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Target Free Approach (TFA) and Reproductive and Child Health (RCH) as Population Policy

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Abstract:

The women's groups were able to actively agitate against population control policies at conference on environment held in Rio-de-Janeiro in 1992, at conference on human rights at Vienna 1993, and then they were able to get the POA (Programme of Action) of the conference on population and development (ICPD) held in Cairo in 1994 to clearly state that the population control will not be promoted through incentives or disincentives nor will any targets be given by the governments for achievements in distribution of contraceptives. The discussions at the conference also pointed that women have problems regarding their reproductive health and these were not attended to. The 'culture of silence' surrounding issues related to sex and reproduction further prevented women from discussing their problems. It was stated at the ICPD that the states will take up programmes for empowerment of women, provide information and services on methods of regulating fertility and promote reproductive health.

With the policies of globalisation and structural adjustment, accepted by the government, pressures from international agencies are influencing the functioning of several programmes in India. Since promotion of population control in the Third World countries has gained considerable importance for several international agencies, reproduction has received attention from these groups. Lower status of women in the society has been exploited to promote vested interests. Though the government of India was a party to the decisions at the ICPD at Cairo, a review of the functioning of the family planning programme shows that the decisions such as 'no-targets' are on paper but women are being oppressed to accept family planning. Health of women continues to be neglected.

The UN organised International Conference on Population and Development held in Cairo in September 1994, stressed the importance of reproductive rights and reproductive health for men and women and emphasised the need for equity in gender relations, responsible sexual behaviour, and the need to enhance access to appropriate information and services. Special efforts were also

to be made to emphasise men's shared responsibility and active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of the children of both sexes. Male responsibilities in family life to be included in the education of children from the earliest ages. Special emphasis to be placed on the prevention of violence against women and children. (Pachauri, 1997, pp.10-11)

Pachauri points out that, "Since 1997, a reproductive and Child Health Programme is being implemented in India. .. These programmes are being redesigned to implement the new paradigm. The focus will shift from achieving demographic targets to addressing client's needs" She rightly expresses doubts about, "it is not clear how these concepts will be operationalised through male-dominated, hierarchical service delivery systems, within patriarchal societies of South Asia".

"Traditionally, all matters related to child-bearing and child-rearing, especially those concerned with pregnancy and child-birth, have been seen as women' domain in Asian societies. On the other hand, men are the decision-makers and sexual and reproductive health decisions are also made by them. Not only do they make decisions regarding sexual behaviours, including use or non-use of contraceptive methods as well as practicing safer sex or risky behaviours, but also control resources and have control over women's time and mobility" (Pachauri, 1997, p.11)

Pachauri points out that the issue of involving men in their programmes is expressed by the health community because of its frustrations in addressing the emerging problem of HIV/AIDS and other sexually transmitted infections by targeting women alone. Secondly, the family planning programme is concerned about increasing contraceptive prevalence, by focussing efforts to generate a demand for male methods. But she expresses doubts about the success of the approach to achieve this through simplication of contraceptive methods such vasectomy, which is already simple, safe and inexpensive. Thirdly, Pachauri points out the role of feminists in involving men in their programmes, having recognised that in patriarchal societies to improve the reproductive health of women, involvemnt of men is essential.

While the above observations are important from the point of improving the programme, one must look at the suggestions in the light of the emphasis that the earlier programme had and how it functioned. This will also point to the

mind-set developed through the training and work experiance of the staff that will be expected to operate new approach to the programme

Indian population policy, was guided by the Demographic goals and had the reduction of the rate of growth of population as the main objective. Though at the Bucharest international population conference Indian health minister had said that "development is the best contraceptive" back home the government had intensified its efforts to control population growth. For reducing the growth of population, fertility was targetted and the reduction of birth rate became the objective of the programme. The efforts culminated in excesses in implementing the programme during 1975-77. This resulted in goverment's down-fall in the general election. Male sterilisation had proved politically volatile. Family planning programme was revamped as "family welfare programme." And in the male-dominated hierarchial society women became targets of the programme. Tubectomy camps, laparoscopy techniques with incentives and disincentives for reaching the targets provided by the demographers, became one point programme. Most of the women sterilised were high parity, older women. Reduction in birth rate was not significant.

