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Gender matters

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‘The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of sustainable development. The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household... The power relations that impede women’s attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public… Achieving change requires policy and programme actions that improve women’s access to secure livelihoods and economic resources, alleviate their extreme responsibilities with regard to housework, remove legal impediments to their participation in public life, and raise social awareness through effective programmes of education and mass communication…

[para 4.1, Chapter IV on Gender Equality, Equity and Empowerment of Women, Program of Action (POA), International Conference on Population and Development (ICPD), 1994.]

THE ICPD Programme of Action has been hailed as a path-breaking document in many respects, foremost being its radical paradigmatic shift from demographic imperatives to qualitative aspects – among which, empowerment and rights of women, gender equality and equity play a major role.[1] This document is in many ways symbolic of the victory of the international women’s movement, especially in mainstreaming a highly contentious and contested international document with a feminist language of gender justice and rights.[2] Having mainstreamed and institutionalized gender language and policy intent, the aftermath of Cairo (and Beijing in 1995)[3] presents a serious challenge to feminists, gender policy advocates and activists.

The challenge is on two fronts. One, to ensure that the gains made in these international conferences are not lost in the country contexts whenever policies and programmes are designed. Two, if policies do incorporate a gender language, in being ever watchful

that they are not operationalised in a diluted and depoliticized form. However, playing the faithful watchdog role has been fraught with complications and problems, as the language of gender has been subject to a free-play of dilution or 'rhetorification', to coin a new word.

Given the handful of women (and men) in India who subscribe to a feminist political content in gender discourse, the task is daunting as the mechanisms for monitoring and ensuring accountability remain poor. The challenge is especially acute in the new millennium as gender sensitive language is becoming politically correct (or incorrect) and (un)fashionable in policy circles and documents. And there remain many new, static and conservative interpretations to 'gender ideologies'.

Post-Cairo, India was one of the few countries to incorporate some elements of the ICPD-POA. In 1996-97, India experimented by first removing targets and then designing the Community Needs Assessment Approach (CNAA) which envisaged a bottom-up and decentralized planning of health and reproductive needs within the community.

The Reproductive and Child Health (RCH) approach followed, which brought into its ambit a lifecycle approach and expanded the state services beyond maternity and child health to include gynecological morbidities including STD/AIDS. It has a section on 'gender sensitivity' which purports to provide good quality care, male participation in family planning, focusing on reproductive tract infections, keeping clinics open at times suitable for women, training in gender sensitivity for service providers and involving elected women members and clients for monitoring[4] (MOHFW, 1997).

In the year 2000, the Indian National Population Policy (NPP 2000) and the state population policy documents were released. Some of these policy documents have attempted to incorporate the language of gender equity and women's empowerment in their goals or objectives and/or strategies. How are these policy intentions supported by concrete strategies for action? To what extents do these policies genuinely engender equity and justice for women? This paper will focus on gender implications of the state and national population policies. First, a framework for analysis will be outlined followed by a brief history of population policy in India. This will be followed by a description of the macro-environment within which these policies are located in India. Next, the population policies, in terms of their gender implications will be outlined, followed by conclusions.

In India, in matters of fertility decisions, multiple forms of power converge on women and several actors mediate control over

women's bodies. They include the husband, the family, the community in some instances (when religion comes into the picture) and the state. One location is the family where gender and other social hierarchies play a role. In the Indian socio-cultural context, women do not make isolated individual decisions about their fertility. Men and elderly women play a critical role in deciding the number and the preferred sex of the children.

Outside the household, in the 'public' sphere, the thrust of health and population (control) policies dictate the options and choices available to women for accessing services. Pro-natalist regimes encourage women's fertility in some countries of Asia, notably Japan, Singapore and Malaysia. Here a denial or restriction in the supply of birth control methods is actively engineered by the state.[5] Anti-natalist countries like India discourage fertility and gear their health and family services towards this end.

The quality of women's relationship with their partners also plays a role in negotiating fertility. At times, however, women subvert family decisions by adopting contraceptives surreptitiously. This is where the family planning services have a critical role in provisioning of safe, affordable and effective contraceptives. Thus the state has the ability to either enable or disable women in control over their bodies and their fertility.

