that the regular employees of the health and family welfare department provide free, high quality, round the year services to all women and men, rather than promote periodic fairs, camps and campaigns.

3. We would remind the government that safe abortion is an essential component of safe motherhood and as such must be included in the policy. We would suggest the inclusion of education campaigns, increased access to quality services, provider training and stringent enforcement of standards for safe abortion.

4.We would definitely recommend that the government expand its strategy for Male Role and Responsibility in the policy, remove all gender blind and gender-discriminatory statements, and be proactive in ensuring that women are able to exercise their reproductive rights, including the right to reproductive health, free of coercion, discrimination and violence. The process would be facilitated by working with youth as well as involving women activists, panchayat representatives, organisations and networks based in Uttar Pradesh in planning, training, monitoring and evaluation.

5. As such the government should invest in systematic training of all service providers for orientation to the paradigm shift of the 'clientcentred' approach; strict monitoring of Quality of Care according to given indicators by the Panchayats, especially women representatives; increased mobility of ANMs and support from their male colleagues in programme implementation, and regular problem-solving supervision at all levels.

6.We strongly feel that the government should not promote invasive, provider controlled and unsafe contraceptive technologies for women, including female sterilisation, and should concentrate on actively promoting male responsibility and safe, non-invasive, women-controlled methods.

On Gujarat's Population Policy

Gujarat Forum of Women's **Studies** and Action **Groups**

The Gujarat Forum of Women's Studies and Action Groups had a meeting on 26th Aug 2000 to discuss the population policy. The Forum is an informal network of academicians, activists and individuals in Gujarat founded in 1995. The meeting on population policy was attended by representatives of rural as well as urban groups, in addition to Women's Studies and Research Centres.

On the basis of the discussions on the population policy we make the following recommendations:

1.We believe that there is a need for a comprehensive health policy rather than a population policy. Every citizen of this country has a right to accessible and high quality health services. A health policy should commit itself to provision of such services to all sections of the population. It is the state's responsibility to ensure that the health care needs of socially and economically vulnerable sections are met without discrimination on the basis of caste or class.

2. The policy envisages privatisation of health care services on the pretext that the state does not have the necessary financial reserves to provide primary health care facilities. We believe this will definitely exacerbate existing social inequalities. The policy also seeks to institute provisions of incentives to aid privatisation of health care facilities. The opening up of health care services to the market will lead to an escalation of prices which will affect poorer populations adversely. It will also lead to the propagation of irrational drug therapy, as private agencies have a history of prescribing medicines with an eye on the profit rather than the health of "the consumer. Privatization will increase corruption , and will culminate in an infringement of citizen's rights to safe and reasonable health care. We therefore oppose privatization and recommend that the state cut down on other expenditure (like defense expenses) to meet health care needs of the people.

3. Women have specific health care needs including the need to control their fertility. All population policies, including the Indian policy tends to see women as reproducers alone, negating their contribution to all sectors of the political, social and economic life of the country. This has been well documented in reports commissioned by the government as well as independent studies. Women therefore become targets for reproductive technologies that seek to control women's bodies that have little regard for safety, long or short-term adverse impacts on women.

4. Incentives and disincentives to both reward and penalize families that do or do not meet targets are tantamount to coercion. We oppose all attempts to coerce families into adopting the state's norm of one or two-child per family. We also oppose violation of democratic rights in the enforcement of population policies. We recommend that there should be no repeat of the unfortunate experiences India has witnessed during the Emergency. The population policy should be implemented in keeping with the letter and spirit of international covenants like CEDAW, of which India is a signatory.

5. The 'cafeteria' approach has severe limitations, as demonstrated in the past. Contraception fulfills an important need in the lives of women and men . However, it is extremely important to ensue that safe, women-friendly choices are available. Informed consent and backup services in case of contraceptive failure should be an indispensable part of the policy. Women need accessible, safe contraception that will be under women's control not with the health service provider. Post operative care should be part of the back up services: no availability of such services should be seen as a serious lapse as it can be a matter of life and death.

6. Contraception should not interfere with women's economic and social activities. Given the power relations embedded in the family and the community, women often have little choice over the contraceptive they want. The policy should be sensitive to existing gender biases within the family, community and the health care system and should be committed to removing these biases that prevent the institution of a holistic approach to the issue of fertility control. The policy should ensure that PHC's are also aware of women's rights and at no point should women's sexual integrity be violated in the pretext of health care.

7. The population policy should address other issues like the communities fear of hospitals and preference for home remedies, failing which they choose to go to private agencies. All the three options are do not measure up to increasing health care needs of women. Poverty and population are both interlinked issues and the policy should take care to see the linkages between the two. As mentioned above, population control, fertility control is dependent on a number of variables like social, economic, political locations. The impact of population policy will therefore affect women and men different. Similarly poverty cannot be de-linked from the development processes being pursued in the country. These

Women's Perspective on Population Policies; Feminist Critique of Population Policies; Population Policy Statement for Gujarat

Renu Khanna

WHOTRACI

Feminists believe that population policies are designed to control the bodies, the fertility and the lives of women, because it is women who bear children. Population policies have in-built racist and eugenic ideologies. These ideologies operate through the process of selection of the ones who have the right to survive while dismissing the minorities, the disabled and indigenous people. They have the goal of eliminating the poor instead of poverty. Population policies represent the interests of the privileged elite and a lifestyle of over-consumption in the countries of the North as well as the elite of the Third World.

Population policies and programmes of most countries and international agencies have been driven more by demographic goals than by quality of life goals. Population size and growth have often been blamed inappropriately as the exclusive or primary causes of problems such as global environmental degradation and poverty. Fertility control programmes have prevailed as solutions when poverty and inequity are root causes that need to be addressed. Population policies and programmes have typically targeted low-income countries and groups often reflecting racial and class biases.

Women's fertility has been the primary object of both pro-natalist and anti-natalist population policies. Women's behaviour rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as in public policy. Sexuality and gender-based power inequities have been largely ignored, and sometimes even strengthened, by population and family planning programmes.

Population control programmes of the 1960s and 70s, devised supposedly for 'poverty eradication' subjected women in the South to a whole range of coercive technologies and methods which have often ruined their health and their lives. By presenting population policies as an expansion of 'reproductive choice' these policies try and cloak the population control agenda in the language of the women's liberation movements. Feminists have also rejected the tendency of the media to blame "population explosion" for the economic and political crises in the Third World. These media images, feminists state, maintain the domination of the privileged elite over the marginalised and underprivileged sections of society.

The economic reforms introduced through the World Bank's and the International Monetary Fund's Structural Adjustment Programmes are reducing the health and food subsidies for the poor in the Third World. The public health and welfare infrastructure are being systematically dismantled and privatized. The reduced health delivery services are being technologized and the poor in general, and poor women in particular, are the main victims of this global policy everywhere. The globalisation of the world market economy is threatening the food security of the poor.

The growth oriented development model is leading to severe environmental degradation in most parts of the world, which is in turn undermining peoples' security and livelihoods. Feminists reject the notion that 'overpopulation' has a causal connection with environmental degradation. The North with 20 per cent of the world's people, consumes 80 per cent of the total resources. One of the key factors causing environmental destruction is the excessive use of energy in production and consumption, energy from non-sustainable resources such as petrochemical, coal and nuclear energies, extraction of which itself destroys the environment.

The growth oriented development model has increased the number of poor, environmental and political migrants and refugees. The phobia of overpopulation has not only distracted policies from the actual causes of migration but has further victimized the victims. It is estimated that 65 per cent migrants and 90 per cent of refugees are women and children. The northern countries in response to migration issues are making stricter laws to close their borders, while in the new free market economy, the resources and capital are flowing freely from the South to the North, dragging migrant and low-wage workers with them. Double standards are practised when it comes to the movement of the world's citizens

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Renu Khanna is *associated with SAHAJ, a health organisation and WOHTRAC, a women's resource centre, in M.S. University, Vadodara*

between those who arc welcome and can afford to move freely and those who arc shunned or exploited for their labour. Goods can move without restriction whereas migration remains constrained.

