

## **Implementing a Reproductive Health Agenda in India: The Beginning**

**Saroj Pachauri, Editor**

Population Council  
South & East Asia Regional Office  
New Delhi, India  
© 1999

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **Introduction**

At the International Conference on Population and Development (ICPD) at Cairo in 1994, consensus was reached on a new agenda for population and development. The ICPD was a triumph for those seeking an end to the great debate that had plagued the population field since the first World Population Conference at Bucharest in 1974; a debate between advocates of development who believed that development is the best contraceptive and, therefore, a necessary precondition to sustained fertility decline and those who asserted that family planning services must be implemented to meet the high demand for fertility control which they believed existed. A notably wide gulf remained between these two essentially academic positions. The practical result was ambivalence and ambiguity in many countries about which approach to take. The ICPD took giant strides toward resolving this conflict by placing the population problem squarely in the development context and focussing attention on individual needs instead of demographic targets.

At the ICPD, the nations of the world agreed that governments should give special attention to the education of girls, the health of women, the survival of infants and young children, and in general, the empowerment of women. At the same time, comprehensive reproductive health services should be provided to enable couples to achieve their reproductive goals, and determine freely and responsibly the number and spacing of their children (United Nations, 1994). The ICPD consensus implied that if governments ensure that this basic package of social policies and reproductive health services is in place, they will simultaneously make strides toward greater social equity and reduce high rates of population growth (Sinding and Fathallah, 1995). Using groundbreaking language, the ICPD Programme of Action strongly endorsed the concepts of reproductive and sexual health and rights, and the need for services to achieve those

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **Translating the ICPD Agenda: The Policy Process in India**

Well before the Cairo conference -- at least a decade earlier -- several NGOs, researchers, women's groups, and donors in India, had sought to change programme direction by moving away from demographic targets and numbers and focussing on how to address the needs of clients, especially women. NGOs and feminists who had formed pressure groups were in the forefront of advancing this agenda. These grassroots voices were heard along with similar echoes from around the world at the ICPD which provided a platform where consensus, on what had been very widely debated issues, was finally reached.

Soon after the Cairo conference, the Government of India set in motion a process to translate the ICPD Programme of Action within the national context. In November 1994, a joint mission of the Government of India and the World Bank was set up to undertake a sectoral review. In 1995, the World Bank submitted a report entitled 'India's Family Welfare Program: Toward a Reproductive and Child Health Approach' to the Government of India (World Bank, 1995). The government decided to adopt the policy and as a first step, in April 1996, removed method-specific contraceptive targets nationwide. This was an essential prerequisite for translating the ICPD agenda in India. On October 15, 1997, the reproductive and child health programme was launched (Ministry of Health and Family Welfare, undated).

#### *Shifting paradigms: from demographic goals to individual needs*

In India, shifting to the reproductive health approach implies sending new implementation signals to 250,000 family welfare staff, that now client satisfaction is the programme's primary goal, with demographic impact a secondary, though important concern. Consequently, broadening the existing package of services is necessary and improving the quality of services top priority (Pachauri, 1995). To achieve these goals two major challenges must be addressed. First, it is necessary to create an understanding of the paradigm shift i.e. a reconceptualisation of the population problem by all stakeholders. And second, service delivery programmes must be redesigned to effectively address the reproductive health needs of people.

The new reproductive and child health programme requires an ideological change in the culture of the programme, from a focus in the past on achieving method-specific contraceptive targets, often using coercive means, to providing client-centred, quality services. For achieving the demographic goal of reducing the rate of population growth at the macro-level, broader social and economic policies -- especially those designed to improve education and enhance employment opportunities for women -- must be promoted.

#### *Addressing clients' needs: essential package of services*

Addressing reproductive health needs implies reducing unwanted fertility as well as the burden of reproductive morbidity and mortality. An essential package of reproductive and child health services to address clients' needs is beginning to be operationalised in India. The rationale for suggesting a package of services is to enable programme planners to: (1) assess the feasibility and management implications for implementing various combinations of health services at different levels of the health service system in diverse settings; and, (2) examine the cost, financing and sustainability implications for implementing these health services (Pachauri, 1995).

Designing a cost-effective package of good quality services that can be made available and accessible to all, especially to the poor, is a real challenge. Although providing comprehensive reproductive health services is a desirable goal, the extent to which the programme can expand without compromising the quality and effectiveness of existing services has to be seriously considered. There is clearly a need to prioritise and to develop a phased approach with an incremental addition of health interventions that require greater skills and resources. Since it is not possible to prepare a blueprint for the entire country, a framework has been proposed for implementing the package of services. The criteria used for prioritising services to be included in

the essential package are: (1) levels of fertility and mortality; (2) disease burden; (3) cost-effectiveness of available health interventions; and, (4) the capacity of the health system to deliver health services (Pachauri, 1995).

A fear which has been articulated by policy planners, programme managers and others concerned about population numbers is that family planning efforts will be 'diluted' if broader reproductive health services are provided. The reality is that family planning forms the centrepiece of the proposed package and good quality contraceptive services cannot be provided without addressing related reproductive health needs. Long years of experience have shown that contraceptive acceptance and continuation depend on ensuring the safety and quality of services. For example, reproductive tract infections are widely prevalent among women and their management is important, not only to relieve the suffering and pain they cause, but to ensure that contraceptive methods can be provided safely and effectively. Sterility, pelvic inflammatory disease, stillbirth and abortions are some of the serious complications that arise if these conditions are left untreated. The fear of sterility and delayed child bearing have been major barriers to contraceptive acceptance. Therefore, the stress on integrated services.

To be implemented nationwide over a five to ten year period, the package of essential reproductive and child health services includes services for the prevention and management of unwanted pregnancy; the promotion of safe motherhood and child survival; nutritional services for vulnerable groups; services for the prevention and management of reproductive tract infections and sexually transmitted infections as well as reproductive health services for adolescents.

Three points deserve emphasis with respect to the package of essential services:

- First, most of the services in the essential package are already included in the family welfare programme but have often not been provided for want of resources, adequate training, and other reasons.
- Second, improvements in health depends on making the whole set of services available because their effectiveness depends on ensuring that they are integrated. Therefore, no priorities are set for services included in the essential package. If sufficient resources are not available, the whole package should be introduced in phases rather than attempting to strengthen individual services on a piecemeal basis. The services included in the essential package are among the most cost-effective.
- Third, although adding new services and improving quality are major challenges, they do not require a quantum increase in resources. It is increasing coverage by filling current gaps in staff and infrastructure that requires substantial additional resources (Measham and Heaver, 1995).

#### *Operationalising the package of essential services*

To operationalise the package of essential services, it must be integrated within the primary health care system. However, the capacity of the health delivery system is not uniform in the country and there is tremendous diversity among regions, states and even within states. Therefore, the design of programme strategies must be context-specific.