In addressing or confronting the state for access to safe and effective contraceptives, the human rights framework is a powerful instrument to ensure women's access to health and reproductive decisions. The state, including the Indian state, is obliged to respect, promote, protect and fulfil women's right to self-determination by most international human rights conventions and treaties. However, when the state supersedes women's/men's right to decide the number of children in the interest of the 'socially desirable goal' of population control/stabilization, women/men's right to birth control gets compromised. This is precisely where the ICPD-POA document's delineation of rights, especially reproductive health and rights in the specific context of population policy, is relevant (see Chapter 7, articles 7.2, 7.3, 7.4).

Starting with the WHO definitions of reproductive and sexual health,[6] this chapter defines reproductive rights as the right to make reproduction decisions free of discrimination, coercion and violence. It defines government duty to base all policies and programmes including family planning programmes on these rights, and to promote equitable gender relations. The chapter states that reproductive health services (including sexual health and family planning) should be linked to the primary health care system, and should include making abortion safe (where it is not against the law), treating reproductive tract infections, sexually transmitted diseases and infertility, in addition to maternal and child health

services plus counselling men and youth for responsible sexual behaviour.

The chapter supports decentralization of services, improvement of quality in the family planning programmes, and strongly argues against any form of coercion in family planning programmes including targets, quotas, incentives and disincentives. It calls upon civil society to monitor programmes and put in place systems to detect and control abuse. The chapter has a strong section on the health needs of adolescents.

However, reproductive health and rights have come under heavy criticism as being western, in sharp contrast to eastern/southern cultural traditions. Further, they are construed as individualistic, androcentric, abstract and universalist (see Sen and Batliwala, 2000). The ethical principles of reproductive rights as delineated by Correa and Petchesky (1994) – bodily integrity, personhood, equality and diversity[7] – help transcend these criticisms by making them applicable across cultural, socio-economic and political contexts.

In India too, the concept of reproductive rights is poorly understood. Further, other social, economic and civic rights like right to livelihood, safe drinking water, sanitation and general health care are juxtaposed as meriting more importance and attention than reproductive rights. A popular critique in India (among some progressive women's groups as well) is that reproductive rights reduce women's identity to their uterus and reproductive organs, diminish their value as persons, and ignore other health and survival needs. The difficulty of translating reproductive rights in local languages is a another critique against this concept.

However, such challenges for translating feminist concepts are not new. Take for instance, the concept of gender. The word for sex and gender is the same – linga – which is also another word for the 'phallus'. In Malyalam, *sex* gets translated as *linga,* and gender becomes *linga-padavi.* Retranslated into English, literally, this could mean 'phallus' for sex and 'phallus status' for gender, ironically giving a centrality to the phallus as an important feminist concept. Yet, these concepts are not rejected but used creatively by feminists, underlining the political significance of creating a new language.[8]

Notwithstanding the above critique of reproductive rights, their conceptualization by feminist scholars[9] as well as the delineation out-lined in ICPD-POA, underscores the relevance of reproductive rights in the Indian context. However, it needs to be emphasized that reproductive rights are not 'stand-alone' or isolated rights, but intimately and intricately connected to other social, economic, civil

and political rights of men and women – with special rights for women for the biological (and social) onus and burdens for reproduction that women bear in the context of gender power relations. It is a powerful feminist political strategy to use reproductive rights as a *struggle-concept* in the context of gender subordination and coercive target oriented population policies. And to ensure that it does not get smothered and lost in the arti-culation of other equally important rights which encompass basic needs.

The diversity and complexity of women's lives across their different identities and socio-political locations in India makes it difficult (and unjust) to indulge in an exercise of hierarchy of rights, and privilege some rights over others. Depending on a woman's specific life-context, different kinds of rights assume importance at different time points to enable her to lead a fulfilling life. Asserting rights as an individual or collectively through institutions (like unions, women's groups) then becomes an important and strategic instrument for women to negotiate with the state and affect or alter policy in the process.

To understand such shifts in policy dynamics, I will adapt Mackintosh (1992) who distinguished between two models of development policy – *policy as prescription* and *policy as process*. These connote a static and dynamic concept of policy respectively. Policy as prescription is just that – what the government/state prescribes for achieving policy objectives and goals and is based on a set of assumptions that the state is inherently benevolent and knows what is best for its citizens. Policy as process seeks to explain how different institutions and actors who are involved, or affected by the policy, take a proactive stance in challenging policy. In the process, they end up forcing changes, making alterations or modifications in the way policy is operationalised.

