

# **Women's Health, Population Control and Collective Action: The Political Economy of Health Policy-Making in India<sup>1</sup>**

Harini Narayanan

**ABSTRACT:** Health policy in India, like all public policy, has always been the product of complex political processes. In the area of women's health, the situation is further complicated by the fact that policy processes have to straddle a treacherous fault-line between target-driven population-control goals on the one hand, and issues of individual reproductive rights and general well-being on the other. Most recent discussions of women's health policy in India argue that over time, such policies and the programmes associated with them are today more inclusive and sensitive to the articulated and apparent needs of the women concerned than they earlier were. Through a historical study of the relevant policy-making processes and discussions with those who intervene in such processes, this paper seeks to widen the debate on the subject by questioning these established views. Further, the paper argues that the trajectory of change has never been simple or linear. Policy shifts over time reflect the greater or lesser influence of a range of actors - including international donor agencies and pharmaceutical companies as well as the health and women's movements - apart from the ideological aims of the party in power. All these influences serve to constantly blur and shift the loci of policy emphases along non-linear trajectories, even if the core concerns remain relatively unchanged.

## **I. Introduction: A Tortuous Process**

When the Union Budget of India 2010-2011 was announced in early 2010, it was clear that nationally run health programmes were not going to be important foci for the government this year. The overall increase in the health budget was only Rs 2,766 crores<sup>2</sup> for all programmes including the National Rural Health Mission (NRHM). The only area related to health in which significant expansions were proposed (though clear budgetary allocations were not declared) was that of health insurance. This was in spite of the fact that a broad spectrum of internal and independent 5-year reviews of the NRHM had indicated that it had brought significant benefits to many areas of primary health-care provision in rural areas around the country, and that fund utilisation levels were impressive and occasionally even exceeded budgetary allocations<sup>3</sup>. This is not an election year; the government's primary concern at this time is the health market rather than public-health services.

Health policy in India, like all public policy, has always been the product of complex political processes. In the area of women's health, the situation is further

complicated by the fact that policy processes have to straddle a treacherous fault-line between target-driven population-control goals on the one hand, and issues of individual reproductive rights and general well-being on the other (Pachauri 1994: 16). This disjuncture runs counter to evidence that all societies – including in India - go through recognisable stages of demographic and socio-economic transition that include an upward curve before population growth rates taper off towards replacement levels (Sen, Amartya 1994; Caldwell 1998; de Pinho 2005: 61-68; Smyth 1996: 63-86), and also that population control cannot be effectively achieved without a concomitant, overall rise in human and economic development indicators (Sen, Amartya 1994; *The Economist* 2009: 30). However, this is a disjuncture that has - from the very first state-sponsored discussions of these two subjects in India over 150 years ago – ensured that policies regarding the two areas of women’s health and population control have always run along interlinked but often contrary trajectories in India.<sup>4</sup>

Most recent discussions of women’s health policy in India argue that over time, such policies and the programmes associated with them have grown less narrow in focus; that they are today more inclusive and sensitive to the articulated and apparent needs of the women concerned than they earlier were (Vaidyanathan 2006; Sen and Iyer 2002). Similar arguments are often made about recent versions of national population-control policies. This paper seeks to widen the debate on the subject by problematising the above views. In the paper, I argue that although there is now a general shift in the *rhetoric* that frames women’s health policy - from a focus on population control to a more holistic vision of women’s health and of public health in general - *on the ground*, public officials implementing policies and programmes often continue to emphasize the goal of restricting family size and promoting contraception over all other women’s-health issues. This paper would, therefore, like to extend the argument made by Roger and Patricia Jeffery in 1997: “Until we are convinced otherwise... we remain suspicious that the hijacking of feminist vocabulary merely masks an agenda (of the state) that actually prioritizes fertility reduction and is prepared to engage with... women’s empowerment solely as a means to that end” (257).

Further, contrary to what is implied by much of the literature (Visaria, L. and Visaria P. 1999; Mukherjee 2002; Ramachandran 2002), the trajectory of change in health policy – even at the level of rhetoric at the national level – has not been steadily or seamlessly progressive. Health policies announced at various points in time by the Government of India reflect the greater or lesser influence of a range of actors at the international, national and local levels, including donor agencies, the powerful pharmaceutical industry, popular health movements and the women’s movement; these influences serve to constantly blur and shift the loci of policy emphases along non-linear trajectories. And though the effectiveness of the influence usually depends on the actors’ rapport with the party in power at any point in time – as might be expected – this is by no means always the case. There have been some successful women’s health campaigns that have been conducted in the face of strong ideological resistance from the party in national government at the time.

This paper will explicate the above arguments through a study of the texts as well as the political economic contexts of some of the major policies undertaken in the areas of health and population control by the Indian government. It is organised in four sections. The section immediately following this introduction will set the stage with a brief background discussion of the overall context of health-related policy-making and health financing in India. The next section will discuss in some detail the history of women’s health policy-making in the country, weaving in the various political economic, national and international factors that have affected the process at various crucial junctures. The fourth section aims to add a significant socio-cultural dimension to the political economic aspects of the issue.