Since men and women have multiple reproductive health needs, the challenge is to provide integrated services to address these needs. However, most health services have so far been provided through vertical programmes. There is a growing understanding that horizontal integration of services must be achieved if reproductive and sexual health and rights are to be universally realised. There must be a convergence of services at the users' level. If services are administered through vertical programmes that originate from different government departments and are funded by various donors, with their own agendas, the result is multiplicity and fragmentation which is wasteful and inefficient. It would be counterproductive to have reproductive health as yet another vertical programme. In fact, the reproductive health approach provides an opportunity for integrating services. The challenge is to strengthen services that are

in place by expanding their reach and improving their quality and by effectively integrating reproductive health services within ongoing programmes (Pachauri, 1996). India has initiated the process to implement the reproductive health agenda -- to make a paradigm shift and to address the needs of the people. This volume provides a glimpse of the processes that are underway.

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

#### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **Rationale and Scope of the Book**

The significant policy shift by India was an outcome of a process of experiential learning that had been underway in the country for several years. Many constituencies in India had opposed coercive, top-down population control policies. Strong arguments had been made to improve the quality of services; to address the reproductive health needs of people, especially women; and, to decentralise programme planning and monitoring. This thinking was in consonance with the larger efforts at democratic decentralisation in the country. The 72nd and 73rd amendments to the Indian Constitution mandated one-third reservations for women in elected bodies at the village level to give a voice to women in decentralised planning processes. Similar views were voiced at the ICPD. The global endorsement of these concepts provided the legitimacy and the additional spark that was needed to catalyse the process of policy change at the national level.

The questions now being asked are: What has been the process of implementing this new policy? What progress has been made since India proposed the paradigm shift? Although it is much too soon to measure impact or draw conclusions, this volume makes a modest attempt to understand the processes underway in the country. The contributors to this volume are scholars and practitioners who have been engaged with these issues in their respective fields of work. They have made an effort to critically examine key policy and programme issues by using empirical data and drawing lessons from the field.

Although by no means exhaustive, this volume brings together a number of important initiatives that are at different stages of development in the country. It provides an analysis of the fertility transition in India; the outcome of removing method-specific targets that had driven the family planning programme for several decades; the design of new methodologies, indicators and processes for monitoring and evaluating decentralised programmes; and, the financial and human resource needs for implementing the reproductive and child health programme. In addition, efforts to forge new partnerships for effectively operationalising the programme, as well as to promote advocacy for making the paradigm shift a reality for India, are discussed.

Services to address reproductive health problems, such as maternal mortality, unsafe abortion, HIV/AIDS, and reproductive tract infections that are being implemented in the country, are assessed. Neglected population groups, particularly adolescents and men, have also been brought into the framework of discussion. Gender and sexuality are cross-cutting themes. Conspicuous by its absence, is a discussion on reproductive rights which reflects a gap in the current discourse.

The chapters in this volume are organised within three broad themes: (1) implementing reproductive health policy; (2) reaching neglected population groups; and, (3) addressing reproductive health problems.

# Implementing a Reproductive Health Agenda in India: The Beginning

## Introductory Essay:

### MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE

Saroj Pachauri

## Implementing Reproductive Health Policy

This section includes a discussion on: the fertility transition in India; the causes and consequences of withdrawing method-specific targets; monitoring and evaluating decentralised programmes; advocacy initiatives; management of financial and human resources; and, promoting partnerships.

### *The fertility transition*

Jain's chapter on fertility transition in India provides a backdrop for subsequent discussions. The author examines the huge disparities in gender equity, levels of fertility, and education. His question is: Can fertility transition, which has been underway in India over the past 20 years, contribute to just social policies for reducing gender and regional disparities in health and education? The rationale for reducing population growth through fertility reduction is to improve social and economic conditions. It is, therefore, important to ascertain the extent to which ongoing fertility transition has contributed to the reduction of disparities and socially valued outcomes. The author examines the positive relationship between women's education and fertility decline -- fertility declines sharply with education where female education is low, but this gap narrows where fertility levels are low. He argues for a redistribution of resources to promote women's education in states that have low female literacy and high fertility.

Although fertility decline is underway in India, there is continued concern about 'controlling the population'. This debate continues at different levels even after the government has changed policy. It is clearly premature to measure the impact of a programme that was launched only 15 months ago. However, a question that could be legitimately asked is: What are the processes underway in different parts of the country and what is the direction of change? Analyses by Khan and Townsend, Visaria and Visaria and Nirmala Murthy address this question.

### *Removal of method-specific targets: a debate*

Method-specific targets were removed nationwide in April 1996. Their sudden and abrupt removal was a dramatic change, a change that shook the system. Its reverberations were felt nationwide. The removal of targets was a necessary first step for making the paradigm shift i.e., changing from an emphasis on population numbers to a focus on quality of services. But because targets had driven the programme for many decades and all policy and programme efforts had been focussed on the achievement of targets, their sudden withdrawal without preparation and without putting in place any alternative monitoring system caused considerable confusion at the field level, especially since the performance of all programme staff had been measured by how effectively they achieved their targets.

Consequently many professionals critiqued the policy change. Some were vociferous in their articulations and predicted chaotic outcomes for India (Ross, 1998). Several people questioned why targets were removed? What was the impact of removing targets on programme performance? What was the effect on birth rates? Would the programme lose momentum under the target-free approach? In their chapter, Khan and Townsend analyse seven case studies to

examine state level experiences. Their analysis shows that: (1) 18 months after targets were removed, implementation of the target-free approach varied considerably across the country. In some states the target approach, in a variant form, was still functional. (2) Most of the states would have preferred a gradual approach to the withdrawal of targets. (3) The consensus of senior state officials was that the target-free approach should be continued and problems in implementing the new policy should be addressed on a priority basis.

The analysis by Khan and Townsend also showed that there was a decline in programme performance in the first year because of the abrupt introduction of the target-free approach. This trend has since been reversed. In the first year, more than three-fourths of the decline in acceptors of sterilisation and IUDs was contributed by three of the four least developed states (Bihar, Madhya Pradesh and Uttar Pradesh). Rajasthan, the fourth such state, actually registered an increase in the use of all methods.

Khan and Townsend reviewed data over a 10 year period to examine the trend in the crude birth rate (CBR). The CBR continued to decline during 1995-1996 (from 28.3 in 1995 to 27.5 in 1996 and 27.2 in 1997); the greatest decline was recorded during 1996-97 (0.9 per 1,000). A continued decline was reported even in states with persistent high fertility such as Uttar Pradesh where the CBR decreased from 34.8 per 1,000 in 1995 to 34.0 in 1996 and to 33.5 in 1997. In addition, operations research in two districts of Uttar Pradesh showed a decline in the total fertility rate during this period; there was no evidence of reduction in contraceptive prevalence under the target-free approach.