The interaction between the prescription and the process is forever dynamic, where the state tries its best to subvert efforts it perceives as contrary to its objectives. This is where coercion, disincentives and incentives come into play in population policies and attempt to put a brake on the process of individual self-determination. It is also buttressed by restricting options in the design and quality of health care provided to the people and by promoting specific types of contraceptives.

However, women's groups protesting against dangerous and harmful contraceptives in India have amply demonstrated that there are niches and spaces within the political system to put brakes on policy. For example, the ban on contraceptives like Net-en and Quinacrine is a case in point. The ban was affected entirely through action and protests by women's groups. In 1985, the Stree Shakti Sanghatna and in 1998, the All India Democratic Women's Association (AIDWA) initiated a public interest litigation against

the State of India challenging Net-en trials and sterilization through injecting Quinacrine, a malarial drug into women's reproductive system. These efforts have effectively stymied the efforts to introduce these contraceptives in the state family planning services. Population policy in the last 50 years continues as a struggle between prescription and process.

In this paper, I make a distinction between analyzing policy per se and policy document. The former is a larger exercise, which includes analyzing the intent on paper and the translation of policy action at the ground level, which can be done when the policy has been implemented over a period of time. The latter, however, remains a document-analysis when the policy is released to the public. Here, the goals and themes of the policy are analyzed in tandem with the strategies stated on paper to operationalise these – to see how they contradict/conflict or reinforce/enable each other. This is best done in the historical context of previous policy formulation and translation that been in operation over the decades. Population policy in India lends itself to such a historical and contemporary analysis, having been in existence for half a century since 1952.

When India launched its family planning programme in 1952, it was primarily initiated with a laudable goal of 'nation-building'. The policy to begin with was relatively benign.[10] The family planning programme was first and foremost embraced by men, keen to contribute to India's development with a personal and patriotic fervor by adopting a small family norm. In fact, educated young men, post-independence, were highly motivated by leaders who believed that India's progress lay in curtailing its population size.

Vasectomy and condoms dominated the programme and many men voluntarily and willingly adopted both. Men in the 1950s and early '60s aptly termed this as recreation without procreation.[11] While diaphragms for women were also available, they lay mostly unused as men took the initiative.[12] It was not until the mid '60s when Lippe's loop, an intra-uterine device (IUD) was introduced, did women come into the picture to adopt it as a spacing method, despite many attendant problems. The '60s was also a period when the oral pill emerged as a popular contraceptive in the West. It journeyed to India not long after, and was officially introduced into the family planning programme. By this time, however, the unstated goal of population policy moved to solving India's food crisis and poverty by reducing the number of people.

By the mid '70s, with the availability of condoms and vasectomy for men and the oral pill and Copper-T, a new IUD for women, an uneven balance was achieved in terms of 'choice' and options available for men and women. It was uneven because women's contraceptives were invasive in nature compared to those for men.

While condoms were non-invasive in the broadest sense of the term, Copper-T by its constant presence in the uterus led to reproductive morbidity and discomfort in the form of excessive bleeding during periods for many women. Further, it was provider controlled as a woman's decision to terminate this method needed support from medical practitioners who in the prevailing policy climate could very well refuse.

The pill though invasive in terms of its side effects for some women – manifested by mood swings, depression, nausea and other morbidities – was user controlled in the sense that women could stop using the pill in case they so decided. The contrast in terms of side effects and invasiveness of the contraceptives available for men and women by mid '70s was very sharp. It was around this time that the first ever Statement of National Population Policy was announced in 1976, and incentives and disincentives became a policy strategy. Coinciding with the now infamous years of the Emergency and forced vasectomies that toppled the government, the 1976 population policy was buried forever. A year later, in 1977, a new policy statement on family welfare emerged.[13] The rapid changes and turnarounds in population policy within a short span of one year during this period are reflective of policy as process through the political clout of Indian men.

The change in nomenclature from family planning to family welfare was deliberate. Massive human rights violations during vasectomies had marked the term family planning with a scandalous and negative connotation. After 25 years, family planning became family welfare, but it was like old wine in new bottle. The only difference being that women became the prime targets for India's population control programme facilitated by the merging of maternal and child health with family welfare. 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, 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.