The situation in India in the area of women’s-health service-delivery is somewhat ironic: large national surveys repeatedly appear to demonstrate that most women want the same thing that the state does: higher levels of contraception than they currently achieve. The gap between the two sides of what is apparently the same coin could perhaps be the result of a lack of sensitivity on the part of the state mechanism to the particular socio-cultural conditions of the end user. Further, the single-minded pursuit of population-control policies without also ensuring meaningful convergence with other programmes aimed at improvements in the physical, social

and economic well-being of the target population can be completely and tragically counter-productive (Saheli 2006: 2-5; Saheli 2006a).

## **II. A complex politico-administrative context**

In India, the process of public health-policy making is an interesting one in political terms. On the one hand, it has not really been a core election issue until the most recent Congress party campaign of 2004. But even after the subject made it to the Congress party manifesto in 2004, it was not, at any point, subject to the kind of popular debate that evocative campaign issues undergo. On the other hand, though, given the centrality of population-control issues to national governance, health – especially women’s health - is an area in which every new government at the Centre feels obliged to intervene.

A further complication arises from the fact that though most health policies as well as high-profile, heavily funded national health programmes in India are coordinated by the government at the national level and supported to various extents by international agencies such as the World Health Organisation (WHO), the World Bank, USAID and the United Nations Population Fund (UNFPA), health administration in India is a so-called ‘state subject’. Thus, on the one hand, there is often very little choice in terms of the specific areas of public health that are targeted for special focus at the local level, and these choices - such as polio eradication, HIV/AIDS, tuberculosis, immunisation or women’s reproductive health - are based on international goals and pressures and, often, resource bases, rather than on local needs. However, each state and city government has to ensure that these goals are carried out in their particular geographical jurisdictions, and often have to find the additional funds or redesignate existing staff to carry them out. Then again, programme priorities may shift with changing priorities at the Centre, and individual states are forced to then go along with the changes if they want to continue to receive Central funding - as Kerala Chief Minister V S Achuthanandan recently pointed out bitterly, in the context of changes made to the NRHM<sup>5</sup>. When there is this kind of vertical intervention that affects the day-to-day functioning of state-level programme managers, there is often “a low level of commitment... at the state level” and a feeling among local managers that there is a privileging of some funding sources (such as the World Bank) over others, and this affects policy implementation<sup>6</sup>.

### Health Financing

Matters are further complicated by the fact that, since health is very rarely central to political debate, national budgetary funding in this area tends to be very low. Even though the national budget allocation for 'health and family welfare' has gone up steadily over the past few years, it is still just 2 per cent of the total budget;<sup>7</sup> overall health spending allocation remains just a little over 6 per cent of the country's gross domestic product and, further, the actual spending is far less: less than a per cent of the GDP. These statistics have to be further viewed in light of two facts: one, that only around 17 per cent of all health expenditure in the country is borne by the state, the rest is shouldered by the individuals concerned (Jan Swasthya Abhiyan 2006)<sup>8</sup>; and two, that perhaps 12 per cent of the country's public health expenditure comes from international sources and is ring-fenced for specific programmes.

The problems of inadequate health-sector funding and the tendency to focus on programme-specific rather than comprehensive health care have been aggravated in the 1990s and 2000s by two more developments. The first is the increasing privatisation of health care at all levels, but especially of tertiary, hospital-based services. The second relates to the increasing clout of the international pharmaceutical industry in the post-liberalisation period that has led, in the Indian context, to the successive erosion of price control for essential drugs including medications vital to the control of maternal mortality, and the constraints placed by the international Trade Related Intellectual Property Rights agreement that have pushed up the prices of many essential drugs<sup>9</sup>.

It is within this broad, overall context that policy related to women's health has been formulated in India over the years. The next section of the paper will take a historical view of this process.

### **III. A Turbulent History**

#### Pre-1975: Hardening positions

The colonial government was the first to raise the spectre of the uncontrollable millions in India. This was at a time when the decadal birth rate was on the verge of being overtaken by the death rate, thanks to the high levels of starvation and disease

that prevailed in the last years of the 19<sup>th</sup> century, and the annual population increase often hovered around 0.1 per cent. Further, this was all still at a time when the population growth rates in Asia and Africa were low as compared to the countries of Europe (Habib 2006: 1-2)

Some of the alarm could have been the result of a gross underestimation of the country's population prior to the taking of the first formal census in 1871, leading demographers to believe that the rate of growth in the period between 1852 and 1871 had been as high as 2.76 per cent per year. It was perhaps also a way to explain away the high rates of poverty and disease – and the low rates of production - that resulted in an appalling state of human development. Whatever the origin of the image of the teeming masses from the colonised world rising up to threaten the world's capacity for sustainability, it was fixed as a recognisable trope by the turn of the century, when the first of the international population conferences was held (Nanda 2004: 1-12).