Interestingly, almost never was the predicted birth rate achieved, nor was the growth rate of the population anywhere near the desired goal. As early as 1962-63, a field survey, conducted by the Demographic Training and Research Centre (DTRC), had clearly showed that when questioned women said that their ideal size of family was 2 or 3 children. The survey, as well as several other researches conducted at the time, had also showed that the couples desired 'small family' more significantly, the women wanted fewer children than their husbands desired. This finding should lead to the conclusion that women were not empowered to meet their own desires.

As a solution to reduce the gap between the desired family size and the actual, one-time motivation method such as IUD (Intra-Uterine Device) that could be fitted by the providers was introduced in the programme. With about 80% women having reproductive tract infections (RTIs) and other un-investigated causes, the women experianced several health problems and almost all the IUDs were pulled out by the women themselves.

Research has since continued searching for female methods that will have longer lasting effects in preventing pregnancy. There were hardly any efforts to know the reasons for gap between desire for small family and actual fertility that was higher than the desire. Inspite of no information on the reasons for the gap, the Demographers continue calling it as an unmet need for contraception and use it for promotion of long-acting, hormonal methods that are provider controlled and

for females. Demographers even argue that if this unmet need is met, the demographic goals could be achieved.

In the 6th Plan the objective of the programme, with the advice of the demographers, was changed to NRR1, i.e. reducing the women in the population so as to reduce the child-bearers and thereby reducing the births in the population. During all these years the Demographers were actively involved in providing calculations on the births averted due of the contraceptives in use and they also provided method specific targets for the future programme.

The Seventh Plan had achieved the target of 42% CPR (Couple Protection Rate) and yet birth rate was higher than expected, showing that targetted CPR does not assure estimated declines in birth rate.

In the light of this reality the arguments put forth by Pachauri, provide the so far overlooked dimension of the population programme, the efforts are made to achieve demographic targets. And an easy way out is to target women. As a remidy, Pachauri suggests that the programme should address inequality that underlies reproductive ill health. However it needs to be added that the emphasis of the programme so far in operation on the demographers guiding the programme, also needs to be reviewed.

Demographers emphasise achieving demographic transition, and which, by their definition means having birth rate close to the death rate. Registrar General reports birth rate of 28.7 (1993) and death rate of 9.3 (1993), indicating a growth rate of population of 19.4 or 1.94 percent. Lowering of the birth rate will certainly reduce growth rate of the population but will it assure improvement in the life of the people? Death rate measures number of persons dying but not who dies. Death rate of the developed countries is around 9, as is the case with India. Obviously the health of the two groups of people is not the same. In India most of those who die are infants, children and the young. In the developed countries those dying are mature adults and the old.

For lowering the fertility demographic goal is TFR of 2.1, i.e. an average of 2.1 children per woman, which is expected to assure stabilisation of the population. National Family Health Survey (NFHS), which represents 99% of the Indian population, shows that TFR (Total Fertility Rate) for India is 3.39 whereas even upto age 5 the number of children surviving is 2.5. And Registrar General (RG) reports 34% of the total deaths are of children under age 15 years. Thus TFR does not assure that the children born will survive. So calculations on the number of children who will replace the parents, based on TFR tends to over-estimate the number of children that will have to be born to replace the parents.

It also needs to be noted that the TFR in India has come down from 5.2 in 1971 to 3.39 in 1992-93 without making much change in early child-bearing and without much improvement in the quality of life. It is known that the birth weight and health conditions of the children under age 5 are indicators of the quality of future population. India has one of the highest proportions of low birth weight (LBW) babies and about 53 percent of the children under age 5 are stunted, wasted and malnourished. (NFHS, p.285) This has happened because in the anxiety of reducing the birth rate the population programme instead of improving the conditions of women and empowering them to take decisions about their sexuality and reproductive life, a short-cut of using the existing male-dominated, hierarchal social structure which is achieving the fertility reduction by promoting sterilisations of young women thereby not only damaging their health but strenthening patriarchy and oppression of women.

NFHS shows that median age of women at sterilisation has come down to 26.3 years and in Andhra Pradesh it is as low as 24.5 years. Current contraceptives are damaging the health of women is shown by NFHS.

About 24% of the sterilised women and about 20% of the IUD as well as pill users are developing health problems. And which means that the women will have to live with pain and suffering from young ages. The unmet need of contraception should not be used to promote harmful, long-acting contraceptives but to look for ways and means of addressing gender equality and for that empowering women.

Demographic transition which assures low growth rate of the population cannot by itself meet the objective of the welfare of the people.