In 1983, the National Health Policy emphasized the need for 'securing small family through *voluntary efforts* and moving towards the goal of population stabilization' (emphasis added). The Parliament voiced the need for a separate national population policy while adopting the health policy. In the absence of a clear-cut population policy, the strategies of incentives and disincentives became the norm accompanied by an aggressive drive to enrol women for sterilizations. In 1991, the National Development Council committee on population brought out its report. But it remained on paper. It was only on the eve of the International

Conference on Population and Development, 1994, held in Cairo that the exercise of a draft National Population Policy under the chairmanship of M.S. Swaminathan was conducted. Opposition from women's organizations to parts of the draft and a concern within government circles about setting up a powerful Population Commission with financial and administrative controls resulted in the document not being formalized (see HealthWatch, 2000).

This brief detour into the chequered history of India's population policy highlights the following.

* One, the Indian population policy is based on an assumption that state intervention is necessary to influence and control individual behaviour and action to meet socially desirable goals like population stabilization.

* Two, population policy in India has thus far, essentially been a population control policy with a smattering of development objectives thrown in – like access to education and health – more in an instrumentalist fashion.

* Three, the prerogative of the state over citizens in deciding the number of children is buttressed by a range of incentives and disincentives to discipline and control fertility (and sexuality) and guide the design and financial allocation of health care systems in the public hospital. Health care providers end up becoming the conduits for implementing such draconian policy, severely compromising genuine health care needs of the people and quality of care.

* Four, post the vasectomy scandal, women form the prime targets for population control and the contraceptives available in the family welfare programme are women-centred. They have progressively moved from user controlled ones like oral pills to provider controlled like IUD or terminal methods like sterilizations. Trials on long acting hormonal contraceptives have been conducted on women flouting all ethical norms of informed choice and consent; examples being injectibles like Depo Provera and Net-en, or implants like Norplant.

The macro environment in which the new population policies are being introduced needs mention at this point. More than 10 years of structural adjustment programmes have contributed to a growing poverty and erosion of livelihoods of the poor, not the least due to alienation of land as a result of large development projects and moves towards privatization of common property resources. Rising unemployment and decline in food security, privatization of services coupled with cutbacks in the thin and shrinking welfare measures has meant that the lives of poor, especially the lower caste and tribal women, are under severe stress. Under conditions of

deteriorating poverty women bear the worst brunt, given gender bias in allocation of meager resources in households and women's reduced access to health and education (see Sen, et al., 2000).

In this bleak scenario of struggle for survival, the decade of the '90s also witnessed certain positive developments for women at the policy, legislative, judicial and programme levels:

* The entry of women into the panchayati raj institutions in the urban and rural areas following the 73rd and 74th amendments to the country's Constitution.

* The setting up of the national and state women's commissions for dealing with situations that constitute violations of women's human rights.

* The Draft National Policy on Women.

* The Supreme Court ruling concerning sexual harassment of women in the workplace.

* The directive banning Quinacrine (as a chemical method for female sterilization) by the Supreme Court.

* The District Primary Education Programme that encourages education of the girl child, plus other measures like mid day meal scheme and free schooling for girl children.

The '90s also witnessed a strengthening and broad-basing of movements by the tribals, dalits, fish workers, farmers and women and many diverse initiatives to demand rights and accountability from the system, emphasizing the significance of policy as process in articulating development policy. On the whole, the overall environment is disabling at one level while enabling counterpoints at another.

The National Population Policy was introduced in February 2000. It combines some elements of the RCH and outlines 11 strategic themes.[14] For each of these, 'operational strategies' are outlined. Broadly, the thrust of NPP 2000 is in the right direction in recognizing '...the most effective development policies are those which are socially just and focus on the well-being of all people.' As far as gender concerns go, the section on 'empowering women for improved health and nutrition', focuses on some critical needs like drinking water, fuel, fodder, child care centres, and access to primary health care with an overwhelming focus on obstetric care. Sexually transmitted diseases also find mention along with reproductive tract infections (RTIs). The primary emphasis and approach of the policy is on women as *wives and mothers.*

Adolescents are mentioned only cursorily, though in another section on 'under-served population groups' a subsection is devoted to adolescents, but the focus is on nutrition, prevention of child marriage and a general mention of information, education and counselling services, without mentioning the specific needs of adolescent boys and girls. For example, there is no mention of gynaecological services for adolescent girls among whom menstrual morbidity is a common complaint. Neither do post-menopausal women find a place in the policy, despite growing statistics of the prevalence of reproductive cancers. The much acclaimed life-cycle approach of the RCH is absent.