These threads were picked up by Indian national leaders, many of whom emphasised their support for state-imposed birth-control policies from the very first Indian population conferences in the 1930s. Interestingly, though, the counter-argument that emphasised that “birth control” could only be “a part of a programme that aimed at poverty, poor health and ignorance, that were the root causes of India's population problem” and that population stabilisation could only be effective in an environment that “afforded greater freedom to women and greater opportunity for real education” was also articulated from fairly early in the century (among others, by an Indian representative, Taraknath Das, at the sixth international Neo-Malthusian and Birth Control Conference in New York in 1925 - Nanda 2004: 3-4).

In the run-up to Independence, the first formal health report for the country was prepared by the Health Survey and Development Committee, under the chairship of senior bureaucrat Joseph Bhore. This report is known for its strongly articulated position in favour of a state-supported welfare model for health services that would be available free to everyone, and would be delivered through a decentralised system that included community and cooperative participation. The committee suggested that the government seek public opinion before taking any top-down policy decisions regarding birth control. It also emphasised the need for “adequate health protection

for mothers and children”, and suggested that population growth rates could be nudged towards stabilisation by raising the age of marriage for girls, improving general standards of living and “controlling fertility through self-restraint” (Bhore 1946).

This relatively benign, holistic position was reflected in the first few Five-Year Plans. The country’s first health minister, Rajkumari Amrit Kaur, a Gandhian, was reluctant to promote anything more than overall human development and natural forms of contraception. Over time, though, the comprehensive, community-based programmes suggested by these prescriptive policy documents were abandoned in favour of narrowly focussed, top-down, target-driven, centrally monitored birth-control programmes, which the next national Health Minister, D P Karmakar, was in favour of. This increasingly hardening position could perhaps be tied in some ways to the growing food-supply anxieties of the 1960s. And as the gradual improvement of basic-health services led to a situation where the birth rate significantly outran the death rate, the panic at the national policy-making level increased – as is evident from the increasingly anxious and strident tone of the ‘family-planning’ slogans<sup>10</sup> adopted by the government during this period.

#### *1975-1985: Age of Extremes*

By the mid-70s, there were male as well as female contraceptives available, though they were unequal in that women’s contraceptives were invasive, and in the case of intra-uterine devices (IUDs), also provider-controlled. The official focus, though, was on targeting the male population. As is well-known and documented, this practice came to a head during the Emergency years of 1975-1977. The country’s first ‘Statement of National Population Policy’ was announced in 1976; this strident document was never discussed or adopted because the Emergency soon ended, with a change of government.

But the Emergency years had been so closely identified with forcible male sterilisation that after that, the Indian state could only salvage its population policy by being seen to change its focus drastically. For one thing, the Family Planning Programme, which had already been integrated with maternal and child health during the Fourth Five-Year Plan (1969-74) and further, with health and nutrition in the Fifth

Plan (1974-79), became the 'Family Welfare Programme' in 1977 (see Jeffery and Jeffery 1997: 40 for a discussion of this 'shift').

More importantly, the locus of official birth-control policy shifted to the woman's body and contraceptive methods developed internationally during the 1960s and the 1970s – such as the 'Pill' and the IUD which, ironically, were seen as major tools for female emancipation internationally - now became central to national population-control and reproductive-health policies. As one researcher pointed out: "Women who went for post-natal check-ups or abortions were arm-twisted into accepting methods like IUDs, pills or sterilization, depending on the number of children and surviving sons (they had), by health workers, whose career and promotions depended on the number of 'cases' they could mobilize for family planning. Thus women's right to birth control got hijacked by the state's agenda of population control, now euphemistically called family welfare" (Mukherjee 2002).

But the late 1970s were also heavily influenced by the international discussions leading up to and flowing from the International Conference on Primary Health Care, held in 1978 at Alma Ata (Almaty, Kazakhstan). This meeting, which resulted in the so-called 'Alma Ata declaration' of 'Health for all by 2000' was also an important influence on Indian national health policy; several progressive health groups as well as representatives of the Government of India attended and contributed to this meeting. This was also the period when the Janata Party came to power, with Raj Narain as Health Minister. The Janata government was keen to show itself as different and progressive in relation to the Congress, especially in the area of population control.

However, while on the one hand, the Alma Ata declaration helped to highlight areas of concern - including women's health - that needed special focus, it also supported the pursuing of 'selective' rather than 'comprehensive' primary health care through vertical programmes that grew less and less flexible over time (Jan Swasthya Abhiyan 2006). In 1983, the new National Health Policy, which reflected all the complex influences detailed above, was announced by the Congress party, which was once again in power with Indira Gandhi leading it.

By the mid-70s, amniocentesis as a means of detecting genetic abnormalities in foetuses was also being tested in India, initially in Delhi, at the All India Institute of Medical Sciences. It proved easy to find volunteers for the research, and the implications of the study became immediately apparent when a good number of the study subjects who were told they had female foetuses promptly demanded abortions (Saheli 2006: 2-5, 2006a). Sex determination tests were banned in government-run hospitals in 1978, but the private medical sector promptly took on the work. A study by *The Lancet* estimated that around 500,000 female foetuses are aborted in India every year (Sheth 2006). And as the next section will show, technological advances have ensured that the link between foetal gender-testing and female foeticide is now more explicit than ever before.