There is a clear evidence that the fertility of the populations of the now developed countries was not only high but it was much higher than the one seen in today's developing countries. The developed countries never had policies to control fertility. As the living conditions, including nutrition and sanitation improved, chances of survival improved and status of women improved, the birth rates came down. Many of these countries now have below replacement fertility without ever having had any population control programme.

Demography as a science prospered under the patronage of developed countries, and especially of the United States of America. Major contribution of the science is in the population control field. Large amounts of money have gone in propagating the belief that population size is at the root of the problems faced by developing countries and population control is the solution to all the problems and there is an urgent need to propagate population control in all these countries. Economists have assured that not the population growth but wrong

planning and management of the resources which promote unequal distribution of wealth and that is at the root of sections of populations remaining poor. World Development Report of the World Bank for the year 1990, which had poverty as its theme, says population growth is not the cause of poverty but poverty leads to rise in population growth.

Similarly there is adequate evidence that neglect of health and well being of women has resulted in poor health of people including high infant, child and maternal mortality. Women of poor health give birth to children with poor health irrespective of their birth order. Women who have poor health and receive inadequate attention during their growing years, during their pregnancies and deliveries, experiance high maternal morbidity and mortality even at first or second pregnancies. Their children also have poor health. So family planning by itself is no solution to the population problems.

Evidence from many poor countries demonstrated that human development indicators are not necessarily correlated with economic prosperity. Quality primary health care, maternal and child survival programmes, good sanitation and primary education can turn the tide. When infant mortality decreases and people feel assured about the survival of their children, family size begins to decline. Globally, the efforts to develop human development indicators and ranking countries according to quality of life, forced demographers and population control wallas to rethink, The environment question, carrying capacity of the planet also pointed towards consumption patterns among the rich and the poor across the world and within countries. All these effectively diffused the 'population bomb'. (Ramachandran, 1996, p.3)

After considerable pressure from the non-government organisations (NGOs), especially those from the South and the women's organisations, discussions at the international conference on environment, held in 1992 in Rio, and international conference on human rights held in 1993 in Vienna, it was agreed that population control programmes were oppressing women and especially the poor from the developing countries and this was happening inspite of the fact that growth of population was not the main cause of environmental problems and consumerist life style among the rich rather than the fertility of poor women was deteriorating environment. It was also pointed out that human rights programmes neglected the rights of women and violence against women was increasing. Finally at the international conference on population and development (ICPD) held in 1994 at Cairo it was decided that population control programmes be replaced by a new approach that was based on gender equity and empowerment of women.

The Cairo conference was the turning point. The entire debate centered around woman's control over her own body, her right to say 'no' and `enough', abortion, invasive contraceptive technologies, male responibility; the right to be treated with respect and dignity; rights of people within unconventional relationships; family reunification rights; forced migration - all these issues turned Cairo into a women's conference. (Ramachandran, 1996, p.4)

Inspite of India being a party to the decisions at ICPD, currently all efforts surrounding issues of mortality, morbidity, child health and survival etc. are linked to the goal of fertility reduction. Basic mind-set of planners, policy-makers, service providers and a large section of decision makers, is still influenced by the old thinking favouring promotion of population control as an urgent need. This mind-set is also affecting the implementing the programme as target free approach (TFA) to family planning. Health Watch an informal network of NGOs organised regional meetings to find out the functioning of TFA and came to the conclusion that the providers of the service - ANMs, MPWs, and PHC doctors etc. who have been trained almost for four decades to work for targets cannot make a quick transition without intensive training. (Ramachandran and Visaria, 1997)

Major obstacle to an effective training is the mind-set which has over decades built all arguments to promote demographic approach for dealing with human issues. It was pointed out that the reproductive health of women was poor and its improvement needed several social and medical interventions. Yet population lobby is using this to target women in reproductive ages. Reproductive and Child Health (RCA) approach of the current population is targetting sexually active women in reproductive ages and those who have not accepted family planning methods. Thus completely ignoring the young, the old and the women who are not child-bearing. Also ignoring the fact that reproductive health cannot be achieved in the absence of comprehensive health care.

Political will plays an important role in bringing about a social change. Unfortunately the political parties in India have never taken serious interest in the population policy and still used the high growth rate of population as an excuse for their failures on all fronts. It is perhaps for the first time that the election manifestos of political parties have mentioned their views on the population issue. Inspite of differenes in approaches to political, economic and ideological issues, all the parties were guided by the demographers and stabilisation of population is said as the main objective of their population policy. (Political Will, 1998) This can have serious implications for the future of the programme.

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