Increasingly, reproductive technologies that arc invented that arc controlled by the providers, that is, the physicians, the drug companies and the state. Contraceptives like the diaphragm, more under the control of women, arc not easily available. Provider-controlled technologies effectively undermine women's control over their lives while burdening them with full responsibility for fertility and absolving men of their responsibility.

In the North, reproductive technologies serve a pro-natalist rather than an anti-natalist goal. In Japan, Canada and elsewhere where the fertility rate has fallen, the govell1ment and media are stating that the 'population' is endangered by this fall. This campaign along with the notion that motherhood must be central to women's lives places pressure on women to have children.

Insufficient research is directed towards indigenous people's traditional family planning and health practices. These are discarded in favour of modern technology and practices.

Feminists of the South state that women's basic needs of food, education, health, work, social and political participation, a life free of violence and oppression should be addressed on their own merit. Meeting women's needs should be not be linked with fertility goals and norms. Women should have access to safe contraception, legal and safe abortion and a wide range of necessary health services of good quality.

Population Policy Statement for Gujarat

The State Health and Family Welfare Department and UNFPA jointly organised a consultative workshop for the State population Policy Development on May 1, 2000. This, state level workshop was attended by representatives from Government departments, NGOs and institution~ working in the field of development. The main objective of this consultative workshop was to bring together experts from various fields to deliberate upon issues related to population and development and to suggest major points for drafting the State Population Policy. Discussion took place on five issues identified by the working group at the state level:

Reproductive and Child Health (RCH); Gender and development; Decentralisation; Public-private partnerships and inter-sectoral co-ordination and resource mobilisation, alternative financing, incentives and disincentives. A host of recommendations emerged, many of which have been included in the statement. The state-level consultation helped to widen the debate and generate creative ideas for the contents of the policy. But the absence of representatives from the departments of education and rural development at the meeting must be criticised, especially as issues of population and development require inter-sectoral approaches.

Population Policy Statement for Gujarat

Under the directive of Chief Minister of Gujarat, the state government has setup a Social Infrastructure Development Board for achieving overall development in the state. Population stabilization by 2008 is a priority of the Board. Towards this end a population policy is under development.

Goal

In accordance with India's National Population Policy, Gujarat's population policy will also focus on improving the quality of life of the people, reducing gender discrimination, empowering women, and ensuring extension service support to achieve replacement level fertility 2.1 by 2008. Respecting the reproductive rights of men and women will be an underlying principle of Gujarat's Population Policy.

Objective

Achievement of this goal calls for 100% access to quality and affordable reproductive health services, including family planning and sexual health services, and significant reduction in infants and maternal mortality. Women's education will remain an important objective not only because it is strongly associated with lower infant mortality and lower fertility, but also for its own sake. Universal access to primary education particularly for girls and closing of the "gender gap" in education will receive priority specific measures will be undertaken to achieve gender equity and equality, and to empower women. The latter requires strong support from men, and their participation in women's empowerment. Women's health and women's education will be encouraged.

Specific Objectives

The immediate objective of the State Population Policy is to provide integrated reproductive health services,

including addressing the unmet need for contraception. The state will strengthen health care infrastructure and support systems to improve access to these services. The long term objective is to reduce the Total Fertility Rate from its current level of 3.2 to replacement level, i.e., to 2.1, by the year 2008. In achieving these objectives, an inter-sectoral approach will he adopted Specific objectives include the following

- § Increase contraceptive prevalence to 70.
- § Reduce Infant Mortality Rate to 16 per 1000 live births.
- § Reduce maternal mortality rate to 100 per 100000 live births.

To achieve these objectives in the context of sustainable economic growth, social development and environmental protection need to he pursued in strategic ways. These are discussed below

PARADIGM SHIH IN REPRODUCTIVE AND CHILD HEALTH SERVICES

Reproductive and Child Health (RCH) services will he strengthened to meet the needs of women, men, adolescents and children. To address the needs of a variety of clients, the range and quality of RCH services will be improved. The focus will he on delaying child bearing among newly married couples. making spacing methods available to those couples who want to space births, improving access to permanent contraception, providing services for emergency contraception, providing safe abortion services, and managing reproductive tract infections and sexually transmitted diseases. Counseling for family planning and other reproductive health services will also be provided including to adolescents. In addition, efforts will be made to increase the participation of men in family planning, encourage responsible sexual and reproductive health behaviors among men, and promote responsible fatherhood. Looking to inter-regional variation in service utilization and other sections needing special attention.

Setting quality indicators and providing rewards for PHCs that effectively provide quality services to clients will strengthen the quality of services. Incentives will be given to health service personnel for increasing quality and availability of services. Great autonomy will be provided to health service institutions, and accountability to communities encouraged. Staff development programmes will be introduced to strengthen capacity. This will include clinical and management training. Cash incentives will no longer he provided for family planning acceptors.

Promote Gender Equality, Women's Empowerment, and Male Participation

The active participation of men is vital for safeguarding the reproductive health of women. To encourage men to share the burden of contraception, vasectomies will be repopularized, in particular non-scalpel vasectomy. Information and education campaigns will also address men, to enhance their understanding of reproductive health concerns and the need for supportive action.

Gender perspectives will he institutionalized in education and training programs, and communication, education and training materials will be screened from a gender perspective. Women and girls will be protected against violence. Laws against sex determination will he vigorously enforced. Efforts will be made to increase age at marriage for girls, and ensure compulsory registration of marriages. The government will take a proactive role in promoting gender equality and particularly in universalizing primary education for girls.

De-Centralization: Structural Changes and Administrative Reforms along with Financial Reforms

Panchayati Raj institutions are important means of furthering decentralized planning and programme implementation. The 73rd and 74^{lh} constitutional amendments act of 1992 has made health, family welfare and education a responsibility of village panchayats. Gujarat has a Panchayati Raj system in operation since 1963. In order to strengthen the potential of this system, appropriate support will he given to panchayats to carry out community need assessments, resource planning and resource mobilization.

Promote Partnership and Inter-sectoral Coordination between GO. NGOs, Corporate, Co-operatives and Private Sector

Partnerships will be promoted between government, non-governmental organizations, the corporate and private sectors and co-operatives. Intersectoral coordination within government will also be enhanced. These efforts will promote synergy, minimize duplication and facilitate utilization of resources.

Resources Mobilization, Alternative Financing, Insurance. Userships, Incentives and Disincentives

Further optimizing the use of resources, the operational efficiency of the system will be improved through research and development initiatives. The government will make efforts to mobilize resources from various sectors. Community cost sharing will be encouraged while safeguarding the poor.

Critique of the **population policy statement**

The participants at the WOHTRAC meeting came up with the following critique and recommendations:

The Government's initiative to set up a Social Infrastructure Development Board for achieving overall development in the State is laudable. Apart from population stabilization by 2008 being a priority, it would be useful to know other priorities of the Board. This would help us to analyse the total context within which Gujarat's Population Policy is being developed and to assess finks for consistency in approach.

The Goal of Gujarat's Population Policy, with its focus on improving the quality of life of people, reducing gender discrimination, empowering women and respecting reproductive rights of men and women in addition to ensuring achievement of replacement level, is also noteworthy. Similarly, the objectives are impressive: 100 percent access to quality and affordable RH Services, the emphasis on women's education not just to reduce IMR and TFR but, also for its own sake, specific measures to achieve gender equity and equality and encouraging men's participation in women's empowerment. However, just as the Policy Statement in its later sections, promotes partnerships and inter-sectoral co-ordination, reproductive and sexual health needs to be contexualised within the framework of comprehensive Primary Health Care. In practical terms, this would entail forging partnerships and co-ordination links with, for instance, communicable diseases control programmes, such as Tuberculosis and Malaria while also emphasising issues such as water supply, sanitation and nutrition, among others. Also gender perspective analysis needs to be applied to health as a whole and not only to reproductive and sexual health. The differential impact and outcome of all diseases on men and women needs be analysed and responded to accordingly. Thus, gender analysis needs to be part of the training and education curricula of all categories of health care providers and managers.