#### *Evidence from the field*

Visaria and Visaria undertook research to assess the impact of removing targets at the field level. Qualitative research was undertaken in two contrasting states, Tamil Nadu in the south and Rajasthan in north. These researchers enquired into issues such as the work load of health staff, whether or not the programme had become more responsive to the needs of the people, and whether the functioning of the programme had changed at the field level. Their analysis showed that in Tamil Nadu, immunisation services, antenatal visits by health workers, and mothers' meetings at the village level had increased significantly over the past 7-8 years, even prior to the ICPD. Workers in Tamil Nadu enjoyed a better status as health care providers than they did when they provided family planning services only. While improvements had begun in Rajasthan, progress was much slower. Services for safe abortion and management of reproductive tract infections (RTIs) were yet to be implemented in both states. Some efforts had begun in Tamil Nadu where there was a higher demand for the government's health services but in Rajasthan these services were yet to be organised.

The results of operations research by Khan and Townsend in Uttar Pradesh showed an improvement, although modest, in the quality of services. For example, field workers had begun to provide clients a range of services and a broader choice of contraceptive methods. Clients were informed about more methods and some women reported less pressure to accept sterilisation which had been the dominant method for years. These results indicated that while the quality of services was still well below the desired standards, the changes that had occurred since 1995 were in the right direction.

#### *Monitoring and evaluating decentralised programmes*

For decades, the impact of the family planning programme had been measured in terms of its contribution toward the increase of contraceptive prevalence and decrease in fertility. Since these indicators neither reflected the impact of service quality, nor measured morbidity and mortality, they were not adequate for measuring the impact of reproductive health services. New monitoring

systems to assess the quality of health services from the perspective of the client were needed (Pachauri, 1995).

In her chapter, Murthy examines the issue of decentralised planning and monitoring. The specific questions that she addresses are: How are quality and client satisfaction ensured? Has there been an increase in the range of services? Do locally determined targets reflect local needs? Have planning and management responsibilities been decentralised? Is community involvement encouraged and if so how? The author concludes that decentralised participative planning which replaced the target system has brought about several qualitative changes. The new mantra (chant) of concern for quality and client satisfaction is beginning to be sanctified. Health workers are becoming increasingly aware of the range of services to be provided; as a result, their self-esteem has improved.

Murthy describes the conceptual framework for planning and monitoring the reproductive and child health programme. The new system uses three tools: (1) activity reports by the workers; (2) technical assessment reports on service quality; and, (3) clients' reports of access, quality and attitudes of service providers. Another new feature is regular household and facility surveys which provide managerially useful information and also give clients a 'voice' to express their views.

Has this policy change had any impact on field operations? Murthy's analysis shows that as there is now no pressure to meet contraceptive targets, almost all states have begun to report an improvement in prenatal care and to focus their attention on providing safe delivery services. The acceptance of reversible methods by younger couples has increased and health workers get credit for identifying contraceptive side effects. Some states have even begun to provide safe delivery services. However, services for emergency obstetric care, safe abortion and treatment of reproductive tract infections and infertility are still not in place. In addition, there are unaddressed issues that relate to the involvement of women and decentralising decision making to the grassroots.

Murthy recommends that research should be undertaken to seek answers to key questions such as: What are the barriers that clients' face in accessing services? What criteria do clients use to judge service quality? How do clients' judgements differ from those of health staff and professionals? Is the policy change improving the effectiveness of the programme? Who provides services at the community level and how do people choose among different providers?

Pathak, Ram and Verma complement Murthy's analysis. They describe the system of monitoring and evaluation that was used in the past and discuss the new indicators for assessing access to services and the quality of care. Rapid household surveys to assess service coverage and quality, and clients' health seeking behaviour and satisfaction, have been designed to monitor the programme at the district level. These household surveys are complemented by surveys of the health facilities. All these surveys are conducted by independent agencies. The authors conclude that the new monitoring system is a marked departure from the earlier top-down system. They discuss the challenges ahead as they foresee that various states in India may eventually emphasise different indicators because their needs and priorities differ significantly.

### *The role of advocacy*

Even though reproductive health rhetoric is now used by many, there are major information gaps at all levels ranging from a lack of understanding of the reproductive health and rights concepts to questions about what short-term and long-term strategies are needed to operationalise the programme. This presents a major deterrent to implementing the new policy. Therefore, strong advocacy efforts are needed to translate the rhetoric into reality. A range of different constituencies, including the government, donors, NGOs, activists, feminists, and researchers must be informed and empowered to catalyse a process of networking with a growing number of

stakeholders so that the ideology and the ethos embodied in the paradigm shift is effectively internalised and programmes responsive to clients' needs are designed and implemented (Pachauri, 1995).

India implemented a population control policy for about four decades when the programme was wedded to a top-down, bureaucratic, target-driven system. In her chapter, Nayyar argues that advocacy is urgently needed to change the mindset of all concerned constituencies. Decision-makers at the national level must send signals to the state level to facilitate the process of policy implementation.

Multiple constituencies must understand the need for change and get engaged in the advocacy process. Although it is difficult and time-consuming to engage in discussion with diverse groups holding different points of view, it is essential to build coalitions and alliances to prepare common ground. After the ICPD, many donors have decided to fund reproductive health programmes. However, there are serious gaps in their understanding of the concepts and the issues. These must be addressed so that donors can be more effective. Therefore, advocacy with donors is also needed. To implement reproductive health services, technical issues need to be understood. It is, therefore, important to involve those that have the expertise such as obstetricians and gynaecologists, physicians, paramedical staff as well as researchers and trainers. Demographers who have led the population field for decades, are natural allies for promoting the reproductive health and rights agenda.

Nayyar underscores how media, a powerful tool for disseminating information and sensitising large numbers of people, can be used for advocacy. However, it is necessary to complement media initiatives with advocacy efforts with the government, NGOs, panchayats, and the people. She discusses the advocacy programmes that are being implemented and draws lessons from these experiences. She asserts that while past efforts were focussed on advocating against an insensitive population policy, now advocacy tools should be used to support government and NGO efforts to implement the programme.

#### *Financial and human resource management*

There is widespread concern that the cost of providing reproductive and child health services to a predominantly rural population will be substantial. Visaria and Visaria review the actual expenditure on the family welfare programme since 1985-86 (both in current and real terms). They show that over the Eighth Plan period 1992-97, the per capita expenditure on family welfare in India increased in two of the five years, fast enough to lead to a modest rise in real terms over the five-year period. Their detailed analysis of activity-specific expenditure over the five years also showed faster increases in the delivery of services. While consistent with the goals of ICPD, the changes cannot really be attributed to it. The recent success of the Government of India in mobilising external assistance augurs well for expanding resource flows to improve the range and quality of services. In the long run, however, the country will need to rely primarily on domestic resources, both public and private, for ensuring the health and welfare of its people.