The strategies for men's cooperation and enabling them to take responsibility for their fertility is touched upon only sketchily. The main concern is to motivate men to adopt contraceptives, especially popularizing the NSV – no scalpel vasectomy – and small family norm, being a responsible husband (taking care of wives during pregnancy) and a responsible father. Strategic issues of gender equality are missed out as men are construed as 'fathers and husbands' and women as 'mothers and wives'. The construction of a conventional gender stereotyping of roles within the policy without acknowledging the relations of power between men and women, has left a big void in the critical provisioning of services beyond such relational roles.

The NPP 2000 also falls short of an ethical approach of enabling people's choice for reproductive decisions by bringing in incentives for the poorest of the poor in India – those below the poverty line, and rewarding local self-government institutions like panchayats and zila parishads in reducing birth rates, infant mortality rates, literacy and so on. As HealthWatch (2000, Issue 9/10) pointed out, '...these should not translate into ground level coercion of (especially) poor women towards unwanted and unsafe sterilizations and IUD insertions…' Given the history of population policies and family planning programmes in India, the pressure of targets will be on women not men, as the collective and institutional memory of the political backlash for meddling with the rights and bodies of men in the mid '70s remains powerful.

Following NPP 2000, several states announced state level population policies. They include Maharashtra, Gujarat, Madhya Pradesh and Uttar Pradesh in 2000 and Rajasthan and Andhra Pradesh in 1999 and 1997 respectively.[15] Ever since 1952, the Centre has funded and fully directed the population policy for the entire country and states have dutifully complied to all directives of the Centre. Fifty years later, for the first time in Indian history, state governments are announcing their own population policies and most of them, except for Gujarat,[16] are at variance and retrogressive in comparison with the NPP in key strategies for implementation. The question arises, how and why has the government complied with

this shift? There has been no formal statement about this delinking, nor have any guidelines been issued for framing the policy. Unlike the central policy, state policies tend to veer away from the ICPD stand against targets and disincentives though they remain broadly faithful to the RCH mandate. This is precisely an area where the gender implications come into the picture.

The common thread that unites these policies are the contradictions inherent in the statements made on *gender equity and women's empowerment* (Rajasthan, Uttar Pradesh, Madhya Pradesh, Gujarat and Andhra Pradesh) while listing out a host of disincentives and incentives (except Gujarat) that seriously undermine the possibility of delivering gender justice and equity.[17]

Both the Rajasthan and Uttar Pradesh policies recommend the induction of long acting, provider controlled contraceptives for women. While Rajasthan is awaiting imprimatur (sanction) of the central government (see M. Rao, 2000), the Uttar Pradesh government seems to be acting on its own volition. Injectibles such as Net-en, Depo Provera and implants like Norplant are known for a range of morbidities they can cause, including bleeding disorders. In tandem with targets and incentives (and disincentives), their abuse potential is high. They are known to act upon the hormonal systems of a woman's body and disrupt menstruation by causing either excessive or a total absence of bleeding. The implications of excessive bleeding are serious for poor women (who constitute the potential targets) who are most often anemic. Further, in a socio-cultural environment where menstruation is associated with superstitions, any disruption of a regular cycle has a negative impact on women's lives.

Rajasthan and Madhya Pradesh bar people with more than two children from contesting the panchayat elections. Apart from being unconstitutional, in terms of gender implications, HealthWatch (1999) pointed out, 'Do we really believe that the male would-be elected official, hungry for a seat, would not consider casting aside his current wife who has borne him more than the allowed number of children in favour of a new one with none or fewer? ...The only people likely to be affected by an electoral restriction would in this case be the cast-off wife and the woman who cannot stand for office because it would mean abandoning her children.'

Further, it discriminates against women from backward areas, where the average total fertility rates (TFR) is above two and concentrated among the poorest and most disenfranchised of the Indian people, from staking their claim to elected bodies through the 33% reservations for women in the panchayati raj institutions. The TFR for Muslims, scheduled castes and tribes according to the latest NFHS-2 Survey is 3.6, 3.2, and 3.1 respectively (see Kulkarni, 2001).

Uttar Pradesh, Madhya Pradesh, Andhra Pradesh and Maharashtra link transfer of resources for anti-poverty schemes like income generation and poverty alleviation programmes, low cost housing and sanitation for weaker sections on the performance of the family planning programme in the area. AP goes a step further and targets poor women by linking performance in RCH and couple protection rate to DWCRA – Development of Women and Children in Rural Areas. In Maharashtra, access to public distribution scheme (PDS), education in government institutions, and access to jobs in government are linked to the two-child norm. Uttar Pradesh and Maharashtra link fund flows to panchayats based on their performance in family planning and RCH.