The paragraph on Specific Objectives reveals a domination of demographic objectives like Unmet Need for Contraception, reducing the Total Fertility Rate (TFR) and increasing Contraceptive Prevalence Rate (CPR). Other objectives like increasing safe Medical Termination of Pregnancies (MTPs), providing quality infertility services and so on, would better reflect the goal of improving the quality of life of the people and a shift away from the demographic orientation of all population policies.

Although the linkages between Nutrition and RCH are evident; the high prevalence of under nutrition in women and children continues to be a challenge, yet the policy gives only a cursory mention of malnutrition reduction in the context of population and quality of life improvement.

Paradigm Shift in Reproductive and Child Health:

Gujarat has a rich tradition of self-help, herbal remedies, other innovations in community health through mature and experienced community health and women's organisations and peoples' organisations. This section of the Policy Statement needs to mention how the existing rich experience will be incorporated in the paradigm shift of the RCH Services. For example, can Gujarat 's RCH Programme incorporate Indigenous Systems of Medicines for reproductive tract infections? Can some of the health promoting pregnancy care and post partum practices be recognised in the MCH package? Can the State adopt a formulary consisting of generic essential drugs?

The section on gender equality, women's empowerment and male participation is rather progressive. None of the other State Population Policies mention violence against women as a health issue, or the need to institutionalise gender perspectives in education and training programmes and screen educational and IEC materials from a gender perspective. The challenge will lie in the translation of these ideas into operational programmes such that the spirit and meaning of gender sensitivity is not lost.

The section on Decentralization, points out that health, family welfare and education are a responsibility of the village panchayats. The Policy Statement mentions that appropriate support will be given to panchayats to carry out community needs assessments, resource planning and resource mobilisation. It also needs to mention that special support will be given to strengthen women's roles within the panchayat system both as panchayat members and as members of the gram sabha.

Partnerships and inter-sectoral co-ordination between Government Organisations (GO), NGOs, corporate, co-operative and private sectors is the need of the hour. Partnerships should take the form of genuine and mutually respectful collaboration between all concerned. The bottom-line of such partnerships should be clear to all: social and health benefits to the largest sections of most needy sections of society with exploitation of none. Mechanisms for monitoring partnerships should be clearly spelt out right from the beginning.

The participants at the workshop concluded that the Population Policy Statement for Gujarat is

essentially a 'progressive document'. It has most of the elements that can form part of a Women's Health Policy. In a memorandum to the Government of Gujarat they urged the government to move a step forward and, instead of a Population Policy, bring out a progressive Women's Health Policy. Gujarat would perhaps be the second state in India (Andhra Pradesh announced a Women's Health Policy in 1996) to bring out such a policy, and the first state to bring out a progressive Women's Health Policy. Such a policy would be more consistent with the stated goal of improving the quality of life of people. It would move away from the continuing focus on controlling women's fertility to a focus on

- improving health services for women
- providing health information for women
- addressing sexuality and gender based power inequities that have been ignored until recently.

The process being followed by the Government of Gujarat in formulating the Population Policy, with its emphasis on a series of consultations, is also consistent with the process of formulating a Women's Health Policy. Brazil, Colombia, South Africa and Australia, countries that have brought out Women's Health Policies in the last decade, have followed highly inclusive processes. Decentralised discussions were held with a wide variety of persons, including representatives of the women's movement, health care providers, researchers and scholars, and men with relevant grassroots experience. Extensive networking and consultations ensured that grassroots' ideas were incorporated in the proposals.

In conclusion the memorandum reiterated the salient recommendations from the earlier sections. Firstly, the effort of the Gujarat Government should be not only on providing quality reproductive and sexual health services, crucial though these are, but also quality comprehensive and universal Primary Health Care services including services for nutrition and control of communicable diseases such as TB and Malaria. Secondly, the policy statement must clearly specify the parameters on which the implementation of the policy will be monitored and the processes that will be institutionalised for monitoring.

Government of Gujarat's Proposal for a 'Two-child Norm'

Contrary to the generally progressive tone of the Population Policy Statement, in June 2001, the Gujarat Government proposed the passing of a bill and enactment of a law for enforcing the 'two-child norm'. The bill would have allowed the Government to give various incentives and disincentives for the enforcement of a two-child norm. The Chief Minister stated in press reports that the recent poverty and unemployment increases in the state were a result of the population growth rate of 22.48 per cent (compared to 21.19 per cent in the preceding decade). The Health Secretary stated that the disincentives would be for entire village communities that did not agree with the two- child norm.

In a concerted advocacy campaign, WOHTRAC made representations to the Chief Minister and the Health Minister as well gave press releases on its stand on the two-child norm. The public debate among several sections of the civil society and the resultant pressure forced the Government of Gujarat to withdraw its proposal..

WOHTRAC's Perspectives on the Two Child Norm

We, at WOHTRAC strongly oppose this move of the Gujarat Government. Our reasons are as follows

(i) The decision on the number of children to have is a personal decision of the family. No government can decide how many children anyone can have. Doing so goes against the basic tenets of democracy.

(ii) Introducing incentives and disincentives for the implementation of such a law would in practice amount to coercion, which violates the basic human rights of citizens by denying them autonomous decision making. Disincentives deprive people, especially the neediest, of the minimum support that is their entitlement, support in terms of rations, health care, education, employment. Both incentives and disincentives lead to increased corruption in the system.

(iii) The two child norm would actually be discriminatory. The disincentives against population increase would be largely applicable to only those couples who already have inadequate exposure to state government facilities, schemes and aid. Those who practice the two child norm are and will be from the class of people who do not depend on state government's facilities. WOHTRAC urges the Government to remove incentive and disincentives either at the individual level or at the level of the community.

(iv) The two child norm in a society which values sons, would lead to an increase in female foeticide. The sex ratio in our state has already declined from 1000: 936 in 1991 to 1000: 919 in 2001 –the two child norm would push down the sex-ratio to the 800s in 2011.

(v) The State Governments' move is surprising because the Central Government in its post ICPD agenda has announced the withdrawal of coercive measures like targets for family planning. The Government of Gujarat has been a signatory to the ICPD's Plan of Action and has committed itself to upholding the principles which respect human rights of all individuals and gender equity amongst its citizens.

(vi) The Government should have a more gender sensitive and women friendly policy.

(vii) WOHTRAC endorses the Government's decision to have a wide ranging debate with representative of women's group, NGOs working with women as well as academics from University departments of Sociology, Women Studies Centres etc. who have been involved in issues related to female foeticide and other similar practices which discriminate against the female population.

(viii) We recommend training of doctors, nurses and other health personnel to provide services which are humane.

(iX) We further recommend that copies of the Medical Termination of Pregnancy (MTP) Act as well as the regulation of the Sex Determination test be prepared in simple and understandable language and are widely disseminated among women groups, PHCs and other centres where health care is provide.

The Government of India has also in the last one year intervened in certain states like Maharashtra and Rajasthan to have them take back their two child norm policies. Would we want the Central Government to intervene in our State on this matter?

Can we be progressive and interpret the Vision 2020 for Human Development for our State in a spirit that upholds the dignity of its citizens?

We would also like to be included in any consultation meetings that the State has in this regard.

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Andhra Pradesh Population Policy - A Note

Sheela Prasad and Veena Shatrughna

Andhra Pradesh (A .. P.) was the first State in India to draft' a State population policy in 1997. Earlier, there used to be a National Population policy which each State implemented. The question that therefore comes to mind is why was there a need felt for a separate State Population policy for AP. and what have been the implications of this policy? The rationale for the State population policy is linked to the economic reforms that the AP. government set in motion from the mid-nineties.

Health Sector Reforms in A.P. :

A.P. was the first State in India to embark on reforms in the health sector under World Bank assistance. This was known as the A.P. First Referral Health Project (APFRHP) and the period was 1995-2002. The amount sanctioned by the World Bank was Rs.560 Crores and the project covered 160 secondary level hospitals in AP. One major reason the APFRHP was initiated was the fact that A.P. already had set in place an autonomous health organization that looked after secondary level care. This was the Andhra Pradesh Vaidya Vidhan Parishad (APVVP) that was established in mid-eighties to improve secondary level health care. As this separate organizational structure existed it made it easier for the World Bank APFRHP to push through its agenda by by-passing the State health department. A.P. has borrowed heavily from the World Bank for these reforms, but the health of its people has not changed for the better. More than 60 per cent of the World Bank funds have gone into civil works, buildings and not into actual health care services.