*1985-1995: Liberalisation, globalisation and the women's movement in India*

Throughout the 1990s, there were several parallel and often conflicting national and international processes which resonated in Indian health policy.

Politically, of course, this was a very volatile period: Rajiv Gandhi was in power until his assassination in 1989. After this, there were the Janata Dal and Samajwadi Janata Dal interregnums, followed by the Congress again under P V Narasimha Rao - with, as is known, an aggressive agenda of economic liberalisation and the integration of India into the globalised economy.

Economic liberalisation allowed the entry of several global drug companies into the country, and this made it easier to widely promote contraceptive trials and foetal sex-testing in India. The national government was often persuaded by multinational drug companies (such as Pfizer, Upjohn and Wyeth-Ayerst) to introduce contraceptive drugs that were often poorly tested, under trial, or insufficiently controlled for disturbing side-effects into the subsidised government distribution programme (Saheli 2005: 7). At the same time, though, the International Conference on Population and Development (ICPD), held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995, generated strongly positive energy in favour of a more humane, individualised, decentralised policy regarding population growth and women's health issues.

Both these trends influenced women's health policy-making at the national level in India during this period.<sup>11</sup> There was, however, not much change in the way health policy filtered down to the local level. Through the 1980s and early 1990s, for instance, the focus of 'public health' and 'family welfare' policies remained nationally motivated, vertical and focussed on reproductive control over women in terms of funding, administration and targets (Nanda 2004: 7).

The interim between the Cairo and Beijing meetings was also an interesting point when several Indian women's groups issued a joint statement addressed to their counterparts in developed countries, pointing out that they (the Indian groups) had supported the latter through their struggle to retain abortion as a legal option for women, and that they now wished to be supported in their campaign for women's health policies that were more sensitive to locally significant cultural and political economic issues (AIDWA 1994). In particular, the concern was with the pursuit of narrow, target-driven population-control policies as part of government-run programmes. To a substantial extent, women's groups in the Western world did respond to the request of the Indian women's groups, and the statement released at the end of the Beijing meeting reflects this response, by making explicit references to the need for the "recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility", and for the need for "gender-sensitive (national) policies and programmes" (Fourth World Conference on Women, Beijing Declaration 1995).

Women's groups in India now felt a sense of urgency, given the increasing availability of sophisticated diagnostic testing techniques and machines in the country. By the mid-1980s, there were many such techniques that could be misused for foetal sex determination, and the non-invasive ultrasonography method overtook amniocentesis as the most popular one used all over the country. Research conducted by the women's group Saheli Women's Resource Centre in 2006 suggested that there was a surge in the manufacture and import of ultrasound machines in the period immediately following economic liberalisation at the national level in the late 1980s, and that the practice of sex determination also rose exponentially during this period (Saheli 2006 *op cit*; 2006a *op cit*).

Women's groups and health activists' groups further perceived direct correlations between coercive population policies on the one hand, and the preference for male children on the other hand, as being instrumental in the destruction of female foetuses following sex-determination testing (Saheli 2006 *op cit*). The worst fears of activists' groups were proved right when the results of the decadal national Census of India 2001 was analysed, and the figures for gender ratios were released. The child sex ratio had declined steadily from 976 in 1961 to 927 in 2001; as a Census department study noted grimly, "a stage may soon come when it would become extremely difficult, if not impossible, to make up for the missing girls..."<sup>12</sup>. A further remarkable feature of this decline in sex ratios was that it was worst – as low as 770 - in some of the most prosperous districts of the country – a trend that is found in many parts of Asia where traditional 'son-preference' persists (*The Economist*: 2010: 65-68). Sustained and highly visible public campaigning, backed by lobbying with government for over two decades; protest against an originally weak piece of legislation, and the filing of a public-interest litigation by the Centre for Enquiry into Health and Allied Themes (CEHAT) and others, eventually resulted in the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act 2002.

Other campaigns targeted the clandestine use of poorly tested drugs as part of the national public-health system. One particularly high-profile campaign was against the surreptitious use of the injectable contraceptives Depo-Provera and the then poorly researched Net-En in government-run clinics. The women to whom Net-En was administered were not told either that this contraceptive was yet to be approved or that it had potentially disturbing side-effects. Three women's organisations – Stree Shakti Sanghatana (Hyderabad), Saheli (Delhi) and Chingari (Ahmedabad) - joined doctors and a journalist to use the important legal instrument of the public-interest legislation (which had just been introduced) to file a case in the Supreme Court of India against the unscrupulous use of Net-En. The Net-En issue was also taken by Saheli to the International Women's Health Meeting in Costa Rica in 1987, where Indian activists found that in an officially published document, the WHO had actually boasted about the fact that its "good relations" with the pharmaceutical industry made the free trial of new drugs in developing countries possible.