Human resources and their management are key to implementing the programme. Mavalankar focuses on this important issue in his chapter. He reviews the current situation of training, supervision, accountability and performance appraisal of programme functionaries and argues for making systemic changes to improve programme management.

Reproductive health is qualitatively and conceptually different from the previous vertical programmes. Therefore, it not only needs strong technical inputs, but also requires a different philosophy of work. To radically change the system's perspective towards client-oriented ways of providing services, training, supervision, performance appraisal and reward systems need to change so that there is an incentive and support for individuals to change their work behaviour,

styles of management and patterns of planning. The author proposes a comprehensive approach for human resource management. There is clearly an urgent need to improve the work ethic if client-centred, gender-sensitive services are to be implemented.

### *Partnerships to advance the agenda*

Since India's independence 51 years ago, the government has been the major actor in promoting population, health and development programmes, especially for the poor. Several public sector programmes have been designed and implemented. In recent years, however, there has been increasing involvement of the non-government sector. Although progress has been slow, there is a clear move towards developing partnerships between the government, the NGOs and the rapidly growing private sector.

The paradigm shift requires that the top-down approach be replaced with planning by the people. The importance of community involvement, both in defining and articulating needs as well as in monitoring service quality is underscored. The assumption is that if people are involved in planning, they will have an ownership in the programme which will be reflected in better utilisation of services and improved health outcomes. NGOs have been particularly effective in bringing into the public domain, the needs and problems of the people, especially of the poor. NGOs have also pioneered innovative ways of providing quality services that are responsive to people's needs (Pachauri, 1997).

In recent years, the panchayat is beginning to be seen as an important partner to involve the community; to provide a voice for the community; and to make programmes accountable to the people. The challenge is how to involve panchayats, which are as yet nascent institutions. With 33 percent reservations for women, there are now some 800,000 women in panchayats. Potentially, they represent a strong political force in decision-making at the grassroots. If their capacity for local governance is strengthened, they could have a significant impact on the process of democratic decentralisation and on enhancing women's roles in this process. Several NGOs and researchers are beginning to work with panchayats and some are involving panchayats in the efforts to address the reproductive health needs of the people.

Mukhopadhyay and Sivaramayya examine these issues by drawing upon the experience of an action research project that they are undertaking in three states. They explore the possibility of utilising NGOs as catalysts within the constitutionally mandated structure of local governance through panchayats. Their project is designed to use reproductive health services as an entry point to empower women and to enhance their political participation at the grassroots. The authors assert that while reproductive health is a natural focal point for women's empowerment, the reproductive and child health programme does not adequately address women's needs. There is little in the design of the programme that envisages genuine participation by women at the grassroots. The problem is further compounded by the fact that health is not a priority for panchayats and that the latter have yet to develop strong systems of governance.

The researchers urge that participatory approaches be used to involve women in action and research. More importantly, support structures are necessary to catalyse a process of empowerment for the powerless. It is here that NGO involvement is needed. By locating such initiatives within a collaborative structure involving the panchayats, it would be possible to ensure long-term sustainability. Therefore, more NGOs should be encouraged to work with panchayats to facilitate these processes.

### *Clients' expenditure on health*

What costs do women incur in seeking health care? What are women's health seeking behaviours? Bhatia and Cleland seek answers to these important questions in their chapter. They

review studies undertaken in India and report on their own research in Karnataka. Their study focussed on adult women to assess the utilisation of government and private sources of health care as well as self-medication. The researchers examine illnesses for different socio-economic groups of women, by their perceived severity, duration and diagnostic category.

For some illnesses, especially genito-urinary problems and anaemia, that are seen as 'a part of life', women frequently resorted to self-medication. A practitioner was, however, consulted for all illnesses perceived to be severe. The results of their study reinforce the findings of others about the dominance of the private sector, that includes qualified and unqualified practitioners, in the provision of health care. The average cost women incurred was Rs.75 (\$ 2.4 ) to visit a private practitioner and Rs.66 (\$ 1.9) to visit a government practitioner. The average annual cost incurred by a woman on health care was Rs. 172 (\$5.5).

Although government services are theoretically free, in 75 percent of the cases women incurred costs when they consulted a government practitioner. Because government practitioners were often involved in private practice, the distinction between the private and the public sectors tended to get blurred. The authors suggest that while there is a need to improve the quality of care at government facilities and make them more affordable for the weaker sections of society, there is also a need for regulatory and supporting policy interventions to promote a viable and efficient private sector.

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

#### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **Reaching Neglected Population Groups**

The contributors draw attention to population subgroups including adolescents and men whose needs have not been addressed by past programmes.

#### *Adolescents: growing numbers growing needs*

Adolescents have been by-passed in past programmes and consequently their needs have neither been assessed nor addressed. Health services for adolescent girls have special significance in India where there is strong son preference and where adolescent pregnancy is the norm. These services would not only impact on the adolescent girls' own health but would also have long-term intergenerational effects by reducing the risk of low birth weight and minimising subsequent child mortality risks (Gopalan, 1989). Malnutrition is an underlying problem that seriously affects the health of adolescent girls and adult women and has its roots in early childhood. About 85 percent of women in India are anaemic. The association between anaemia and low birth weight, prematurity, perinatal mortality and maternal mortality has been extensively documented in India (Pachauri and Marwah, 1971; Ramachandran, 1992; Prema et al, 1981) but the problem has yet to be addressed.

As India witnesses the entry of the largest ever generation of adolescents, compelling arguments are being made for examining the special needs of this neglected and vulnerable population subgroup (adolescents, 10-19 years of age, represent about a fifth of India's population). Early discussions are beginning to focus on how adolescent programmes should be designed and implemented. Should special programmes be targeted at adolescents or should sexual and

reproductive health services be mainstreamed within existing primary health care programmes? What strategies should be designed to reach adolescents in school and out of school? How should programmes target boys and girls? What strategies can most effectively involve parents, teachers, and communities? How can the multiple needs of adolescents be addressed holistically and sensitively? These are among the many challenges facing stakeholders attempting to address the social and biological needs of adolescents in India (Pachauri, 1998).

Singh examines the policy environment in the country and discusses recent policies and programmes that aim to address the multiple needs of adolescents and youth. She asserts that the ICPD provided a platform, a space and a vocabulary for a discourse on the needs of adolescents, but that there remains a paucity of information on how to address these needs. She argues that while policy makers in India have long recognised the potential of youth, their approach to harness this potential has remained paternalistic. The ICPD redefined adolescents and youth within the framework of rights and choices. The author underscores the need to further the understanding of the government and the civil society so that effective strategies can be designed to translate rights into the realities of adolescents' lives.