The health status in A.P. was the lowest among the four southern states and per capita government health expenditure at Rs.69 was below the national average. AP. had a high fertility rate (3.1 in 1991) among the four southern states and the lowest age at marriage leading to rapid population growth during (1981-1991). Infant mortality and maternal mortality rates were also high. The government saw these as embarrassing statistics for a State that was aiming for a global image, in the forefront of the Information Technology Revolution. The State has a thriving private health sector which caters to the needs of 75 per cent of the total out-patients and 70 per cent of in- patients. Of the total 33,983 doctors registered in the State, only 5148 are in the government sector. It is against this background of a depressing health scenario and reforms in the health sector that the State Population Policy was framed in 1997.

A.P. Population Policy

The "inspiration" or role model for the A.P. population policy came from Tamilnadu, and the fact that the latter had been able to sharply reduce its fertility rate between 1981- 1991. "In the 1951 census, although A.P. had almost the same population size (31 million) as Tamilnadu (30 *million), difference in population size between the two States has increased to II million in the 1991 census. A.P. with a population of66.5 million and Tamilnadu with a population of* 55.8 *million". (Government of A.P.,* Strategy Paper on Health and Family Welfare in A.P., *January,* 200 I p . .3) For A.P. the impetus for change was the India Population Project VIII (IPP 8) funded by the World Bank. The IPP-8 is a continuation of the earlier IPPs that had been initiated in selected States and districts. This program was successful to some extent in addressing women's maternal and child health needs as it was handed over to groups of NGO's in the urban areas. Many of these NGO's worked with commitment in mobilizing slum women, training them as link volunteers, urging women to use government health services, mediating between the government doctors and the slum women. The IPP-8 had a Reproductive and Child health (RCH) focus that emerged out of the 1994 International Conference on Population and Development held in Cairo that called for a more holistic population policy approach. An attempt was made to integrate this RCH approach into the State's population policy but one finds that this attempt was largely on paper in the rural areas and to some extent worked in select urban areas where the urban health posts did provide some services. The main objective of the State Population Policy was to bring down the fertility rate and it was largely to achieve this demographic goal that government efforts were directed.

It must be remembered here that the timing of the State population policy was important. At the time (1995-97) health reforms were beginning in A.P., the Chief Minister had projected A.P. as a model state for economic growth, I.T and governance and was looking for international funds and foreign

The authors are associated with National Institute of Nutrition and Anveshi Resource Centre, Hyderabad

direct investment. But this vibrant economic/ IT image of a modem reformist State was tarnished by its low social health status.

In the case of A.P., the high fertility rate was used to explain inadequacies of the State in providing poor *health facilities, lack* of *drinking* water, housing, sanitation and the rising morbidity levels. Instead of admitting the failure in tackling these structural issues, 'the State found it easier to blame high population growth and adopted a coercive population policy to reduce fertility rates. This was an agenda that was reinforced and pushed by the foreign funders, primarily the World Bank. Therefore, the two features that mark the State population policy are its demographic target of fertility reduction and an aggressive pro-active role of the State's machinery to achieve it.

The Fallout of the AP Population Policy

The demographic goals set in the population policy found its echoes in the later Vision 2020 document brought out by the State in the late 90's. The Vision 2020 document had a section titled, "Promoting Family Welfare and Population Control" which spelt out the strategies to reduce the State's population growth from 1.6 per cent per year to the target of 0.8 per cent by 2020. The primacy given to family planning in A.P.'s Vision 2020 can be gauged from this sentence in the report "family planning will need to be at the core of the efforts of all the self-help groups such as DWCRA". (Government of Andhra Pradesh, Vision 2020, p.99). In 200 I January, a Strategy paper on Health was circulated by the government which again underscored the population stabilization objectives of the State. This paper was more problematic as it had a more aggressive posture than the Vision 2020 document as seen from statements like, "Sterilisation performance is far above over all India levels and is standing on the top compared to neighbouring States". (Strategy Paper p.8).

These health policy documents that followed the State population policy combined to put the burden of A.P.'s high fertility on women, particularly poor women. The efforts of the state's health system were directed towards pushing family planning measures and meeting targets regardless of the other health needs of women. In most of the districts Family Planning camps were organized- women herded into shabbily set up operation theatres, no pre-operative tests done, operated in minutes and discharged without much medical advice given or information shared and without any other health need of theirs addressed. Often, follow-up services are missing or weak and the women left to suffer their anxieties and pain without any proper medical advice.

A.P.'s population policy has achieved its demographic goal. In the 200tcensus, A.P. is shown as the state that has recorded one of the fastest declines in fertility rate from 3.1 in 1991 to 2.1 in 2001. A.P. is today held up as a model for other states to emulate in controlling their *population.* Amidst all *the* excitement of achieving demographic transition and obsession with fertility reduction, it is necessary to understand how this fertility decline took place.

While the RCH programme as part of IPP VIII has addressed women's health needs better than earlier programmes, most of this is confined to urban areas and some select rural areas as RCH was not a universal project for the entire State. This apart, if we compare NFHS - 2 and the 200 I census data there are some disturbing trends that emerge. The sharp decline in fertility in A.P. is not backed by a comparable decline in infant mortality, morbidity or a rise in literacy, age at marriage or standard of living. Historically, any demographic transition process should be associated with these accompanying changes. This has not happened in the case of A.P. - the fall in fertility has been achieved alone and it is this reality that needs to be' recognised. One reason for the sharp reduction in fertility is the aggressive population policy goals that set up targets for each district and mobilized government apparatus to achieve them. There were awards, incentives for best district/ mandal that were keenly fought for by Collectors, health staff and NGO's. Indeed Telugu newspapers have a number of reports on these functions with photographs. Most of the fertility decline has come through sterilization of women. While A.P. has a higher vasectomy acceptance than other States, the burden of population control is shared largely by women. Among the districts in A.P. that show a lower fertility are Srikakulam, West Godavari, Krishna and Guntur. While the last three districts are known to be the more developed parts of A.P. and hence can explain their fertility decline, it is Srikakulam, that raises our concern. This district is poor and largely tribal and it makes the fertility decline here more difficult to explain. Does the fall in fertility rates in Srikakulam suggest a more aggressive population control policy on poor and marginal groups? Or are the very poor choosing to have small families due to poverty'? In fact, the government itself admits that while it has, succeeded in bringing down fertility, it has not done' much in reducing morbidity and mortality rates in the State.

There have been reports in the press of various coercive measures adopted to meet its sterilization targets. Refusal to issue ration cards, land pattas; drinking water connections and being denied' benefits of government schemes are all arm twisting measures adopted by the State in response to the objectives of the population policy. This is countered by awards and incentives given to those

who agree to get sterilized - gold chains, sewing machines, and rights, DWCRA membership and cash.

Conclusion

It is precisely this kind of a population policy that victimizes poor rural women and sees *them* only as "sterilization targets" without addressing their more pressing health needs that the Group Against Targeted Sterilisation (GATS) Opposed (sec Box). The more recent reports (June 2001) of beginning Net-En trials (a hormonal injectable contraceptive) suggest that the Andhra Pradesh strategy of fertility decline will soon become policy in the other "population problem" States. There is an urgent need to counter such coercive measures that see "quantity" of the poor as a problem and refuse to recognize that "quality" of life is what needs to change for them.

The Role of Demography **in AP**

Enormous investments have been made in the generation of demographic data _ on birth and death rates, age specific fertility rates, contraception use rates, contraception use by method, by age, by parity and indeed speculation over the unmet needs for contraception, etc. - every year by international agencies like the UNFPA, WHO, UNICEF, UNDP and the World Bank. These are faithfully reproduced by different arms of the government, quasi government bodies and the NGOs. Together they have redefined and reframed health concerns and health debates in India. The dominant assumption today in India is that we are on the threshold of progress, but for this nagging demographic profile (read population problem), pointing to the images of irrational Indians with more than two kids.... in contrast to the 'rational' upper class and caste, patriotic Indians. (Did we not take Pulse Polio to every nook and corner of these vast lands, what else do they, the poor, want?).