By any criteria, the scheduled castes and tribes are among the poorest in India. Depriving them of social security in the face of worsening macro-economic environment and increasing rural poverty in the name of family planning acceptance or RCH performance is both unethical and unconstitutional. Despite the prevalence of patronage and leakage in the disbursement of development programmes, some meager benefits do percolate to the poor. Cutbacks in PDS and poverty alleviation programmes would mean a worsening of livelihood options for the poor, especially women, given the gender bias in food and other resource allocations within the household. The most serious implications are for girls' education, women's access to income and jobs, and their health status and child survival.

The state seems to be shedding its last vestige of responsibility and accountability to the weaker sections. The health indicators of SC/STs compared to other communities and caste Hindus are telling. They have the highest infant and child mortality rates in India and fare the worst in almost all reproductive and child health indicators (see Kulkarni, 2001).[18] The percentage of women from SC/ST who receive ante-natal check ups and immunization, institutional or assisted deliveries, post-natal check ups is the lowest among all communities and religions. Both severe and moderate forms of anemia are high among the women and children. Further, and not surprisingly, more SC/ST children remain deprived of immunization and are malnourished.[19] Given these reinforcing factors of high infant mortality and of poor reproductive health care, SC/ST fertility rates are higher – for which they will now be penalized in the new incentive/disincentive system of state policies.

In all four states, the medical officers' and health workers' performance will be the criteria for disbursing funds for the panchayats. Further, their assessment will hinge on RCH performance. This will seriously distort delivery of rural health care services and other rural development programmes, and counter the ICPD by bringing back top-down targets into the picture. Disqualification from government jobs for persons married before

legal age will also discriminate against women more than men and hold them responsible for a deeply entrenched social custom of child marriage over which they have no individual control. In terms of government jobs, women form the lower-most rung of workers – anganwadi teachers and auxiliary nurse and midwives.

A gender analysis of both national and state population policies demonstrates a simplistic and technical understanding and approach to gender equality and women's empowerment. A serious cause for concern is the jettisoning of the Cairo commitments in the design of state population policies which have the potential of depriving the poorest in India, especially women, of their rights to livelihood and self-determination with the introduction of targets, incentives and disincentives. Equally significant is the retrogression in state polices from the national population policy. In this context, the instructions given by the Centre to the states to formulate their own policies need to be categorically questioned. Family welfare has always been a centrally directed programme. The sudden turnaround to a negative situation of no clear guidelines by the Centre to the states on the non-negotiable principles and ethics espoused in the ICPD-POA (some of which the NPP 2000 has taken care to include) while formulating population policy, forces one to wonder if the NPP 2000 is just a 'showpiece' to the rest of the world while the business of targets, introduction of dangerous contraceptives for women and flouting a large number of human rights in the name of population stabilization, continues at the ground level under state supervision.

A significant fertility transition is underway in large parts of India (see Rao, 2000; Sen and Iyer, 2001) and fertility is projected to reach replacement levels in two decades from now (Visaria and Visaria in Sen and Iyer, 2001). Sen and Iyer emphasize how unnecessary, unjust and ineffective incentives and disincentives are in such a situation, especially when it is population momentum that is responsible for population growth in India.

Our population policy history amply demonstrates that prescriptive policies can be subjected to people's power and unleash processes that can force a change in policy design and implementation. In this context, there is an urgent need for working towards a human rights framework and framing reproductive rights as a part of a package of other rights that improve women's options for self determination and ensure their access to good quality, affordable and comprehensive primary health care services that fulfil women-specific needs.

Footnotes

1. Chapter 4 of the POA, ICPD jettisons the language of women's status for an acknowledgement of power relations.

2. The highly contentious atmosphere and debate in Cairo can be gauged by the

disparate and wide range of voices and actors, each with their own agenda that were thrown together in Cairo to cobble a consensus document. These include traditional family planning establishments, environmentalists, religious fundamentalists, women's organizations (including feminists) as well as the northern and southern country groupings – European Union and USA vs. the G-77 group of nations.

3. At the World Conference on Women (WCW) in Beijing, 1995, the Platform for Action (PFA) was adopted as a direction for women's policy the world over.