The Net-En and Depo-Provera cases were eventually clubbed together by the court, and in August 2000, the petition was finally disposed of without ever having been formally admitted in court. This was after the Ministry of Health and Family Welfare - one of the defendants to the case – promised not to include Depo-Provera in its formal population-control programme, and to introduce Net-En only where there were adequate facilities for follow-up and counselling (Saheli *op cit*). More recently, women's groups were assured that these drugs would not be used in the National Family Welfare Programme without adequate prior testing and research (Saheli 2005: 15).

Similarly successful campaigns were conducted by a spectrum of women's and health groups against the practice of testing insertable sterilisation drugs (Saheli 2000: 4, 31) and slow-release, sub-dermal contraceptive implants in government-run hospitals and health centres (Saheli 2006a) without prior informed consent or sustained follow-up. There was repeated evidence of pressure from international drug companies to have these drugs included in widespread government programmes before sufficient research had been conducted into their safety and efficacy – on the other hand, though, international pressure of other kinds sometimes also helped to curb this inclusion. For instance, in the late 1990s, the manufacturers of the contraceptive implant Norplant - Wyeth-Ayerst - were subject to lawsuits from thousands of women in the developed world on the grounds that the side-effects experienced were far more severe than had been made apparent in the drug-related literature, and in 1999, Norplant was withdrawn for further testing from the UK market. This international development, along with strong and concerted protests by Indian women's groups, eventually led to the withdrawal of the drug from the state-run women's health programme.

This sustained and successful women's health campaign eventually petered out after the state finally pulled back on its activities in this area. But the effects of the campaign still reverberate today in that the government now actively seeks the view of women's health groups when it wishes to introduce new contraceptive measures into its national population-control programme<sup>13</sup>. Interestingly, this campaign is remembered with varying degrees of displeasure by representatives of many major international donor agencies and internationally-funded non-governmental agencies

(NGOs) working in the area of women's health in Indian today, and is frequently cited as a case in which "feminist groups" obstructed the entry of potentially useful contraceptive interventions; the exact details of the campaign conducted by these "feminist groups" are generally not elaborated upon.<sup>14</sup>.

As indicated earlier, this was politically a very volatile period in India. After Narasimha Rao, there was another period when governments of various hues rose and fell very quickly, and finally, the Bharatiya Janata Party (BJP) under A.B. Vajpayee, took over for a full five-year term in 1998. Even within each government during these tumultuous times, the union Health Minister kept changing – the Health Minister was often replaced repeatedly within the same year. However, the process of economic liberalisation was a continuous underlying theme, and after Narasimha Rao, the BJP government in particular was very open to intervention – and financial support – from international agencies; this set the stage for the RCH programmes of the late 1990s.

#### *1995 to today: The Era of Big Missions*

Apart from the above-mentioned large, vertically controlled Reproductive and Child Health (RCH) programmes – (Phases I and II (1997/98-2009/10), other policies like the National Population Policy 2000 and the National Health Policy 2002 were also announced during this time. And finally, there was the National Rural Health Mission 2005-2012, which attracted substantial funds from the Indian government – at least in its initial years. It is interesting to follow the trajectory of these various programmes.

This was also the period in which the two People's Health Assemblies (PHAs - Dhaka, 2000, and Ecuador, 2005) took place. Even though there was despair that the goals of the 1978 Alma Ata meeting had not been achieved, these progressive health assemblies generated enormous energy and hope, and were echoed in the formation of numerous national PHAs, including the Jan Swasthya Abhiyan - a federation of 21 organisations in India.

#### *1. The RCH Programme*

The Reproductive and Child Health (RCH) programme was announced during the brief Janata Dal government's tenure in 1997, but it really took shape during the BJP government that followed. This programme was run by the Ministry of Health

and Family Welfare, Government of India, with the support of soft loans from the World Bank, and grants from other international agencies including DFID and the United Nations Population Fund.

At a presentation at a UNICEF conference in late 2006, the RCH programme was referred to as a ‘paradigm shift’ inspired by the Cairo meeting in 1994. The programme was held out as one that viewed women’s health in a holistic manner for the first time, and also as one that adopted a ‘Target Free Approach’ - later renamed the ‘Community Needs Assessment Approach’ (Vaidyanathan 2006). A careful reading of this presentation document, however, reveals that the phrase ‘target-free’ here merely refers to a slightly increased flexibility in terms of the *methods of fertility regulation* on offer, and not a relaxation of population-control goal-setting itself.

There is no doubt that the RCH programme, especially in the revised Phase II, covers a range of maternal and newborn health issues with a depth that was not seen in earlier programmes, but its priorities are clear at every stage: the very first section of the chapter titled “Improving Health Outcomes”, for instance, deals with the topic, “Population Stabilization” in exhaustive detail. Field visits made to RCH centres around Delhi as part of the current research confirmed that though a range of reproductive and newborn-health services are offered, the staff “talks to the patient about contraception from the time she first comes to [the health centre].”<sup>15</sup> The one thing that has changed over the years is that clients are now offered a choice of contraceptive ‘methods’ instead of being pushed towards specific ones.