The dubious role of the demographer and statistician in health planning has come to stay, and population indices are more important than the experience of ill health or the morbidity data of the poor in this country. Fevers including cerebral malaria, major respiratory problems, including tuberculosis, under nutrition, diarrhoeas, goiter, flourosis, genital infections, malignancies of different organs, and even mental distress of different kinds, are no longer valid concerns, but a high fertility rate can set the Government machinery into top gear in Andhra Pradesh.

There is mute acceptance when a target of 7 lakh sterilization operations per year has been set for AP by the demographers. Numbers have mesmerized us, and this mind set guides the middle classes: the bureaucracy and the doctors deployed in make-shift camps to do these 7 lakh tubectomies. The conditions are no different in district hospitals and even the teaching hospitals. A few doctors who have protested against the unrealistic targets and the unacceptable conditions were informed by the district collectors on phone that they must continue tubal ligations because the targets must be met. Because demography does not· measure quality care, and ill health, medical standards and health concerns at these camps are secondary when 100-150 women must be sterilized on a single day. Another area of concern is that in these days of reducing numbers, it has not been found necessary to even do a general examination in these camps to detect hypertension, diabetes, rheumatic heart disease, goiter and other chronic conditions, nor a pelvic examination and a cervical smear to detect infections, erosions or growth, despite the knowledge that cervical cancer is a killer in this country.

India is the only country that allows the bureaucracy to control the medical profession. The IMA, and the other professional bodies have abdicated and are disinterested in these programmes even though every medical student is taught about the importance of a thorough medical examine before a surgery is performed. Advanced countries would have harvested a rich data base on the health status of their population in these camps but this is not a priority for India. Even the nutrition status of women using weight, heights, arm circumference, and hemoglobin levels and symptoms of ill health due to acute and chronic illnesses, have gone unnoticed in these camps. A few doctors protested last year against such inhuman camp condition - not because of their concern for ethics, but a court case had threatened a doctor who had performed a surgery in these camps resulting in the death of a woman.

There is a feverish pitch at which national and international bodies are churning out fertility indicators every year, forcing Andhra Pradesh to set newer targets, against the 'achievements' of Tamil Nadu or China. We are drawn into debates about whether Pakistan has truly overtaken us or whether the figures show us in much better light when compared to Bangladesh, but AP will not get into any debate which talks about the incidence of TB, leprosy, malaria, Japanese encephalitis, and other preventable or treatable conditions. If the international and national agencies, had produced data on the health problems of the people, their access to treatment, capacity to buy medicine etc., the Indian state would have been forced to recognize achievement in terms of numbers of infections prevented, cervical smears taken to detect early cancers, TB, hypertension and diabetes

detected and treated, and other relevant data.

A middle class conscious about its rights to health (free or subsidized) and well being (the cities are flooded with clinics offering help for obesity, menopause, and even osteoporosis) rarely acknowledge the fact that the poor in the rural areas also fall sick and need health care. The deluge of demographic data has produced a clear class divide in perception of health needs. One can hear the shrill voices pointing to the population problem (read population of poor), truly unable to relate to the ill health and suffering of the poor in AP targeted sterilization appears to be an easier route to demographic transition, the Kerala model of literacy is too slow and perhaps risky (memories of the anti liquor campaigns in AP still haunt the government), Literacy requires too many negotiations and AP is not prepared to take a chance again, and in any case the state is in a hurry to make the demographic transition

Protests against targeted sterilization organized by women's groups and NGOs rocked the state in 1999, it highlighted the unacceptable conditions in the camps set up every year and the absence of follow up care. The press fed on demographic figures found it very difficult to report our concerns, and even the doctors said "Yes, but what about the population problem". We were informed sheepishly that women "came voluntarily". ANMs rounding up women with promises of health care, and ration cards and even land pattas perceived the whole effort as truly voluntary. The notion of voluntary in our conditions does not conform to the bourgeois liberal notion of choice.

With SAP and World Bank and our own home grown versions of development, the end result is that the only health care offered to women in AP is tubal ligation. The poor have also learnt not to expect anything else.

Women, who do not access even this health service offered by the state because of the knowledge of side effects of tubectomy done in women with PID, have learnt to contribute their bit towards demographic transition by giving away their baby girls, resorting to sex selective abortions, or even infanticide. Some women it appears will not accept severe infection. Many men have also come forward for vasectomies to save their women from infections and possible hysterectomies later. (The mean age of tubectomy in certain areas of AP is 23 years with hysterectomy five years later). In the West, major studies would have been commissioned to get to the root of this phenomenon, resulting in a few major MD theses by the departments of epidemiology. We do not know of any similar interests in our medical schools or teaching hospitals.

The above concerns do not make interesting copy for the press, nor does it enthuse human rights, organizations, who are not sure that it is a bad thing for the country. They recommend family-planning and equate it with women's empowerment.

Maharashtra's coercive population policy

Chayanika

After the International Conference on Population and Development in Cairo in 1994, the debates around how to effectively reduce the population of the country became very civilised. Everybody began talking about the issue of human rights of women and denouncing the programme that targeted thousands of them with forced sterilisations and other contraceptive procedures. It seemed that the days of coercive measures to acquire the required family size, were gone.

We in women's groups, who had been shouting ourselves hoarse about the atrocities of the family planning (FP) programme, were assured that target orientation was a thing of the past and that the days of consent, with the focus on larger issues of reproductive and sexual health, had arrived. Government functionaries and health workers started trying to figure out what exactly had to be different in the newly started Reproductive and Child Health (RCH) Programme.

However, it did not take long for reality to surface. The motives of the population control programme being handled by the RCH programme soon started becoming visible. Under the garb of meeting the "unmet need" of contraceptives, harmful, longacting, hormonal injections were made available in the open market and then through service-providing non-governmental organisations. Of late there has been talk of introducing them in the state-run hospitals as part of the RCH programme. Targets for sterilisations continued and for most government functionaries they remained a reality.

And finally we had a new national population policy which was passed at the Centre without much debate and which was followed or preceded by various state level population policies (I). Andhra Pradesh, Rajasthan and Madhya Pradesh began the trend and Maharashtra soon followed. None of these state policies minced any words while stating their intentions and motives and the measures they would take to achieve the reduction in population.

The Maharashtra State Population Policy

The Maharashtra State Population Policy, announced in March 2000, stresses the 'small family norm' to achieve overall targets for reduction of the fertility rate, birth rate, infant mortality rate and neonatal mortality rate. Various methods suggested include awarding those who help the state achieve its targets, though most methods are about punishing those of the populace who fail to adhere to the requirement of the small family (2). Those who dare to have a third child after May 2001 will not be entitled to many government schemes, many allowances if part of the state machinery, and the freedom to contest elections for local governance bodies. A subsequent government order stated clearly that the third child thus born would not be entitled to food and other subsidised goods offered under the public distribution scheme. These families would not also be entitled to as many as 50 government schemes meant for the needy (3).

Apart from these restrictive measures, the policy talks of other measures like improving the services of the health system by rewarding discipline and good behaviour of health providers; strict implementation of some of the existing acts like the Child Marriage Act and the Prenatal Sex Determination Techniques Act; assessing government functionaries and panchayats for their performance in family planning and awarding subsequent rewards and punishments to them; and forming various committees and councils under the able guidance of the chief minister, the deputy chief minister and even the "Honourable Chief Minister's wife" and the "Guardian minister's wife"!

So here we have it all laid bare for us. The targets, the process of rewarding and the methods of disincentives and punishments all continue. Families (in actuality women) will now be forced to accept whatever family planning methods are made available because producing more than two children can be suicidal for the whole family. Thus the policy ensures that there will be no need for explicit coercion for acceptance of contraceptive· methods.