Singh discusses the many cutting edge policies that have been recently formulated for youth, and more particularly for girls, and draws on innovative government initiatives. Her key messages are: (1) the government and NGOs must form true partnerships to move this agenda forward; and, (2) youth must be brought in as equal partners in the process of designing policies and programmes to address their needs.

By examining the nascent but valiant efforts of pioneering NGOs implementing community-based programmes, Mamdani draws attention to the problems faced by married and unmarried adolescents and provides insights into strategic approaches NGOs employ to address them. Through her analysis, she integrates national data with information gleaned through NGO experiences in different parts of the country. She explores the special risks to adolescents of early marriage, unwanted pregnancy, abortion, malnutrition, HIV/AIDS and sexually transmitted infections.

The author weaves within her discourse, an analysis of the social, cultural, and political contexts within which these problems arise and are perpetuated. As she discusses the work of NGOs with adolescents in rural, urban, and tribal communities, she focuses on the adolescent girl who, because of gender differentials, is particularly disadvantaged in these communities. She discusses the prevailing gender norms that impede access to health and education and underscores the importance of designing appropriate services for adolescents. Mamdani assesses early efforts made to address the needs of adolescents in resource poor settings, within culturally hostile environments. This documentation of NGO experiences should provide useful lessons for government and non-government organisations that are currently grappling with these urgent and challenging problems.

#### *Men as responsible partners in reproductive health*

Since gender inequalities favour men in patriarchal societies and sexual and reproductive health decisions are made by them, there is a growing realisation that unless men are reached, programme efforts will have limited impact. While focussing on women and addressing their reproductive health needs, special efforts should be made to encourage men to take responsibility for reproductive health as responsible sexual partners, husbands and fathers (Pachauri, 1998).

Research on HIV/AIDS and sexuality has highlighted the inadequacy of strategies that target only women. Because of unequal gender-power relations, women are especially vulnerable as they are unable to negotiate changes in sexual behaviour to prevent unwanted pregnancy and to

practice safer sex. Research on sexual negotiation strategies has dramatically underscored the need for involving men in programmes that aim at bringing about changes in sexual behaviour for the prevention of infection. However, such behaviour change is as relevant for addressing other reproductive health problems. Therefore, men's involvement as responsible partners is essential. Besides, men, too, have reproductive and sexual health needs that should be addressed (Pachauri, 1997).

In her chapter, Raju analyses men's roles in reproductive and sexual health matters by drawing upon the experience of NGOs working with men to address reproductive health problems in poor rural, tribal and urban slum communities. In most cases, men have been included in programmes that aim to improve women's health within the existing paradigm of gender relations in which men's roles continue to be defined in traditional ways. Obviously, the NGOs themselves operate within the same contexts and face the same dilemma as the people. While NGOs have not engineered major social change. Their very efforts to include men have meant questioning the prevailing gender construct, but within limits. The author exemplifies how these issues are addressed at the grassroots. A related concern is whether involving men might jeopardise women's right to privacy and control over their bodies. The experience of some NGOs shows that this fear is unfounded when women themselves demand men's involvement.

NGOs are undertaking a variety of innovative and creative programmes that can provide important lessons. But is there an enabling policy environment within which these experiences can be upscaled? Raju's examination of government policy shows scarce recognition of these concerns even as India makes a paradigm shift. Men's roles do not find a place in the design of reproductive health programmes. Although there is some discussion on increasing the use of male methods such as vasectomy and condoms, there has not been a discourse around issues of male responsibility and there is little mention of these issues in government documents. On the other hand, there is growing momentum at the policy and programme levels within government departments that are concerned with improving women's status and reducing gender disparities. The women's movement has propelled this agenda.

Raju argues that unless efforts are mainstreamed within public sector programmes, men's involvement in reproductive health will remain a marginalised issue. In a country where gender differentials are so rigidly defined, this is a real challenge. Rapidly changing societal norms, values and aspirations; an unprecedented spread of messages through the media; and, a strong women's movement that is now beginning to take roots at the village level, provide new opportunities and challenges. Joint efforts by the government, NGOs and the civil society can make a difference.

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

#### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **Addressing Reproductive Health Problems**

Several reproductive health problems including HIV/AIDS, reproductive tract infections, safe motherhood and abortion are discussed by the contributors to this volume. Sexual health and sexuality are cross-cutting issues.

*HIV/AIDS: a problem denied*

India is now thought to have more HIV positive persons than any other country in the world but denial of the problem has impeded action. After the first AIDS case was reported in India in May 1986, some 6,600 AIDS cases were reported by September 1998 (NACO, 1998). These figures are believed to be a gross underestimate. Over the years, there has been a steep rise in the reported seropositivity rate -- from 2.5 per 1,000 in 1986 to 22.0 per 1,000 in 1998 (NACO, 1998). The prevalence of HIV infection has been on the rise in practically all states and all population groups in India. The increase is observed irrespective of when the infection reached any particular state. The dominant mode of HIV transmission is heterosexual which accounts for about two-thirds of the infections in India. Therefore, promoting safer sexual behaviours lies at the heart of strategies for preventing HIV/AIDS (Pachauri, 1994).

In her chapter, Ramasubban traces the development of efforts to address the HIV/AIDS problem and draws attention to the serious gulf between rhetoric and reality. The author examines the problem within the country's political and socio-cultural context and analyses the impeding and fostering factors. She argues that: "AIDS, as no other disease before it, holds up a mirror to Indian society, compelling both policy makers and members of the civil society to bring on centre-stage policies, social processes, social groups and behaviours that had hitherto been relegated to the margins."

Ramasubban weaves into her discussion of the national programme, two best practices, one of which is state-led in Tamil Nadu and the other is an NGO-led effort in West Bengal. The strategic approaches employed differ widely, underscoring the importance of designing programmes to respond to local contexts, needs and opportunities. These case studies provide insights into how challenges to confront politically and culturally sensitive issues related to gender and sexuality can be creatively addressed. To advance the HIV/AIDS agenda, a wider public discourse and frank discussion on these issues, that have been carefully skirted in the past, will be necessary. The author concludes that HIV/AIDS prevention and care is not as yet a part of the mainstream social process. She makes a case for bridging the gap between women's powerlessness and the uncharted terrain of men's sexual behaviours; between AIDS control measures and primary health care strategies; and, between health policy formulation and its implementation.

Sethi's chapter complements Ramasubban's by providing an overview of the government's programme. In 1992, the government launched a national response through a well conceptualised programme that was designed to promote partnerships within government bureaucracies, as well as with NGOs, the corporate sector and other players. A comprehensive plan was formulated to decentralise authority to the states; establish sentinel surveillance systems; promote condom use; rationalise blood safety; and, initiate hospital infection control procedures. In addition, pioneering behavioural research was undertaken to help design appropriate intervention strategies. Efforts were also initiated to address social, ethical and legal issues. Although well conceived, the denial of the problem and the near absence of political will resulted in poor implementation of the programme. Thus, the country lost precious time because of a faltering programme that never took roots.