The other major repressive area of conventional population-control planning that the RCH document – especially in the revised Phase II – is generally credited with doing away with is that of motivating people towards fertility regulation by offering them a range of incentives and disincentives that are unconnected to health – such as cash gifts or subsidised housing, or penalties that curb political participation. But as discussed earlier, these programmatic nuances are often negated by the prescriptions provided by other, parallel national programmes such as the National Population Policy (NPP) 2000.

## **2. The National Population Policy 2000**

The National Population Policy (NPP), 2000 was another outcome of the energy generated by the Cairo and Beijing meetings. Though it reiterated that “stabilising population” was “an essential requirement for promoting sustainable development with more equitable distribution” (and not the reverse), the NPP promised to be “gender-sensitive”, acknowledging that population stabilisation was “as much a function of making reproductive health care more accessible and affordable for all, as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communication.” Among other policy prescriptions, the NPP claimed to advocate a target-free approach to family-planning services and voluntary and informed consent as the basis for the availing of such services. But in a classic example of official double-speak, the NPP also had a detailed and substantial section titled “Promotional and Motivational Measures for Adoption of Small Family Norm” that provided a comprehensive list of 16 measures that could not be described as anything but target-motivated.

In an interesting departure from the policies pursued until then, the NPP advocated the “decentralization of planning and implementation which will promote need-based, demand-driven, area/location specific, integrated and high quality reproductive and child health care services,” “convergence in implementation with all other relevant social sectors,” and “commitments from and collaboration with the NGO sector and the private/corporate sector... to augment the pool of diverse health care providers”.

The move towards decentralisation however, had some interesting fall-outs. On the one hand, some state governments (especially in the south and the north-east) which had traditionally ignored the carrot-and-stick population-control methods earlier advocated by the Central government, and had actually achieved internationally acceptable, ‘ideal’ population replacement levels and gender ratios, simply continued to function as they always had. Meanwhile, other - northern and eastern Indian - states that had not managed to bring either population growth levels or gender ratios to demographically acceptable levels and were under intense political pressure to do so simply ignored the directives of the NPP and continued to pursue

restrictive measures that included the prevention of those with children beyond a specified number from holding or seeking political office at the local level, and the denial of already meagre state-provided cash-transfer maternity benefits<sup>16</sup> to poor women having their third or later children.

### **3. The National Rural Health Mission 2005-2012**

One of the first acts of the UPA government was to announce the National Rural Health Mission 2005-2012 (NRHM 2005). In a departure from the norm, better healthcare had been on both the UPA's campaign manifesto and in the National Common Minimum Programme declared by the government after it won the election. Prime Minister Manmohan Singh formally announced the NRHM, but Congress-party President Sonia Gandhi was said to be personally interested in this and other social-welfare programmes announced by the government at the time. The NRHM document stated that it aimed to fulfil the government's promises in the area of healthcare by strengthening primary healthcare facilities around the country and by simultaneously increasing public health spending. Pending the eventual announcement of an Urban Health Mission, the NRHM was temporarily extended to the poorer sections of urban areas.

As is known, the announcement of a major public-health programme, along with several other socio-economic schemes, was a direct acknowledgement of the fact that the Congress won the 2004 election – as well as the one in 2009 - with the support of the rural poor who had been among the worst affected by the BJP's 'India Shining' campaign. Paradoxically, the overwhelming nature of the victories – especially the one in 2009 - has probably allowed the Congress to feel less pressure to demonstrate its continued commitment to its health missions, and funding levels as well as discussions on a proposed urban health mission have since stagnated.

One of the other main goals of the NRHM was clearly to reclaim control over the health arena from international agencies, which the previous government was seen as having been close to. To some extent, in matters of funding, at least, this aim has been achieved – even though many of the public-health goals of international donor agencies - such as polio control<sup>17</sup> - are still being emphasised over local issues such as water-borne diseases. For one thing, the NRHM subsumed the RCH and other,

smaller, national health programmes into itself. With an initial outlay of almost Rs 4,700 billion for the first year, and a stated goal of an additional 30% over the existing annual budgetary outlay each successive year, the NRHM committed to spend as much in a year as the RCH II programme committed over a 5-year period, thus dramatically reducing the amount of funding accessed through international donors.

As was mentioned at the start of this paper, the NRHM has also been subjected to a wide-ranging and fairly rigorous set of mid-term reviews, though it is not clear if the government will provide the funding support necessary to follow up on all the recommendations. Further, while RCH II was itself the result of a far more transparent and consultative process than was RCH I (this happened in part as a response to criticism of the apparently closed and inflexible nature of RCH I - Government of India 2005), the NRHM was an even more widely consultative process. Whereas RCH II depended mainly on inputs from international agencies, the NRHM invited 10 Indian public-health professionals to join its Mission Steering Group, and also drew on the recommendations of a range of progressive health activist groups (including the Jan Swasthya Abhiyan), activist-academics, and other independent experts. It envisaged an explicit and formal role for NGOs and village-level Panchayati Raj institutions in the carrying out and monitoring of Mission activities.

As listed in the NRHM Mission document, the “key components” of the Mission included the creation of a huge cadre of so-called Accredited Social Health Activists (ASHAs) to help with primary-health outreach services, especially in the area of maternal care and childbirth. Inevitably, a reduction in the total fertility rate to 2.1 across the country was declared as a desirable outcome, but the suggestion was that this aim would be sought through the overall strengthening of the primary-health and environmental apparatus.