The aim of the family planning programme has been controlling numbers, particularly the numbers of the poor. This policy, by penalising the poorest of the poor, in fact states this most clearly. Further, in doing so, it does not at all tackle the problem that it presumably set out to solve - that of scarcity (at least as stated by most proponents of population control). Their understanding of the population problem itself is, however, problematic.

Chayanika is a women's activist based ill Mumbai . *The' article is reprinted with permission from Issues in Medical Ethics; January 2001;* 9 (*I)*

The Population "Problem"

As children we have all gone through the misery or joy of solving 'arithmetic sums' of the kind: "It takes one person eight days to build a wall. How many days would it take to complete the task if three persons worked on it?" Or the more complex version of this kind of problem: "Ten men and eight women consume a bag of wheat in five days. If women eat half as much as men, how many days would three men and fifteen women take to finish the same bag?"

The idea was to simplify real-life situations to teach some mathematical concepts. Or else how can we just talk of so many men doing a task or consuming something without talking of the differences within all these people? This same logic is, however, applied in descriptions of realities, of life and the world of adults whenever there is any discussion about the issue of population.

The argument is simple. The world has a finite quantity of resources (‘x'). The current population (‘Y’) will consume the resources in 'z' days. But with the current rate of population growth (‘r'), imagine how soon the world would run out of its resources! The logic and the presentation is so similar to what all of us have learned in our maths that the only possible solution appears to be reducing 'r'. Arrest population growth to postpone the end of the world.

But pause and think if this is the reality or if a very simplified version of it in which the blame of the situation is being placed squarely on the shoulders of those who do not consume at the same rate but may have large numbers. The poor 'who breed irresponsibly' are being made scapegoats in this strident plea to save the world.

The statement can be reformulated to suggest an alternative solution. If the population increases at the rate 'r ', what should be the rate of consumption so that the same resources last for 'z' days? The mathematical solution now would be to reduce the rate of consumption. Even if the number of people increased at the same rate, the resources could last longer if the existing people and the new additions consumed less. Of course, the social implications are very different, and these are bypassed in the debate on the population problem.

When talking of a population policy there is no mention of patterns of resource consumption, of how much can be consumed, of issues like the vast and continuously growing difference in how many resources are used by whom. We do not even question whether everyone is consuming at the same rate, and has the same access and right to use them in the same way. There is an inherent assumption that all people are equivalent in their use of resources, so the stress is only on controlling numbers through "small families".

The "Solution" Sought

The present population policy document goes ahead to not only control numbers by advocating the small family norm but also to ensure that those whose numbers are sought to be reduced do not get what is their due from the state and the society to survive. Those living below the poverty line (which itself is at a level at which survival is not possible) are being denied the wherewithal to survive.

Not granting food under the already restricted public distribution scheme, not allowing access to other welfare schemes of the government, withholding advances and allowances due to all employees of the State - these are some of the measures that are going to accomplish nothing but make the destitute even more so and thus automatically reduce their numbers even further. How much of the problem of scarcity are we going to address by controlling in this manner the use of resources by people who anyway consume even less than the prescribed bare minimum is a question unasked.

The policy is blind to the findings of many studies all over the world: The cause of poverty is not too many people in the family, although poverty could be a reason for large families. The fact that children of the poor do not survive to live as healthy adults is one of the reasons for giving birth to more children. Reduced access to basic needs would only increase the child mortality rate, especially that of the girl child. Along with cultural reasons for strong son preference, this practice exists in a situation in which there is no welfare available for the older population and the son's family remains the only support mechanism. A policy to reduce family size by reducing access to a marginally better life sends the message: the "solution" to the current problem is to eliminate those who need help. Prevent the poor from being born, and prevent those already born, from surviving.

Medical Ethics

What is the role of the health care system, of individual doctors and other medical professionals in this scenario? According to the code of medical ethics formulated by the Medical Council of India (4), the principal objective of the medical profession is to render service to humanity with (4) full respect for the dignity of man.

The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to individuals but also to society.

This means opposing draconian measures like the Maharashtra population policy for the good of society and its overall health, particularly for the health of those who are already marginalised and weakened by various economic and social forces. In a society with an ever-widening gap between the 'haves' and 'have nots', as welfare measures are curtailed, unemployment and the resulting poverty actually force people to give birth to more children, people should not be further penalised for their poverty. It is our responsibility to build a healthier society that looks after the needs of all those who constitute it.

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3. Maharashtra to come down hard on that third child. The Indian Express, *September 2000*

4. Medical Council of India: Code of Medical Ethics. Declaration

(contd. from page 8)

what they expected from the forthcoming annual meet on the theme, and also, if possible, state whether, and if so, what their contribution to the theme would be. At the end, based on the discussions, it was agreed that the deliberations could be classified into the following:

1. A critical look at what passes for Nutrition Education in the country. How can we do it differently? This question arose from the experience of having to confront populations at the ground level who have no or very little wherewithal to buy food. Much of nutrition education at present does not question development paradigms that have made food inaccessible to large sections of the population. Under such circumstances to continue disseminating knowledge on balanced diets, etc., becomes not just embarrassing but also meaningless.

2.Several policy interventions have been made over the years to address the issue of nutritional deficiency and thereby increase the nutritional levels of the marginalised and deprived sections of the population- PDS, ICDS, Micro-nutrient programmes, etc. These need to be carefully evaluated for their contribution to the purpose for which they were set up.

3. Policies aimed at ensuring and protecting minimum levels of wages and employment levels of the population have over the years become completely disassociated from their original purpose of ensuring decent levels of living for the working population. An examination of wages and employment from the angle of their ability to provide minimum security levels for the population is long overdue.

4.The consequences of prolonged periods of malnutrition, undernutrition, etc., beginning from childhood and their implications for subsequent health of adolescents, adults, mothers, older persons-different segments of the population at different periods in their life- need to be causally established if preventive health policies have to be privileged over curative ones.

5. Fundamental to the entire theme of Nutrition is the politics of food and food production in the country. This issue has tremendous ramifications. The politics of land, agricultural policy, irrigation policy, food procurement and distribution both at the national and household level etc., all have a role in the manner in which a nation ensures the food security of its population. Over the years a significant manifestation of how this has been ensured or neglected shows itself in the nutritional status of its population. The fact that almost 90% of our children are malnourished after 50 years of independence is a telling indictment of our food policy. The political economy of food needs critical examination from a nutrition impact perspective.

It was realized that each of the above issue is vast and can by no stretch of imagination be covered exhaustively within the space of one annual meet. Nevertheless, it was decided that the annual meet would be utilized more to:

[a] take stock of existing stock of knowledge on the theme,

[b] identify individuals, groups, institutions that have worked on one or several components of the theme

[c] encourage the collection and analyses of new and existing data from a nutrition perspective.

The following members have agreed to contribute background material on the different components of the theme:

[1] Status of Nutrition-Veena Shatrughna

[2] Nutrition Education-Neha, Audrey, Sarojini and Millie to explore potential contributors, Shubda.

[3] Nutrition interventions — Farida for NEN, FORCES to be contacted, Renu to explore data from Gujarat

[4] Wages and Employment — Millie, Meena, Padmini

[5] Health Consequences of inadequate nutrition — Anand Zachariah to be contacted, Neha, Sabala and Vijalakshmi

[6] Politics of Food — Ravi Duggal, Ramakant, Rationing Kriti Samiti to be contacted.

(Minutes of MAM prepared by S. *Sridhar and minutes of Women and Health Cell meeting prepared by Padmini Swaminathan.)*

Report of the Mid Annual Meeting of Medico Friend Circle at Sewagram

July 12-14, 2001

In all 26 participants attended the Mid Annual Meet.

The first two days were devoted to finalising the Annual Meet theme, Nutrition and Food Security. The Women and Health cell met separately (see separate report) as also the PHC cell. Other issues discussed included the study on starvation-related deaths in Badwani by Abhay Shukla, et al; the status of the injectable contraceptives campaign, the use of Pre Natal Medical Technologies, and the condemnation of female foeticide by religious heads.

The meeting started at 11.00 am on July 12 with a brief presentation by Chinu, supplemented by Sridhar, on the theme note that was already circulated in the e-forum.