Over the last couple of years, there has been a 're-awakening'. National programme efforts are being revived once more. The new agenda that has been framed is based on lessons learned from past experiences, nationally and globally. And although many of the challenges underscored in Ramasubban's chapter still remain to be addressed, advocacy efforts are underway at all levels of the bureaucracy to generate the political will. In addition, carefully carved designs to decentralise programmes are being creatively prepared. Sethi discusses the new agenda.

In her review, the author also draws attention to the shared concerns between the reproductive health and AIDS control programmes. The ideological underpinnings of a commitment to uphold human rights, provide informed choice, promote gender equity, and implement people-centred, need-based services as well as to encourage non-judgmental, inclusive attitudes to sexuality, are virtually the same. Programmatically, too, there are several areas of convergence related to

sexually transmitted infections, safe motherhood, child survival, and safe sex. Thus, there is a strong, mutually supportive relationship between the processes and philosophy globally endorsed at the ICPD and the direction in which the national response to HIV/AIDS is developing.

In their chapter, Verma, Bhende and Mane discuss the NGO response to HIV/AIDS and focus on NGOs that are addressing women's needs. The authors study programmes that focus particularly on empowering women as well as those concerned with controlling HIV/AIDS. The experience of NGOs that are integrating these services within broader reproductive health programmes is also discussed. Their research shows that NGOs are employing diverse strategies to combat the problem.

They examine a variety of innovative strategies employed by NGOs to involve and mobilise communities and provide health services. Interventions targeted at adolescent girls and boys at the community level and within schools and colleges are discussed. Deriving lessons from these experiences, the authors conclude that NGOs are broadening their agendas and are now addressing the needs, not only of sex workers, but also of women in the general population. Women are being viewed not just as mothers but are being recognised as individuals in their own right, and sensitive issues related to sexuality and sexual behaviours are being increasingly addressed. And finally, although not always explicit, there is a growing recognition that empowering women is essential. While gender issues are difficult to address in HIV/AIDS programmes, it is important to design strategies to deal with these underlying problems for a meaningful long term impact.

#### *Reproductive tract infections: an implementation challenge*

Research in India shows that poor women carry a heavy burden of reproductive morbidity; a significant component of such morbidity is unrelated to pregnancy and is due to reproductive tract infections, many of which are sexually transmitted; these reproductive illnesses among women are invisible because of the 'culture of silence' that surrounds them; and women do not have access to health care for these illnesses. As past programmes have recognised women only as mothers, many women were not served and many reproductive health problems not addressed (Pachauri, 1994). Recent efforts to implement the essential package of reproductive health services have underscored the complexity of diagnosing and treating reproductive tract infections in women.

Mamdani reviews several community-based prevalence studies that have drawn attention to the magnitude of the problem. She states that the impetus for the management and control of sexually transmitted infections followed the advent of HIV/AIDS. The author examines NGO models to address the problem of reproductive tract infections. Although at a relatively embryonic stage in their efforts, NGO programmes provide valuable insights into strategies employed, difficulties encountered, as well as sustainability issues. A discussion on upscaling NGO innovations throws up numerous challenges including the management of symptomatic and asymptomatic infections in men and women, screening of pregnant women, and targeting high risk populations.

The author discusses the conflicts in grappling with this problem. There is a tension between what is ideal and what is possible in our efforts to manage RTIs. She suggests that while the government should draw upon NGO experiences, it must also experiment itself since it is clear that there are no simple, viable, universal solutions. However, the need for and the benefits of addressing the problem of RTIs are no longer in question.

#### *Saving mothers' lives: a continuing neglect*

The magnitude of women's reproductive health problems is reflected in the number of deaths related to pregnancy and childbirth, the most direct indicator of reproductive health care. India's maternal mortality ratio, 420 per 100,000 live births (International Institute of Population Sciences, 1994), is fifty times higher than that of many developed countries and six times higher than that of neighbouring Sri Lanka (Ascadi and Johnson-Ascadi, 1990).

Mortality statistics, however, tell only a part of the story. For every woman who dies many more suffer serious illnesses. Community-based data on maternal morbidity are scarce. A recent study showed that for every maternal death, there were 541 morbidities in India (Fortney et al, 1996). Eighty percent of the women reported at least one morbidity during pregnancy and the puerperium; 24 percent reported five or more morbidities. Life-threatening and serious morbidities were reported by 46 percent of the women. For every woman who died from pregnancy-related causes, there were 25 who suffered from chronic morbidity (Fortney et al, 1996).

These data underscore the high level of unmet need for maternity care in India. By some estimates, better care during labour and delivery could prevent 50-80 percent of maternal deaths. But, the vast majority of births take place at home and are handled mostly by untrained birth attendants. As recently as 1992-1993, no more than 16 percent of all rural births were conducted in institutions and as many as two-thirds were delivered by traditional birth attendants (International Institute of Population Sciences, 1994).

In his chapter, Mavalankar reviews the status of the safe motherhood programme, which he states was a major departure from the maternal and child health (MCH) programme of the past. He finds that the safe motherhood programme received low priority at the policy and implementation levels. There was little political commitment. Most strategies that were designed were not implemented. There was a lack of co-ordination between inputs, processes and outputs. And because monitoring systems were not put in place, it was difficult to assess impact. However, it was evident from available information that the objective of the programme, which was to save mothers' lives, was not met.

One might ask why is it that maternal mortality rates have continued to stagnate in India? A maternal and child health programme made no dent in 40 years and even after a special safe motherhood programme was implemented, no impact was perceptible. Do mothers' lives not matter? Or are the forces that perpetuate gender discrimination so strong in society, of which the health service delivery system is but a part, that no programme can make a difference?

The reproductive health approach represents an effort to redress this neglect. Although critiqued by some as a 'feminist agenda', the need for this shift in paradigm can hardly be minimised. However, there is clearly a need to learn from past experience and to ensure that the reproductive and child health programme does not suffer the same pitfalls. The reproductive health approach aims to involve the community and to make the programme accountable to the people. It is necessary to ensure that accountability mechanisms are put in place so that the programme is indeed responsive to clients' needs and is implemented in the spirit in which it has been conceptualised.

#### *Unsafe abortion: a pervasive problem*

Unsafe induced abortion is the single greatest cause of maternal mortality, and at the same time, the most preventable. Of all the major causes of maternal death, those that lead to abortion deaths are the best understood. Women need not die or suffer medical consequences from abortions because abortions do not kill women; it is unsafely performed abortions which kill (Maine, 1991). Although abortion was legalised in India over 27 years ago, it is still a neglected problem. Access to safe abortion services remains problematic for poor women, especially in rural areas.