There is evidence that over time, the Mission aims have been retooled to respond to criticism from progressive health groups like the Jan Swasthya Abhiyan. For instance, the ASHA concept came from health groups which were, however, unhappy that the so-called ASHAs were to be paid on the basis of performance, which included charges for ‘motivating’ people to undergo tubectomies and vasectomies.

Health activists saw this as just another way to encourage potentially coercive population control without stating it as a primary goal of the Mission, since it would push the ASHA health worker to show evidence of various activities, including birth-control activities, in order to be paid. After sustained lobbying and the release of the review documents, the Union (federal) Health and Family Welfare Ministry announced that it would not stop the system of incentives, but that it would also pay all its ASHAs basic fixed monthly remunerations of a modest Rs 500 each (*The Hindu, op cit*). While this compromise may be taken as evidence of a responsive government or successful intervention by health groups, it is also interesting to note that it is still considered necessary to encourage primary-health workers to nudge people towards specific birth-control choices.

### **5. The Draft National Urban Health Mission**

Even though early drafts of this document have been in circulation within health-policy circles since the mid-2000s, there has been no move to formally start the programme; perhaps it will be on hold till the 2012 elections – which will coincide with the announcement of the next 5-Year Plan. In its draft form, the NUHM anticipates a budgetary commitment from the Central government of Rs 8,600 crores over a four-year period, with the Central government paying out the entire amount for the first year, while state and local governments are expected to make up the difference during subsequent years.

This ‘mission’ document attempts to appeal to all possible health constituencies: NGOs supported by the big international agencies, independent health activists, an increasingly globalising health market and a polity that is still overwhelmingly poor and poorly serviced. It also appears – so far - to be the product of a generally less consultative process than the NRHM was. Among other things, this proposed Mission aims to encourage the participation of the NGO and private sectors in health-service provision at the secondary and tertiary levels, while the state will focus on strengthening the primary healthcare system. The poor will be expected to pay for private services at the post-primary level through state-subsidised health-insurance programmes and health-based micro-credit systems; they are already being issued ‘smart’ health cards that will keep track of their health histories.

An army of female community health workers called ‘Urban Social Health Activists’ (USHAs) are to be deployed to mobilise, educate and monitor individual health needs at the community level. And though the list of incentive areas for USHAs does not specifically include ‘family-planning’ commitments, the document does mention that USHAs will be eligible for all the incentive-based payments offered for similar community-health work under other programmes.

Even though issues of women’s health that are listed as programme focuses appear to largely be restricted to childbirth and birth control, the reduction of the total fertility rate is only one of 14 wide-ranging goals that include various areas of physical and mental health for all sections of the population. Though it is still very much on the agenda, reproductive control at last appears not to dominate a general-health programme.

This relatively dramatic shift in rhetorical focus may not be the result of increased sensitivity so much as an awareness that one way or the other, the state’s population limitation goals are already well on their way to being reached. Three successive National Family Health Surveys (NFHS), conducted between 1992 and 2006, have shown that the country’s total fertility rate has actually already come down from 3.78 in 1998-99 to 2.8 for India’s urban poor. The rate for India overall is even more dramatic, having gone down from 3.40 in 1992-93 to 2.06 in 2005-06. The urban poor, at least, are only behind the rest of the population by about seven years. (The NFHS survey does not track changing economic status, though it does include social-development indicators – most of which showed a modest level of improvement during this time period.) However, old habits die hard, and it remains to be seen whether the NUHM will indeed usher in – on the part of the many local arms of the state - a more benign attitude towards individual reproductive behaviour in the country.

#### **IV. Conclusion: The Cultural Bind**

The Indian state’s anxiously insistent efforts to educate and push people to control family sizes are particularly interesting in the context of the information regarding contraceptive use and demand collected by the NFHS surveys<sup>18</sup>. Each of these surveys, which covered around 90,000 women from all over India, reported that

a greater number of women desired to use contraceptives than actually did. This would suggest that they either did not have access to the drugs or other facilities they desired, or that they were in social situations where they could not make contraceptive choices freely. Further, despite decades of state-run ‘family-planning’ programmes, knowledge of contraceptive practice and consequences is also persistently low (Ram *et al* 2009). That family sizes have reduced everywhere in the country despite this disjuncture is remarkable, and arguably the result of economic and socio-cultural change and better access to services.

Studies conducted in Thailand (Rosenfield and Min, in Robinson and Ross 2007: 221-234) and Indonesia (Hull, in Robinson and Ross 2007: 235-256; Murthy and Klugman 2004: i82) have suggested that when important local cultural practices and biases are taken into account in the process of policy-making, the results can change dramatically. Perhaps some such radical re-examination of socio-cultural practices will need to be conducted and combined with an old-fashioned emphasis on all-round development in terms of socio-economic indicators, before the intensely personal need for better health is reconciled with national reproductive-health goals in a manner that is fair and acceptable to all.