It was felt that the issues delineated in the note ranged over a wide canvas. It may therefore be desirable to narrow our focus, keeping in mind the range of competencies available/accessible to the MFC group. Should we stick to the more 'objective' criteria of nutrition/malnutrition and the related available data? Or should we look at the overall prevailing picture of severe under-nutrition, starvation and starvation-related deaths? Should we also look at the issues of political economy related to under-nutrition/starvation? Are we medicalising the issue of nutrition by sticking to the 'objective' criteria? May be what we need to do is to more clearly establish the linkages.

The major part of the afternoon of July 12 was devoted to a wide ranging review of nutritional issues, as viewed especially by a nutrition scientist. This presentation by Veena Shatrughna, using recent data, led the group to understand that while there were methodological issues and problems in measuring and correlating nutrition and undernutrition, the overall nationwide picture was quite dismal. More than 90% of Indian children are malnourished.

Rapidly going through the ways of monitoring/ measuring nutritional status (mid-arm circumference, Gomez classification, Body Mass Index, etc.), Veena observed that in the history of calculating RDI (Recommended Dietary Intake), at first types of foods were specified, now however only the nature of the food, such as carbohydrate, protein, etc., is mentioned, so that the politics of food and food preferences gets hidden. For instance, the 1993 WDR mentions the need to provide micronutrients packaged without mentioning that a country cannot give its people fruits and vegetables as it does not produce them for the people. There is also the need to link these to larger issues such as opposing the WTO conditionalities of subsidies (which should logically ought not to apply to countries whose populations have not reached their normal heights and weights) and other related measures.

There also appeared to be no major discrimination, from the data presented, between the male and the female child, contrary to popular wisdom in development circles. Men are as deprived as women in terms of calories. Neither have we been able to bridge the many micronutrient deficiencies (for instance iron and calcium). Veena mentioned that issues such as the special focus on 'girl child' tends to remove the responsibility of these issues from the nation and push it on the woman. Amar however felt that discrimination against the girl child cannot be ignored in our fight against poverty, as the discrimination persists due the belief that she be given less as she requires less. As one of the many policy implications, we may need to insist that cutting subsidy and related measures need to apply, if at all, to only families above the poverty line.

One needs to emphasise, it was felt, on livable wages instead of focussing on tech fixes like introducing micro-nutrient tablets in the ICDS. Increasing local per capita availability of fruits and vegetables as contrasted to exporting them need to be seriously considered.

After Veena 's presentation, the discussion that continued, and went on post-dinner, reverted to the structure and content of the theme for the Annual Meet of 2002. Some felt none of us (present) has worked on WTO and Food Security and so the issue should not be taken up. Others felt nevertheless it was necessary to link upto 'larger' questions if necessary by calling upon expertise outside the group. It may be necessary to complement NIN//NNMB data with other macro level data and micro level empirical studies.

The right to food security is to be seen- as part of the right to life (Art 21 of the Constitution) even as we debate whether to increase wages or increase subsidy and regulate market economy. We also

need to, as part of the Annual Meet theme, critique existing delivery mechanisms and nutritional policies and programmes like ICDS, PDS, etc. We may need to look into cropping systems and sustainable agriculture.

Too narrow a focus in the theme meet will keep away a lot of people. Our focus should be such that people can identify and immediately apply to their work.

Day 2: *July 13,2001*

10. The morning started with a presentation by Abhay Shukla on an ongoing study of the CEHAT team on malnutrition and suspected starvation related deaths in tribal villages around Badwani, MP. A convenience sample of 9 villages in Pati block was taken. A 100% survey of the 1663 children in the age group 1-5 years showed that 75.7% children were malnourished. A more accurate estimation of the grade of malnutrition in a random cluster sample comprising one-fourth of the hamlets (a total of 311 children) showed that 88.1 % children were malnourished, a quarter of them severely (as contrasted from an expected corresponding figure for rural Maharashtra of around 10%). About 42% of children in the second year were severely malnourished, a very high figure. Possible sources of error in estimating malnutrition were discussed, and the investigating team will cross check certain facts before going public with the figures. If true, the figures indicate ill-health of frightening proportions.

74 1 • An equally disturbing figure that came to light was the apparently high number of deaths in the summer of 200 I, in 3 villages a small distance from the area surveyed for malnutrition. This amounted to a death rate almost twice that of in other quarters of the year. About 40% of the deaths seem to be definitely starvation-related. The discussion focussed on the methodology involved in declaring a death as due to starvation. The immediate cause of death in most starving individuals would more likely than not be intercurrent infection. Therefore, finding "pure" starvation deaths to satisfy a government of the seriousness of the famine situation was difficult. The group is currently trying to evolve a verbal autopsy method for use in the field that would clearly bring out the underlying cause of starvation.

A point of urgency in this matter was that a group of activists are trying to gather as much data as possible to prove the existence of famine and starvation conditions in Western India. This information would feed into a PIL aimed at forcing governments to act on the matter. It was reported that the government's lawyers submitted during the hearings in the Supreme Court that if it could be shown that a person had eaten a "single grain during six weeks prior to death", the death cannot be said to be because of starvation. The prosecuting lawyers fumed at this, but had to keep their counsel, since they were not aware of any alternative accepted definition of starvation. This led the members (at the mfc meeting) to question why the issue of deaths due to starvation, a politically contentious relationship difficult to establish in "pure" form, was being given such overpowering status, when the fact of severe food shortage in homes could be proved in many other ways. It was suggested that BMI (Body Mass Index) of the adults in the villages be estimated, as also actual dietary intakes, and this data be used as an adjunct to arguments in the case - as proof of long standing undernutrition.

The presentation by Abhay was followed by an intense discussion on the validity/authenticity of the data, problems of proving starvation as the cause of death and how starvation deaths tend to get obfuscated/controverted by government lawyers. Often lawyers too are unable to interpret the data. All starvation deaths, in the end, are hastened usually by a trivial infection.

Doubts were expressed on the (human) rights approach in such cases, as it inevitably necessitates approaching courts. The issue was however considered important for MFC and members took the responsibility to collect data in their respective areas and contact others on this issue

Commenting on the data presented, Sridhar felt that mortality peaks/clustering during a certain period is not an atypical event. Nevertheless, in the present case, proving that deaths were due to starvation is not impossible and the situation was serious enough for the government to take action. He, however, felt that the malnutrition figures quoted need to be looked into again.

At this point the group broke up for the cell meets and then reconvened later in the afternoon.

[The PHC cell- consisting of Abhay Shukla, Amita Pitre, Anuj, Narendra Gupta, Sridhar and Chinu met and further carried the discussion on the study on starvation deaths reported by Abhay. It was decided to suggest to the larger group that a session on this study and related issues be given time in a plenary at the theme meet. The PHC cell further went on to discuss an outline for the meet which was later presented in the plenary. The Report of the Women and Health Cell is being separately presented following this report.]

The report of the PHC cell, and the Women and Health cell were presented to the larger group.

What emerged was the following outline of the 2day Annual Meet which was to be followed by the AGM of the MFC on the third day (Jan 24-25-26, 2002).

Day I (January 24, 2002)

9-11 AM Registration, Introductions, Tea Break

11-1.30 PM Trends in Nutrition and Under-nutrition - Veena Shatrughna & two others (15 minute presentation + 30 minute discussion)

2.30-6.00 PM (Day 1)

to 8.30 -11.00 AM (Day 2)

Parallel workshops on:

1. Nutrition Interventions, Nutrition Education, Programmes and Policies: ICDS, Mid Day Meal, TIN HAP, etc.
2. Field level micro studies on nutrition, under nutrition.
3. Politics of food security, food as a rights Issue.

11.00 - 1.00 PM Plenary/Reporting of Workshops

2.00 - 4.00 PM - Investigating and documenting under-nutrition, starvation and starvation-related deaths (Abhay Shukla, Amita, et al and S. Sridhar - 2 separate papers).