The conceptual link between family planning and abortion is fundamental. Effective contraception is an important means of preventing unwanted pregnancy thus pre-empting the need for abortion. In the absence of safe contraceptive backup, however, women will continue to be forced to employ unsafe means for terminating unwanted pregnancies with attendant high maternal mortality and morbidity.

Khan and co-authors review the literature on abortion in India and show widely differing annual estimates ranging between 5 to 6 million and more. A situational analysis of services for the medical termination of pregnancy in the public sector in four states of India shows that there are many systemic problems in delivering services. There are serious issues of access, quality and cost, especially for the poor. There is a wide gulf between the demand for services and the availability of facilities for safe abortion. Consequently, women resort to unsafe abortions, risking their lives. Abortion contributes to 12 percent of maternal deaths in India (Registrar General of India, 1990).

The researchers conclude that while there is a need to equip more facilities, merely increasing the number of facilities will not solve the problem. The proportion of approved facilities that could provide safe abortion are not doing so because of the lack of trained staff. Also, many women do not know that abortion is legal. The social distance between service providers and users presents a major barrier. Can menstrual regulation services by paramedical staff be considered for India? Would the medical establishment allow for such a possibility? The authors recommend that the Medical Termination of Pregnancy (MTP) Act be modified and demedicalised so that it is more responsive to women's needs. The momentum generated post-ICPD should be harnessed to promote a wider public debate. The challenge is to achieve these objectives without creating a controversy around this sensitive issue.

#### *Sexuality: a cross cutting theme*

Reproductive health is related to sexual health in particular and to sexuality in general. In past programmes, these issues were carefully skirted. A discussion of sex and sexuality was taboo because of its political and cultural sensitivity. Ignoring the linkages between family planning, reproductive health and sexuality resulted in several programmatic distortions. Many reproductive and sexual health needs were not addressed and many client groups neglected (Pachauri, 1994; Germaine, 1994). For example, the needs of adolescents and young people who constitute a large proportion of the population and who are sexually active both within and outside marriage, were ignored.

The problem of HIV/AIDS has opened up a discussion on sex and sexuality because persuading people to have safe sex is at the core of programmes for AIDS prevention. Women's special vulnerability because of gender disparities has become evident. Women's sexuality represents the interface between two of the most potent and insidious forms of oppression that prevail in Indian society, gender and sexuality (Ramasubban, 1995). The reluctance to address these issues has limited the effectiveness of programmes designed to improve women's health, promote family planning, and prevent HIV and other sexually transmitted infections (Pachauri, 1994).

As issues related to sexuality are inextricably linked to reproductive health, they are discussed in several chapters in this book. Peltó, however, addresses these issues explicitly in his chapter. The author traces the tenor of the discourse from the 1980s to the present by drawing on research on sexuality undertaken in India. His articulation provides insights into an area where there has been little documentation. In this state-of-the-art paper, the author discusses the experiences of several sub-categories of men and women in rural, tribal and urban slum areas of India. These include sexual experiences of married women as well as women with multiple sexual partners; experiences of unmarried men and men's first sexual experiences; sexual behaviours of

adolescents and sex with relatives. The author illustrates the issues by providing quotes from the field. These voices bring to life and humanise the problems that people face in the real world.

Pelto identifies the challenges ahead and argues that if effective interventions are to be designed, more sophisticated research will be needed to understand sexual negotiation strategies between spouses; issues related to domestic violence and sexual coercion; and, sexual practices of men who have sex with men who are a hidden risk category. A major challenge is to develop and refine methodological and conceptual research tools to undertake evaluative research so that interventions relevant to people's lives can be designed.

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **Addressing Challenges Into the Next Century**

The contributors to this volume have analysed India's first steps in making a paradigm shift. The challenges ahead are many, some more formidable than others, but the first challenge of changing policy in the largest democracy in the world, has been overcome. India is now on the threshold of change as it operationalises the new agenda. There is now no turning back.

The inevitability of moving this agenda forward is established despite concerns articulated by many, especially those who still support policies to control population numbers, even when these have been coercive and have violated reproductive rights. The proponents of this ideology have continued to critique India's policy change. For example, when targets were removed, the initial problems at the field level were presented as evidence that the decision to change policy was ill conceived (Ross, 1998; Narayana, 1998).

Such a conclusion is premature as it is based on very early evidence, focussing narrowly on the immediate aftermath of the removal of method-specific targets alone. Although the authors of this volume also document problems, they extend their assessment well beyond targets and examine the broader reproductive and child health programme as it is being planned and operationalised in the country.

Considering that this programme was officially launched only 15 months ago, the momentum is significant. Several essential first steps have been taken. For example, decentralised planning processes are now underway; new monitoring and evaluation systems are being operationalised; human resource development strategies are being re-examined; innovative ways to provide information are being tried; a discourse on how to address the needs of adolescents is on the national agenda; there is a growing momentum for enhancing women's empowerment; and, efforts have been initiated to address sexual and reproductive health problems of women and men.

While important first steps have been taken, concerted efforts will, undoubtedly, be needed to sustain the momentum. In addition, many unaddressed problems still remain. Reproductive health is inextricably linked to the issue of rights. The removal of method-specific targets implies that people can now make informed contraceptive choices. Contraceptive choice is linked to larger reproductive choice issues and to reproductive rights. Poor women in India have few life

choices. Is reproductive choice a reality in this context? Reproductive rights have not as yet been brought into the national discourse.

Reproductive rights cannot be realised if gender disparities prevail. If policies that promote social justice, women's empowerment and reproductive health can converge to create a synergy; if NGOs, governments, activists and researchers can together promote advocacy initiatives; and if these growing networks can raise the resources and influence macro-level policy, only then can reproductive rights become a reality for India.

Efforts by the government, NGOs, and the private sector must be supported by those of the people, the civil society at large, to sustain the momentum to operationalise reproductive health and rights, and to bring about social change that will eventually determine the success of these endeavours. The government alone cannot achieve these ambitious goals. It must, therefore, actively seek partnerships with NGOs, the private sector, *panchayats* and the people. Such partnerships are necessary not only to complement the government's own programme but also to ensure its accountability to the people.

And finally, advocacy efforts should be enhanced to promote an understanding of the paradigm change. The shift in paradigm has mind-boggling implications because it calls for a change from a top-down, male-dominated, bureaucratic, target-driven programme, to client-friendly, gender-sensitive services that respond to people's needs. The analyses presented in this volume validate that the programme is moving on the right path. A strong political will and concerted efforts of all stakeholders will be needed to create the synergy to move the new agenda forward.