4. See R. Kumar (forthcoming), for an interesting critique of the gender sensitivity in RCH.

5. For example, oral pills were banned in Japan when the government wanted to increase fertility.

6. Following Iran and Pakistan's objection, discussion on sexual health was considerably abbreviated in the final ICPD-POA document.

7. *Bodily Integrity* – signifies control over one's body and freedom from violence and abuse. *Personhood* – autonomy, self determination and respect for individual's desire and capacity to make decisions. *Equality* – enshrines equality between men and women while recognizing women's greater biological and social burden in reproduction. Also, equality among and between women of different social groups. *Diversity* – without violating the above three principles, respecting differences among women spanning different economic, cultural, social backgrounds and different sexual preferences.

8. Some women activists in Kerala stick to the English words *gender* and *sex* to avoid this problem, hoping they will become a part of the local-lingo much as other English words in Malayalam. Yet another attempt is to use 'aan padvi' and 'penn-padvi' for gender, man- status/position and women-status/position respectively. But sex remains linga or phallus.

9. See Correa and Petchesky, 1994; Correa, 1994; Petchesky and Judd, 1998.

10. See Visaria and Chari (1998) for a detailed assessment of population policy in India.

11. For example, one male respondent, a physicist, in 1995, shared this in one of the interviews I conducted among men who adopted contraception. Regarding his personal choice of going in for vasectomy after three children by the mid '50s, he recounts a public meeting addressed by a nationalist leader. The speech on India's future and the importance of family planning motivated him and his friends with most of them going in for a vasectomy.

12. And I suspect, the 'unease' of having to insert the diaphragm correctly and accurately in the inner recesses of the vagina at a critical moment and time before sex, unlike say a condom, which relatively speaking, can be easily slipped on like a sock. This also needs to be viewed against the rigid social and cultural values among women about touching the innermost reaches of the vagina, a body part associated with 'pollution' of menstrual bleeding and birthing in India.

13. Both the policy statements of 1976 and 1977 were laid on the table of the house, but never discussed or adopted. See National Population Policy, 2000, page 31, Appendix II.

14. The themes are decentralized planning and programme implementation,

convergence of service delivery at village level, empowering women for improved health and nutrition, child health and survival, underserved population groups, diverse health care providers, collaboration with NGOs and private sector, mainstreaming Indian systems of medicine and homeopathy, contraceptive technology and research on RCH, providing for the older population, information, education and counselling. See HealthWatch, 2000a for an abridged version of the policy.

15. The material for national and state population policies is from the following sources: National Population Policy Document, MOHFW, GOI; HealthWatch Updates, 2000, 2 issues; Kulkarni, 2001; Rao, 2000; Sen and Iyer, 2001.

16. See Khanna, 2000. She concludes that the Gujarat policy statement is essentially a progressive one.

17. The information on state policies was culled from Rao (2000), Sen and Iyer (2001), Prakasamma, Dasgupta, Khanna, Ramachandran (HealthWatch Update, 2000).

18. NFHS-2 (1998-99) shows an IMR of 83 and 84 for SC and ST respectively. For caste Hindus it is 77, and 59, 49, 53 for Muslims, Christian and Sikhs respectively. The differentials are similar for under five mortality rates.

19. See Kulkarni (2001) for detailed tables.

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Why Gender Matters was a very interesting read. I would highly recommend this book to other teachers and parents. In fact, it would have been beneficial for me to read this book when I was finishing up my undergrad about to go into my career.Â Gender matters. You can ignore that reality if you like, but ignoring it doesn't make it go away. When girls and boys are given no guidance, the result often is girls who present themselves as sexual objects and boys who engage in reckless physical risk taking." GENDER MATTERS. Why it is difficult to get justice for rape victims. YEJIDE GBENGA-OGUNDARE Jun 17, 2020. GENDER MATTERS. Why it is difficult to predict success of gender equality. GENDER MATTERS.Â Though women have been internationally recognised as active agents of peace in conflicts, their roles as key players and change agents of peace have continued to be unacknowledged. But women have made landmark strides in sustaining peaceâ€¦ GENDER MATTERS. Women and peace in crisis situations. Gender Matters - A manual on addressing gender-based violence with young people - Council of Europe. 9. gender matters. For more information or to get involved in the â€œStop Domestic Violence.Â The aim of GENDER MATTERS is to provide information, perspectives and resources for deepening and widening this focus on gender and human rights. Why do we need a resource addressing gender and gender-based violence? At one level, the reason for working on gender and gender issues should be self-evident.