4.00 - 6.30 PM (Day 2) Common statements, future action

Note: The Organising Committee will finalise a note for wide circulation to e-forums, journals, NGOs and academic institutions. We will seek to get all papers by October 2001 end. Sarojini and group committed to prepare substantial papers on PDS. Other commitments are given in Women and Health Cell report.

Other Issues (non-theme related) Discussed *Depo and Injectable. Contraceptives:* The discussion on injectable contraceptives began with Sarojini apprising the group of the developments following the dismissal of the Supreme Court case on Net-En in August 2000. In its dismissal the Supreme Court allowed the Govt of India to provide the contraceptive through a limited number of institutions provided adequate facilities, follow-up care and counselling were ensured. (These were the demands of the petitioners.) The Government of India was now planning to introduce Net-En through 12 medical colleges in the country. Several groups in Delhi including the Delhi Science Forum, AIDWA, etc., met the Health Minister, and the Health Secretary and presented a Memorandum against this move. On the World Population Day (July 10,2001), around 350 persons gathered in Delhi for a demonstration. About the Depo case which continued to be in the Supreme Court even after the dismissal of the Net-En case, Sarojini was informed by Amit Sengupta recently that this case too had been dismissed in February 2001. AIDAN and Jagori who were copetitioner/respondent had no knowledge of the dismissal. And from Renu shared, there continues to be confusion about the status even in Government circles.

Renu Khanna explained to the group about the invitation from UNFPA to be a part of a group to develop terms and reference for a multi-centric client perspective study on DeP9. She wanted the group's opinion on her participation.

The group felt that even if Depo was administered in a humane and client-sensitive manner, it was objectionable as a contraceptive. Therefore, in no way MFC as a group can be involved with Depo except by way of asking it not to be used at all in the country. Also access to documents on the use of Depo can be had even otherwise, even if not so easily. MFC would need to continue its opposition to injectables on the grounds of lack of long-term safety, quality of services around provision and costs. A signature campaign initiated by the Delhi group(s) would be supported by MFC members. The idea of a review petition to challenge the dismissals was also mooted.

Pre-Natal Diagnostics Techniques Act (PNDTA):

Ravi Duggal gave an update on the on the CEHAT-MASUM PIL, filed in the Supreme Court in February 2000. In May 200 I, the Supreme Court passed an order directing the Ministry of Health and Family Welfare to create awareness of the contents of the ACT and to set up a machinery to take action against the guilty. CEHAT's focus in the campaign has been that the medical profession should be made accountable rather than highlighting the social issue of son preference. THE PIL is also demanding an amendment to the ACT on two accounts. Firstly, that all pre-conception sex selection techniques and not just sex determination techniques should be brought under the preview of the ACT; and

secondly, the woman who comes for diagnostic tests should not be identified as an offender.

Amar Jesani pointed out that discussions around sex selection and female foeticide invariably lead to confusion around the issues of MTPs and safe abortions. Arguments against sex selection and female foeticide tend to become weapons in the hands of pro-lifers and the anti-abortion lobby. There is a need to clarify one's position on both issues separately: while we oppose abortions following from prenatal and sex selection diagnostic tests as these are discriminatory, we uphold women's right to safe abortions.

Following this, there was an intense discussion on the recent meeting of the religious heads in New Delhi, organised by IMA, UNICEF and the National Commission for Women. The basis for organising such a meeting was questioned. Why bring in religious heads into this discussion when they have amply demonstrated over and over again how antiwoman their positions are. Secondly, representatives of the State (like the NCW) using these religious leaders to "advance" their cause is objectionable.

Day 3, *July* 14,2001

There was discussion on organisational matters. *Brochure:* The organisational office has about 200 copies of the brochure remaining. Since it has not been revised since a long time, the content needs updating. Members also felt that certain sections can be rewritten to reflect more clearly the evolution and activities of MFC till more recent times. It was suggested that an alternative draft be prepared and circulated on the e-forum, and comments and suggestions of members elicited before finalisation of the draft. Amar offered to make an alternative draft by mid-August. The format can also be reconsidered. The brochure should be ready September-end.

Convenorship: Since the present convenor had indicated his unavailability after the mid-annual meet, it had been decided in the last AGM to identify the next convenor right away, and request her / him to take over six months earlier than usual. At the Jan 2000 AGM, a number of members had expressed willingness to take on this responsibility at some point in the future. However, all of them had expressed inability to take over this year, and consequently it became necessary to look for an alternative. At the mid-annual meet, N B Sarojini, of SAMA, Delhi, who is a current executive committee member, was requested, and has agreed to be the next convenor. This decision will have to be ratified at the AGM in January 2002, and the term of the new convenor will last for two years thereafter, but for other than 'legal' purposes, Sarojini takes over with immediate effect.

Bulletin: The editor strongly expressed the need for logistical support in bringing out the bulletin; particularly in managing subscription lists; and dispatch of an issue after the printing was complete. She estimated the total labour involved to be to the tune of about two five days over two months, and suggested that MFC should make a financial commitment to the editorial office to get these tasks done. After discussing several options, it was decided to let the editor have the discretion to spend the minimum needed to have paid help for tasks of postal dispatch from Mumbai. This will add to the production cost of each issue. It was felt that, while supporting NGOs could provide infrastructure support, MFC should bear part of the emoluments paid to the NGOs employees who are assigned MFC work.

At present the MFC bulletin does not enjoy postal concessions that such publications would normally do, because it is registered at one place (Wardha) and printed at another. The editor has found it difficult to determine the exact procedure needed to effect an appropriate change in the place of registration, but estimates that once initiated, the file pushing will take a few months to complete. In the light of lesser printing costs at Pune, it was resolved to explore possibilities of shifting the printing and dispatch of the bulletin to Pune, and hence of getting the bulleting registered at Pune. Neha will report to the EC at the earliest on the possibilities.

Editorial guidelines for M FC Bulletin and other publications: Although Padma's 'draft guidelines to guidelines' have been circulated twice, members have not given any substantive responses yet. After a brief discussion, it was resolved that the editor of the bulletin formulate guidelines that can then be circulated and discussed in the light of Padma's draft. This can be finalized at the next AGM.

Scanning past issues of the Bulletin: The scanning of past issues of the bulletin had been halted due to the non-availability of appropriate technical help at Surat, but an alternative had just been found. Thus far, about 40 issues have been scanned, and starting in August, the rest of the job should be quickly completed. The scanning will be done mainly in the text format as far as the print quality of the original document will permit, and made available as HTML on the website as well as on CD. What cannot be easily scanned as text can be retyped. The scanning at least will be completed at

Surat. Neha and Sridhar will follow up on this matter with the scanners in Surat , and with Roy for uploading this on to the website. CEHAT has offered to bear the costs.

Website: The website has not been kept regularly updated since it was first created, something that had been feared when it was first set up. It was that recent bulletins and announcements and reports of meets be placed on the website with immediate effect, as well as address of EC members and' members of various cells. Depending on space available, past issues of the bulletin can be added. A search engine could facilitate searching for material, and linkages to other sites of common interest can also be planned. Neha and Roy will follow up the matter.

(Cont'd on page 8)

The Medico Friend Circle (MFC) is an all India group of socially conscious individuals from diverse backgrounds, who come together because of a common concern about the health problems in the country. MFC is trying to critically analyse the existing health care system while searching for a system of health care which is humane and which can meet the needs of the vast majority of the population in our country. About half of the M FC members are doctors and medical students, the rest include researchers, health and gender activists, community health experts, public health professional's academicians and students from different disciplines. A loosely knit and informal national organisation, the group has been meeting annually for more than twenty-five years.

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MFC Convenor's Office:

S. Sridhar; ARCH, Mangrol 393145,Rajpipla Taluka, Narmada District, Gujarat.

Email:sridhar.mfc@softhome.net

Editorial Office:

C/o Neha Madhiwalla; B3 Fariyas, 143 August Kranti Marg, Mumbai 400 036.

Email: mfcbulletin@rediffmail.com

Editorial committee: Neha Madhiwalla, Sandhya Srinivasan. Meena, Gopal, Tejal Barai,
Editorial office: c/o Neha Madhiwalla. B3 Fariyas, 143 August Kranti Marg, Mumbai - 400 036;
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