## **Implementing a Reproductive Health Agenda in India: The Beginning**

### **Introductory Essay:**

#### **MOVING TOWARDS REPRODUCTIVE HEALTH: ISSUES AND EVIDENCE**

Saroj Pachauri

### **References**

Ascadi, G.T.F., and Johnson-Ascadi, G. 1990. Safe Motherhood in South Asia: Socio-cultural and Demographic Aspects of Maternal Health. Background paper for the Safe Motherhood South Asia Conference, Lahore.

Fortney, J.A., and Jason, B.S. (eds.). 1996. The Base of the Iceberg: Prevalence and Perceptions of Maternal Morbidity in Four Developing Countries: The Maternal Morbidity Network. Family Health International, Research Triangle Park, USA.

Germaine, A., Nowrojee, S., and Pyne, H.H. 1994. Setting a New Agenda: Sexual and Reproductive Health and Rights. In: G. Sen, A. Germaine, and L.C. Chen, (eds.). Population Policies Reconsidered: Health, Empowerment and Rights. Harvard Series on Population and International Health. Boston: Harvard University Press.

Gopalan, C. 1989. Women and Nutrition in India - General Considerations. In: C. Gopalan and S. Kaur (eds.). Women and Nutrition in India. 1-16. Nutrition Foundation of India Special Publication Series 5.

Government of India. 1997. Reproductive and Child Health Programme. Ministry of Health and Family Welfare. New Delhi, India.

International Institute of Population Sciences. 1994. National Family Health Survey, 1992-93, India Introductory Report, Mumbai, India.

Jain, A.K. 1992. Conclusions: Recommended Next Steps. In: A.K. Jain (ed.). Managing Quality of Care in Population Programs, USA: Kumarian Press.

Jain, A., and Bruce, J. 1994. A Reproductive Health Approach to the Objectives and Assessment of Family Planning Programs. In: G. Lin, A. Germaine, and L.C. Chen (eds.). Population Policies Reconsidered: Health Empowerment and Rights. 192-211. Boston: Harvard School of Public Health.

Maine, D. 1991. Safe Motherhood Programs: Options and Issues. Columbia University Center for Population and Family Health, New York.

Measham, A., and Heaver, M. 1995. India's Family Welfare Program: Moving to a Reproductive and Child Health Approach. Directions in Development. World Bank, Washington D.C., USA.

National AIDS Control Organisation. 1998. NEXUS. Population Services International, New Delhi, India.

Narayana, G. 1998. Summary. The Policy Project. Targets for Family Planning in India. An Analysis of Policy Change, Consequences, and Alternative Choices. The Policy Project, the Futures Group, New Delhi, India.

Pachauri, S. 1998. Unmet Reproductive and Sexual Health Needs in South Asia. Journal of Health and Population in Developing Countries. 1(2):29-30.

Pachauri, S. 1998. Adolescents in Asia: Issues and Challenges. Demography India. Vol. 27, No. 1.

Pachauri, S. 1997. Defining a Reproductive Health Package for India: A Proposed Framework. In: M. Krishnaraj, R. Sudarshan, and A. Shariff (eds.). Gender, Population and Development. New Delhi: Oxford University Press.

Pachauri, S. 1997. Point of View. In: Toward a New Partnership: Encouraging the Positive Involvement of Men as Supportive

Partners in Reproductive Health. Population Council Newsletter No.3, November 1997.

Pachauri, S. 1997. Advocacy for Reproductive Health. Lecture at Maharaja Sayajirao University and Society for Operations Research and Training, Baroda, India, July 16, 1997.

Pachauri, S. 1997. Breaking the Silence. In: S. Solomon, and R.P. Rajan, (eds.). Whispers from Within: Unheard Voices of People with HIV/AIDS. Chennai: Navshakti, India.

Pachauri, S. 1996. A Shift from Family Planning to Reproductive Health: New Challenges. In: K. Srinivasan, (ed.). Population Policy and Reproductive Health. Population Foundation of India. New Delhi: Hindustan Publishing Corporation.

Pachauri, S. 1996. 'Paradigm Shifts', Seminar, Reproductive Health, New Delhi, India.

Pachauri, S. 1995. Defining an Essential Package of Reproductive and Child Health Services. In: India's Family Welfare Program: Towards a Reproductive and Child Health Approach. Population and Human Resources, Operations Division, South Asia Country Department (India, Nepal and Bhutan). World Bank, Washington DC., USA.

Pachauri, S. (ed.). 1994. Reaching India's Poor: Non-governmental Approaches to Community Health. India and Thousand Oaks, London: Sage Publications.

Pachauri, S. 1994. Women's Reproductive Health in India: Research Needs and Priorities. In: J. Gittlesohn, M.E. Bentley, P.J. Pelto, M. Nag, S. Pachauri, A.D. Harrison, and L.T. Landman, (eds.). Listening to Women Talk about their Health Issues and Evidence from India. New Delhi: The Ford Foundation and Har-Anand Publications, New Delhi, India.

Pachauri, S. 1994. Relationship between AIDS and Family Planning Programmes: A Rationale for Developing Integrated Reproductive Health Services. Health Transitions Review, Supplement to Volume 4.

Pachauri, S., and Marwah, S.M. 1971. A Correlation Study of Birth Weight and Some Maternal Factors. Indian Journal of Medical Research, 25(9): 604-612.

Prema, K., Neelakumari, S., and Ramalakshmi, B.A. 1981. Anaemia and Adverse Obstetric Outcome. Nutrition Reports International, 23.

Ramachandran, P. 1992. Anaemia in Pregnancy. In: S.S. Ratnam, B.K. Rao, and S. Arulkumaran (eds.). Obstetrics and

Gynecology for Postgraduates, Volume I. Madras: Orient Longmans Ltd.

Ramasubban, R. 1995. Patriarchy and the risks of HIV transmission. In: M. Dasgupta, T.N. Krishnan and Lincoln Chen (eds.). Women, Health and Development in India. Mumbai: Oxford University Press.

Ross, J.A. 1998. The Policy Project. Targets for Family Planning in India. An Analysis of Policy Change, Consequences, and Alternative Choices. The Policy Project, the Futures Group, New Delhi, India.

Registrar General of India. 1990. Survey of Census of Death, (Rural) Annual Report, 1990. Office of the Registrar General, New Delhi, India.

Sinding, W.S. and Fathalla, M. 1995. From Demographic Targets to Individual Needs: The Great Transition. The UNFPA Magazine Populi. 22(8):18-21.

United Nations. 1994. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. A/CONF.171/13.

World Bank 1995. India's Family Welfare Program: Toward a Reproductive and Child Health Approach. World Bank Population and Human Resources Division, South Asia Country Department II, Report No. 14644-IN. World Bank, Washington D.C., USA.