As the country moves towards a clear reduction in fertility rates, the politics of the process will perhaps also be obfuscated, and the ‘real’ reasons for outcomes may never be clearly understood. Meanwhile, as long as the country’s population base continues to be high and the absolute numbers of people in India continue to rise exponentially, it is doubtful whether the local state’s obsession with reproductive control will be sufficiently balanced by concern for other areas of healthcare. Further, even if – as has happened with recent policies – reproductive control ceases to be the centrepiece of national health policy, the conflation of women’s health issues with birth control appears to be unchanging – with all the attendant implications in terms of funding priorities and coercive local practices.

And finally, any change in the nature of government at the national level may, as past experience has shown, lead to the announcement of yet another trajectory in health policy rhetoric – even if the core concerns remain unchanging.

## NOTES

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<sup>2</sup> [indiabudget.nic.in/](http://indiabudget.nic.in/)

<sup>3</sup> Ministry of Health and Family Welfare, GOI, “National Rural Health Mission: Meeting People’s Health Needs in Partnership with States, The Journey So Far 2005-2010”; [www.mohfw.nic.in/nrhm.htm](http://www.mohfw.nic.in/nrhm.htm)

<sup>4</sup> A.R. Nanda, Executive Director, Population Foundation of India, and former Secretary, Department of Family Welfare; also former Registrar-General & Census Commissioner of India, Delhi, interviewed on 6 November 2006 and 10 July 2008.

A total of around 45 interviews were conducted between October 2006 and October 2008 with a range of individuals involved with the formulation and implementation of women’s health policy and services in Delhi as part of the project, ‘Collective Action around Service Delivery’, coordinated by the Institute of Development Studies at the University of Sussex, UK. Thirty-five of the above-mentioned interviews were then put through network analysis using the software UCINET. A report based on this analysis is forthcoming. This paper draws on these and other interviews as well as the textual analysis of a range of health-policy documents and field observations at primary-health centres in the National Capital Territory of Delhi.

<sup>5</sup> ‘Centre encroaching on States’ freedom: VS’, <http://beta.thehindu.com/>, accessed on 24 July 2010.

<sup>6</sup> Mathur, Shiv Chandra, “Reproductive and Child Health in India”, [www.publichealth.pitt.edu/supercourse/SupercoursePPT/9011-10001/9871.ppt](http://www.publichealth.pitt.edu/supercourse/SupercoursePPT/9011-10001/9871.ppt), accessed on 29 June 2006.

<sup>7</sup> [indiabudget.nic.in/](http://indiabudget.nic.in/)

<sup>8</sup> For a point of comparison, health spending as a proportion of GDP in OECD countries went up from 7 per cent in 1990 to just under 9 per cent in 2004; the public share of health spending averaged around 73 per cent, and went up to 90 per cent in some cases. [http://www.oecd.org/document/30/0,3343,en\\_2649\\_34631\\_12968734\\_1\\_1\\_1\\_37407,00.html](http://www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_37407,00.html), accessed on December 22 2009.

<sup>9</sup> Interview with Dr Mohan Rao, Professor, Department of Community Health and Social Medicine, Jawaharlal Nehru University, Delhi, on 30 October 2006 and 21 February 2008. For a discussion of the international scene see Leys 2009: 11-15, Applbaum 2009: 89-90

<sup>10</sup> Some of the better-known of India’s ‘public-service’ ‘family-planning’ messages over time may be found on <http://mohfw.nic.in/dofw%20website/dofw.htm>.

<sup>11</sup> Interviews with Dr Vandana Prasad, consulting paediatrician and member, Public Health Resource Network and the JSA, Delhi, 25 July 2008 and 20 November 2006; JSA material.

<sup>12</sup> Office of the Registrar General and Census Commissioner, India, Ministry of Health and Family Welfare, Government of India, United Nations Population Fund, ‘Missing... Mapping the Adverse Child Sex Ratio in India’, 2003: 3.

<sup>13</sup> Interview with N B Sarojini, SAMA, 29 April 2008; Dr Vandana Prasad, 25 July 2008.

<sup>14</sup> Various representatives of international donor organisations and NGOs reacted in broadly similar tones to the question: “Are there any associations or organisations that are important in the women’s health sector and get in the way of the health movement’s work or make it difficult?”

<sup>15</sup> Impressions based on visits to ‘Stree Shakti’ health camps at Nizamuddin village and the Bhai Ram Camp, as well as to the East Delhi Municipal Corporation of Delhi Dispensary and Delhi State RCH centre, and the Jangpura Municipal Dispensary.

<sup>16</sup> The programme of cash transfers offered in return for institutional deliveries is the Janani Suraksha Yojana.

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<sup>17</sup> While no one suggests that the eradication of polio or the treatment of AIDS is undesirable, there is a strong feeling among public-health practitioners and activists in India that a disproportionate amount of money and local-staff time goes to internationally supported campaigns like polio control where the numbers of those affected are miniscule in relative terms, while more widely prevalent and easily controllable killer diseases such as dysentery get far less time, attention and money.

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